**Testimony of Victoria Veltri**
**State Healthcare Advocate**
**Before the Appropriations Committee**
**Governor's Budget Proposal**
**February 27, 2015**

Good evening, Senator Bye, Representative Walker, Senator Kane, Representative Ziobron, and members of the Appropriations 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 insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I appreciate the opportunity to comment on the Governor's Human Service budget proposal. There is no question that the budget climate is extremely difficult this year. However, I must oppose many of the proposed cuts in the Department of Social Services budget, as I believe they will increase the uninsured rate in our state and dampen efforts to achieve increased access to care, improved quality of care and reduced healthcare costs.

Although I am the vice chair of the Access Health CT Board of Directors, it should be noted that the testimony that follows reflects my position and not that of the Board of Directors.

**Removing HUSKY A Adults from Medicaid**

OHA opposes removing HUSKY A adults with incomes between 138% and 185% of the federal poverty level from Medicaid. There are multiple reasons for our opposition to this proposal.

1) First and foremost, OHA believes that while Access Health CT is positioned to mechanize healthcare coverage to the adults in this income category, the plan options offered to this income group are more likely than not to be unaffordable from a premium and cost sharing perspective, despite substantial subsidies from the federal government. This cut will translate into a higher uninsured rate and potential increased healthcare costs as people resort to higher cost care options when they cannot afford premiums and/or cost sharing.

This is no fault of Access Health CT. While the committees that advise the Access Health CT Board of Directors were able to come to consensus on the platinum and gold and two silver standard plan designs, consensus could not be reached on the cost sharing reduction options for people in the 185-200% FPL income bracket and the 138-185% FPL income bracket. Despite the outstanding efforts of the staff of Access Health CT and the efforts of the advisory committees, the constraints of the federal actuarial value (AV) calculator—a formula that calculates actuarial value based on various inputs of cost-sharing across service categories--prevent adjustments that in OHA's view would allow for affordability protections for the lowest income populations that approach those offered in the current Medicaid program. Actuarial value (AV) is the measure of out of pocket costs, excluding premium, a plan will pay. Platinum plans have a 90% AV, meaning the plan will pay about 90% of the out of pocket costs of the plan while a consumer would pay 10%. Gold plans have an AV of 80%, silver, 70%, and bronze, 60%. Lower AV plans have lower premiums and higher cost-sharing. Access Health CT must use the AV calculator to develop plan designs. At this point, early on in the federal and state exchanges, the AV calculator offers little flexibility. In out years, this will hopefully change.

The federal government offers two forms of assistance to people in lower income categories—advance premium tax credits or APTCs (offered to all individuals and families between 138-

400% FPL) that are based on the costs of the second lowest silver plan, and cost sharing subsidies to individuals below 200% FPL. Cost sharing subsidies are available **only** at the silver level while APTCs can be used at any level—platinum, gold silver or bronze. Therefore, for an individual or family at a lower income, an APTC goes farther to offset premium in a bronze plan than in a silver plan, but a bronze plan does not offer cost-sharing reductions. The best silver cost sharing reduction plan designs for people at the lowest income ranges that the Access Health CT staff, through diligent effort and multiple requests to try to reduce out of pocket costs, could develop within the limits of the AV calculator, resulted in, in addition to a substantially reduced monthly premium:

- A family maximum of $1600
- $10 PCP co-pay
- $30 specialist co-pay
- $75 co-pay per day for hospital admission up to a maximum of $300
- Co-pays for laboratory and radiology services
- Co-pays for prescription drugs of $5 per generic, $10 for Tier 2, $30 for Tier 3 and 20% co-insurance up to a maximum of $60[1]

These cost-sharing requirements will substantially affect low-income individuals' ability to access providers and needed (and perhaps maintenance) medications that could prevent unnecessary hospital admissions or other higher cost care options. If a caregiver in this income category chooses a bronze plan because he or she faces a premium in the silver cost-sharing reduction plans, the caregiver will face a $5000 deductible before accessing a generic maintenance medication with a $5 copayment.[2] As co-payments are not waiveable (and cost

[1] See http://www.ct.gov/hix/lib/hix/IND_plans_approved_by_ACs_amended_2-16-15.pdf, accessed February 25, 2015. (The consumer committee could not vote on the final plan designs because of lack of a quorum. The Board approved the designs at its February 19, 2015 board meeting. The Healthcare Advocate voted against the Silver 87% and 94% plan designs and the bronze plan design.)
[2] Ibid.

sharing reductions are not available in bronze plans) and more practices and facilities require payments of deductibles in advance of treatment, people may find themselves with no meaningful healthcare option of a regular source of care and instead rely on higher cost emergency departments, leaving hospitals unfunded for that care. OHA believes that the risks of imposing premiums and cost sharing at the silver levels and the added risk of individuals choosing bronze plans are too great to the low-income population to support such an option. OHA is also very concerned that the budget proposal will inadvertently undo the good work done by DSS to ensure a regular source of care for HUSKY recipients, access to the Behavioral Health Partnership, care coordination and intensive case management, all at low cost with a big return in terms of access, quality and cost-containment.

2) The cost of covering a current HUSKY A recipient is approximately $600 per individual per year of which the state pays $300. That $600 cost will be eclipsed for a family in half a year in premiums in private coverage while exposing families to substantial out of pocket costs above that amount. OHA is aware that Connecticut may be the last remaining state in the country to offer Medicaid up to 185% FPL for families (and higher for pregnant women). However, Connecticut's widest in the country income gap between the top fifth and bottom fifth, substantial rates of poverty in the state, and Connecticut's high cost of living, warrant extending Medicaid to 185% FPL for families. There is no available option on the Exchange that will hold adults in this income category harmless.

**Commented [DF1]:** This is different from Arielle's numbers. She has $349 pmpm for Husky A

3) Health insurance coverage under the Exchange does not include dental coverage as part of the package for adults. Adults in HUSKY A have dental coverage as part of the HUSKY plan. While that coverage is not as robust as OHA would like it to be, it is by far superior to having no coverage. To access dental coverage on the Exchange, one has to purchase a dental policy, paying a separate and unsubsidized premium. Neither APTCs nor cost sharing reductions

extend to dental coverage. Current HUSKY A adults will be without dental coverage if they lose eligibility for Medicaid as a result of the budget proposal. Lack of access to dental coverage results in lack of access to dental care, which in turn can lead to serious health conditions, including heart disease. OHA has repeatedly opposed the removal of dental coverage for adults on Medicaid for this reason.

4) Advocates have presented ample evidence that putting adults in one type of coverage and their kids in another jeopardizes access to care for both caregivers and the children in that family.

5) Finally, OHA believes that including the HUSKY A adult cohort in the Exchange also runs the risk of increasing health insurance premiums for all individual policyholders on the Exchange. Premiums for individual insurance are based on one risk pool. Everyone is included. If history is any lesson, utilization patterns of low-income people reflect higher than average medical needs and higher levels of utilization and medication, which will be reflected in higher insurance premiums for all purchasers on the Exchange. In OHA's view, this not only jeopardizes the ability of low-income individuals to purchase policies on the Exchange, even with a subsidy, but could also contribute to increased premiums across the board, jeopardizing overall enrollment and sustainability of the Exchange, particularly for the non-APTC purchasers of insurance.

**Commented [DF2]:** Does this contradict the message re low cost for the Husky A pop? Husky C is the highest cost by far.

**Commented [DF3]:** Should we talk about the potential impact of these folks losing or not using their AHCT plans due to cost, and the likely associated uncompensated care hospitals will have to bear.

**Lowering Eligibility for Pregnant Women to 133% FPL**

For the same reasons articulated above and for public health reasons, OHA opposes reducing the income eligibility for pregnant women for Medicaid. It is not wise public policy to erect barriers that will prevent pregnant women from receiving medically necessary preventive screenings and prenatal care. While most preventive care is covered at no cost under the ACA to individuals enrolled in insurance plans and non-grandfathered group health plans, accessing

**Commented [DF4]:** We've also just been informed that pregnancy is not a qualifying event for enrollment, so uninsured pregnant women will have no access to prenatal care.

health coverage on the private market still requires payment of premium dollars to access health coverage. For the reasons stated above, OHA believes that even subsidized premiums will be out of reach for people at low incomes, making healthcare coverage, even for preventive services, inaccessible for pregnant women at this income level.

**Medicaid Provider Rate Reduction** will hurt access to care and increase cost shifting – see facility fees discussion. The proposal is ambiguous at best.

**Reduced eligibility for CHCPE and increased cost-sharing for CHCPE** - BAD, Freezing intake-bad – prevents people from staying at home and containing costs. Again, this is an easy cut if we are looking at a two year budget. It's a bad cut if we are thinking of the future.

Duals demonstration removed funding

Medicare co-pays for duals = WE negotiated a wrap around a long time ago that has continually been eroded. Drug costs are too much for this population

Performance payments – cuts against what we are trying to do with health reform—lost incentive

Personal needs allowance in nursing homes—reduced—BAD and cruel

Loss of funding for legal services under the SSBG

Reduce funding for "various programs" – what does this mean?

Like reimbursement for detox services at substance use residential programs

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.