



**Testimony of Victoria Veltri  
Acting Healthcare Advocate & General Counsel**

**Before the Insurance and Real Estate Committee  
In support of SB 12, SB 15, SB 17, SB 18 and SB 21  
February 3, 2011**

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Coutu, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, Acting Healthcare Advocate and General Counsel with the Office Healthcare Advocate (“OHA”). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

OHA supports SB 12, AN ACT CONCERNING COPAYMENTS FOR PREVENTIVE SERVICES. OHA has supported this measure in the past. While the Patient Protection and Affordable Care Act (ACA) prevents non-grandfathered plans from applying copayments to preventive services, grandfathered plans are not subject to this provision of the ACA. Passage of SB 12 will ensure that Connecticut residents covered in any type of plan have access to preventive services, encouraging better health care. SB 12’s list of preventive services appears to be more comprehensive than the list under the ACA. The committee may wish to consider aligning the definition of preventive services in SB 12 to that in the ACA.

OHA supports the concept of SB 15, AN ACT CONCERNING RATE APPROVALS FOR LONG-TERM CARE INSURANCE POLICIES. It is past time to ensure the availability of public comment and transparency in the long-term care insurance market. Individuals who are subject to repeated double digit rate increases in the long-term care market deserve the chance to scrutinize and comment on proposed rate increases.

OHA supports SB 18, AN ACT CONCERNING APPEALS OF HEALTH INSURANCE BENEFITS DENIALS. This bill contains provisions consistent with our recent proposals that provide deference to a provider's medical judgment. No reviewer in a utilization review company can ever truly step completely into the shoes of a provider in the application of medical judgment in a specific case. Every year, the utilization review companies, many of whom are subsidiaries of the insurers themselves, are making medical determinations. In our experience, the insurers are going beyond medical necessity coverage determinations to substitute their medical judgment for that of the providers. This happens in surgical cases and behavioral health cases more and more frequently. An insurer may determine that a service is not medically necessary, but it is not the insurer's role to practice medicine on a patient they have never examined – suggesting an alternative, lower-level of care or a different kind of surgery, for example. While the insurers might argue that the decisions they are making are merely coverage determinations, more often than not, they are de facto denials of services or treatment. In most cases, consumers cannot afford to go ahead with a medical treatment that has been denied.

The insurers will undoubtedly testify that to provide a presumption of medical necessity for a provider's judgment will destroy managed care. We reject that notion. Insurers can still subject a service to prior authorization or post-service utilization review. The only change this bill makes is to shift the burden to where it properly belongs, onto the insurers. It is not unheard of for provider's decisions to be accorded deference. Such deference exists in Medicaid and in Social Security for disability determinations. We've witnessed a significant level of second guessing of providers; MCO peer reviews that are not based on a complete record; and, arbitrary limitations made on approved services. We need to restore deference to the providers who actually examine and treat the patient.

OHA supports the provisions of SB 18 requiring the utilization review company to furnish a provider and an enrollee with the information the company used to make its determination. This information is crucial for the preparation of an appeal.

OHA also supports SB 21, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS. The limitation of coverage for routine patient care costs to clinical trials for cancer is allowable under Connecticut law. However, there are treatments for other disabling, progressive or life-threatening medical conditions that also undergo clinical trials. With rapidly advancing medical technology, it's likely that clinical trials for the treatment of illnesses other than cancer will be available to those who cannot succeed on approved treatments. The bill logically links eligibility for reimbursement to Medicare clinical policy in addition to the existing options. The bill appropriately limits coverage of routine patient care costs to individuals with disabling, progressive, or life-threatening medical conditions. This is a fair and overdue extension of our current statutory scheme.

Finally OHA supports the common sense proposals of SB 17, AN ACT CONCERNING WELLNESS PROGRAMS AND EXPANSION OF HEALTH INSURANCE COVERAGE. OHA has testified in favor of this bill in the past. UConn analysts put the estimated cost of covering these services at about \$.71 per member per month plus 0-3% of premium costs for wellness programs. The analysis deemed these costs would not impact the existing health care financial burden of enrollees.

Thank you for the opportunity to submit this testimony. If you have any questions, please contact me at [victoria.veltri@ct.gov](mailto:victoria.veltri@ct.gov) of 860-297-3982.