



**Testimony of Kevin P. Lembo, State Healthcare Advocate
In Support of S.B. 164, 817, 389 and 819**

**Insurance And Real Estate Committee
February 6, 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 to testify on several bills.

The Office of the Healthcare Advocate supports **S.B. 164, An Act Requiring Health Insurance Coverage for Emergency Medical Conditions**. This legislation would clarify current statutory language to ensure that emergency medical conditions are covered under group and individual policies. The test of whether there was an emergency condition is the "prudent lay-person" standard. The legislative debates on Public Act 97-99, often referred to as the managed care bill of rights, reflect the fact that the legislature intended that emergency medical conditions should be covered. The fact that most insurers in the state offer coverage for emergency medical conditions supports this view. Just last year, for the first time, a company made a filing with the Insurance Department to offer a health care plan with no coverage for emergency medical conditions. When the Insurance Department informed the company that it would not approve the plan, the plan threatened legal action, pointing out that current law does not mandate coverage for emergency medical conditions. After an analysis of the pertinent law, the Department determined that it had no clear statutory basis to disapprove the plan.

I cannot imagine that there is a single consumer in this room who thinks that insurers are not required to provide emergency medical coverage, yet that can be the case under the language of the current law. The current language does not require coverage for emergency treatment and related facility charges; it only prescribes the basis of reimbursement to providers if an insurer covers emergency medical conditions. To begin with, we suggest a minor change to the language of S.B. 164 that would ensure coverage for not only the treatment of emergency medical conditions, but also for any facility charges that are incurred as a result of the emergency medical condition. I have attached suggested language.

Next, we support the spirit of **S.B. 817**. We know there are several proposals to extend coverage for dependent, unmarried children. Since there appears to be such strong support, we hope a compromise can be reached. However, OHA would oppose any bill that would require that an unmarried, dependent child to be in school full-time in order to be eligible for this coverage.

OHA also supports both **S.B. 389** and **S.B. 819**. These bills would require individual and group plan coverage for routine patient care costs associated with clinical trials for treatment of serious or life-threatening diseases. These same costs for cancer clinical trials are currently covered under state law. As a matter of sound public policy and fairness, we should extend the same coverage to people struggling with serious or life-threatening and debilitating diseases like multiple sclerosis, cardiomyopathy, and others.

It seems that each year, there is debate on doing a cost analysis of required coverages, and this year is no exception. There are three bills today that mention this subject, **S.B. 250**, **H.B. 5494**, and **H.B. 6053** and one coming up for a hearing on Thursday, **S.B. 259**. OHA supports the concept of studying the potential costs of required coverage. I am unsure, however, if the cost of required coverage warrants immediate attention as a cost driver when there hasn't been an independent analysis to find this out. There were dire warnings in the past about the cost of implementing mental health parity legislation, which proved to be exaggerated, partially because of insurers' ability to use utilization management tools to control costs. There are benefits to these required coverages that may not seem apparent on the surface, but which ultimately keep costs balanced across groups. Mandates effectively require pooling of risk across all people in the market.

H.B. 6053 appears to suspend current mandates while a study is performed. Instead of enacting either S.B. 250 or H.B. 6053 in their current forms, we propose that you obtain, over the next year, and in time for next year's legislative session, an independent and unbiased assessment of the costs of these "mandates". What is the value of this independent assessment? Let me give you a couple of examples, the Connecticut Health Insurance Policy Council's report, *A Proposal for Healthcare Reform in Connecticut*, states on page 8 that Connecticut's "mandates are estimated to constitute as much as 30-40% of the cost of coverage, *but since most commercial insurance would in any case include many of the mandated benefits*, the true incremental cost of the mandates is estimated at 15-20%." (emphasis added) A report conducted in the spring of 2006 by the Lewin Group, the same entity that assisted in the preparation of the CHIPC report, analyzed the proposed federal "Enzi" legislation of last year and estimated that only 2.5% of premiums for fully-insured plans in Connecticut reflect the state mandates *in excess of what is typically provided in large employer health plans* that are not subject to state regulation. Some might argue that this is the more accurate analysis since it compares fully-insured plans to the self-insured market. The difference in results, however, proves that it is vital for everyone to be on the same page and asking the same question on costs and comparisons, without a pre-determined or desired outcome. An independent cost study, conducted under aegis of a small ad-hoc committee composed of a few members of the insurance committee, members of the health and insurance industries, consumer advocates and consumers should yield an accurate and more comprehensive result as to the true costs of mandates. Concrete action, if necessary, could be taken upon conclusion of the study and in time for next year's session.

Further, coverage by diagnosis is a dangerous way to offer insurance. Too often we look at insurance as coverage for discrete conditions instead of viewing it as insurance for a human being. If insurers should be required to cover all medically necessary care for an individual, as we proposed in our joint bill with the Attorney General, the need for what we now call multiple mandates may well disappear.

An Act Requiring Coverage for Emergency Services

(NEW) **Mandatory coverage for emergency services.** Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after October 1, 2007, shall provide coverage for the treatment of emergency medical conditions and any associated facility charges for such treatment. For the purposes of this section, an emergency medical condition is a condition such that a prudent lay-person, acting reasonably, would have believed that emergency medical treatment is needed.

(NEW) **Mandatory coverage for emergency services.** Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after October 1, 2007, shall provide coverage for the treatment of emergency medical conditions and any associated facility charges for such treatment. For the purposes of this section, an emergency medical condition is a condition such that a prudent lay-person, acting reasonably, would have believed that emergency medical treatment is needed.