



AHIP Testimony on HB 5487  
Connecticut Insurance and Real Estate Committee – March 13, 2012

I am Brian Quigley, Regional Director for America's Health Insurance Plans. AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of insurance products, including major medical, long term care, disability income, dental, vision, specified disease and other supplemental coverages. I appear today for the Connecticut Association of Health Plans to indicate our strong opposition to HB 5487, an Act concerning the recommendations of the Small Business Healthcare Working Group and claims information required to be provided by insurers.

Connecticut has a competitive small group market. I served on the 1990 Blue Ribbon Commission on State Health Insurance that developed the first small group reform law in the nation. Unlike many of the surrounding states, which have chosen to excessively regulate the small group market, Connecticut has had a relatively stable, more affordable small group market, despite high health care costs similar to its neighboring states. That Blue Ribbon Commission and the legislature carefully balanced their approach to rating reform and the new federal law has taken a similar approach. This bill would go to the extreme with pure community rating, an experiment that has failed in other states. It is interesting that the report on which this bill is based cites New York and Vermont in its recommendation for a change to pure community rating. New York has among the highest rates in the country and Vermont basically destroyed their small group market when they went to pure community rating. They had to allow essentially experience rating by association to have any reasonable coverage available for small employers. A December 2006 report by Elliot Wicks done for the State of Vermont clearly points out how pure community rating sends the small group market into a death spiral as younger healthier groups drop out. Those with other options leave the small group market. In Vermont, the market was cut in half within a matter of years. Without a strong enforceable mandate for all to have coverage, the imposition of pure community rating will create turmoil in the small group market. Even the mandate under the federal law, which is a fairly weak mandate, will not be sufficient for younger, healthier groups or individuals to drop out of the market. The penalties will be significantly less than the premiums they will have to pay under pure community rating.

Association coverage of small groups is a complicated business and the rules for such coverage under the new federal law are not clear yet. Mandating that every carrier must offer a quote to any association that requests it does not recognize the expense and complexity of developing such a quote, and the many issues to be addressed. Among the questions are what the rules of the association may be as to how long members must stay in or keep their coverage, what wellness programs an association may have, who will perform what functions as between the association and the carrier, how many carriers may be selling to a given association and what happens to a small employer that leaves the association as to the premium they have as a member of that association and the coverage they have in that association. Without clear regulatory policy on all these issues, it is very unfair to ask carriers to make quotes whenever any association asks. It is very expensive and time consuming and may result in no business for that carrier.

These same concerns apply to the mandate in the bill that every carrier must offer a quote to any large employer.

We are also concerned about the need for and timing of the bill's allowance for small employers to enter into the Healthcare Partnership program offered through the Comptroller's office. It is not clear what the pricing will be for those small employers or what coverages will be made available to them. It could be that the program will attract more high cost groups seeking better benefits, which could result in a significant potential liability for the state. It could mean that better risks join the state plan if it is priced in a manner in which private carriers cannot compete, making the private market much more expensive. The potential for adverse selection is very significant and this bill does not address the many issues that need to be resolved





to answer those concerns. With the advent of the Exchange at hand, it seems unnecessary to create these potential complications in a market that is functioning well.

The provision in the bill that allows any small employer to require their carrier to turn over to the Comptroller a great deal of information does not make sense. The Comptroller is not the regulator for the carriers, the Insurance Department is. The carriers already have to send the Insurance Department significant amounts of information. Carriers will soon be having to share a great deal of information with the Exchange and also with whatever department is given jurisdiction for the all payer claims data system that the state will be creating. Creating an additional filing for the Comptroller is unnecessary and expensive. With the new federal MLR requirements placing significant limitations on carrier administrative expenses, this is not the time to be creating more costly reporting requirements when they are not necessary.

Finally, our members do not believe it will be possible to report the actuarial value for products 60 days following final federal regulations on the subject.

Connecticut was first in the nation to create a regulated small group market and that law remains the standard for the country. With many pieces of federal reform in place and others becoming a reality soon, the market disruptions that will occur as a result of this bill are not necessary and could threaten the successful start for the Exchange. We urge you to reject HB 5487.

[bquigley@ahip.org](mailto:bquigley@ahip.org)  
860-533-9393



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America's Health Insurance Plans  
601 Pennsylvania Ave., NW  
Suite 500  
Washington, DC 20004

202.778.3200  
[www.ahip.org](http://www.ahip.org)