Public Health Committee
JOINT FAVORABLE REPORT

Bill No.: SB-180
Title: AN ACT CONCERNING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.
Vote Date: 3/4/2024
Vote Action: Joint Favorable
PH Date: 2/26/2024
File No.: 18

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SPONSORS OF BILL:

The Public Health Committee

REASONS FOR BILL:

An adverse determination is a denial, reduction, or termination of coverage by a health maintenance organization (HMO) or a health review agent that a health care service is not medically necessary, nor appropriate, and coverage is denied. This bill increases the requirement to qualify as a "clinical peer" for insurance adverse determination reviews. It also requires that the person be licensed in the same specialty, rather than a similar specialty, as the professional under review. It also establishes a rebuttal presumption that a health care service is medically necessary if it was ordered by a health care professional acting within their scope of practice. For utilization reviews, it imposes that a carrier has the burden of proof to establish that the health care service is not medically necessary. For adverse reviews, a carrier may reasonably substantiate that the service is not medically necessary. It also requires that health carriers authorize clinical peers to reverse initial adverse determinations that were found to be medically necessity.

RESPONSE FROM ADMINISTRATION/AGENCY:

Martin Looney, Senator (11th District), Connecticut General Assembly (CGA):
This legislation will create a presumption that treatment ordered by a physician is medically necessary, as well as allow physicians to practice medicine and limit the ability of health insurers to interfere. The bill will bring appeals of adverse determinations in line with most areas of law regarding burden of proof. The insurer is the only party with the knowledge as to why a claim was denied. In the appeal of an adverse determination, neither the patient nor the provider knew why the carrier declined the service. Under the current framework the burden of proof is on the patient and provider. This legislation will require that clinical peers

used in adverse determination reviews are to be certified specialists in the same subspeciality. It would also allow the clinical peer to have the authority to overturn the adverse determination.

NATURE AND SOURCES OF SUPPORT:

Connecticut Hospital Association (CHA):
Most Connecticut residents receive their health insurance benefits through commercial coverage and nearly all private healthcare plan arrangements rely on utilization management. The most widely used form of utilization management is prior authorization which is now being used by many plans to restrict access. Additionally, plans are also continuously changing the rules that govern prior authorization, often in the middle of provider-insurer contract periods. This legislation helps to ensure that appropriate patient care is not delayed by the overzealous use of utilization management processes.

Connecticut State Medical Society (CSMS):
Prior authorization typically involves physicians completing extensive paperwork, submitting clinical documentation, and engaging in phone calls or online submissions to justify the requested treatment or medication. Patients may experience prolonged wait times which can exacerbate health conditions. In some cases, patients may even forgo the recommended treatments all together. The concern with the current peer-peer review is that an insurer assigns a peer who specializes in a different medical specialty. This practice leads to concern about the reviewer's understanding of the specific clinical considerations involved in the requested treatment or procedure.

Dante Brittis, President, Connecticut Orthopedic Society:
In his testimony, Dr. Brittis shares a personal story. A commercially insured orthopedic patient needed surgery. The initial prior authorization was submitted in January 2022 and denied on the basis that "clinical studies have not proven that these procedures are effective for treatment of the member's condition". The denial was appealed, and the surgeon requested a peer-peer review of the denial. The peer was a family physician that denied the surgeon's appeal on behalf of the patient. Several months later, the patient was notified that the denial decision was reversed based on an independent company review and the surgery approved. Several months of waiting and a huge amount of effort on the staff to appeal two denials on the patient is inefficient and puts a huge burden on the physician and their practice.

NATURE AND SOURCES OF OPPOSITION:

Susan Halpin, Executive Director, CT Association of Health Plans:
Medical records are in the possession of providers and members and thus, carriers have no ability to rebut the presumption that a particular procedure, treatment or drug is medically necessary. Less than 15% of treatments are subject to prior authorization. 13% of the state's population who purchase insurance are under fully insured health plans which are subject to state regulation. Consumers in this market are the most price sensitive and the least able to afford the associated premium increases. Passing this legislation will encourage more people to go self-insured to avoid the onerous nature of additional state requirements. Removing the term “similar” from the requirement “same [or similar] specialty” regarding the definition of clinical peer, will result in significant consequences, and will largely result in an end to the

prior authorization process at least under fully insured plans. Finding a doctor in the exact same specialty for every review within the tight time frames required by statute is nearly impossible. In addition, the Biden Administration just released their final rule on prior authorization within the last couple of weeks that addresses many of the concerns raised around utilization review. These new rulings should be given time to work before imposing another layer of regulation.

Sarah Lynn Geiger, Regional Director, America's Health Insurance Plans:
It is not always clinically necessary to have a physician of the same specialty available to conduct every prior authorization review request. This flexibility is important for timely responses so as not to disrupt patient care, especially due to the small number of specialty providers available in certain fields. If a health plan requires prior authorization to assess a cancer patient's response to radiation therapy, a medical oncologist, pediatric oncologist, surgical oncologist, and a radiologist would be able to provide an appropriate clinical assessment. If this bill is passed, then only a radiologist oncologist would be allowed for the review. A n America's Health Insurance Plans survey of insurance providers shows that up to 30% of prior authorization requests reviewed by clinicians are for unnecessary care that is not supported by medical evidence. In addition, America's Health Insurance Plans project with John Hopkins University School of Medicine found that 10% of physicians proceeded with care inconsistent with evidence-based standards of care.

Sam Hallemeier, Senior Director of State Affairs, Pharmaceutical Care Management Association (PCMA):
PCMA is a national organization representing America's pharmacy benefit managers (PBM's). PCMA is concerned that this bill will remove tools used by PBMs, such as prior authorization and step therapy, which are used to ensure safe, appropriate, and cost-effective drugs. Removal of prior authorization and step therapy would increase projected drug costs by an estimated 4.6% over the next 10 years. In addition, some drugs have a high risk of abuse or overuse. Prior authorization is required to help ensure appropriate use. Specialty medications often have significant side effects and require patient education to be taken effectively, so they also often require prior authorization. In addition, many drugs that commonly appear on prior authorization lists are those that are heavily advertised directly to consumers or have off-label uses not approved by the Food and Drug Administration. The use of prior authorization and step therapy guided by pharmacy and therapeutics committees comprised of physicians, pharmacists, and other medical professionals can generate savings of up to 50% for targeted drugs or drug categories, and the use of step therapy has demonstrated savings of more than 10% in targeted categories for PBM clients.

Reported by: Piotr Kolakowski **Date: 3/7/2024**