Office of the Healthcare Advocate
STATE OF CONNECTICUT

Testimony of Ted Doolittle
Office of the Healthcare Advocate
Before the Insurance and Real Estate Committee
Re SB 346
March 5, 2020

Good morning, Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato, and members of the Insurance and Real Estate Committee. For the record, I am Ted Doolittle, Healthcare Advocate for the State of Connecticut. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a consumer-focused mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; assisting consumers in disputes with their health insurance carriers; and informing legislators and regulators regarding problems that consumers are facing in accessing care, and proposing solutions to those problems.

I appreciate the opportunity to comment in strong support of SB 346, An Act Concerning Public Options for Health Care in Connecticut. This committee has often heard from many stakeholders, including myself, that the rising cost of health coverage, driven by rising health care costs, is a major obstacle preventing small and medium-sized employers from hiring workers in Connecticut, and a significant drain on the personal finances of many in Connecticut. I have testified in support of measures to control costs while maintaining high-quality care, and I strongly support the public option as a comprehensive plan to accomplish these two goals.

This bill establishes an ambitious program of policy initiatives. First, it calls for the Office of the State Comptroller, in consultation with the Office of Health Strategy, to establish the

"ConnectHealth Program" which will offer high-quality, low-cost coverage to employees of non-profits, small businesses, members of multi-employer plans (sometimes called "Taft-Hartley health plans") and consumers purchasing health coverage on the individual market. Under this bill, the ConnectHealth Program must have a minimum Medical Loss Ratio of 90%, which will mean that it must spend at least 90% of premium dollars collected to pay for claims. This is higher than the MLRs specified in the Affordable Care Act for insurance offered on the Marketplace, which pursuant to federal requirements must spend at least 80% (in the individual and small group markets) and 85% (in the large group market) of premiums collected on claims. It is my understanding that the experience of the OSC in administering the state employee and retiree benefits programs is such that an ambitious MLR of 90% is attainable, and I applaud the efforts of OSC here.

I further support the proposal in this bill to implement state-financed cost-sharing subsidies for enrollees in the ConnectHealth Program who do not qualify for cost-sharing subsidies under the ACA. In a time of great uncertainty about the future of the ACA, the legislature has done a lot of work to establish in state law the substantive rights and mandates that are current Federal law under the ACA. However, the potential loss of Federal subsidies for coverage under the ACA would be devastating for many low-income consumers, and it is heartening to see this proposal included in the bill.

The bill also creates a statewide dental benefit for consumers. Access to dental care is an important public health issue and I applaud its inclusion here.

As the state's Healthcare Advocate, I do have some considerations that I believe would help consumers and would make ConnectHealth an industry leader in health coverage and customer experience. First of all, consumers should be able to see what they are buying. The ConnectHealth program should provide information to consumers prior to the point of sale regarding provider networks and plan design. In order to facilitate comparison shopping, this information should be as close as possible to the information that is provided regarding plans available on the Access Health CT Exchange. Second, the program should also be required to provide potential buyers with as much information as possible about their all-in costs (*i.e.*, premium plus all forms of cost sharing). The all-in cost information should include both maximum exposure, as well as information about how

much the buyer or their family is likely to experience, based on expected utilization. This could be accomplished by for instance providing the predicted inter-quartile all-in cost ranges (*i.e.*, providing the expected 25th and 75th percentile of all-in costs). The goal should be to provide a potential buyer with the closest possible estimate of the individual buyer's own likely actual all-in costs. The ultimate goal should be for the plan to use data from the All-Payer Claims Database to provide consumers with information about their expected total annual health cost experience over a given year, based on the household and demographic information, and estimates of health care usage for the next year, that consumers have provided, prior to sale. In subsequent years, as soon as technically feasible, the plan should augment such estimates with consumers' own claims data from prior years – in other words, purchasers in subsequent years should be able to predict their all-in costs using their own actual claims experience from the prior year. While it is possible for a family's claims history to vary wildly from year to year, more commonly health conditions remain fairly stable, so the best gauge of a family's medical needs next year is often their experience from last year.

Third, the plan should pro-rate the annual deductible for consumers who subscribe to the plan partway through the year, in order to treat more fairly an individual who may have already satisfied the deductible in their old plan and must now meet a second deductible in a short amount of time, simply because they have had to change plans.

The plan should consider offering at least as an option a plan that discards utilization review of individual claims altogether, in favor of more rigorous, searching review at the provider level – a new, consumer-friendly category of No-Denial or Low-Denial Health Plan.. It could create a network in which only select, highly trusted providers were admitted. Instead of individualized utilization review, the plan could periodically review the network at the provider level. Providers who upon review were found not to be practicing appropriately could be educated, or even removed or required to repay the carrier for inappropriate services they ordered. Developing such a trusted network or tier would save the expense of claim-by-claim utilization review, while seeing a large boost in customer satisfaction, since consumers would be able to count on their treating providers' recommended treatments always being covered, so long as their provider was a member in good standing.

I do wish to raise two further suggestions for this committee. Section 1331 of the Affordable Care Act provided for an optional state program called the Basic Health Plan, which uses Federal funding to provide affordable coverage to low-income individuals who do not qualify for Medicaid or for subsidized coverage on the Exchange. Minnesota and New York have adopted the Basic Health Plan option, with considerable success. Insofar as possible, the state should explore whether the Basic Health Plan might be a suitable vehicle for the ConnectHealth Program, or at least for enrollees in the ConnectHealth Program who meet the income requirements, and if so, should seek to maximize any Federal funding that may be available to support this program. Finally, the Office of the Healthcare Advocate should be added as an ex-officio, non-voting member of the advisory council.

Thank you very much for your consideration of this testimony. If you have any questions concerning our position on this issue, please feel free to contact me at Ted.Doolittle@ct.gov.