Quality is Our Bottom Line

Insurance and Real Estate Committee

PUBLIC HEARING

Tuesday, March 10, 2020

Connecticut Association of Health Plans

Testimony in Opposition to

H.B. No. 5257 AA REQUIRING HEALTH INSURANCE COVERAGE FOR PRESCRIPTION EYEGLASSES FOR COVERED DEPENDENT CHILDREN WHO ARE YOUNGER THAN NINETEEN YEARS OF AGE.

The Connecticut Association of Health Plans respectfully opposes H.B. 5257.

Please consider that the Affordable Care Act (ACA) requires qualified health plans (QHPs) offered on the Exchange to include a federally defined essential health benefits package (EHB). While states are allowed to mandate benefits in excess of the EHB, federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the Exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB unless they are already part of the benchmark plan.

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.

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Furthermore, the ACA requires strict adherence to a particular timeline that would be undermined by the various mandates under consideration. Connecticut's Exchange is **right now** preparing their standard benefit designs and carriers are **right now** preparing their non-standard plan designs. Health carriers must then file their associated rates with the Department of Insurance. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been finalized and rates have been filed, then 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 refiling 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.

We urge your opposition.