



**Testimony of Kevin P. Lembo, State Healthcare Advocate
On Bills S.B. 1349, S.B.1371, H.B. 7284 and H.B. 6652
Insurance And Real Estate Committee
March 6, 2007**

Good morning, 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 to testify on several bills, including **Raised Bills S.B. 1349, S.B. 1371, H.B. 7284 and Committee Bill H.B. 6652.**

The Office of the Healthcare Advocate (OHA) believes that there are concepts in each of these bills that deserve further exploration, but we do not support each bill in total. There are concepts in some of these bills with which we disagree. The potential access to healthcare coverage, and access itself, requires a much more cohesive, inclusive and deliberative process than can be achieved through the introduction of dozens of sometimes confusing and conflicting individual healthcare reform bills.

S.B. 1349, AN ACT ESTABLISHING THE CONNECTICUT SELECT CARE CHOICES PROGRAM, places health care purchasing authority with the Office of the State Comptroller. **S.B. 1371, AN ACT ESTABLISHING THE CONNECTICUT SAVES HEALTHCARE PROGRAM**, places that authority within a Connecticut Saves Health Care Commission appointed by legislative leaders. While it is critical to have broad-based input into the design of an appropriate plan, we believe that the Comptroller's office is the logical place to expand insurance purchasing authority for Connecticut residents. Placing this authority into a multi-layered arrangement through the Office of the Health Care Access and the Department of Insurance, or solely the Department of Insurance, as **H.B. 6652** and **H.B. 7284** respectively do, does not recognize the vast experience and expertise that the state already has in leveraging its purchasing power through the Office of the State Comptroller. Neither OHCA nor CID has experience in purchasing healthcare insurance for hundreds of thousands of individuals. We do not need to reinvent the purchasing mechanism – it exists in the Comptroller's Office.

While we applaud the fact that **S.B. 1349 and S.B.1371** do not allow for the provision of limited benefit plans as a solution to solving the crisis of the uninsured, we are unsure why the offered plans will have an actuarial value based on employer plans across New England rather than just the Connecticut market. The benefit plans outlined in **H.B. 6652**, however, consist of at least one limited benefit plan. No disclosure or regulation of these plans can disguise what these plans really represent, affordable, but generally meaningless, coverage. The existence and expansion of these types of plans facilitate an undermining of the existing, traditional health insurance market, as they peel away all the

so-called "good risk" leaving behind the older, sicker populations. There is no Connecticut law authorizing any waiver of insurance mandates or allowing insurance plans that do not provide meaningful benefits. We believe that limited benefit plans are legally prohibited under Connecticut law, and will be seeking an independent review and advisory opinion as to the legality of these plans. HSAs also deliver a false promise of meaningful coverage. We believe that they are bad for consumers and bad for the market.

The Office of the Healthcare Advocate continues to support the exploration of a sound reinsurance program. However, we do not support the idea in **H.B. 6652** of a reinsurance program through the Department of Social Services and the Medicaid program. There are some considerable access problems that need to be addressed in Medicaid prior to routing any additional persons into the program for needed ongoing, high-cost care. While there are many sound provisions in H.B. 6652 that address some of these current Medicaid issues (for instance, sections 18-21), there are some, including the reinsurance provisions, that would make an already overburdened and over-extended agency even more overburdened. Further, enrolling fee-for-service patients into the HUSKY program as HB 6652 proposes, for instance, will only force premiums and capitation payments to skyrocket.

There are some provisions in several of these bills, including the inclusion of required medical loss ratios and the required increase in reimbursement rates that are logical, vital, accountable steps. At the same time, however, there are several provisions that we believe are unnecessary and wasteful, such as the creation of new commission on healthy lifestyles and several layers of bureaucracy in a plan that includes a health care reform commission, a separate Connecticut Connector and the insurance plans themselves.

We appreciate the efforts that the committee, the advocate community, and state agencies have made in an attempt to address the problems of access to healthcare and healthcare insurance coverage. We still strongly believe, however, that in the rush to do something, we may get it wrong. This important an issue requires the collaboration of all interested parties. It deserves study. One or two possible solutions must be hammered out for the consideration of the people of our state. The subsequent discussion must be taken to the people at times and places that are convenient for them. It will require a disciplined and organized effort. It may even require a special session, at the conclusion of the community meeting phase, devoted solely to this issue. We would like to see a positive outcome that everyone can take credit for, not one for which we will all share blame. We suggest slowing down, speaking with the people, and trying to reach true consensus on the future.