



FTR

DIVERSIFIED GROUP BROKERAGE
CORPORATION

TESTIMONY BEFORE
INSURANCE AND REAL ESTATE COMMITTEE
HUMAN SERVICES COMMITTEE
PUBLIC HEALTH COMMITTEE

THURSDAY JANUARY 31, 2013

LEGISLATIVE OFFICE BUILDING, ROOM 2C

To: The Legislative Committee on Insurance and Real Estate Committee
From: Diversified Group Brokerage
Date: January 31, 2013

Thank you for the opportunity to submit testimony today. I am Brooks Goodison the President of Diversified Group Brokerage Corporation doing business as Diversified Administration Corporation (DGB/DAC), located at 369 North Main Street Marlborough, CT 06447. We provide health plan administrative services, such as claims processing, enrollment, eligibility, billing, customer service, risk management, as well as comprehensive population health management services, to self-funded employers in the state of Connecticut over the last 45 years.

As a testament to our long standing place in the community and understanding of the consumption of health care, we are a Connecticut company, with 100% of our business services located in Connecticut. We provide employment for 65 full time employees in Connecticut as well several part time positions which serve approximately 200 employer groups in our State.

Today we are submitting testimony on SB 596, "*Active Purchaser*". We respectfully request that the state insurance exchange not be granted the authority they are requesting as part of their duties. It is our opinion that granting this authority would be detrimental and a significant step backward in controlling health care costs in our state.

We contend that there needs to be competition in health care. Giving the health exchanges this authority would likely drive out carriers and choices which hurts competition.

The biggest challenge in controlling health care costs is the lack of transparency allowed by providers of care. It is widely known that there is little meaningful transparency in health care cost and quality. There are virtually no other transactions similar to the way we purchase health care, where the party receiving the benefit is virtually disconnected from the transaction. This makes absolutely no sense and is un-relatable to any other thing we buy. This dynamic is also largely responsible for the cost increases we find ourselves dealing with and a leading contributor to the warped perceptions many stakeholders find themselves in— Consider human psychology and the crazy idea many Americans have that they want to pay for dirt cheap coverage, but get gold-plated services paid.

Evidenced by the current issues surrounding Federal Medicare reimbursements as well as State Medicaid reimbursements, it is clear that when the government negotiates these services, the State of Connecticut in this instance, the end effect will likely be as it always is; any movement gained through negotiation by the government will be passed on, as deemed by the providers, and paid for by cost-shifting the rest to the private market. Ultimately, the burden will fall on the shoulders of the individuals of the state of Connecticut which does not solve a thing.

Another significant point to consider is that fewer and fewer providers accept Medicare and Medicaid patients presumably because the reimbursements are too low which leaves those folks with coverage but challenged by limited access due to the reimbursements negotiated. When the State tries to negotiate health care, it will ultimately be at the expense of everyone else without really making progress on controlling costs.

When only looking at the administrative efficiencies reported by Medicare, it would seem that the Exchange might help by throwing its negotiating weight behind leveraging better administrative fees. While this may seem attractive at first, in the long run you get what you pay for. Medicare administration looks inexpensive because of how it looks against the denominator of the total costs of the system. In other words, if you cut costs on administration and medical management and population health management, claim costs balloon out of control. This can skew the perception of lower administrative costs as a percentage of total costs.

TPAs like Diversified may have higher administrative costs as a percentage of the total cost of running a plan, but we work hard to shrink the size of the pie. Said differently, we lower the denominator. Please understand, in our model under ERISA, there is compulsory disclosure and understanding of all fees and clear expectations of what we must deliver to the customer for the fees we charge—all of which are described and negotiated up front, before we do one service on behalf of the plan. Consider the contrast between what I describe above and how doctors and hospitals deliver their charges. It is

also important to note that we as a TPA also function in a highly competitive environment where shopping for these administrative services is relatively easy for employers and plans.

Again we contest it is the cost of the care not the cost of administration. We see the issue as skyrocketing claim costs. The first step we all need to take on this issue is the use leverage to compel clear, concise data on costs and quality. There is really no excuse for not doing so.

Again, we request that the Exchange be denied the ability to negotiate on behalf of the State. Once the State is the insurance company and the expansion of Medicare and Medicare is well underway, it will likely be a budget buster and a difficult obstacle to navigate. This is an obstacle that can be avoided.

We thank you again for the opportunity to provide testimony. I can be reached at the address on this letterhead or at 860-295-0238 ext. 432.

Sincerely,

Brooks Goodison
President