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OFFICE OF THE
HEALTHCARE ADVOCATE
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
General Counsel**

**Before the Insurance and Real Estate Committee
In support of SB 256 and SB 393
March 9, 2010**

Good afternoon, Representative Fontana, Senator Crisco, Senator Caligiuri, Representative D'Amelio, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, 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.

I am here today to testify on behalf of OHA, in favor of SB 256, AN ACT CONCERNING ASSESSMENTS FOR HEALTH BENEFIT REVIEWS PERFORMED BY THE INSURANCE DEPARTMENT. This bill does not change the substance of Subdivision (1) of subsection (b) of section 38a-21 of the 2010 supplement to the general statutes, but it clarifies that the costs of the reviews of prospective consumer protections are to be assessed against domestic carriers. OHA supports the reviews as an objective method to assist policymakers. (OHA notes that the first review in this series concluded that adding several consumer protections of P.A. 09-188 would total \$0.51 PMPM, and up to an additional \$0.21 PMPM for wellness programs. The report concluded that there would be no effect on the healthcare financial burden for enrollees in both high-cost and low-cost plans.)

OHA also supports SB 393, AN ACT CONCERNING STANDARDS IN HEALTH CARE PROVIDER CONTRACTS. One of the most consistent problems for which providers and consumers contact our office is denial of a claim after the insurer has

previously provided authorization for the service to the provider and the consumer. These denials of payment can come almost immediately after the service is delivered in reliance on the prior authorization, or much later, even up to four or five years after the service and after the insurer has paid the claim. Consumers and providers should be able to rely on prior authorization as a valid determination of medical necessity and guarantee of payment on the date of issuance. The insurer or utilization review company is in a position to determine the consumer's eligibility status on the date of review. Prior authorizations are often granted for a window of time. The eligibility for that window of time should be fixed by the insurer, e.g., two weeks, one month, etc.

In this circumstance, where a consumer is truly ineligible for services on the day that a provider who obtained prior authorization performs those services, the provider has acted appropriately in reliance on the prior authorization. SB 393 will require that the insurer pay the provider for the services.

Thank you for providing me the opportunity to speak with you today. Please contact me with any questions at victoria.veltri@ct.gov.