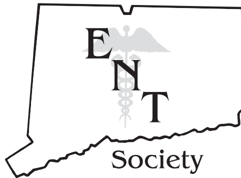

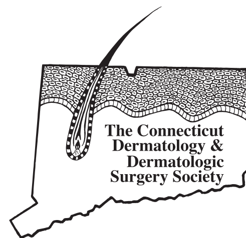

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**Milton Armm, M.D.**
**Testimony in Support of**
**Senate Bill 29: AN ACT CONCERNING THE BURDEN OF PROOF DURING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.**
**Senate Bill 37: AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF PRESCRIBED DRUGS DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES**
**Senate Bill 38: AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIW REQUESTS**

**Insurance and Real Estate Committee**
**February 7, 2019**

**Senators Lesser, Kelly, Representatives Scanlon, and Pavalock-DAmato, and other distinguished members of the Insurance and Real Estate Committee. My name is Milton Armm, M.D. I am a board certified urologist practicing in Bridgeport, CT. I am Past President of the Connecticut Urology Society representing over 1000 physicians in the above-mentioned medical specialty societies in SUPPORT of Senate Bill 29, 37 and 38, all addressing adverse determinations.**

This is not the first year that we have given testimony on the burden borne by the medical community when insurance companies issue an adverse determination on a claim, or declare that a treatment or procedure is not medically necessary. Perhaps with your assistance and vision, this can be the last year. Senate Bills, 29,37 and 38 all seek to hold the insurance industry accountable and require it to bear the burden of proof when their determinations challenge the medial decisions of the physicians or other healthcare providers rendering care, whether it be for a prescribed medication, therapy, or procedure. Currently, physicians on the front lines of health care are forced to interrupt their vital patient care by putting down their stethoscopes and EHR keyboards to justify, usually to a non-M.D. insurance person, that the treatment in question is medically appropriate and necessary.

These three bills aim to address the problem faced every day by physicians and that is the challenge by insurers on physicians' medical authority. These bills appropriately try to amend the Utilization Review Statutes to place a presumption that each health care service under review **is** medically necessary, and the burden of proving otherwise should lie squarely on the **insurer prior** to denying coverage for a service.

For over 20 years, Connecticut's professional medical societies have been completely consistent in our message that no one is more qualified to determine the most 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. This legislation becomes even more critical with recent reports of "professionals" providing utilization review services that failed to perform the expected and necessary 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 the reporting of these determinations is the documentation used or identified by the reviewer when denying the service. This "black box" approach hampers the provider's understanding of the process used and opportunities for learning for future instances -- and worst of all, it undermines and destroys the effectiveness of any meaningful appeal process. It is difficult to argue against that which is hidden and unrevealed.

Central to the proposed legislation is defining what constitutes an adverse benefit determination. We believe that all the following circumstances constitute an adverse benefit determination:

(l) 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 believe that any adverse determination must be clearly explained to both patient and provider, in a written and/or electronic notice that should include at least the following:

- Explanation of benefits
- Reason for denial, with as much specificity as possible, including the preponderance of 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 the 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 and clinical judgement used for the determination, not just the literature relied upon.

Burnout and provider "non-wellness" is a growing and widespread phenomenon leading to provider loss of drive and enthusiasm, departure from the profession, diminished health or sadly, even life. High on the list of stressors and causes includes the vast amount of time and energy required to counter adverse determinations and utilization review rejections. This is invaluable time which is robbed from patient care, and often denies the providers and patients opportunities for timely care and treatments leaving both parties frustrated and untreated.

We strongly believe it is high time that the burden of medical necessity proof be placed not on the providers, but rather upon the health plan or the utilization review company. Such proof requires clear-cut documentation and rationale used when a service or treatment is denied. The burden of proof should be borne by the accusers, and we strongly urge the Committee members to support SB 29, 37 and 38.