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**Testimony of Sheldon Toubman Before the Public Health Committee
in Support of SB 425 (Requiring a Basic Health Program)**

Good afternoon, Senator Gerratana, Representative Ritter and members of the Public Health Committee. I am a staff attorney with New Haven Legal Assistance Association and I am here to testify strongly in support of SB 425, which will provide Connecticut's low-income residents between 133 and 200% of the federal poverty level with the benefits of a Basic Health Program ("BHP"), a critical option for all states under the Patient Protection and Affordable Care Act ("PPACA"), while assuring there is **no cost to the state's taxpayers**.

Without a BHP, individuals over 133% of the federal poverty level would be required to get insurance from a risk-based insurer through the Health Insurance Exchange. Unfortunately, all estimates indicate that, for individuals between this income level and 200% of the federal poverty level, even with the substantial federal tax subsidies, this coverage will be unaffordable for many. For example, even the most conservative estimate by the state's consultant, Mercer, Inc., found that individuals at the bottom of this income band, 133%, would have to pay at least \$100 per month for coverage, when, for the current HUSKY A Medicaid program, there is no cost-sharing even at 185% of poverty-- precisely because of the unaffordability of such costs at these income levels.

Beyond that, without a BHP, individuals in this band:

- would be subject to substantial disruptions in provider access as their incomes went above and below 133% of the poverty level
- would find that children and parents in the same family would be in completely different plans
- would be subject to having the federal government collect from them the amount of any tax subsidies overpaid due to errors from fluctuating income
- would be required to get their health care coverage through a risk-based insurer with a direct financial incentive to deny care
- would not be able to access the breadth of Medicaid benefits (if the BHP provides Medicaid-like benefits, as provided in SB 425).

What a broad coalition of advocates and providers are seeking is an efficient, unitary system for all non-elderly individuals up to 200% of the poverty level, based on the Medicaid program, with the same benefits, cost-sharing protections, consumer protections and provider network for BHP enrollees as are available under that program. This will make access to health care seamless and affordable for individuals who go above and below the 133% guideline and among individuals in the same family. The substantial benefits of a Medicaid-like BHP, particularly when administered along-side Medicaid, with low overhead, efficiencies of scale, and joint administration through the same non-risk administrative services organization (ASO) and with the same provider network, cannot be overstated.

In its January 19, 2012 report to the Board of the Health Insurance Exchange, Mercer found that such a Medicaid-like BHP system with the same cost-sharing protections as Medicaid also is financially feasible in Connecticut, without any need for additional state dollars beyond what it will be receiving from the federal government to run this program (95% of saved tax subsidy payments which would otherwise be made for these individuals in the health insurance exchange). Mercer concluded that “under any scenario based on the estimated subsidy and costs modeled in this analysis, the result is that **it would be financially feasible for Connecticut to offer a BHP option at Medicaid provider reimbursement levels *with no costs to the State.***” (page 188)(emphasis added).

Recognizing that seemingly modest cost-sharing still would cause many at the 133 to 200% of poverty income levels to opt not to participate in the BHP, Mercer modeled cost-sharing to match Medicaid in Connecticut, i.e., no premiums and no cost-sharing:

This [no cost-sharing] Medicaid scenario provides the best advantage to this low-income population, *which would also have the best chance of maximizing enrollment.* (page 187)(emphasis added).

Even for this scenario, Mercer concluded that it would cost 7% less for Connecticut to run a BHP program compared to how much it would be paid by the federal government for creating the BHP (page 187).

In reaching its conclusions about a 7% cushion, however, Mercer **substantially underestimated** the savings from a BHP over (95% of) federal subsidies for enrollment with the exchange, in three important ways.

First, it assumed that the administrative cost for providing Medicaid-like services to the BHP group would be “15% (including profit, risk, contingency loading)” (pages 184, 185). But the total administrative costs for administering Medicaid on a non-risk basis through a non-profit ASO are more like **8%**, not 15%.

Second, placing all Medicaid and BHP enrollees under one efficient administrative system, presumably through all the same ASOs, will avoid the administrative costs of someone

around 133% of poverty churning between different systems and different sets of providers as their income fluctuates. Beyond this, just having everyone in one system will bring economies of scale, further driving down administrative costs.

Third, in moving from the managed care organization (MCO) model to the ASO model for the Medicaid/HUSKY B population in January of this year, the Malloy Administration made clear that it assumes substantial savings from finally coordinating health care in a way that the risk-based MCOs always promised but rarely delivered on. Specifically, through the adoption of patient-centered medical homes which are paid modestly to coordinate all health care for their patients, a lot of unnecessary diagnosis and treatment can be avoided.

For all of these reasons, the 7% margin for the state taking on a BHP with no cost-sharing for BHP enrollees identified by Mercer is quite a conservative estimate. The margin is likely much larger than that.

However, even if Mercer is wrong, this committee need not be concerned about the state taxpayers being required to subsidize **any** of the cost of the BHP. Section 1(b) of SB 425 provides that, in the event the Governor's special advisor for health care reform "determines that the cost of medical assistance provided to enrollees in the basic health program will exceed the federal subsidies available to the state to fund the program," she, in consultation with the Commissioner of Social Services, "shall develop a plan, or revised plan, for the basic health program that maximizes benefits and minimizes cost-sharing, utilizing funds available from federal subsidies to fund the program." If this is deemed not to be clear enough, I have included at the end of my testimony some proposed revisions to section 1(b) which make crystal clear that the special advisor can identify a threatened excess of BHP costs over federal receipts at any time, and that, upon the submission of a plan to address the likely excess so that the BHP remains cost-neutral, this committee and the other committees of cognizance will be given full authority to review and approve, reject or modify that plan.

Thus, while it is true that Connecticut does not have all the guidance it would like before moving forward with the development of a BHP system, this is no reason to delay its adoption, while delay would harm the implementation of the PPACA. The health insurance exchange is being developed right now, and its designers need to know now who is in it and who is not; there is no more time to wait. Based on Mercer's projections, the federal payments will be more than sufficient to fully cover the cost of a Medicaid-like BHP. But if it turns out that the cost of a Medicaid-like BHP is higher than expected and exceeds the federal payments, SB 425, either as it stands or as amended, will shield the state taxpayers from having to take up any of that cost.

Finally, under the PPACA, any savings beyond what it costs to run the BHP must be plowed back into the program to improve it by expanding benefits or increasing provider rates. Given the concerns with provider access under Medicaid in part due to low reimbursement rates for some categories of providers, it will be important to prioritize provider rates with any excess

savings. However, even if provider rates in the BHP are not increased over Medicaid rates (which, under the PPACA, must be increased to Medicare rates during 2013-2014 for primary care), the BHP population will be better served with a BHP with affordable care than through an unaffordable plan obtainable only through a risk-based Exchange insurer. According to Mercer, **50%** of the same population would forego participation in the Exchange due to this unaffordability (page 192), meaning that, for half of the population, the provider reimbursements would not be low; they would be non-existent.

In sum, the BHP option is a far better means than enrollment in the health insurance exchange for reducing the rolls of the uninsured, and at no additional cost to the state. SB 425 would allow this option to move forward, creating a plan that will efficiently provide quality, affordable care for all non-elderly individuals up to 200% of the poverty level, through a unitary, seamless system, to the benefit of enrollees and the taxpayers alike. I therefore urge you to pass favorably on SB 425.

Thank you for considering my testimony.

Proposed Revisions to Section 1(b) of Raised Bill No. 425 (additions shown in bold)

Section 1. (NEW) (*Effective from passage*)

(b) Medical assistance provided through the basic health program shall include the benefits, limits on cost-sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act, unless the special advisor determines that the cost of medical assistance provided to enrollees in the basic health program will **at any time** exceed the federal subsidies available to the state to fund the program. If the special advisor so determines, the special advisor, in consultation with the commissioner, shall develop a plan, **or revised plan**, for the basic health program that maximizes benefits and minimizes cost-sharing, utilizing funds available from federal subsidies to fund the program, **and shall submit this plan or revised plan to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, insurance and real estate and appropriations and the budgets of state agencies for approval in accordance with the procedure set forth in Section 2 of this enactment.**