

6582



**Testimony of Kevin Lembo, State Healthcare Advocate  
Before the Public Health, Insurance and Real Estate and Human Services Committees**

***In Support of HB 6582, SB 1022, SB 1045, SB 1046, SB 1049, SB 1050, SB 819, HB 6600  
In Partial Support of HB 5172, SB 988, HB 6417, SB 1048  
In Opposition to SB 990, SB 992***

**March 2, 2009**

Good morning distinguished members of the Public Health, Insurance and Real Estate and Human Services Committees. For the record, my name is Kevin Lembo, and I am the State Healthcare Advocate. The Office of the Healthcare Advocate (“OHA”) 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.

**INSURANCE**

**Bills We Support**

- 1) **HB 6582**, *An Act Establishing the Connecticut Healthcare Partnership*

OHA supports the creation of the Connecticut Healthcare Partnership. H.B. 6582 seeks to provide coverage for public employees and employees of certain nonprofit employers in the state of Connecticut by allowing these employees to enroll in the State of Connecticut employee plan, effectively expanding the State of Connecticut employee pool which should increase the state’s leverage in bargaining with insurers, but also decrease the number of uninsured in the state of Connecticut.

H.B. 6582 is one of several promising proposals circulating through the Capitol for committee action. The goals of this bill are good and the bill needs to be examined in tandem with similar and already enacted laws involving public employees such as MEHIP.

HB 6582 would also convert the plans under section 5-259(a) of the general statutes from fully-insured to self-insured plans. If the plans are converted, we must maintain compliance with the consumer protections contained in the insurance statutes. Generally speaking, conversion to a self-insured product would allow the state more control over the healthcare partnership and state employee plans, and will provide the state with additional tools to drive down costs. However, in today's very rough economy, we have to be careful not to jeopardize the predictable costs we now pay in the fully-insured plan. Recently, Comptroller Wyman and her staff negotiated very attractive contracts for the state. A thorough analysis of the projected versus actual utilization of services must be undertaken before we commit to the conversion to self-insured.

I am pleased to see the idea of pooling of risk on a large scale as a strategy to bring down health costs and to use the savings to expand healthcare coverage. As far back as 2006, I warned against the risk of segmenting the market and the need for pooling risk and developing strategies with all stakeholders to address access to healthcare, so I am delighted to see the idea of pooling large groups becoming more in the mainstream of our healthcare reform thinking. I am pleased to continue to support this concept.

### Partial Support

#### 3) *HB 5172, An Act Establishing the Healthy Steps Program*

We believe that this bill is complicated and deserves further study. The bill is comprehensive in its focus on lifestyle issues, premium subsidies, employer tax credits, incentives for employees who already have HSA accounts, the establishment of a reinsurance program to entice participation of healthcare plans and to allow continuation of coverage for insureds when their incurred claims above the lifetime maximum through re-insurance. However, the bill also contains and allows for the provision of mandate-lite health care plans. I 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. Availability without adequacy is a false and dangerous choice for consumers.

Once again, we support a mandate cost study through an independent entity; we believe that it will prove that mandated consumer protections have been falsely derided as the primary health cost driver in health care costs. Studies by The Segal Group show that mandates are responsible for only a very small portion of the increase in health expenditures in the last few years.

We support the coordination of the delivery of services to the aged, blind, disabled and elderly populations enrolled in Medicaid. Care coordination for this population has been long overlooked; however, we oppose the enrollment of this population into capitated at-risk managed care plans as described in Section 21. Section 21 is inconsistent with Section 20, as Section 20 envisions a plan for better care coordination prior to any changes in the delivery system. We do not believe that a population with intensive healthcare needs can be well served through the at-risk model currently in effect for HUSKY families.

I support the language in Section 24 would restore continuous eligibility for children in HUSKY. Lack of continuous eligibility has created barriers in access to care and increased the administrative burdens on DSS. This is a common sense proposal.

Finally, we do not support the housing of a healthcare reform commission in the Office of Health Care Access. Such a commission must be housed in an independent agency, that is unrestricted in its mission, to serve healthcare consumers.

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. 5172. However, they must be part of the larger strategy.

## **HUMAN SERVICES**

### **Bills We Partially Support**

#### 1) **SB 819**, *An Act Concerning Improvements to the HUSKY Program*

While we support a review of the HUSKY Program to determine areas of the program needing improvement and providing recommendations for such improvement we believe such a report should be conducted by a performance monitoring entity, not by the Commissioner of Social Services. The Department of Social Services should continually monitor the program for improvements. However, an independent review is more likely to be comprehensive and unbiased. Such a review should also include a financial review. An independent entity could complete a review within the time frame prescribed in the bill.

We support the concept raised in Section 2 of this bill; however, the application to HUSKY Plus is essentially incorrect. Behavioral health services to HUSKY B recipients are provided through the Behavioral Health Partnership. While peer support is critical to those with behavioral health needs and a peer support telephone service would be beneficial to recipients of public assistance and likely a cost-savings to the state in averted emergency room admissions, the committee may want to discuss the issue more thoroughly with Value Options to determine what peer supports it has in place already for the populations it serves.

#### 2) **SB 988**, *An Act Concerning Medicaid Funding for SAGA and Charter Oak*

We tentatively support this bill, with revisions to its language that appear below. We cannot support a waiver under the Health Insurance Flexibility and Accountability (HIFA) Demonstration Waiver initiative. We believe that the drafters of this bill may have inadvertently used the HIFA language to describe the proposed demonstration project because this bill is nearly identical to one raised in 2003 that only included SAGA.

Waivers allow states to avoid compliance with specific legal requirements of the Medicaid Act. There are several kinds of waivers that states can obtain. However, it is important to note that while waivers allow states to avoid compliance with some specific provisions of the Medicaid Act, provisions of the Medicaid Act not specifically waived remain in force, i.e., the

state must still comply with non-waived Medicaid provisions. Recipients' rights to due process protections (e.g., notice, right to a hearing, etc.) also remain in effect under a waiver.

For the purpose of a demonstration project, such as an expansion of coverage, Section 1115 of the Social Security Act gives CMS the ability to waive any of a state's legal requirements under Section 1902 of the Medicaid Act, 42 U.S.C. § 1396a, which includes EPSDT, equal access to care and some other important provisions as long as, in CMS' judgment, the state's program complies with the objectives of the Medicaid Act. They are the most sweeping kinds of waivers that CMS grants, and, for that reason, there have been some legal challenges raised to CMS' interpretation of its power to waive certain requirements of the Medicaid Act. Importantly, CMS requires the states to show that their 1115 waivers are budget neutral with respect to the federal costs under the program. That means that, under a waiver, a state is restricted in its federal spending to an amount that is equal to what it spent prior to the waiver plus some adjustment for trends in health care costs. This requirement of budget neutrality is not codified. It is longstanding policy of CMS, however. There is a possibility, though the likelihood of which is currently unknown, that this policy will be reversed under the new federal administration.

The HIFA initiative is a type of 1115 waiver created by the Bush administration which was not separately authorized in federal statute. Under a HIFA waiver, a state could include new populations under a Medicaid "expansion", but the federal government would not offer any additional funding to so. This meant that there had to be trade-offs in Medicaid, in the form of substantial co-pays and/or premiums or benefit cuts to keep the federal costs capped at what they were before the waiver. It's akin to having two people who split \$2 and then adding a third person to the group; now each person has to make due with \$0.66. The HIFA language must be dropped from the bill.

There is no question that SAGA could become a more stable and accessible healthcare program if it were incorporated into Medicaid by means of a waiver. The vehicle would be a demonstration project or an 1115(b) waiver; that is, a waiver allowed under section 1115 of the Social Security Act. Any such waiver must hold all Medicaid recipients harmless.

The proposal to include Charter Oak in an 1115 demonstration project waiver to take advantage of matching federal funds for the program requires more scrutiny. We must be sure that incorporating Charter Oak into the waiver does not jeopardize any protections for the existing Medicaid population. More importantly, to be considered a Medicaid expansion, Charter Oak must also be dramatically improved in its range of coverage, and limits on coverage must be reduced. Essentially, it should be a true Medicaid benefit. For the benefit to be meaningful it must provide access to coverage—more needs to be done to attract providers. The program will not translate into a successful program merely by its inclusion in an 1115 waiver.

Finally, if SAGA and Charter Oak are included in an 1115 demonstration project, enrollees in these programs must have the due process protections of Medicaid including the right to notice and a fair hearing when access is denied and benefits are partially denied, denied, terminated or suspended. These protections should be included in any approved waiver. To

address the concerns OHA has with this bill as drafted, we suggest the following alternative language for this bill which we understand will also be offered by others testifying today:

"Section 1. (NEW) (Effective from passage) (a) Not later than January 1, 2010, the Commissioner of Social Services shall apply to the Secretary of the United States Department of Health and Human Services for a waiver of section 1902(a)(10)(A) of the federal Social Security Act and such other sections of federal law as the Secretary may require, in order to operate a demonstration project under section 1115 of that Act for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under (1) the state-administered general assistance program, and (2) the Charter Oak Health Plan, established pursuant to section 17b-311 of the general statutes. No such waiver shall be submitted which would permit or require any reduction in eligibility, coverage or services under the existing Medicaid program for the aged, blind and disabled and the HUSKY program, Part A in effect at the time of the approval of the waiver, in order to gain approval from the Secretary. The commissioner shall submit the application for the demonstration project to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations prior to submitting the application to the federal government in accordance with section 17b-8 of the general statutes. (b) If the proposed demonstration project is approved by the Secretary, the commissioner shall submit the demonstration project, as so approved, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations, in accordance with section 17b-8 of the general statutes, for consideration and approval, prior to implementation of the demonstration project."

3) **HB 6417** – *An Act Concerning Medicaid Administration and Services*

While the objective of Section 1 of this bill is good, there is an existing body that could take on these functions. With some additional prescriptive language that requires the cooperation of the Department of Social Services with the production of data – the insertion of “teeth” into the legislation--the Medicaid Managed Care Advisory Council could take on the monitoring of the administration of the Medicaid program. Legislative leaders already participate on the council and the council has the added benefit of including provider and consumer voices.

We fully support Sections 2 and 3 of the bill. The operation of programs outside the traditional rule-making process has created substantial problems for enrollees and advocates, who have had little or no access to policy manuals that purportedly regulate DSS programs. We also support the bill’s requirement that draft regulations be shared with the Medicaid managed care council and the Behavioral Health Partnership Oversight council and joint standing committees when the subject matter of the regulation falls under the purview of the councils or committees.

This issue was most glaringly evident when DSS proposed last year to promulgate new regulations on EPSDT scheduling assistance. Many advocates never saw the notice of the

proposed regulation in time to provide comment on the proposed regulation; nor did the Medicaid managed care council. DSS extended the time period for comment, but it should be up to DSS to distribute draft regulations to oversight bodies. Relying on publication in the Connecticut Law Journal does not provide sufficient access to non-lawyers of proposed regulations.

### **Bills We Oppose**

#### **1) SB 990 – *An Act Concerning Expanding the HUSKY Formulary***

We oppose this bill which would subject psychiatric medications for ALL public assistance beneficiaries—despite the bill’s title—to the state’s preferred drug list, inevitably resulting in burdensome prior authorization requirements for these vulnerable populations. Recipients of SAGA, Medicaid fee-for-service and HUSKY (A & B) would face sometimes insurmountable barriers accessing their medications.

While at first blush it may not seem onerous to include psychiatric medications on the preferred drug list, the problems with prior authorization experienced by so many recipients for non-psychiatric medications, portend huge difficulties for enrollees with severe mental illness. Any savings generated by this proposal will be more than outweighed by the costs of lack of access to medically necessary anti-psychotics, anti-depressants, mood stabilizers and other mental health prescription drugs.

#### **2) SB 992 – *An Act Concerning Lowering Pharmaceutical Costs***

OHA opposes this bill, not because the concept of lowering pharmaceutical costs is not timely and appropriate, but because this issue is complex. The expertise for developing a plan to lower pharmaceutical costs across all state purchasers likely resides outside of state government. DSS is not equipped to handle such a broad-reaching endeavor as this. DSS has enough on its plate already. This is not a fair or appropriate burden to place on the Department whose expertise is solely public assistance programs. We recommend that such a study be undertaken, but the state should consider the hiring of outside experts to complete it and make recommendations to the legislature for eventual adoption of a joint purchasing strategy for pharmaceuticals.

## **PUBLIC HEALTH**

### **Bills We Support**

#### **1) SB 1045 – *An Act Concerning Responsibility for Hospital Never Events***

We support this bill. It is appropriate in terms of decreasing costs and of incentivizing appropriate treatment in hospital settings. 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. We are pleased to see the addition of a section to last year's bill that holds patients harmless from any expenses associated with the "never events" described in the bill. We would also like to see a provisions that imposes severe penalties on any facility that tries to recover from patients or their estates expenses for these "never events."

2) **SB 1046** --*An Act Concerning Restricted Access to Prescription Drug Information*

OHA supports this package of necessary consumer protections in the areas of prescription drug marketing, mining and disclosure. The bills work together to ensure medically necessary prescribing and to contain healthcare costs.

The pharmaceutical industry buys information contained in pharmacy records from companies known as health information organizations ("HIOs") which purchase the record from pharmacies. The data is "mined" to target drug marketing to physicians by merging these data with a list of prescriber identification numbers purchased from the American Medical Association. Pharmaceutical manufacturers may also monitor the use of certain drugs and return to exert more pressure on a provider to prescribe a drug if the data shows that the provider is not prescribing up to their standard or expectation.

Marketing based on prescriber data is a key factor in the skyrocketing costs of prescription drugs, the increased usage of expensive brand-name medicines and higher insurance premiums. Marketing based on prescriber data often involves biased and inaccurate information about health risks, and encourages the prescribing of new drugs that might be riskier to patients than already established evidence based treatments. Sales of prescriber data take place without the explicit consent, and generally without the knowledge, of prescribers. Data mining also jeopardizes the safety and confidentiality of patient records

SB 1046 prohibits the disclosure of patient or health care provider specific information regarding pharmaceutical drug prescriptions, otherwise known as data mining, except in very limited circumstances, such as drug recalls. The proposal is based on laws enacted in Maine, New Hampshire and Vermont.

3) **SB 1049** – *An Act Prohibiting Certain Gifts from Pharmaceutical and Medical Device companies to Healthcare Providers*

Prescription drug spending rose 500% between 2000 and 2005. Nearly one-third of the increase is attributed to marketing efforts. Gifts and incentives come along with the heavy sales pitch for the latest and "greatest" generation of medication, which are expensive and suspect. Studies reviewed in the *Journal of the American Medical Association* found that even small gifts influence prescribing decisions. Token gifts including company logos drive up name recognition. Regardless of their value, all gifts create demands for reciprocity. The research shows that the latest and "greatest" drug is often not the best, but always the most expensive – adding unnecessary cost the system. At the end of the day this is a case of a powerful commercial influence being wielded over prescribers and consumers. That influence needs to be reigned in.

SB 1049 adopts the provisions of the successful Massachusetts law prohibiting almost all gifts from pharmaceutical and medical device companies to health care providers and their employees. Samples and payments for participating in clinical trials would still be permitted under SB 1049. This is especially important for those patients who do not have insurance and for ongoing medical research.

SB 1049 also requires the disclosure or certain financial assistance to providers from pharmaceutical manufacturers and medical device companies for scholarships or other educational funds to permit medical students, residents, fellows and other health care professionals in training to attend educational conferences.

4) **SB 1050** – *An Act Concerning the Establishment of an Academic Detailing Program*

OHA supports the establishment of an academic detailing program to educate providers on the details, including the costs and benefits of new medications. Such education is necessary to ensure ongoing unbiased medical education for providers on newer pharmaceuticals. Allowing for continuing medical education credit detailing education should provide the incentive providers need to obtain unbiased education about newer pharmaceuticals. The bill allows the Commissioner of DPH to seek non-governmental funding for the program and encourages the Commissioner to work with DSS to seek Medicaid reimbursement for the program.

4) **HB 6600** – *An Act Concerning the Establishment of the Sustinet Plan*

OHA supports the establishment of Sustinet. So many people worked very hard to put this piece of legislation together, and they deserve praise from all of us. The development of the proposal is consistent with the federal movement to expand health insurance availability. Sustinet, like the Connecticut Health Partnership and the work of the HealthFirst Authority have brought together some of the best minds in the state and country to tackle the critical need for healthcare reform in Connecticut.

The Sustinet proposal contains many sound ideas based the adoption of the Institute of Medicine's principles of healthcare reform. Section 16 authorizes OHA to develop and update the model benefit packages and to recommend guidelines for establishing an incentive system to recognize employers that provide health benefits equal to or greater than the model plan. The inclusion of our office in Section 16 is an appropriate evolution of our work and is keeping with the spirit of our office's creations. We will work with OFA and the legislature to craft a fiscal note for the section.

Please note that on line 1170 of the bill, the word "contact" should read "contract".

**Bill that We Partially Support**

1) **SB 1048**, An Act concerning Bulk Purchasing of Prescription Drugs

OHA partially supports SB 1048. We must examine the benefits of bulk purchasing of drugs across all state programs—it is long overdue. This bill directs the Comptroller, the Commissioner of DPH and the Commissioner of DSS to develop a program, but it gives DSS the duty to submit the plan in consultation with the Comptroller and the DPH Commissioner. This bill is markedly better than SB 922 by involving other state purchasers of drugs in plan development. However, the expertise for development of such a plan likely resides outside of state government. We recommend that such a study be undertaken, but the state should consider the hiring of outside experts to complete it and make recommendations to the legislature for eventual adoption of a joint purchasing strategy for pharmaceuticals.

Thank you for attention to my testimony. If you have any additional questions or need additional information, please contact me at (860)297-3989 or Vicki Veltri, General Counsel, at (860)297-3982 or [Victoria.veltri@ct.gov](mailto:Victoria.veltri@ct.gov).

