Testimony in Support of Senate Bill 209 An Act Reducing The Time Frame For Urgent Care Adverse Determination Review Requests and Senate Bill 211 An Act Concerning The Burden Of Proof During Adverse Determination and Utilization Review Requests
Insurance and Real Estate Committee
March 1, 2018

Senators Kelly and Larson, Representative Scanlon and members of the Insurance and Real Estate Committee, on behalf of the physicians and physician-in-training members of Connecticut State Medical Society (CSMS) and the organizations listed above, thank you for the opportunity to testify in support of **Senate Bill 209 An Act Reducing The Time Frame For Urgent Care Adverse Determination Review Requests and Senate Bill 211 An Act Concerning The Burden Of Proof During Adverse Determination and Utilization Review Requests**.

Senate Bill 209 is a concept to which we have testified in previous sessions. The language proposes to decrease from seventy-two to forty-eight hours the utilization review period for urgent care reviews, expedited review requests and expedited external review requests when requested services are denied. Currently three days are afforded to make these critical determinations.

Any prudent individual would consider waiting three days for a decision in an urgent situation far too long, regardless of the diagnosis, the condition being treated, or the medical treatment prescribed. Add to this period another seventy-two hours during the pendency of an expedited review, plus another seventy-two hours should an expedited external appeal be necessary, and a patient could have to wait up to nine days to receive a coverage decision for medically necessary care. This is not acceptable.

Senate Bill 211 rightfully amends Utilization Review Statutes to place a rebuttable presumption that each health care service under review is medically necessary. It places the burden of proving otherwise on the insurer prior to denying coverage for a service.

As mentioned in other testimonies over the years, our organizations have been consistent in our message for well over 20 years now that no one is more qualified to determine appropriate and necessary treatment than the patient-physician team. We fully believe that if a treating physician deems a service medically necessary it should be incumbent upon the insurer, not the physician to prove otherwise. Passing such legislation has become more critical with recent reports of professionals providing utilization review that have failed to provide comprehensive review of records.

An adverse determination in the context of health care services generally refers to the determination made by a health care plan or by a utilization review program that a health care service is not medically necessary for the patient's care. However, what is often missing in reporting these determinations or rather decisions tied to the medical necessity of care, is the documentation used or identified by the insurer or utilization review company in denying the service. This hampers the understanding and effectiveness of any appeal by the patient and provider.

CSMS believes that any adverse determination must be noticed to the patient and provider of medical care services in a written or electronic notice form and should include at least the following: explanation of benefits; reason for denial with as much specificity as possible, including the peer reviewed medical literature that suggests or indicates that the proposed or provided medical service is deemed or determined to be not medically necessary. The adverse determination notice must contain a description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the member's right to bring a civil action following an adverse benefit determination. When notice of an adverse benefit determination is given, the member must be informed of his or her right to receive upon request and free of charge: internal rules, guidelines, protocols, medical literature, or other similar criteria relied upon in making the determination. In cases involving medical necessity or experimental treatment, health plans must provide free of charge an explanation of the scientific or clinical judgment for the determination, not just the literature relied upon. We strongly believe it must be incumbent upon the health plan or the utilization review company to bear the burden of proof that a service is not medically necessary. Such proof undoubtedly requires documentation and rationale when a service is denied for lack of medical necessity.

Critical to the proposed legislation is what constitutes an adverse benefit determination. CSMS believes that all the following circumstances constitute an adverse benefit determination:

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
(2) The reduction, suspension, or termination of a previously authorized service.
(3) The denial, in whole or in part, of payment for a service.
(4) The failure to provide services in a timely manner, as defined by statute.
(5) The failure of an insurer to act within the established timeframes regarding the standard resolution of grievances and appeals.
(6) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

We urge the Committee members to support SB 209 and 211.