Testimony of Victoria Veltri
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Before the Appropriations Committee
Governor's Budget Proposal
February 27, 2015

Good evening, Senator Bye, Representative Walker, Senator Kane, Representative Ziobron, and members of the Appropriations 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.

I appreciate the opportunity to comment on the Governor's Human Service budget proposal. There is no question that the budget climate is extremely difficult this year. However, I must oppose many of the proposed cuts in the Department of Social Services budget, as I believe they will increase the uninsured rate in our state and dampen efforts to achieve increased access to care, improved quality of care and reduced healthcare costs.

Although I am the vice chair of the Access Health CT Board of Directors, it should be noted that the testimony that follows reflects my position as the state's Healthcare Advocate, and not that of the Board of Directors.

Office of the Healthcare Advocate
STATE OF CONNECTICUT

Removing HUSKY A Adults from Medicaid

OHA opposes removing HUSKY A adults with incomes between 138% and 185% of the federal poverty level from Medicaid. There are multiple reasons for our opposition to this proposal.

1) First and foremost, OHA believes that while Access Health CT is positioned to mechanize healthcare coverage to the adults in this income category, the plan options offered to this income group are more likely than not to be unaffordable from a premium and cost sharing perspective, despite substantial subsidies from the federal government. This cut will translate into a higher uninsured rate and potential increased healthcare costs as people resort to higher cost care options when they cannot afford premiums and/or cost sharing.

This is no fault of Access Health CT. While the committees that advise the Access Health CT Board of Directors were able to come to consensus on the platinum and gold and two silver standard plan designs, consensus could not be reached on the cost sharing reduction options for people in the 185-200% FPL income bracket and the 138-185% FPL income bracket. Despite the outstanding efforts of the staff of Access Health CT and the efforts of the advisory committees, the constraints of the federal actuarial value (AV) calculator—a formula that calculates actuarial value based on various inputs of cost-sharing across service categories--prevent adjustments that, in OHA's view, would allow for affordability protections for the lowest income populations that approach those offered in the current Medicaid program. Actuarial value (AV) is the measure of out of pocket costs, excluding premium, a plan will pay. Platinum plans have a 90% AV, meaning the plan will pay about 90% of the out of pocket costs of the plan while a consumer would pay 10%. Gold plans have an AV of 80%, silver -70%, and

bronze - 60%. Lower AV plans have lower premiums and higher cost-sharing. Access Health CT must use the AV calculator to develop plan designs. At this point, early on in the federal and state exchanges, the AV calculator offers little flexibility. In out years, this will hopefully change.

The federal government offers two forms of assistance to people in lower income categories—advance premium tax credits or APTCs (offered to all individuals and families between 138-400% FPL) that are based on the costs of the second lowest silver plan, and cost sharing subsidies to individuals below 200% FPL. Cost sharing subsidies are available **only** at the silver level while APTCs can be used at any level—platinum, gold silver or bronze. Therefore, for an individual or family at a lower income, an APTC goes farther to offset premium in a bronze plan than in a silver plan, but a bronze plan does not offer cost-sharing reductions. The best silver cost sharing reduction plan designs for people at the lowest income ranges that the Access Health CT staff, through diligent effort and multiple requests to try to reduce out of pocket costs, could develop within the limits of the AV calculator, resulted in, in addition to a substantially reduced monthly premium:

- A family maximum of $1600
- $10 PCP co-pay
- $30 specialist co-pay
- $75 co-pay per day for hospital admission up to a maximum of $300
- Co-pays for laboratory and radiology services
- Co-pays for prescription drugs of $5 per generic, $10 for Tier 2, $30 for Tier 3 and 20% co-insurance up to a maximum of $60[1]

[1] See http://www.ct.gov/hix/lib/hix/IND_plans_approved_by_ACs_amended_2-16-15.pdf, accessed February 25, 2015. (The consumer committee could not vote on the final plan designs because of lack of a quorum. The Board approved the designs at its February 19, 2015 board meeting. The Healthcare Advocate voted against the Silver 87% and 94% plan designs and the bronze plan design.)

These cost-sharing requirements will substantially affect low-income individuals' ability to access providers and needed (and perhaps maintenance) medications that could prevent unnecessary hospital admissions or other higher cost care options. If a caregiver in this income category chooses a bronze plan because he or she faces a premium in the silver cost-sharing reduction plans, the caregiver will face a $5000 deductible before accessing a generic maintenance medication with a $5 copayment.[2] As co-payments are not waiveable (and cost sharing reductions are not available in bronze plans) and more practices and facilities require payments of deductibles in advance of treatment, people may find themselves with no meaningful healthcare option of a regular source of care and instead rely on higher cost emergency departments, leaving hospitals unfunded for that care. OHA believes that the risks of imposing premiums and cost sharing at the silver levels and the added risk of individuals choosing bronze plans are too great to the low-income population to support such an option. OHA is also very concerned that the budget proposal will inadvertently undo the good work done by DSS to ensure a regular source of care for HUSKY recipients, access to the Behavioral Health Partnership, care coordination and intensive case management, all at low cost with a big return in terms of access, quality and cost-containment.

2) The cost of covering a current HUSKY A recipient is approximately $600 per individual per year of which the state pays $300. That $600 cost will be eclipsed for a family in half a year in premiums in private coverage while exposing families to substantial out of pocket costs above that amount. OHA is aware that Connecticut may be the last remaining state in the country to offer Medicaid up to 185% FPL for families (and higher for pregnant women). However, Connecticut's widest in the country income gap between the top fifth and bottom fifth, substantial rates of poverty in the state, and Connecticut's high cost of living, warrant extending

[2] Ibid.

Medicaid to 185% FPL for families. There is no available option on the Exchange that will hold adults in this income category harmless.

3) Health insurance coverage under the Exchange does not include dental coverage as part of the package for adults. Adults in HUSKY A have dental coverage as part of the HUSKY plan. While that coverage is not as robust as OHA would like it to be, it is by far superior to having no coverage. To access dental coverage on the Exchange, one has to purchase a dental policy, paying a separate and unsubsidized premium. Neither APTCs nor cost sharing reductions extend to dental coverage. Current HUSKY A adults will be without dental coverage if they lose eligibility for Medicaid as a result of the budget proposal. Lack of access to dental coverage results in lack of access to dental care, which in turn can lead to serious health conditions, including heart disease. OHA has repeatedly opposed the removal of dental coverage for adults on Medicaid for this reason.

4) Advocates have presented ample evidence that putting adults in one type of coverage and their kids in another jeopardizes access to care for both caregivers and the children in that family.

5) Finally, OHA believes that including the HUSKY A adult cohort in the Exchange also runs the risk of increasing health insurance premiums for all individual policyholders on the Exchange. Premiums for individual insurance are based on one risk pool. Everyone is included. If history is any lesson, utilization patterns of low-income people reflect higher than average medical needs and higher levels of utilization and medication, which will be reflected in higher insurance premiums for all purchasers on the Exchange. In OHA's view, this not only jeopardizes the ability of low-income individuals to purchase policies on the Exchange, even with a subsidy, but could also contribute to increased premiums across the board, jeopardizing

overall enrollment and sustainability of the Exchange, particularly for the non-APTC purchasers of insurance.

Lowering Eligibility for Pregnant Women to 133% FPL

For the same reasons articulated above and for public health reasons, OHA opposes reducing the income eligibility for pregnant women for Medicaid. It is not wise public policy to erect barriers that will prevent pregnant women from receiving medically necessary preventive screenings and prenatal care. While most preventive care is covered at no cost under the ACA to individuals enrolled in insurance plans and non-grandfathered group health plans, accessing health coverage on the private market still requires payment of premium dollars to access health coverage. Of particular relevance to this population is the reality that, should a women in this income range become pregnant but, for the reasons stated above, may be uninsured, they may not enroll in coverage outside of the open enrollment period absent a qualifying life event (QLE). The birth of a child constitutes a QLE, but pregnancy does not, so it is likely that many low income women may have no access to affordable pre-natal care. OHA believes that even subsidized premiums will be out of reach for people at low incomes, making healthcare coverage, even for preventive services, inaccessible for pregnant women at this income level.

Medicaid Provider Rate Reduction

The proposal to reduce Medicaid provider reimbursement will hurt access to care and increase cost shifting. OHA has received many complaints from consumers who enrolled for health insurance through Access Health CT and were deemed to be Medicaid eligible, one of the most frequent being not Medicaid itself, but the lack of available providers in their area. Reducing reimbursements further jeopardizes this network, disincentivizing provider participation or creating an economically unsustainable model for provider who might wish to continue to participate. Hospital testimony before the Bipartisan Roundtable on Hospitals and Healthcare

confirmed the adverse economic impact of the already low rates, noting that the increased imposition of facility fees for qualified services were intended to offset the losses in revenue related to Medicare and Medicaid reimbursement rates. Further reductions will only exacerbate this trend, reduce the pool of available providers and make it that much more difficult for consumers to receive effective, timely treatment in the most appropriate and cost effective setting.

Reduced eligibility for Connecticut Home Care Program for Elders (CHCPE) and increased cost-sharing for CHCPE

The proposal modifying eligibility and cost-sharing for the CHCPE fails to account for the myriad of benefits that consumers as well as provider and the state derive from this program. CHCPE permits qualified individuals to receive medically necessary care at home, with significant associated cost savings as well as promoting the quality and comfort for the patient. While the short term savings may seem reasonable, the long view may very well demonstrate significantly higher costs for this population if they have to receive these services. Specifically, this proposal freezes the Category 1 benefit, which helps to prevent those at risk of needing hospitalization or skilled nursing from being admitted to those facilities. Continuing these benefits enables these people to receive medically appropriate care at home, at lower cost, with greater comfort and the associated improved response to treatment, and avoid the risk of contracting a hospital acquired infection, a serious risk for this elderly population.

Removal of Funding for the Federal Demonstration to Integrate Care for Dually Eligible Individuals

The removal of funding for this project fails to acknowledge the long term savings likely to result from this initiative. As our population ages, and life expectancies grow, the

development of an effective, cost effective and responsive mechanism to assist these dually eligible consumers coordinating their complex care needs, identify appropriate and effective care management models and promote continuing quality enhancements becomes critical to controlling future healthcare costs for this population. This project is specifically aimed at achieving these goals in a comprehensive and inclusive manner, and should not be eliminated.

Medicare co-pays for duals

Similarly, the proposal to require this dual population to pay all of their medication co-pays fails to recognize the potential impact in this population. Without the assistance currently available due to the wrap around Connecticut has had in place for years, the cost of medications for these consumers, many of whom have very limited income, will be prohibitive. This financial challenge has historically resulted in people opting to forgo taking prescribed medications, either at all or as prescribed, which can significantly impact their course of treatment, potentially leading to a need for significantly higher cost services as the conditions managed by the prescribed medication may be less well managed. This could lead to increases in ED visits, disease progression and hospital admissions, the costs of which far exceed the minimal savings anticipated by this reduction.

Reduction of Medicaid performance payments

This proposal is directly contrary to the state's ongoing healthcare reform efforts which promotes performance metrics and incentivizes quality. This reduction will significantly disincentivize provider participation.

Additional provisions of this proposal go against our ongoing commitment to its citizens, including the reduction of the personal needs allowance in nursing homes, the only source of income for many of these individuals and the removal of funding for legal services under the

Social Services Block Grant, which supports the only legal resource that many consumers have available to them for assistance.

However, the expansion of conditions for which Medicaid reimbursement is available for detoxification treatment is good public policy. It acknowledges the wide range of substances contributing to Connecticut's substance use problem, maximizes available funding sources and promotes access to treatment in residential treatment programs for consumers struggling with substance use. I wholeheartedly support this provision.

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.