Testimony of Jon Kingsdale, Ph.D.
Before the Insurance and Real Estate Committee on HB 7267
March 7, 2019

Good afternoon, and thank you for the opportunity to appear before the Committee. I have been asked by the Connecticut Association of Health Plans to comment on the proposal in HB 7267, section 7, authorizing the State Comptroller to establish and market a group health insurance purchasing pool for small employers.

Before commenting, allow me to introduce myself: I have worked in health insurance and related fields for some forty years: at several non-profit health plans, as a health policy consultant – including work for AccessHealthCT – in academia – I currently teach health policy at Boston and Brown Universities – and I started and lead the Massachusetts Health Connector, the model for the Affordable Care Act. I have a deep, professional commitment to expanding coverage for the uninsured and containing health care costs.

I commend the Comptroller and this Committee for addressing the relentless inflation in U.S. healthcare spending. However, Section 7 of this bill, authorizing the Comptroller to enroll small employers in the state employees’ plan or a new plan for small employers, offers little prospect for containing costs and not a little disruption to the existing market. Why do I doubt its potential for reducing costs?

First, because aggregating purchasing power for small employers is duplicative of existing efforts. Recently revised federal regulations encourage private entities to develop such pooled purchasing arrangements, known as Association Health Plans, including insured or self-insured arrangements for all small employers in a state or sub-state regions.1 Numerous efforts to do so are now underway across the country.ii

Second, and more to the point, such initiatives pre-date the ACA and have proven ineffectual in containing healthcare costs. To understand why, consider how such savings might be achieved: by law, at least 80% of small-group premiums must go toward employee claims costs. Grouping thousands of employees together from many small firms does not change their claims costs. The only way that such associations can reduce claims costs, other than cutting benefits, is to select against the communitywide risk pool established by the ACA. That is, if healthier-than-average firms join the pool, then their claims costs will come down – but only at the expense (literally) of leaving outside the association a sicker pool of community-rated small employers to be priced up.

This is one way that small-business associations have succeeded in the past, which is why the Obama administration strictly regulated them under the ACA. Whether or not justified, a not
unreasonable fear that the Comptroller’s new purchasing pool will select against the communitywide small-group risk pool may actually drive up Connecticut’s small-group adjusted community rates. This is the disruption I mentioned.

Could the Comptroller’s pool save on the other 20% of premiums? Possibly, by avoiding state premium taxes, as a self-insured, administrative services only (ASO) pool, but that simply represents a subsidy by the state in foregone tax revenues; if this were the intent, wouldn’t it be fairer to reduce the premium tax on all small employers?

Could scale economies in administrative costs, such as eliminating the brokers’ commissions in favor of a smaller insurance consultant’s fee, be achieved. Yes, but these are small reductions that any private association can also achieve. Indeed, the key to achieving even these modest savings is administrative efficiency and marketing prowess (needed to build the purchasing pool), and my own extensive experience with public insurance exchanges does not make me sanguine about the competitive advantage of the public sector in either regard.

Finally, I would suggest that while policy-makers in every state and at the federal level as well have been promising rate relief to small employers for decades now, I have yet to see it happen. In this state, as in this country, the primary culprit behind high premiums is the high prices that are paid in the private sector for drugs, hospitals, and other clinical services. Serious efforts at cost containment will have to address the pricing of medical services, not shuffling groups of patients from one risk pool or administrative mechanism to another.

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