



## Public Health Committee Public Hearing

Friday, March 14, 2014

Connecticut Association of Health Plans

Testimony in Opposition to

### HB 5529 An Act Concerning The Definitions Of Medical Necessity

The Connecticut Association of Health Plans respectfully urges rejection of HB 5529 An Act Concerning the Definitions of Medical Necessity.

The bill before you proposes to remove from the statutory definition of "medical necessity" the provision requiring that such decisions be "based on credible scientific evidence published in peer-reviewed medical literature." *Removal of this language runs completely contrary to current health care reform efforts that strive to utilize best practices and clinically proven modalities and we would question why Connecticut would want to move in this direction.*

If passed, HB 5529 would require coverage for all types of investigational and experimental treatment without consideration as to whether such treatments have proved beneficial in the past, or for that matter harmful. It would also provide for unprecedented off-label drug use that could allow, for example, a lifetime of IV antibiotic treatment for Lyme disease – a procedure that's been incredibly controversial within the medical community itself. While cost would be an obvious concern with removal of this language from the definition, safety would be paramount.

Connecticut's definition of "medical necessity" is a *nationally recognized model that was borne out of the national class action lawsuit settlements that were agreed to between the large managed care organizations and a number of state and national medical societies.*

The current statute actually goes to great lengths in detailing "credible scientific evidence".

38a-591a(28) states: "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) or Elsevier Science for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the Secretary of the United States Department of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: (i) The American Hospital Formulary Service - Drug Information; (ii) Drug Facts and Comparisons; (iii) The American Dental Association's Accepted Dental Therapeutics; and (iv) The United States Pharmacopoeia - Drug Information;

(E) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: (i) The Agency for Healthcare Research and Quality; (ii) the National Institutes of Health; (iii) the National Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers for Medicare and Medicaid Services; (vi) the Food and Drug Administration; and (vii) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(F) Any other findings, studies or research conducted by or under the auspices of a source comparable to those listed in subparagraphs (E)(i) to (E)(v), inclusive, of this subdivision.

To the extent that the bill before you is aimed at mental health issues specifically (*though its application is much broader than that*) please consider that Public Act 13-3 just went into effect this past October and lays out specific standards for mental health and substance abuse requests. These measures should be provided the opportunity to work before layering on additional regulatory requirements. They include:

- Expedited review requirements. 24 hour turnaround for most coverage requests.
- Specified clinical review requirements; comparison responsibilities for any deviations.
- New requirements for denial notices.
- New ability for "peer to peer" discussions before the point of denial.
- Continuation of coverage requirements during appeal.
- New requirements regarding the use of clinical peers.
- New requirements by CID to analyze statistical abnormalities.
- New requirements on CID to conduct federal parity compliance checks.

- New mental health tool kit just released by CID. Carriers are posting to their websites.
- New requirements for DCF and DHMAS to provide consultation and care coordination for PCPs.

In instances where legitimate differences of opinion still arise as to what should be considered medically necessary, Connecticut has one final measure of patient protection in statute – an external appeal conducted by outside experts – which can be accessed via the Department of Insurance. Any decision rendered by external appeal is binding on both parties. Generally speaking the Department receives about 100 such requests each year (out of millions of claims approved and processed) and the final decisions rendered generally run 50/50 indicating is pretty fair and balanced process.

HB 5529, we would submit, will do more harm than good if passed and we urge its rejection. Thank you for your consideration.