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FTR

Insurance Committee Public Hearing

Tuesday, February 19, 2013

**Connecticut Association of Health Plans
Testimony in Opposition to**

HB 5432 AAC EXPANDING HEALTH INSURANCE COVERAGE OF SPECIALIZED FORMULA FOR CHILDREN WITH EOSINOPHILIC DISORDERS

HB 5433 AAC HEALTH INSURANCE COVERAGE FOR HEARING AIDS

HB 5512 AA EXPANDING HEALTH INSURANCE COVERAGE FOR MENTAL HEALTH SERVICES

HB 5636 AAC HEALTH INSURANCE COVERAGE FOR BREAST THERMOGRAPHY

HB 5644 AA REQUIRING HEALTH INSURANCE COVERAGE OF FERTILITY PRESERVATION

SB 858 AAC HEALTH INSURANCE COVERAGE FOR TELEMEDICINE SERVICES

SB 862 AA REQUIRING HEALTH INSURANCE COVERAGE FOR LUNG CANCER SCREENING

The Connecticut Association of Health Plans (CTAHP) respectfully opposes the following bills: HB 5432 AAC Expanding Health Insurance Coverage of Specialized Formula for Children with Eosinophilic Disorders, HB 5433 AAC Health Insurance Coverage for Hearing Aids, HB 5512 AA Expanding Health Insurance Coverage for Mental Health Services, HB 5636 AAC Health Insurance Coverage for Breast Thermography, HB 5644 AA Requiring Health Insurance Coverage of Fertility Preservation, SB 858 AAC Health Insurance Coverage for Telemedicine Services and SB 862 AA Requiring Health Insurance Coverage for Lung Cancer Screening.

While every mandate under consideration by the legislature is laudable in its intent, each must be considered in the context of the larger debate on access and affordability of health care and *now must also be viewed in the context of federal health care reform and the applicability of the Patient Protection and Affordable Care Act of 2010 (PPACA).*

Please consider recent testimony submitted by the Department of Insurance relative to proposed mandates under consideration last year which urges the Committee to understand the future financial obligations that new or additional health insurance mandates may place on the State of Connecticut and taxpayers stating that:

“In simple terms, all mandated coverage beyond the required essential benefits will be at the State’s expense. Those costs may not be delegated to the individual purchaser of insurance or the insurer”.

With the vision of health care reform in the implementation stages, we must be careful as a state to recognize the costs associated with additional mandates. In discussing these proposals, please also keep in mind that:

- Connecticut has approximately **49 mandates, which is the 5th highest** behind Maryland (58), Virginia (53), California (51) and Texas (50). The average number of mandates per state is 34. (OLR Report 2004-R-0277 based on info provided by the Blue Cross/Blue Shield Assoc.)
- For all mandates listed, the total cost impact reported reflects a range of **6.1% minimum to 46.3% maximum**. (OLR Report 2004-R-0277 based on info provided by the Dept. of Insurance)
- State mandated benefits are not applicable to all employers. Large employers that self-insure their employee benefit plans are not subject to mandates. **Small employers bear the brunt of the costs**. (OLR Report 2004-R-0277)
- The National Center for Policy Analysis (NCPA) estimates that **25% of the uninsured are priced out of the market by state mandates**. A study commissioned by the Health Insurance Assoc. of America (HIAA) and released in January 1999, reported that “...a fifth to a quarter of the uninsured have no coverage because of state mandates, and federal mandates are likely to have larger effects. (OLR Report 2004-R-0277)
- **Mandates increased 25-fold over the period, 1970-1996, an average annual growth rate of more than 15%**. (PriceWaterhouseCoopers: The Factors Fueling rising Healthcare Costs- April 2002)
- National statistics suggest that **for every 1% increase in premiums, 300,000 people become uninsured**. (Lewin Group Letter: 1999)
- “According to a survey released in 2002 by the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), employers faced an average **12.7% increase in health insurance premiums** that year. A survey conducted by Hewitt Associates shows that employers encountered an **additional 13% to 15% increase in 2003**. The outlook is for more double-digit increases. **If premiums continue to escalate at their current rate, employers will pare down the benefits offered, shift a greater share of the cost to their employees, or be forced to stop providing coverage.**” (OLR Report 2004-R-0277)

HB 5636 requires mandated coverage for Thermography Screening. Again, we would point out the same concern with respect to new mandates and the state's liability for the associated costs under federal health care reform. However, in addition, please note the following reference taken off the *American Cancer Society's website* stating that:

“Thermography has been around for many years, and some scientists are still trying to improve the technology to use it in breast imaging. But no study has yet shown that it is an effective screening tool for finding breast cancer early.”

Mandating a benefit that has yet to be proven effective is ill advised and we would strongly urge the Committee's rejection of this bill and the bills listed above. Thank you for your consideration.

American Cancer Society Website

Thermography (thermal imaging)

Thermography is a way to measure and map the heat on the surface of the breast using a special heat-sensing camera. It is based on the idea that the temperature rises in areas with increased blood flow and metabolism, which could be a sign of a tumor.

Thermography has been around for many years, and some scientists are still trying to improve the technology to use it in breast imaging. But no study has yet shown that it is an effective screening tool for finding breast cancer early. It should not be used as a substitute for mammograms.

Newer versions of this test are better able to find very small temperature differences. They may prove to be more accurate than older versions, and are now being studied to find out if they might be useful in finding cancer.