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Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, March 6, 2014

Connecticut Association of Health Plans

Testimony in Opposition to

SB 190 AA REQUIRING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS

SB 200 AA EXPANDING HEALTH INSURANCE COVERAGE FOR SPECIALIZED FORMULA

HB 5245 AA REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR CANCER PATIENTS

HB 5249 AAC COPAYMENTS FOR OCCUPATIONAL THERAPY SERVICES

HB 5251 AA LIMITING OUT-OF-POCKET EXPENSES FOR PRESCRIPTION DRUGS

The Connecticut Association of Health Plans respectfully requests rejection of the above noted bills which we believe qualify as new mandates under the Affordable Care Act (ACA) and thereby require that the State of Connecticut pick-up the associated cost. Please consider last year's OLR summary for a similar bill.

The Affordable Care Act (P.L. 111-148) allows a state to require health plans sold through its exchange to offer benefits beyond those already included in its "essential health benefits," but the act requires the state to defray the cost of these additional benefits. The requirement applies to mandates enacted after December 31, 2011. As a result, the state would be required to pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after this date.

It's also worth noting that none of the mandates under consideration by the Committee would apply to those individuals, including state employees, that are covered by self-insured plans. The burden of this cost would fall only on the fully-insured market who are generally smaller employers.

More and more companies and government entities that can afford to take the risk are moving to self-funded plans which allow them to set their benefit structures more within the scope of their individual group's needs and budget. The ratio of self-insured to fully-insured groups in CT is now nearing 60% to 40% . As the ACA recognized, the system cannot continue to absorb the additional costs of new mandates.

While some of the proposals under consideration seek to limit cost-sharing arrangements like copays, deductibles and coinsurance instead of just mandating a particular treatment, they are equally problematic. ACA requires fairly strict adherence to a particular timeline that would be undermined by the proposals in question. Connecticut's Exchange is right now preparing their standard benefit designs and carriers are right now preparing their non-standard plan designs which are due into the appropriate entities by March 27th. Health carriers must then file the associated rates with the Department of Insurance by April 30th. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been finalized and rates have been filed, the Exchange and the carriers will have to reopen the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. The sheer volume of mandates and the other insurance provisions under consideration by the Committee add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market – all of which is to the benefit to Connecticut's citizens.