



**Testimony of Victoria Veltri  
State Healthcare Advocate  
Before the Public Health Committee  
In Support of SB 425  
March 21, 2012**

Good morning, Representative Ritter, Senator Gerratana, Senator Welch, Representative Perillo, and members of Public Health Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate (“OHA”). 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.

Connecticut has an unprecedented opportunity to implement healthcare reform initiatives that will provide equity in access to affordable, quality healthcare for all of its citizens. Senate Bill 425 builds on the protections of the Patient Protection and Affordable Care Act (PPACA) by enabling the development and implementation of a basic Health Plan (BHP) for individuals with incomes between 133 and 200% of the federal poverty level (FPL). Despite the inherent promise in health care reform, individuals in this income range remain far less likely to be able to afford expected premiums and cost sharing in the Exchange. Mercer estimates that this would range from \$75 per month for people at 133% FPL, or 5.8% of their total income, to \$200 per

month, 10.7% of their income, for those at 200% FPL. For a family of four living at 200% FPL, this factor can reach as high as \$5993, or 13% of income.

While it is ideal to have as many lives in the Exchange as possible so that the pooled risk can be diluted as much as possible, it remains likely that many people between 133% and 200% of FPL will simply be priced out of the system and remain either un- or under-insured. Given that the cost of living in Hartford is 21.8% higher than the national average, and 22.1% higher in New Haven, it is implausible to believe that the very population intended to benefit from the reforms envisioned by PPACA and Connecticut's health reform efforts would be able to sustain these costs.<sup>1</sup> This result benefits no one since, if this group cannot obtain affordable coverage, when they do require care, it will likely be in a more costly setting and uncompensated, shifting the financial burden onto providers and, through cost-shifting, the rest of us as well.

Concern has been expressed that by creating a BHP that mirrors Medicaid, low provider reimbursement must also follow so that it may be financially sustainable. SB 425 addresses this concern by requiring that the BHP be designed to operate within the federal subsidies provided by PPACA, which will give states 95% of the expected premium for the selected benchmark plan and 95-100% of the cost-sharing subsidies. In addition, SB 425 shifts HUSKY parents into the BHP, resulting in an increase in federal subsidies from 50% for HUSKY to 95% for the BHP, with estimated savings to the state of nearly \$50 million, mandating that these savings be utilized to increase provider compensation rates. In 2010, Connecticut hospitals provided an adjusted amount of \$250 million in uncompensated care (UC). In 2008, 84% of UC was due to the uninsured and, assuming a similar trend, \$210 million of the 2010 UC costs are due to the uninsured.<sup>2</sup> The implementation of a BHP will make affordable healthcare accessible to this population, decreasing the incidence of UC for hospitals in Connecticut and providing a greater measure of financial stability. Indeed, the total margin for

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<sup>1</sup> <http://www.census.gov/compendia/statab/2012/tables/12s0728.pdf>

<sup>2</sup> [http://www.ct.gov/dph/lib/dph/ohca/publications/2010/uncompensated\\_care\\_brief12-18-09.pdf](http://www.ct.gov/dph/lib/dph/ohca/publications/2010/uncompensated_care_brief12-18-09.pdf)

Connecticut hospitals increased 2.61% and total assets increased \$350 million in 2010.<sup>3</sup> SB 425, by decreasing the uninsured population, can substantially increase hospital's revenue. In 2010, Connecticut hospitals reported \$630 million in charges to uninsured patients, recouping only 13%.<sup>4</sup> Assuming that this population was covered and reimbursement provided at Medicaid rates, hospitals would realize a 200% increase in their reimbursement from this population.

One issue surrounding the implementation of the Exchange concerns "churning", the movement of people in and out of plans as their income fluctuates. While this issue cannot be eliminated, the implementation of a BHP will significantly reduce its impact on the plans by raising the Exchange eligibility from 133% to 200% FPL. There will inevitably be churning at this level, but far less than is predicted at 133% FPL. Studies indicate that of people starting below 133% FPL, 54% had increases in their income over one year that rendered them ineligible for Medicaid, but that a third of them moved back below 133% during that same year.<sup>5</sup> More relevantly, for those between 133% and 200% FPL, 43% saw decreased income that brought them below 133% within the year.<sup>6</sup> By having the BHP mirror Medicaid, the financial and practical impact of such movement across plans can be mitigated, as the systems and administration may be shared, creating a seamless transition for members and reducing administrative overhead and complexity.

The creation of a BHP will substantially reduce the cost insuring this vulnerable, low income population, increasing their access, sustainability and overall health, while protecting the long term viability of the Exchange by designing and alternate coverage mechanism for this higher morbidity population. This lower income, uninsured population utilizes about 60% as much medical care as insured and, as such, would likely bring increased costs to the Exchange, requiring increased premiums that would

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<sup>3</sup> <http://www.ct.gov/dph/lib/dph/ohca/publications/2011/fsreport2010.pdf>

<sup>4</sup> Ibid.

<sup>5</sup> Benjamin D. Sommers and Sara Rosenbaum. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs*, 20, no. 2 (2011): 228-236.

<sup>6</sup> Ibid.

not significantly impact those above 200% FPL, but would jeopardize the stability of this price sensitive population between 133-200% FPL.<sup>7</sup>

Thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at [victoria.veltri@ct.gov](mailto:victoria.veltri@ct.gov).

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<sup>7</sup> Mercer Government Human Services Consulting. Health insurance Planning Report for the State of Connecticut, January 19, 2012, p. 30.