Testimony for the Insurance &Real Estate Committee

On

HB 8586 AN ACT CONCERNING PRIOR AUTHORIZATIONS AND HEALTH CARE PROVIDER CONTRACTS.

March 9, 2021

On behalf of the physicians and physicians in training in the above medical societies we offer this testimony **in support** of **RB 6586 AAC Prior Authorizations and Health Care Provider Contracts**. We applaud the committee for its vital endorsement of transparency and the timeframes for response and determination contained in this bill. According to the AMA, this is among the best in the nation for protecting patients and providers as our current processes actually delay and impede patient care! The processes and protections outlined in this excellent legislation will significantly benefit the residents of Connecticut, and empower patients to receive the best care they can in a timely fashion. We do request, however, a few suggested modifications that will strengthen this legislation.

In the definition of "Prior Authorization" in lines 611-620, no mention is made of heath care professionals or providers who do not provide inpatient care in a hospital or skilled nursing facility, despite their inclusion in all other references to prior authorization and dispute resolution. This may have simply been a drafting error, but we strongly request the inclusion of outpatient caregivers, such as the following addition to the **(end of line 620: "… or C) any laboratory test, procedure, service, surgery, treatment, continuing treatment, or other healthcare service or covered benefit performed or ordered by a participating provider to the covered person."**

Similarly, in lines 731-736 which defines the working group on prior authorization, no representative of non-hospital providers is provided. We request the inclusion of an outpatient care provider representative on the panel as well, who could offer valuable insights and input.

Many of our dedicated CT providers have been experiencing reimbursement challenges for certain provided services. Many procedures no longer require preauthorization -- payment is based on a retrospective review of medical necessity. The issue arises when insurers claim a lack of medical necessity and deny payment after the fact. Providers are forbidden by statute, and this bill, from billing patients when these claims are denied in this way. We feel strongly that the patient should not be put in the middle of this. Instead of requiring the extra step of getting approval from the patient or their authorized representatives, we ask that physicians' offices be allowed to directly appeal these cases to the insurers without involving the patient or their representatives. **A simple modification lines 400-402 could state that providers providing covered care to covered patients be able to appeal and file grievances when claims are denied under the conditions addressed in that section.**

We applaud the efforts to streamline and automate the approval and appeals processes as outlined in lines 1040-1093. Standardized entry and processes will greatly ease the burden on the health care system of obtaining authorization and approval, and working through appeals. Please recognize, however, that for some of our colleagues who have provided excellent patient care for many years, a non-electronic version should be preserved to allow for continuity of care, as well as to serve as an important backup mechanism should systems experience any "hiccups" in functioning from time to time.

We very much appreciate the hold on recoupment of re-audited claims after they have been approved and services provided in good faith based on that approval. We ask that recoupment after prior review and approval be disallowed entirely. Care that was given in good faith after review and approval should not be punished. Time and resources expended cannot be regenerated after the fact, including the requirement of providers to submit most claims within 90 days. At the very least, an upper limit should be placed on how far into the future such audits can be done, and we suggest a limit of one, or at the most, two years. Insurers have massive resources to devote to this issue. We should not be held responsible for their inability to do their job.

One final suggestion: we feel that the language in lines 1605 -1607 would be clearer and better interpreted if the underlined language in line 1606-7 were moved and inserted after "covered person" in line 1605.

We truly appreciate the strong efforts and language in this bill and gratefully acknowledge the improvements in what is currently a very difficult, and at times confusing and opaque process for patients and providers. It is fair and thorough. We hope our suggestions are acceptable and incorporated. If you have any questions or concerns with the language we suggested please do not hesitate to contact us at: wlk@wlkct.com or debbieosborn36@yahoo.com

Thank you for addressing our concerns with this bill and stay safe.