



**Testimony of Kevin P. Lembo, MPA, State Healthcare Advocate
Informational Hearing on Healthcare**

**Insurance And Real Estate Committee
January 4, 2007**

Good afternoon Senator Crisco, Representative O'Connor, and members of the Insurance and Real Estate Committee. For the record, I am State Healthcare Advocate Kevin Lembo, and I thank you for the opportunity to appear before you today as we commence a very important year in healthcare reform in our state.

Coverage, specifically "healthcare coverage", is a phrase most of us are talking about these days, but the word is meaningless without context. For instance, one person may have healthcare coverage, but the only thing that's covered under their plan is catastrophic care at an enormous price tag. At the same time, a person may have healthcare coverage or "access" to healthcare coverage because he or she managed to scrape enough money together to afford their \$700 individual monthly premium, but that person doesn't have any money left to afford to go to the doctor because he or she also has a \$ 1,000 deductible. One could also have what looks like a generous benefit plan, only to find out that there are multiple restrictions under the plan, like limitations on the number of visits to a particular type of provider, unreasonable prior authorization requirements or, a limited benefit design that caps total healthcare expenditures at as little as \$1,000 per year. Finally, one can have healthcare coverage and be woefully underinsured, with nowhere to go for help with the huge medical bills for their child who remains at home, but who requires constant nursing or services like speech therapy or occupational therapy that are restricted under some private plans.

Healthcare coverage must be meaningful -- the benefit package needs to be as comprehensive as affordability will allow.

But, access to coverage is not enough. Coverage is only meaningful when access to healthcare is part of the bargain.

Medical Necessity

People come to the Office of the Healthcare Advocate when they are told that they can't get outpatient psychotherapy or prescription drugs or surgery paid for because their insurance company says it is not medically necessary. Most consumers are confused by this phrase, assuming that what was recommended by a licensed medical provider, who is credentialed by the consumer's insurance company, is medically necessary. I think that

this is what most of us justifiably assume -- that licensed medical professionals who know us and see us regularly, would recommend medically necessary care. We expect that our providers should get some deference for their decisions, but that's not the way things work now. Instead, some insurance companies use rigid criteria, applied to the average person without consideration for our individual medical histories, to determine what care is medically necessary. After the company makes its decision, it sends a notice that someone's care has been denied because it's not "medically necessary" often, without further explanation.

We hope to address this issue this session. Our office has proposed a joint bill with the Attorney General to ensure that consumers get the medically necessary care they need. We have met with some of you already about this bill, and we think it will promote proper decision-making about whether a service is medically necessary. The draft bill language is attached to my printed testimony for your review.

Accountability

Access to care and healthcare reform must also begin with accountability and transparency. These concepts naturally lend themselves to determining what cost inefficiencies or containments need to be addressed. Let me give just one example of why we need to be deliberative and thorough in our discussions. The problems of access to care for low-income HUSKY recipients is well known -- dental access, specialist access are significant problems and remain so. The current FOI litigation may finally allow us the access to the information we all need to decide whether the \$700 million we are spending on Medicaid managed care is going to service provision or is attributable to unnecessary administrative costs at the HMOs.

Unfortunately, provider access problems are not limited to Medicaid. I used Medicaid as an example because it's illustrative of the pervasive problem of lack of accountability on provider access issues. Our office has received many calls from consumers, including state employees, with private insurance through large insurance companies. Many of these folks complain about the same things the Medicaid population complains about, and we need to sit up and take notice. People call because they've already called their insurance company to get help finding a provider to treat their seriously mentally ill child, and instead of getting help, they are directed to computerized provider lists. After making as many as forty phone calls to providers who have dropped out of the network, never been in the network, died, closed their practices, aren't taking any new patients, or have a six-month waiting list, the consumers give up on the promises in their insurance contract.

Accountability ensures that this type of access problem gets addressed now, even before we expand healthcare coverage. That's why I'm also putting forward an amended managed care bill of rights bill that would expand consumer rights, but more importantly, requires vigorous enforcement of those rights. I've also attached a copy of draft language for your review.

Additionally, it is my conclusion, after a year has passed from the time this concept was first proposed by the Committee for Program Review and Investigation, that responsibility for the annual Managed Care Consumer Report Card should be moved to our agency from the Insurance Department. The Report Card could be greatly improved and become more meaningful and comprehensive for consumers if the independent Office of the Healthcare Advocate took charge. As a watchdog entity, this addition to our responsibilities would be completely consistent with our charge and mission. In addition, an enhanced Managed Care Consumer Report Card would have a sentinel effect in the health insurance market leading to improvements in quality and access, as well as potential cost containment if the various elements of the Managed Care Bill of Rights mentioned above are simultaneously approved.

Healthcare reform

Recently, you all received an email from me that contained our proposal for Ten (10) Principles for Healthcare Reform in Connecticut (they are also attached). Healthcare reform discussions are taking place at all levels of government and in consumer groups and business organizations around the state. For us to have the best possible reform product at the end of the day, it is vital that we come to agreement on our guiding principles – a yardstick, if you will – against which we can measure reform proposals as they are offered.

I would also encourage the committee to consider legislative and administrative action to:

- Conduct and/or fund a State Impediments Study of our existing insurance law with an eye toward further reform in the small group and individual markets.
- Create a contractual relationship with Independent Actuaries and Cost Estimators so that the committee can have unbiased evaluation.
- Consider action in the individual market – where there is huge expense, underwriting issues, and growing need – and follow the lead of other states with guaranteed issue and underwriting restrictions.

This effort is going to take discussions across all fields of study, all branches of government, all types of businesses, small and large, and a whole range of consumer advocates. We must avoid the temptation to rush into what we think might be a good plan without the input of those most knowledgeable, and those most directly affected. It is too easy to get this wrong. Pushing too hard on any one lever of healthcare reform can have severe and long-term negative implications. It is policy work that requires a scalpel, not a chainsaw.

We offer our office's assistance – as we are able – in framing some of the healthcare issues, reviewing plans, and offering any support we can as you undertake this important task. If we cannot answer your question, we will say so and work with our colleagues in other states to gather more information. I commend the committee for beginning the legislative year on this positive and collaborative note and look forward to working with you all in the weeks and months ahead.