TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
INSURANCE AND REAL ESTATE COMMITTEE
Tuesday, February 27, 2024

SB 211, An Act Concerning Health Insurance

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 211, An Act Concerning Health Insurance.** CHA supports the legislation and offers comments on those issues that should be included in the study required by the bill.

Connecticut hospitals are critical to their communities. They are confronting the challenges posed by a post-pandemic healthcare system with an exemplary healthcare workforce that continues to provide outstanding care. But challenges remain. Hospitals are treating sicker patients, it continues to be challenging to hire and retain staff, and the financial headwinds are grave. Through it all, hospitals are steadfast, providing high-quality 24-hour care for everyone who walks through their doors, focusing on making Connecticut's healthcare system more equitable, and driving world-class innovation right here in Connecticut.

SB 211 requires the Connecticut Insurance Department to conduct a study concerning health insurance issues in the state and provide a report by January 1, 2025. As part of the study, CHA believes the following issues should be explored:

- Prior authorization processes
- Prepayment and postpayment auditing
- Automated algorithmic downcoding and downgrading
- Dispute resolution and appeals

Private health insurance is the source of coverage in the employer-sponsored, small group, and individual insurance markets. Increasingly, private health insurers also offer Medicare Advantage plans, which administer Medicare benefits under full-risk, capitated arrangements with the federal government. Medicare Advantage is a major feature of today's healthcare market; enrollment has more than doubled in Connecticut in the past ten years. Nearly all private health plan coverage arrangements, whether commercial or Medicare Advantage, rely on practices and policies in the above areas to manage access to services and payment to providers.

Prior Authorization Processes

Nearly all private health plan coverage arrangements, whether commercial or Medicare Advantage, rely on prior authorization and concurrent review as a means to gatekeep access to medical benefits. These review processes should be in accordance with established policy in contractual agreements and ensure prompt, fair, and equitable application of appropriate clinical criteria. Recommendations for exploration in the study include:

- Documented authorization processes
- Access to real-time information
- Financial accountability for delayed authorizations

Prepayment and Postpayment Auditing

Prepayment audits are by definition applied before a claim is paid and consequently have a considerable impact on payments to providers related to delays associated with the review process.

Postpayment audits involve a review of paid claims for correctness of payment (i.e., paid appropriately as primary or secondary coverage), for in-network (versus out-of-network) status, and for documentation review of billed diagnostic and service codes.

Contracts with health plans typically permit audits to review coverage, coding, and billing compliance. However, there should be a reason for the audit, and the topics addressed should work towards greater efficiency in claims processing rather than to enable delayed payments (in the case of prepayment audits) and reduced or denied payments (in the case of postpayment audits). Recommendations for exploration in the study follow:

- Reasonable timeframes for documentation requests and payer adherence to audit timeframes
- Timely communication of audit findings
- Adherence to contractual limits on audit processes
- Postpayment audit communication
- Timely communication of policy changes

Automated Algorithmic Downcoding and Downgrading

Health plans have recently introduced automated algorithmic editing of claims upon submission without medical record review. Algorithmic processing is often not transparent with many initial denials being overturned through lengthy and costly appeals processes. Recommendations for exploration in the study follow:

- Medical record reviews prior to downcoding
- Reimbursement during the determination period
- Access to transparent, real-time information

Dispute Resolution and Appeals

Health plans establish processes that enable providers to appeal authorization decisions, postpayment and prepayment audit determinations, and automated downgrading/downcoding. These processes can be a source of inefficiency and administrative burden and add cost to the system. Recommendations for exploration in the study follow:

- Clear dispute and appeals processes
- Deemed approval for failure to follow policies
- Payment of interest for payer delays

In addition to the items listed above, the following broadly applicable areas should also be included in the required study:

- Transparent policy changes
- Evidence-based clinical criteria
- Payers' vendors' adherence to contractual requirement

CHA appreciates the Committee's attention to these issues which delay and deny patient care and add enormous administrative cost to the healthcare system.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.