Office of the
Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Kevin Lembo, State Healthcare Advocate
Before the Insurance and Real Estate Committee
In Support of H.B. 5696, H.B. 5692, H.B. 5695, S.B. 491 and S.B. 482 and
In Opposition to H.B. 5709, S.B. 492, and H.B. 5690
March 6, 2008

Good morning Senator Crisco, Representative O'Connor, Senator Caliguri, Representative Witkos and members of the Insurance and Real Estate Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office 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.

BILLS WE SUPPORT

1) H.B. 5696 - An Act Requiring Insurance coverage for Autism Spectrum Disorder Therapies

We support this bill as a reasonable attempt to ensure coverage of medically necessary therapies for those with autism. However, we believe, generally, that coverage dictated by diagnosis or condition is not the best way to provide healthcare coverage. What we've run into in our office, particularly with speech therapy, are insurer coverage policies that restrict speech therapy coverage only to those who have actually lost speech and are seeking to restore it, as opposed allowing for a range of speech therapy that many people need, regardless of their conditions and whether they have lost speech. This bill is an acknowledgement that very harsh limits can be reached when insurance coverage is based on a diagnosis. It provides the range of therapies that those with autism would need. We support this bill, and urge the committee to review the practice of approving therapies by diagnosis rather than on the most important factor, the medical necessity of the therapy.

2) S.B. 491 - An Act Concerning Medical Loss Ratios

We support **S.B. 491**. S.B. 491 addresses an element of accountability by requiring insurers to achieve a medical loss ratio of at least eighty-seven and one-half percent.

The insurance industry defines the percentage of premium spent on providing medical care to patients as the "medical loss ratio." This choice of words is disconcerting, but reflective of industry's drive to maximize profits. The concept that

any such expenditure represents a "loss" seems contradictory to the product sold, but as private for-profit entities, medical insurance companies are obligated to perform first for their shareholders, a key reason that a standard of performance needs to be adopted.

As consumers we have a right to expect that we are receiving contractually or statutorily required medically necessary care for our premiums, and that no more than a reasonable amount of additional expense goes toward administrative costs and profit margin. No one can expect that insurers will have zero administrative costs in running their programs, but these costs must be reasonable. S.B. 491 sets a reasonable standard.

Many states are taking steps to curb excessive administrative costs and profits. New Jersey implemented a minimum loss ratio requirement statute over 10 years ago with tens of millions of dollars in excess premiums refunded to policy holders annually. The U.S. General Accounting Office reported that federal loss ratio standards have resulted in significant decreases in excessive premium charges for Medigap plans.

Instead of maximizing profits, insurers instead had to maximize efficiency and administration. With more premium dollars available for direct healthcare, additional services may be offered, physicians' reimbursements may increase and premiums may decrease.

As the committee further shapes S.B. 491's concept, it is important to consider all of the elements that may impact an insurer's medical loss ratio and how that information is reported. A clear definition, or at least a consistent use of the phrase "medical loss ratio", will be necessary to ensure accurate comparisons between companies and within companies from year-to-year. That means that the Insurance Department would have to issue clear guidance or regulation. Questions will need to be answered including:

1) Should the cost of administering subcontracted services be counted as part of the medical loss?

We would argue that the cost of subcontracting a service also contains an element of administrative expense, not just medical expense. Counting the total amount paid to the subcontractor as a medical cost artificially inflates the medical loss ratio -- making it look like more money has been spent on direct care. (An example -- Company A subcontracts its mental health services to Company C and pays Company C $ 5.00 per member per month to administer the subcontract and pay providers. In our view Company A could only count what is actually paid to mental health providers, through this subcontract, as medical cost. The portion of the $ 5.00 that Company C uses for their administrative cost, should be reflected in Company A's report to the Insurance Commissioner as non-medical.)

2) Would the medical loss ratio of individual policies be grouped with an insurer's group policies?

This is relevant since historically, medical loss ratios for individual plans tend to be much lower. They should be reported separately.

Connecticut Insurance Department data over the last five years shows self-reported medical loss ratios all over the map (they are attached to my testimony for your review). As a result, it's difficult to draw any concrete conclusions on where our premium dollars are being spent. In some cases, the ratios are declining into the mid-seventy percent range, or lower. Most of the insurers, including the HMOs, have never consistently reported a medical lost ratio in the mid eighty percent range, but the standard is clearly reachable since the companies have reached that target at least once. Since the insurers often state or report that their medical loss ratios are in the mid-eighty percent range, they should not have any concerns about this bill requiring the same, and should feel confident that the requirement of a specific medical loss ratio will drive their businesses to be more efficient, cut down on unnecessary administrative costs and maximize the percent of their premiums that fund obligatory medical services.

This bill drives home accountability on the insurer side of the equation. I urge your support and ultimate adoption.

Other bills OHA supports:

3) **H.B. 5692 – An Act Concerning Unfair Trade Practices**

We support this bill which prevents preferred provider networks from representing that a provider is part of the network unless the provider has taken some affirmative action to enroll. Notwithstanding the fact that many preferred provider network (PPN) contracts allow for assignment of the contract to other entities, assignment of the contract does not mean a provider is actually accepting patients or other wise affirmatively participating in the network. PPNs have a responsibility to report to the Insurance Department their provider directories and their network providers' rate of accepting new patients. This bill takes a positive step to ensuring that PPNs are accurately and routinely determining the availability of providers in their networks and are making the correct determination that unless a provider indicates a willingness to be part of the network, the PPN should not represent that provider as actively participating in the network.

4) **H.B. 5695 – An Act Concerning Responsibility for Hospital Never Events**

It would be wonderful to say that "never events" never occur, but they do, adding human suffering and unnecessary financial burdens to our already vulnerable system. Our support of this bill is conditioned on the addition of a section to this bill that a) holds patients harmless from any expenses associated with the "never events" described in the bill and b) imposes severe penalties on any facility that tries to recover from patients or their estates expenses for these "never events."

5) **S.B. 482 – An Act Concerning Health Care Claims**

We support the purposes of this bill which are to prevent insurers from unduly influencing the prescribing of medically necessary medications to enrollees and to reign in the kind of fraudulent conduct engaged in by at least one insurer in California; that is, awarding employees for denying claims. This kind of conduct is reprehensible. While we do not have any evidence that any insurer in Connecticut is currently engaged in this kind of conduct, S.B. 482 will put insurers on notice that such conduct will not be tolerated. While there is some protection in the utilization review sections of the insurance statutes for utilization review company conduct in reviewing whether a procedure or services should be authorized, the protections offered by S.B. 482 are broader in scope and apply to all claims, which is appropriate.

BILLS WE OPPOSE

1) **H.B. 5690 – An Act Concerning the Freedom of Information Act**

We oppose this bill. It is entirely unnecessary. This bill would re-write the Freedom of Information Act (FOIA) to solely address the Medicaid managed care organizations' (MCOs') desire to be free from public accountability. The Governor and DSS have already committed to the importance and role of the FOIA in the over $700 million Medicaid managed care program. That commitment was most recently demonstrated by the inclusion of a provision in the HUSKY RFPs that states that the contracting organizations would be subject to FOIA as they are performing a governmental function.

This Act is an attempt to narrow the meaning of "government function" under the FOIA and raises ambiguities that do not currently exist in the statute, in the FOIC's ruling or the court's ruling. First, the bill defines "managed care organization" as one defined in Conn.Gen.Stat. § 38a-478. That definition is one that has not been used by DSS in the past to define the MCOs participating in the HUSKY program, although each of the organizations, including the only non-profit participant, meets the definition. Second, the bill narrows the scope of documents subject to FOIA to those "specifically created for the purpose of performing a governmental function" which would necessarily exempt from disclosure documents used by the MCOs in both HUSKY and other lines of business. The current law is more in line with the purpose of FOIA in requiring disclosure of documents "related to the performance of the governmental function."

It's also interesting that the attempt here is to create an entirely new subsection of the FOIA, solely for the benefit of one type of entity doing business with the state and engaging in a governmental function. Presumably, there are other entities that are performing a governmental function and have not yet been to the FOIC to contest their claims. This Act gives the MCOs a special status that is unwarranted & unprecedented under the law.

The MCOs, nor any other entity performing a governmental function, needs any independent protection under the law to claim exemptions under the FOIA statute. The right of final disclosure has always rested with the public agency. The MCOs or other contractors are free to negotiate an arrangement via their contracts with the public agency to determine how the contractors' concerns about potential claims of confidentiality will be handled. That contract could include the right of the contractor to proceed to court to protect its interests prior to the release of documents from the public agency. As the MCOs well know a contract amendment giving them the right to go to court to prevent disclosure of documents it asserts are confidential or proprietary was offered to each of them.

This bill is unnecessary and attempts to give the MCOs a special status in law. The current law is adequate to address the governmental function issue and exemption issues for all state contractors. This bill should be rejected.

2) **S.B. 492 – An Act Making Technical Revisions and Minor Changes to the Insurance Statutes**

We oppose this bill. This bill, which has been labeled as an attempt to level the playing field for insurers, will do the exact opposite for the municipalities who plan to join. The bill's title is quite a misnomer given the major changes it would make. When MEHIP was enacted into law, it was correctly perceived as a mechanism to make it feasible and more enticing to pool state and town resources and to use the state's leverage to buy the best healthcare for many people at the best price possible. There isn't a person who has walked through the Capitol in the last few years who hasn't heard the benefits of pooling risk and the advantages this grouping can have for the state and our municipalities.

As everyone knows quite well, many towns across the state are facing significant crises with their healthcare expenses skyrocketing. Their budgets are strained, too. The grouping of towns for the purposed of purchasing health insurance was and is a good idea that brought a balance in power between towns and insurance companies. S.B. 492 only tips this power back to the insurers. MEHIP has made incremental, positive change since its inception, but every step of the way, another roadblock is put up to stop it from going forward. This is the most recent. People are expecting and are primed to go forward with this plan. It should not be delayed again.

3) **H.B. 5709 – An Act concerning Access to Quality and Affordable Health Care**

We opposed this bill. It would create a series of affordable health care plans that would operate outside the consumer protections of the Insurance Statutes. Mandate-lite plans would be created. Important protections such as mental health parity would be side-lined. We cannot continue to offer "less than" plans to the uninsured. The uninsured deserve the same protections of the law as we do. Affordable mandate-lite plans will not remedy the problem of increasing health costs as services that are not covered by such

plans will be borne by consumers directly at full charge and passed on as a remaining cost-shift to all people insured in comprehensive healthcare plans. Absent a more comprehensive solution, we urge you to vote no on this bill.

OTHER

H.B. 5721 – An Act Establishing the Healthy Steps Program

We believe that this bill is complicated and deserves further study. While there is some focus on lifestyle issues that we believe is appropriate, the bill also contains and allows for the provision of mandate-lite affordable health care plans. We do not support the state's involvement, even through a "Connecticut Connector" of stripped down health care plans as a way of solving the issue of the uninsured in Connecticut. We cannot remedy the issue of the uninsured by making a new class of underinsured in Connecticut.

The protections in Connecticut's statutes are for the benefit of every state employee and public official as well as all fully-insured and individually insured persons in the state. Those protections are vital public policy decisions that should benefit all of Connecticut's citizens. We support a mandate cost study through an independent entity as we believe that it will prove that mandated consumer protections have been falsely derided as the primary health cost driver. Recent studies by The Segal Group show that mandates are responsible for only a very small portion of the increase in health expenditures in each of the last two years, on the order of approximately 2% of the average 11% trend rate. Finally, we believe that H.B. 5721 is best suited for study by the Health First Authority, the body created last year by the legislature and the Governor to develop some solutions to the uninsurance issue in Connecticut. That body is made up of insurers, employers, advocates, government personnel and others and is the best representative of the variety of interests at stake when developing large-scale health reform. There may be a place in our state solution to the problem of the un- and underinsured, for many of the concepts raised in H.B. 5721. However, they must be part of the larger strategy.