

State of Connecticut
HOUSE OF REPRESENTATIVES



Christopher G. Donovan
Speaker of the House

**Testimony of Speaker of the House Christopher G. Donovan
To the Insurance and Real Estate, Human Services and Public Health Committees
In support of House Bill 6582:
An Act Establishing the Connecticut Healthcare Partnership
March 2, 2009**

Good morning Representative Fontana, Senator Crisco, Representative Walker, Senator Doyle, Representative Ritter, Senator Harris, and members of the Insurance and Real Estate, Human Services and Public Health Committees. Thank you all for coming together today for this joint hearing on many important healthcare proposals.

I appreciate the opportunity to express my strong support for House Bill 6582, *An Act Establishing the Connecticut Healthcare Partnership*. As you will recall, it passed both the House and the Senate last year, but was vetoed by the Governor. Many of you voted in favor of it and some of you even hosted me in your communities as I traveled the state promoting this proposal. Time and again I was met with enthusiasm and support by municipal officials, union leaders, small business owners and non-profit organizations—and that was before we felt the full impact of the economic downturn. Our state has experienced many changes in the past year, and I would argue that the need for this legislation has grown.

HB 6582 would open the state employee health plan to municipalities, non-profits and small employers on a completely voluntary basis. This proposal would streamline our healthcare system and provide financial relief to local governments, non-profits and small employers. These groups would be able to take advantage of the increased bargaining power and reduced administrative costs associated with the State plan, as well as the comprehensive benefits that state employees currently receive.

Recent proposals to create healthcare purchasing pools have generated significant attention. David Osborne, expert in budgeting and improving government performance, argues that because governments are such large players in the healthcare marketplace, they can get better care at better prices by creating large statewide healthcare purchasing pools and including both public and private employers. When health insurers compete for this market, the result is affordable high quality care.

The state employee health plan has been providing good benefits to our employees, while keeping cost increases to a minimum. In fact, while many employers struggle under substantially higher premiums each year, the annual premium costs for the various medical and dental plans from which state employees can choose dropped an average of 16% in the last year.

Making these benefits available to non-state employees will stimulate our economy by allowing employers to stretch their dollars further, prevent layoffs and eventually attract talented people and grow their businesses. This would doubly assist the many non-profit providers the state depends on for health and human services, which have gone without adequate cost of living rate increases for several years.

The major change to the current proposal is that the state employee health plan will switch from fully insured to self-insured under an agreement between the state employees and the State. This will result in an immediate savings to the State equal to approximately two months of premiums. Under the self-insured structure, the State will pay actual medical claims directly to medical providers through an administrative services only (ASO) arrangement with a third party administrator. The savings are a result of the transition from paying monthly premiums (which include risk service charges) up front to paying the actual claims after they have been incurred

Most large employers self-insure because it costs less. A self-insured plan will allow the State to realize long-term savings by directly managing the medical claims and health service utilization. The State will be able to create real incentives for wellness and prevention and use scientific data for case management services to keep healthcare costs down.

I hope you will agree that this is an important step toward our goals of saving state dollars, providing relief to municipalities, and the small businesses and non-profits we rely on, and expanding access to high quality affordable healthcare options.

I urge your support for this important proposal.

OFA Memorandum

Memo to: Laura Jordan
From: Spencer Cain
Date: February 11, 2009
Subject: Cost Analysis of Self Insuring the State's Health Care Plan

You have asked what would be the savings to state if the employee health plan was fully self-insured as compared to our current plan, which is a negotiated fully insured plan.

The cost of health plans includes loss costs related to payments made on behalf of clients to health care providers and the cost of administering the plan. Loss costs for state employees and retirees are generally in the range of 80 percent of the premium paid to health plans but can vary from year to year based upon the health experience of the pool of covered lives. In addition, the cost of administration includes the processing of claims, establishing provider networks, negotiating provider payments, and providing utilization review and disease management services. Private health insurers are also required to maintain minimum reserve requirements based upon Connecticut insurance law.

To the extent that the State of Connecticut can provide these services at a cost less than private health plans, savings could be achieved. However, at this point in time the state does not have the infrastructure to process claims, nor has it established provider networks or negotiated rates with specific health care providers. The state would not be required by law to provide for reserves to cover claims. It is likely that the state would contract with a third party administrator to provide those services that the state would be unable to provide through its own staff.

If the state moved to self-insurance it would pay for claims on an incurred and reported basis. When an entity moves from fully-insured plans to a self-insured mechanism, the premiums paid to a health insurer cease and the claims would instead be paid through a self insurance pool, which would be appropriated by the legislature. Due to the fact that there is a lag in the payment of health care claim from the time they are incurred until the time they are reported to the self-insurance pool administrator, there is a potential short term one-time savings. Health claims from providers general take 30 to 60 days to be paid depending upon the amount of time it takes the provider to submit a claim and the amount of time it takes the self-insurance administrator to pay those claims.

Currently, the comptroller pays approximately \$72.5 million in health care premiums a month for active and retired state employees. The lag in claims incurred and not paid will result in a significant savings in the first two months of the transition. The savings would be the difference between paying \$145 million to a health plan for two months of

premiums and the amount paid for claims incurred and reported in the first two months. Assuming that half the claims that are incurred are paid in the first two months, the state would obtain a temporary savings of \$72.5 million for the fiscal year the transition took place.

When the state went from self insurance to fully insured 1999, a payment \$65 million was made for claims that had been incurred by the third party administrator but not paid due to the lag in claims as well as a deficiency in the funds provided to the administrator.