



Special Meeting of the All-Payer Claims Database Policy & Procedure Enhancement Subcommittee

NOTICE OF MEETING AND AGENDA

Date: Thursday, July 17, 2014
Time: 11:00 a.m. to 1:00 p.m.
Location: Legislative Office Building, Room 1D
300 Capitol Avenue
Hartford, CT 06103
Conference: 1-877-716-3135
Participant Code: 23333608
Directions: <http://www.cga.ct.gov/asp/menu/DrivingDirections.asp#LOB>

- I. Call to Order and Introductions
- II. Public Comment
- III. Review and Approval of Minutes for May 8, 2014 Meeting
- IV. Process for Amending APCD Policies and Procedures
- V. Development Planning for APCD
- VI. Dental Commentary Review and State Comparison
- VII. Denied Claims Discussion
- VIII. Next Steps
- IX. Future Meetings
- X. Adjournment

Public comment of the agenda is limited to two minutes per person and is not to exceed the first 15 minutes of each meeting. A sign-in sheet will be provided.

Access Health CT is pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Christen Orticari at (860) 241-8444.

Meeting materials will become available at: www.ct.gov/hix following each meeting.

For further information concerning this meeting, please contact Christen Orticari at (860) 241-8444 or Christen.Orticari@ct.gov.



**Special Meeting of the All Payer Claims Database Policy and Procedure Enhancement
Subcommittee
Draft - Meeting Minutes**

Date: Thursday, May 8th, 2014
Time: 9:10 a.m. – 11:00 a.m. EST
Location: Legislative Office Building, Room 1D

Members Present

Matthew Katz, Mary Taylor, Olga Armah, Jean Rexford (phone), Demian Fontanella, Brenda Shipley

Members Absent

None.

Other Participants

AHA: Tamim Ahmed, Robert Blundo, Christen Orticari, Matthew Salner

Additional Attendees: Mary Boudreau, Matthew Giaquinto, Carol Dingeldey, Jonathon Knapp, Bruce Silverman, Vincent Doll

I. Call to Order and Introductions

Matthew Katz called the meeting to order at 9:10 am. Mr. Katz provided a brief overview and members introduced themselves. Mr. Katz requested that participation through the phone line be kept to solely members.

II. Public Comment

Vincent Doll introduced himself and provided a public commentary on behalf of United Healthcare (UHC). Mr. Doll summarized the letter from UHC, which iterated their perspective on the addition of the dental data APCD submission requirement with regard to the administrative burdens it would impose on clinical delivery in reporting. Mr. Doll opined that the added burden far outweighed the incremental benefit of adding this small class of data in the APCD dataset for the assessment of cost and appropriateness of care. Mr. Doll noted aspects of dental data captured under the medical policy to highlight that dental data was already included to an extent. Mr. Doll requested that the APCD not

require fields such as diagnosis codes and modifiers if the state decided to move forward with the inclusion of dental data.

III. Review and Approval of Minutes for February 21, 2014 Meeting

Olga Armah requested the spelling of her last name be corrected. **Demian Fontanella motioned to make one administrative change to incorporate the correct spelling of Ms. Armah's last name into the draft minutes. Mary Taylor seconded. The motion was passed unanimously without abstention.**

IV. Overview of Claims Adjustment Reason Codes and Remittance Advice Codes

Robert Blundo reviewed the coding standards for denied claims by providing a brief description of claims adjustment reason codes, remittance advice codes, their use in the industry, and the benefits and challenges associated with their usage. Mr. Blundo summarized future plans in the industry to mandate and standardize the use of claims adjustment reason codes and remittance advice codes. Mr. Blundo commented that the reason codes were received by providers as information that justified the denial of a claim. Ms. Taylor clarified that carriers had different claims processing systems that were linked to the CARCs and RARCs. Ms. Taylor informed members about carriers' ongoing efforts to standardize CACGs, CARCs and RARCs.

Mr. Blundo presented the AMA National Report Card in slide six, which presented an overview of overall denial rates. Mr. Katz commented that the report was derived from a self-reported, random sampling of provider ERA data. Mr. Blundo demonstrated that the graph showed the rate and reasons for denial varied from insurer to insurer, and year to year. Mr. Blundo presented the variation and frequency of CARC and RARC codes across different carriers. Mr. Katz commented that the information on frequently used denial adjustment and reason codes usages could be helpful for subcommittee consideration of which components of denial code information would be most useful to capture. Mr. Blundo further broke down the information on frequently used CARCs and RARCs to display total percentages and average across payers. Mr. Blundo reviewed claim denial rates across states and commented that the main challenges in the submission and translation of CARCs and RARCs was due to the variance in proprietary mapping among carriers as it would likely yield challenges in cross payer analysis. Mr. Blundo and Mr. Katz explained ongoing initiatives to resolve these difficulties through the implementation of industry mandates such as CAQH CORE operating rules to be used on increasingly more types of transactions through the progression of time. Members discussed the need for stakeholders to assume a uniform coding approach while keeping in mind that changes may affect the scrubbing of data.

V. Review of Denied Claims Data Use Cases

Mr. Katz presented reasons for the collection of denied claims. Mr. Katz included a table with data pulled from all physicians who were identified as having denials among the top insurers in various states

listed, and provided information on the frequency of claim denials provided without reason for several CPT / HCPCS codes across a 13-month timespan. Mr. Katz commented that members were often not informed of the reason for the denial of their claims unless they were aware of their coverage and how the denial related to their benefits. Mr. Katz explained that imaging services and flu vaccines were prime examples since the service administration was often denied without patient information. Ms. Taylor commented that carriers may have had multiple codes for a claim wherein some codes may be denied and others accepted, which then could create barriers preventing accurate translation among other external parties, such as researchers, providers, and carriers, who might seek to understand exactly which service was denied, to what degree, and why it was denied. Mr. Katz observed from his research that claims often had ambiguous information on their denials since certain service lines or facets of the procedure coded varied by carrier and tended not to be communicated to patients or providers in full. Mr. Katz suggested that this ambiguity of information served to highlight a learning opportunity for those in the industry to troubleshoot and resolve areas of widespread uncertainty by searching for and identifying a way to communicate complex service information when recording payments. Mr. Katz continued to review the variation in claim denials across states for common procedures.

Mr. Katz provided two CPT code-specific and two general narrative use cases to afford members an understanding of benefits that could be derived through analyzing and synthesizing denied claims information. Mr. Katz explained the first use case, which portrayed the variation of denial rate across payers for a common health care service allocated a certain CPT code, and explained that the graph, on slide 16, showed service count volume and percentage of service denial varied across payers. Mr. Katz indicated that the second use case provided variance in denial per payer across states, and noted that denials in Connecticut were lower than in other states in this instance. Mr. Katz explained that use of denied claims to provide this information may be useful for patients making decisions about their health plan. Ms. Taylor commented that the use cases presented seemed to focus on the carrier, did not take into account all other involved parties, and did not account for the clinical criteria used by carriers determine eligibility and coverage. Mr. Fontanella suggested that the APCD report on services that may be denied more often with one provider versus another provider. Mr. Katz explained that the use cases served as a starting point and did not take into account all aspects of information that made up a comprehensive understanding of why a claim was denied. Mr. Katz asked for clarification regarding whether we may be able to include carrier names with the data since some states were allowed to disclose their names, while others were did not have this permission due to state restrictions. Matthew Salner commented that the issue would be clarified. Ms. Taylor opined that for the Connecticut APCD to not be contentious, it was important for all parties involved to be treated fairly and to take time to understand roles, responsibilities and challenges within this collaborative process. Mr. Katz commented that the Connecticut APCD was far from making a decision on the denied claims issue. Ms. Shipley reminded members that a large percentage of the population in Connecticut was covered by self-insured employers whose benefit plan designs were not subject to the state mandates, and commented that they may be structured by the employer to yield a higher rate of claims denials. Ms. Shipley explained that in this situation the carrier was simply a third party administrator for those plans so even if the employee had their coverage through a given carrier, it would be the employer who would more directly have an effect on the structure of the benefit plan component.

Mr. Katz presented the remainder of the use cases for denied claims to highlight the variation in denial rates across states and across carriers. Mr. Katz opined that information to be garnered through the analysis of denied claims denied could provide consumers more specific benefit design information, and afford them the opportunity to make more informed decisions. Mr. Katz recommended next steps be taken to garner information on how the denial of claims correlated with CARCs and RARCs from the carrier perspective in an effort to better understand the barriers concerns and opportunities. Mr. Katz asked that members start to deliberate approaches for the collection of CARC and RARC data, and then take next steps to toward developing a timeline for denied claims intake. Ms. Taylor requested that the subcommittee consider appropriate use cases from the research and consumer stakeholders to better understand how denied claims information would be productive for making informed health care decisions. Mr. Katz commented that the vendor would be able to provide insight to the logistics of their incorporation upon contracting phase completion. Members collectively agreed on the need to take preparatory measures for the fair and accurate collection, and reporting of denied claims data.

VI. Discussion of Dental Data Collection and Stakeholder Engagement

Mr. Blundo introduced the topic of dental data collection, briefly discussed ongoing measures to prepare for dental claims collection, and asked that members be cognizant that the Data Submission Guide (DSG) required revisions to enable the dental data submission and intake process. Mr. Blundo informed members that stakeholders from the dental industry had been invited to speak as a panel to support the identification and development of next steps, such as revisions to the DSG, and to also address barriers, challenges, and opportunities for the collection and synthesis of dental claim components into the database. Mr. Blundo stated the importance of gathering viewpoints on opportunities and challenges from those in the industry. Mr. Katz introduced guest speakers from dental industry. Mary Beaudreau from the CT Oral Health Advocacy Initiative provided an overview of the report she developed based on the challenges and opportunities expressed by organizations who partnered with the advocacy group. Ms. Beaudreau explained parts of the ADA dental claim form such as types of transactions, company plan, and those typically not filled out, or filled out in an inconsistent way. Ms. Beaudreau explained that the field requesting the treating dentist for a given location was often not included by the dentist when completing the form, or was left out as a form field altogether. Ms. Beaudreau informed members that carriers tended not to submit treatment per tooth and often submitted by region differently. Mr. Silverman explained the disparity of data quality, availability and usage in the dental marketplace versus medical. Mr. Silverman informed members that the estimated average monthly volume of dental claims was approximately 78,200 with an average payout of 14.3 million dollars, and then commented that of those numbers 6,200 claims were from insured consumers with a payout of about 1.1 million dollars with the remainder applied to self-insured consumers. Mr. Silverman stated that Delta Dental of New Jersey (DDNJ) received 3.06 million claims with approximately 69 percent received electronically and the rest in paper form in 2013 for the purpose of highlighting that that just fewer than one million claims were received on paper and required time-consuming manual entry into their systems. Mr. Doll commented that the benefits of reporting dental data per all DSG-required fields may be incremental and seemed to be far outweighed by the administrative burden of reporting. The guest speakers from the dental industry echoed these concerns, and agreed that since

the dental nomenclature and coding was distinct from medical, there were several data elements and attributes that were not retained by or were unavailable to dental payers for APCD submissions.

Jonathon Knapp commented that dental benefits in terms of minimums and maximums were vastly different, and this information would need to be taken into account when planning for dental data intake. Ms. Dingeldey opined that inconsistencies in documentation originated at the provider-level and manifested in ways such as differences in the recording of benefits and recording of contractual obligation information. Ms. Dingeldey explained that in future APCD submissions, these inconsistencies would prevent valid tracking and analysis of practice patterns. Mr. Doll commented that because many PPO or POS dental plans had a limited number of dentists in-network, many out of network dentists were selected, which would further limit the successful completion of fields required by the DSG for submission to the APCD. Mr. Katz suggested that the AHA staff review and provide an update on ongoing dental claims collection practices across other states. Ms. Taylor asked that members and AHA staff be mindful of the critical importance of setting reasonable thresholds and accommodating waivers for threshold variance requests since not all thresholds would be able to be met. Mr. Katz thanked the representatives for their attendance and insight.

Mr. Salner summarized the implications of the policies and procedures for APCD collection of dental data. Mr. Salner clarified that the APCD Administrator shall establish a schedule similar to medical for submitting dental data for formal incorporation into the DSG. Mr. Salner further explained process to modify the policies and procedures.

VII. Next Steps

Members deliberated holding a June meeting to receive feedback from reporting entities on the use cases for denied claims, and potentially also from the academic perspective. Mr. Katz reminded the subcommittee the next APCD Advisory Group meeting would be held from 9:00 a.m. to 11:00 a.m. on June 12, 2014.

VIII. Future Meetings

The next meeting would be held in June on a date to be decided by members following meeting adjournment.

IX. Adjournment

Mr. Katz motioned to adjourn the meeting. The motion was seconded and passed unanimously. The meeting was adjourned at 11:00 a.m.



Connecticut's Health Insurance Marketplace

All-Payer Claims Database Policy & Procedures Enhancements Subcommittee Meeting

July 17, 2014

Agenda

- i. Call to Order and Introductions
- ii. Public Comment
- iii. Review and Approval of Minutes for May 8, 2014 Meeting
- iv. Process for Amending APCD Policies and Procedures
- v. Development Planning for APCD
- vi. Dental Commentary Review and State Comparison
- vii. Denied Claims Discussion
- viii. Next Steps
- ix. Future Meetings
- x. Adjournment

Public Comment

Approval of Meeting Minutes

Process for Amending APCD Policies and Procedures

Process for Amending APCD Policies and Procedures

- AHCT staff presents draft Policies and Procedures amendments to Policies and Procedures Subcommittee
- Subcommittee approves draft, sends to APCD Advisory Group
- APCD Advisory Group approves draft, sends to AHCT Board
- AHCT staff presents draft to AHCT Board
- AHCT Board approves draft to be posted for 30 day public comment period
- Stakeholders and public submit comments to AHCT
- AHCT staff reports on public comments to AHCT Board and APCD Advisory Group
- AHCT Board votes to adopt Policies and Procedures
- Policies and Procedures become effective upon Board passage

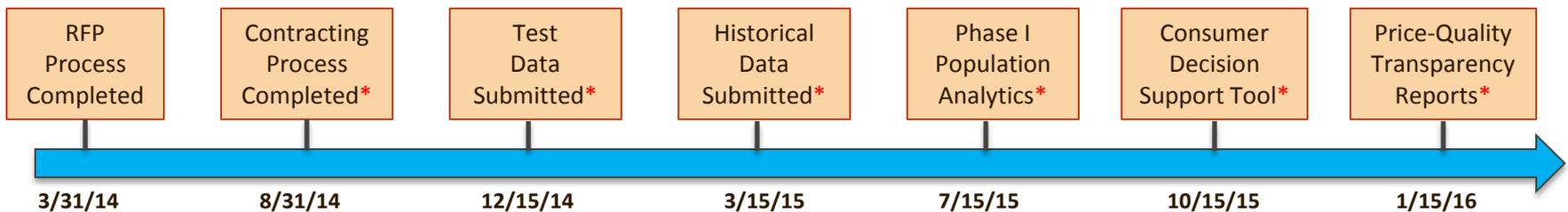
Process for Amending APCD Data Submission Guide

- AHCT staff presents draft Data Submission Guide amendments to Policies and Procedures Subcommittee
- Subcommittee reviews, amends and recommends policy enhancement(s) to APCD Advisory Group
- APCD Advisory Group makes decision based on recommendations from the subcommittee
- AHCT staff posts draft on website for 30-day public comment period
- Stakeholders and public submit comments to AHCT
- AHCT staff reports on public comments to APCD Advisory Group
- AHCT staff posts final DSG amendments to website
- Amended DSG becomes effective 90 days after final version posted on website

Development Planning for APCD

Development Planning for APCD - Timeline

- RFP process for vendor selection for developing & managing APCD completed March 31, 2014
- Vendor negotiation in progress and expected to be completed by August, 2014
- Data in-take infrastructure will need to be created by the data submitters to link with the APCD vendor for automated submissions and retrievals via secured web-based transmissions, Sept. – Nov., 2014
- Test data is expected to be submitted in December, 2014
- Pending data quality validation tests, historical data is expected to be submitted in March, 2015
- Phase I reporting – population analytics – is expected to be available in July, 2015
- Consumer Decision Support Tool, i.e., enabling Exchange enrollees to choose the right plan, is targeted to be released in October of 2015
- Price/Quality transparency tools is expected to be launched in Jan 2016



Note: '*' expected; timeline will slip if contract is not finalized by 8/31/2014

Development Planning for APCD - Core Components

Objectives

The following capabilities and components have been deemed absolutely necessary for a well functioning APCD. Some of these elements in the scope are explicitly included in the Policy & Procedure document. Other elements are needed to complement the primary scope.

- ✓ Collection of medical & pharmacy claims data from various carriers, including ASO data
- ✓ Collection of Medicare data
- ✓ Collection of Medicaid data
- ✓ Developing data validation process for collected data
- ✓ Developing and optimizing various infrastructures – ETL, Production and Managed Hosted environments
- ✓ Ensuring application of risk and clinical groupers from 3M, CMS and others TBD
- ✓ Development of a Master Provider Index
- ✓ Development of a Master Patient Index
- ✓ Development of a web tool for exhibiting reports from APCD data
- ✓ Development of price and quality transparency reports
- ✓ Development of various population & epidemiological reports
- ✓ Collection of dental data

Dental Commentary Review and State Comparison

- **Evaluation of Current State Practices:**
 - Reviewed 8 APCD states:
 - How many dental components are requested?
 - What field level thresholds are prescribed?
 - Which requested fields are unique to CT?
 - How many states collect dental?:
 - 50% (4/8) Collect Dental Data w/ Public DSG
 - 50% (6/12) Collect Dental Data including All APCDs

| | Average Fields Requested | % w/ Public Threshold | % Overlap |
|------------------|--------------------------|-----------------------|-----------|
| CT | 70 | | |
| States w/ Dental | 70.75 (50 – 113) | 1 | 97.1% |

DSG Dental Threshold % Comparison

| Field Name | CT Threshold % | Comparison Threshold % 1 | Comparison Threshold % 2 | % Difference | |
|--------------------------------|----------------|--------------------------|--------------------------|--------------|-------|
| Insurance Type Code / Product | 100% | 98% | 95% | -2% | -5% |
| SSN | 75% | 70% | 99.9% | -5% | -.01% |
| Plan Specific Contract Number | 98% | 70% | | -28% | N/A |
| Member State | 100% | 99% | 99.9% | -1% | -.01% |
| Member ZIP Code | 100% | 99% | 97% | -1% | -3% |
| Date of Service - From | 99% | 99% | 95% | 0% | -4% |
| National Provider ID - Service | 99% | 98% | | -1% | |
| Paid Date | 100% | 98% | | -2% | |
| Diagnosis Code | 75% | 1% | | -74% | |
| CDT Code | 99% | 99% | 95% | 0% | -4% |

Dental Components Frequently Submitted By Providers:

- Type of Transaction
- Company Plan name
- Name of policy holder, Address, Date of Birth, Gender, ID#, Plan/Group Number, Patient's Relationship to Patient, Employer Name
- Patient Relationship to Policyholder, Patient name and address, Date of birth and gender
- Procedure date, procedure code, qty., description, fee
- Authorization signatures
- Billing Dentist or Dental Entity

Dental Components Inconsistently Submitted By Providers:

- Treating Dentist and location
- Missing teeth information
- Fields 25 – 28 of the ADA Dental Claim Form
- Diagnosis Codes
- Procedure Modifiers

Dental Data Process Challenges:

- In general, only services within payer liability will be submitted to a payer. In 2008, the reported median annual maximum was \$1,500¹.
- Varying methods for submitted fee charges across dental providers. (e.g. UCR vs. contracted rate)
- Unlike medical, ICD coding for dental billing is not required for reimbursement.
- Certain providers (FQHCs, capitated, etc.) may not submit all services performed.
- Non-standard demographic variables (race, ethnicity, language, etc.) are not required during enrollment nor claim submission.
- NPI requirements vary based on transaction type under HIPAA.
- Not all eligibility DSG components will be applicable to dental plans

1. GAO DENTAL SERVICES Information on Coverage, Payments, and Fee Variation: <http://www.gao.gov/assets/660/657454.pdf>

Denied Claims Discussion

Next Steps

TO: Access Health Analytics

FROM: Keith Stover & Susan Halpin, Connecticut Association of Health Plans

DATE: June 24, 2014

RE: Industry Statement on the Collection of Fully Denied Claims by the APCD

The Connecticut Association of Health Plans has been pleased to participate in the development of the Connecticut All-Payer Claims Database (APCD). The industry strongly believes in the mission of the APCD as articulated in the initial policy and procedures document and looks forward to partnering with all stakeholders in its successful implementation.

The payer community firmly believes that all efforts at present should be focused on achieving the initial goals as currently outlined for the database. Any consideration of changes in functionality should be postponed until well after the APCD is operational. The task at hand is monumental and will require significant resources by both the state and its health insurance carriers for successful implementation and the Association respectfully suggests that Access Health move forward with the current objectives before diverting precious financial and personnel resources to the collection of fully denied claims which is challenging at best and fraught with problems at worst. It is in that vein, that we offer the following comments.

CT has more urgent priorities than an analysis of denied claims. Like other state APCDs, CT should be focused on information that helps consumers, especially price transparency and quality of care provided.

It is preferable to start with the basics when setting up an APCD. Similar to the approach the exchange took with developing its web portal, it is best to focus on what is known to work. Once the APCD is up and running, the Advisory group and its subcommittees should set priorities for the next three years and determine what additional data elements, if any, are needed to support those priorities.

CT APCD Policy and Procedure Subcommittee - Collection of Fully Denied Claims Information

General comments on collection of denied claims

APCDs generally do not collect fully denied claims from carriers. There are many challenges associated with collection and use of fully denied claims including:

- Fully denied claims may ultimately be paid at a later date, so using fully denied claims in analysis can lead to an inaccurate reflection of paid v. unpaid claims.
- Fully denied claims for reasons other than administrative (duplicate claims, member not eligible, etc.) are a very small percentage of all claims and are not needed for most analytical purposes. Fully denied claim rates for commercial carriers nationally range from .54% to 2.64% (AMA National Health Insurer Survey)
 - Administrative denials account for the vast majority of denied claims examples of which follow:
 - Benefit for services is based on the difference between Medicare's allowable expense and the amount Medicare approved.
 - Records show the claim has already been processed.
 - Non-covered amount is the Medicare Part B deductible plus the dollar amount that is over Medicare's allowance.
 - No dollar amount was billed, therefore, no allowance is made.
 - Amount charged represents the amount indicated on the Explanation of Benefits
 - According to member's plan, only expenses covered by Medicare part B are covered.
 - Medicare did not approve service or indicated member not responsible for the expense.
 - Coding issue.
 - Not an eligible enrollee.
 - Claim is past billing period.
 - Not a covered benefit.
 - Re-route to proper payer.
 - Additional documentation needed.
 - Required pre-certification not obtained.
 - Pharmacy data, alone, could present numerous difficulties. Please consider that:
 - For pharmacy claims, there is a high incidence of administrative denials. As claims are adjudicated in real-time, pharmacies sometimes submit a claim 2 to 3 times.. A pharmacy claim could reject for a variety of reasons before being accepted: no refills available leading to a physician call, or refill too soon which leading to a member call.

As these examples aptly demonstrate, denied data does not paint a single picture. It is interpretative based upon plan design and product. Furthermore, payers map their individual health plan denial codes to industry- standard codes and use differing IT systems which create variability in the reasons for denial and may impact any analysis.

While some may argue that claim denial data may help inform consumers, the Association is concerned that the exact opposite may occur leading to consumer confusion and misunderstanding. Please note that:

- Denied claim lines may in fact be paid claims. A carrier may be paying for a service in another way that would not be reflected in the denial rate. For example, a provider may bill for several separate services using a CPT code for each. However, there may be a CPT code that is used for that combined set of services. In this case, the carrier may pay for the services under the combined services CPT code and deny the single service CPT codes. It will look like there are volumes of denials for a service but in fact the service is paid – it is just improper billing by the provider.
- Self-funded plan sponsors develop unique plans of benefits for their employees. Connecticut has a large volume of self-funded business including Medicaid and the state employees, and self-funded plan sponsors may have unique plan designs that do not cover certain services. Consumers basing purchasing decisions on published denial rates may not understand the possible impact unique plan designs may have on the denial rates. Also, consumers covered under self-funded plans may not understand that their plan may have unique benefits and the general denial rates may not apply.
- Claim data isn't current or real time. All claim data necessarily lags dates of service. By the time claim data is available for analysis it will be a minimum of six months past the process date and a month or more additional past the date of service. Carrier payment policies may change in the interim, medical norms may change, technology and science may change, and the information the consumer uses will be stale.
- Claim decisions are often unique to a member. Denied claims, especially for experimental and investigational or the “services/procedures that are difficult to receive” are usually very specific to the particular member’s medical situation. One can’t conclude that because a carrier has denied coverage for a certain service for 40 people the carrier will also deny coverage for someone else. Information on denied claims could cause a consumer to reach an inaccurate conclusion – essentially pointing a consumer in the wrong direction.
- Denial rates cannot be applied to a particular member’s situation. Denials of coverage for routine or preventive care, including mandated benefits, ACA required coverage, etc., would also be unique to a patient. Data on denied claims for a service could be misinterpreted by consumers who would not know the reasons why a claim for these services would be denied. It is important that the consumer talk with the carrier and read the plan material and base their purchasing decision on the facts for that carrier.
- Denials of claims may be appropriate and explainable. Variations among carriers’ denial rates for certain procedures could have many explanations. While it may be a matter of interest for stakeholders, any variability may have a reasonable basis and may not warrant concern. Consumers would have to have an in-depth of knowledge about the coverage criteria for each carrier, and about the patient panel and plan designs for each plan a carrier offers in order to draw any conclusions about the denial rates. It is very unlikely that a consumer would have this specialized knowledge. The variations in carrier denial rates would not provide a consumer usable information, and in fact could harm the consumer by presenting information that could lead to inaccurate conclusions.

- Low denial rates do not guarantee coverage for a particular member. Publication of denial rates for procedures/services by carriers will not guarantee coverage for a particular consumer. It may give the consumer false confidence that a service will be paid and cause harm to the consumer because they relied on a general set of statistics about denial rates.
- The most accurate information on what is covered comes from the carrier. The best information on what services/procedures is available on carrier websites, where coverage policy bulletins are posted. These bulletins include detailed information the carriers' rationale for coverage decisions, and lay out the criteria by which the service is covered under the policy. Consumers can also call customer service for assistance.

Perhaps most importantly, the Affordable Care Act is encouraging payment transformation in favor of quality over quantity. As such, the move to ACOS, PCMH and other like arrangements is changing how providers are reimbursed. Information about services rendered may be submitted via an encounter form, but payment may be made in a lump sum for a group of services – individual claim line denials will not exist for providers in these arrangements. This may skew the published statistics about denial rates which will only reflect payments made under fee for service arrangements.

Stringent carrier/payer regulatory oversight is appropriately within the jurisdiction of industry regulators and should not be a function of the APCD even if only “implied”. Please note that:

- The CT Department of Insurance (DOI) already reviews carrier denied claims to assure carriers are complying with CT law. The data submitted for the Consumer Report Card is also used by the Department to review utilization review denials.
- Information about carrier denials is already available to consumers and interested parties. The Department of Insurance publishes an annual Consumer Report Card that includes information on utilization review and claim denials, including:
 - Aggregate utilization review denial information
 - Extensive information on Behavioral Health, Chemical Dependency and Alcohol and other Drug Services utilization review decisions is included .
 - Claim denial information by high level category (not a covered benefit, not medically necessary, etc.)
 - Report card also includes information about mandated benefit laws, and provides useful context for the information presented.
- Carriers' compliance with CT law is routinely examined. The CT DOI conducts frequent examinations of carrier compliance with CT laws and regulations. Findings of non-compliance must be addressed by the carrier and carriers often must pay fines related to non-compliance.
- CMS will audit QHP plans for compliance with ACA requirements, including coverage of EHBs.
- Consumers can request assistance for denials. In addition to the appeal process required by state and federal law, consumers have the right to ask the CT DOI for assistance in resolving complaints including situations where a consumer disagrees with a carrier's denial of coverage. The Department publishes an Annual Ranking Report each year on justified complaints against

carriers in CT. Likewise, CT has an Office of Health Care Advocate who is charged with assisting consumers with any carrier challenges.

- Providers file appeals of denied claims. Providers do appeal denials of coverage and recourse to address specific denials.
- Providers are knowledgeable about denied claims. Providers receive notices of denial and are familiar with carrier requirements for payment. Also, as shown in the presentation to the subcommittee, there are other entities that aggregate types of denial information and publish analyses of that data.

Given these concerns and the financial implications of collecting administrative denial information, such as the need for excess storage capacity and new data analytic capabilities, without any associated return on investment, the Association respectfully urges the Committee to resist the temptations of taking on too much too soon and instead recommends that all stakeholders focus on the priorities as initially outlined.

Thank you for your consideration.