

Testimony of
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To
The Labor and Public Employees Committee

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Honored Chairmen, distinguished Committee members, thank you for the opportunity to speak with you today about S.B. 7314. I am here before you today as Vice President for Program and Policy of the Universal Health Care Foundation of Connecticut. The Foundation urges this Committee to embrace a broad and bold view of what it will take to achieve quality, affordable health care for adults and children in Connecticut. We urge you to adopt a vision that lives up to our values as a state. One place to start to build a comprehensive reform is with the principles issued by the Institute of Medicine in 2003. The principles define universal health care as a system that

- includes everyone;
- is continuous and portable
- is affordable to individuals and sustainable to society; and
- enhances health and well-being.

As many of you are aware, last year the foundation has commissioned analytical work to develop comprehensive health policy options to cover all of Connecticut's residents. We have worked with the Urban Institute, the Economic and Social Research Institute and Dr. Jonathan Gruber of MIT. Based in part on some of this analytical work, S.B. 7314 is an important piece of legislation that would move Connecticut's health coverage in a positive direction. I hope to cover three topics in connection with the bill: the basic vision animating the proposal; two structural changes to the proposal that our researchers have recently recommended; and several possible technical changes.

Basic vision

S.B. 7314 would insure all residents of Connecticut through competing, private health insurance plans offering a range of benefits. Some coverage would include comprehensive health services typical of private employers in New England. The state's role would be to administer a purchasing pool through which state residents could obtain their choice of health plans.

Under this approach, health insurance decisions would be in the hands of the individual family, not the employer. Each person could select the health coverage that best fits his or her needs and keep that coverage, regardless of job changes.

Based on income, consumers would pay a percentage of the premium, up to 30 percent. This would give families an incentive to select less costly coverage.

In addition, each employer above a certain size would contribute a certain percentage of payroll.

Low-income residents previously eligible for HUSKY and SAGA would receive the bulk of their care through the purchasing pool, giving them access to the same reimbursement levels and the same health care providers that serve middle-class residents. In addition, low-income families would receive supplemental services and protection against cost-sharing so that they would retain the level of help currently guaranteed by HUSKY and Medicaid.

A similar, market-based approach has been used for years with federal employees. Not only has the Federal Employee Health Benefits Program (FEHBP) provided millions of federal employees with comprehensive, affordable coverage, the competitive features of the program along with enrollees' incentive to select less expensive options have limited cost growth. For example, from 2002-2007, while employer-sponsored insurance rose at an average rate of 11 percent per year, FEHBP insurance premiums rose by an annual average of 7 percent.

A prior version of this proposal was analyzed by Dr. Jonathan Gruber of the Massachusetts Institute of Technology, who found that it would lower employers' health care costs by \$170 million a year and give households \$640 million a year in additional resources that could be devoted to purposes other than purchasing health care. As a result of these savings and other factors, an analysis using the REMI macroeconomic model for Connecticut projected that

the proposal would add 2,000 and 6,000 jobs to Connecticut's economy and increase the state's GDP by \$320 million to \$470 million.

Structural changes

We recommend two major structural changes. First, the proposal could be administered through a separate, non-lapsing account, outside the General Fund. A revenue intercept would direct to this account contributions from employers, individuals, and the federal government. As a result, hundreds of millions of dollars in federal contributions that, in the past, counted against the spending cap would be outside the cap. This could perhaps increase the state's capacity to meet other pressing needs.

Second, we would recommend a different approach to employer-based coverage. Our earlier proposal, like the legislation before the committee, applied differential payment obligations to ensure that employers would pay more for coverage outside the purchasing pool than if their workers were covered through the pool. Because of a recent ERISA opinion from the Fourth Circuit Court of Appeals, we would recommend changing this approach and instead phase in purchasing pool coverage without varying an employer's payments based on the benefits it provides to its workers.

Such an alternative approach could begin by providing coverage through the purchasing pool to two groups: (a) state residents who are not enrolled in health insurance offered by a private employer; and (b) employees of very small firms that have a payroll under the average for a company with 10 employees (\$265,000 a year, according to Dr. Gruber).

Under this approach, firms could "opt in" to the pool. Any firm whose workers received coverage through the purchasing pool would pay 14 percent of payroll above the \$265,000 threshold level (capping at \$200,000 per employee the payroll to which the payment obligation would apply).

After this initial step, coverage through the purchasing pool would gradually expand to progressively larger firms. At each stage, an independent evaluation could be conducted that would report to the Legislature the results of the coverage to date.

Technical changes

A number of technical changes would help the bill accomplish its objectives more effectively.

First, the purchasing pool could be directed to have more than one benchmark option. That would provide at least some competitive pressure, among benchmark options, for efficiency and quality. Among other benefits, default enrollment shares could be awarded to the low-cost benchmark option with the best record of service to prior default enrollees (rather than enrollees in general, as under the current bill). Under this approach, the maximum percentage subsidy would be capped near the lowest-cost benchmark plan, with consumers paying the full increase in premium for more coverage more expensive than the cap.

Second, low-income adults categorically ineligible for Medicaid coverage by state plan amendment could receive Medicaid coverage up to 185 percent of the federal poverty level (FPL), rather than 150 percent, the level provided by the current bill. That same 185 percent income level would be the maximum for adults enrolled in the pool who can also receive supplemental services and protection against cost sharing.

Third, the language concerning Section 125 of the Internal Revenue Code may need fine-tuning. The basic notion here is that pool plans becomes the employer's group coverage, under federal law, and employers would be required to let their workers' contribute pre-tax dollars to pay the premiums for that coverage.

Fourth, in terms of employer-based coverage, each employer could be offered a choice either to have its offers of employer-sponsored insurance (ESI) accepted by operation of law (roughly along the lines in the current bill) or to give its employees the option to leave ESI for the pool. A firm choosing the latter option would pay its pro rata share of pool costs for these enrollees, adjusted to compensate for any differences between the average risk level of state residents and the risk profile of people whom the company offers ESI but who instead opt for the pool.

Fifth, the deadline for statewide information technology adoption could be delayed. October 1, 2008 may not be feasible.

Sixth, Title XIX of the Social Security Act, not Title XXI, needs to be the basis of the waiver that seeks federal funds for adults not categorically eligible for Medicaid. To provide additional confidence that low-income people will be helped, not harmed, DSS could be prohibited from implementing the waiver until its terms are approved by the House and Senate. In addition, the prohibition against a reduction in covered services and similar consequences would need to apply to individuals eligible for HUSKY, Medicaid, or SAGA under state law as effect on a prior date, such as October 1, 2006.

Seventh, Medicaid beneficiaries who qualify on the basis of severe disability could continue to receive coverage through current Medicaid providers, rather than the more mainstream plans that will be offered through the pool.

Eighth, parents who receive Medicaid coverage with incomes above 185 percent of FPL (like children above 300 percent of FPL) could be limited to the benefits and cost-sharing protection afforded by the benchmark coverage. The state would nevertheless benefit from federal matching funds for such individuals.

Ninth, personal responsibility discounts could be provided to individuals who either (a) are not obese or smoking; (b) are obese and/or smoking but enrolled in a nutrition-exercise-tobacco-cessation program; or (c) seek to enroll in such a program, are unable to enroll only because no such program is available to them, place their names on waiting lists for openings in such programs, and take advantage of all such openings.

Tenth, employers could receive a credit for workplace wellness programs based on the lifetime health cost savings from such a program, discounted to present value.

Eleventh, the primary care provider network strengthened by the bill might not be limited to Federally Qualified Health Centers and similar providers. Instead, a broader range of primary care centers might qualify.

There may be other areas where technical refinements could be helpful. The Foundation looks forward to answering any questions I can and making available our research resources to the Committee and its able staff to produce the best possible outcome for the residents of Connecticut.