



**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Public Health Committee
In support of SB 253 & SB 687
March 11, 2015**

Good afternoon, Representative Ritter, Senator Gerratana, Senator Markley, Representative Srinivasan and members of the Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate 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 plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Thank you for the opportunity to comment on SB 253, AAC Payment To An Ambulance Service and SB 687, AAC Notice To Patients Of Costs For Routine Health Services. Both proposed bills advance fairness and transparency in healthcare billing.

SB 687 requires health care providers to inform patients of the cost for routine medical treatment and services. As consumers increasingly take on more responsibility for the cost of their care, with large health insurance deductibles and sharing an increased amount of the cost of a service, providing as much information as possible concerning that liability is crucial. Information concerning the actual charges for a service is necessary for consumers to make informed decisions about where and with whom to receive treatment.

Of course, the charges only reflect one component of the costs of a consumer's healthcare experience. True transparency requires that consumers receive advance notice of the allowed amount, or the discounted rate that each provider has agreed to accept from the health plan in return for plan participation, for each service. Consumer cost sharing for in-network treatment is based not on the total charge, but on this discounted rate.

Massachusetts recently enacted legislation promoting this transparency, requiring health plans as well as providers to provide real time estimates concerning the cost of a given service. Given the exorbitant costs of many common medical services, an accurate estimate of what a service will cost has become a necessity for consumers to fully evaluate the most appropriate course of treatment for their individual circumstances. In nearly every other segment of society, consumers have information concerning cost, quality, reviews, and more about a product or service on which to rely before making important and expensive decisions. Why should healthcare be any different?

A similar principle is promoted by SB 253, which requires that ambulance companies to only begin billing consumers for the service after the insurer has issued a denial. What this bill proposed affirms is the variation in consumer cost sharing. By requiring these companies to allow the consumer's claim to be processed for payment by the health plan prior to billing for the services, SB 253 acknowledges the differences in the allowed amount among health plans and ambulance providers. However, simply waiting for a denial of coverage does not necessarily mean that the consumer's liability has been established, although there will be much more clarity following the health plan's review of the claim. Consumers also have a robust appeal mechanism available to challenge any adverse determination by the health plan.

Both of these proposed bills promote transparency, consumer protection and principles of fairness and equity, and enhance the information available to consumers as they make important decisions about their health care. Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.