



STATE OF CONNECTICUT  
OFFICE OF POLICY AND MANAGEMENT

6582

TESTIMONY PRESENTED TO THE PUBLIC HEALTH, INSURANCE AND REAL  
ESTATE AND HUMAN SERVICES COMMITTEES  
March 2, 2009

Robert L. Genuario  
Secretary  
Office of Policy and Management

Opposing House Bill No. #6582

AN ACT ESTABLISHING THE CONNECTICUT HEALTHCARE PARTNERSHIP

---

Senators Harris, Crisco, and Doyle, Representatives Ritter, Fontana, and Walker, Senators Debicella, Caligiuri, and Kane, Representatives Giegler, D'Amelio and Gibbons and distinguished members of the Public Health, Insurance and Real Estate, and Human Services Committees, I am Robert L. Genuario, Secretary of the Office of Policy and Management. I come before you this morning to testify in opposition to House Bill 6582, "An Act Establishing The Connecticut Healthcare Partnership".

As we are all aware, issues associated with health care costs and access are complex and defy easy solutions. Even given these complexities, however, we have continued to make progress here in Connecticut. Recently the U.S. Census Bureau documented our significant progress in reducing the number of uninsured residents in this state.

While well-intentioned, House Bill 6582 will not lead to reducing the number of the uninsured nor will it reduce costs. In fact, the evidence indicates that this proposal will increase our costs for public employee health benefits at a time when we are struggling to make resources available to meet the needs of our most vulnerable populations.

As we discussed last year, the pooling proposal again contained in this bill is fundamentally unworkable.

As it happens, the U.S. Congressional Budget Office, in its December 2008 report, looked at the issues associated with opening up the Federal Employee Health Benefit plan in the same fashion as the bill proposes to do with the State employee plan. According to CBO, if those joining the federal plan were to pay the same premium as federal employees, as is being proposed in House Bill 6582, the FEHB

plan would most likely attract those with above-average costs for health care. As a result, the uniform premium would rise causing the cost to increase for federal employees, the federal government and those joining the plan. This is exactly the reaction we saw from the market when this proposal was raised here in Connecticut last session.

We note that the bill does provide for a community-based rating under existing State law for small businesses seeking to join the State plan. Under these provisions, factors such as age and geographic location can be utilized in setting rates, but not health history. Using the federal example once again, however, CBO predicts that the total premiums charged to non-federal employees would likely still be substantially higher than those observed in the individual market based on adverse selection issues.

It is critical to note that as a result of Connecticut's progressive regulatory framework for health insurance for small businesses, including our community rating statutes, our State has a healthy and viable small business market that provides affordable coverage tailored to meet the needs of small businesses and their employees. Connecticut is viewed as a leader in this regard across the country.

The problems and viability issues associated with the current proposal can be demonstrated by what is—and is not—being done in other states. We looked at the 26 states that we know of that have opened their State plans to local governments or which have established programs similar to our MEHIP. We found that no state opens its state employee plan to small businesses or generally to non-profits. No state appeared to have both a MEHIP type program and a provision to allow local governments into the State employee plan. Most all of the states take specific steps to mitigate negative cost impacts on the state or the issues of adverse selection discussed previously. These measures include having separate pools for local employees, separate ratings for local employees, requiring participation of certain local employees, and penalties for leaving the pool. We also found that 22 of the states established the benefit plans administratively, with four doing so through collective bargaining agreements negotiated periodically.

In looking at comparisons of premium rates for municipalities and the State, in many instances the State's costs are higher than the local costs. The causes and accuracy of the cost differences are not easy to determine since they are driven by factors such as plan design, demographics of the group, and other factors. As was found in the case of New Haven last year, these have to be analyzed on a case by case basis. Where premiums are higher at the local level as a result of factors such as claims experience or regional cost differences (which can cause cost variations of 16 to 18% across the state), the impact of these towns joining the State plan would be clearly be to increase costs to the State, its employees and others in the plan.

While some relatively modest administrative savings compared to the full cost of premiums may be possible for some local governments with this proposal, these savings can best be achieved through efforts such as the Comptroller's E-MEHIP

plan and working with municipalities to work together in the procurement of health insurance, as a number of local governments already have. The other and greater challenge to be addressed is to increase the value received from the underlying claims that comprise the vast bulk of our growing health insurance costs. Health care economists indicate that a significant portion of our nation's consumption of health care services is not necessary or effective in terms of improving health care outcomes.

House Bill 6582 contains a provision for the Comptroller to convert the existing state employee health plan to a self insured plan for the benefit period beginning on or after July 1, 2009. The State is currently in the first year of three year contracts with each of the health care insurers. The State has procured caps for the premium increases in next two years. The caps guarantee that the premiums can not increase by more than negotiated cap percentage amount. This effective cost containment tool will be eliminated if switched to a self insured plan.

Currently, the state employee plan is experiencing high claims activity and switching to a self insured plan at this time will not only shift the risk from the insurers to the State but will also cost the State more money, thereby increasing the anticipated deficits projected during the biennium. Based on information obtained from the Comptroller's Office, switching to a self insured plan could result in FY 2010 rates that are 5.9% higher than the cap guarantee under the existing fully insured plan. This translates into an additional \$69 million in health costs for active and retired state employees in FY 2010. This amount does not even include the additional costs to set up a reserve which should be at least \$100 million. To not establish a reserve for the medical claims would be extremely reckless, especially in light of the current claims experience of the State plan.

These costs would dramatically increase if non-state public, municipal-related, small employer and non-profit employees are included in the same pool as the state employees plan. The State is bound by existing health contracts that did not incorporate an expanded pool. The rates and caps were developed using the very specific demographics of state employees and retirees. Adding a large, unknown group of employees and retirees to the current pool would drive changes in utilization rates and claims costs. Material changes such as these require renegotiation of the agreements.

Once again, while we appreciate the intent behind House Bill 6582, we continue to have serious reservations regarding the adverse consequences on the State budget that would result from passage of this bill. And let me repeat: this bill does not decrease the number of those who are uninsured; rather it merely provide a more generous benefit package to those who choose to sign up for it and passes that cost along to state taxpayers.

All that said, we are happy to work with you and the other members of the General Assembly in building upon our joint record of improving access to affordable and effective health care. I would like to again thank the committee for the opportunity to present this testimony. I will be happy to answer any questions you may have.