**Testimony of Ted Doolittle**
**Office of the Healthcare Advocate**
**Before the Insurance and Real Estate Committee**
**Re SB 842**
**February 9, 2021**

Good afternoon, Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D'Amato, and members of the Insurance and Real Estate Committee. For the record, I am Ted Doolittle, Healthcare Advocate for the State of Connecticut. While I am unable to participate today in person due to an important family obligation, Staff Attorney Sean King of this office will be available to answer any questions you may have. The Office of the Healthcare Advocate ("OHA") is an independent state agency with a consumer-focused mission: assuring consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; assisting consumers in disputes with their health insurance carriers; and informing legislators and regulators regarding problems that consumers are facing in accessing care, and proposing solutions to those problems.

SB 842 is complicated and OHA has had limited time to review the proposal. This testimony thus focuses on only one aspect of the proposed legislation, namely the public option proposal whereby the Office of the State Comptroller would be charged with developing a new health coverage option that could be purchased by individuals and small businesses around the state, in addition to – not instead of – the other options available for individuals and small groups to purchase health coverage.

The chief aim of this testimony is to provide factual context and expert analysis from the insurance consumer perspective concerning the current state of health coverage availability to individuals and small groups, and to clarify the nature of the insurance option being proposed in SB 842, as we understand it so far. This type of clarification is

needed here because health coverage and the dynamics of the commercial health insurance market are quite complicated, and so the debate around systemic healthcare coverage reform as a result all too commonly is not accurately informed.

Opposition to public option bills typically centers on several objections that upon examination all turn out to be weak. Analysis of these objections reveals that the main cause of this weakness is that the facts or assumptions relied on are either outdated, or in some cases never existed in the American healthcare system in the first place. These errors of thinking are in some cases understandable because they often are grounded in political science or economic theories that may have validity outside healthcare, but over the past 30 years or so have been decisively shown by peer-reviewed academic work and research not to apply to the special arena of health care. When it comes to economic theory and policy, healthcare in fact is different. [1]

The main objections are as follows:

- Maybe this legislature trusts Comptroller Kevin Lembo to run this massive new health plan in a way the General Assembly will agree with, but Mr. Lembo will not be comptroller forever, and the people of Connecticut in the future may regret giving the comptroller's office so much power.
- The people of Connecticut will be on the hook if anything goes wrong. This plan poses serious financial risks to the government of Connecticut and its taxpayers, at a time when the state budget is already stretched thin.
- This is a job killer for Connecticut.
- This will be bad for the insurance companies in Connecticut, and should be viewed as an unpatriotic attack by big-government liberals on one of the state's leading industries.
- This is the first step toward single payer. Any increased government involvement in healthcare is bad. This is socialized medicine. It is unfair and impossible for private industry to compete with government subsidized healthcare.

We discuss these misconceptions in turn.

[1] https://digitalho.com/blog/why-economic-evaluation-of-health-and-healthcare-is-different-from-traditional-goods-and-services/

1. **Myth: The people of Connecticut may live to regret investing so much authority over healthcare in the Office of the State Comptroller.** Folks may agree with and trust the direction of the current Comptroller, Kevin Lembo, but he won't be Comptroller forever, and one day that office will be held by an individual who promotes policies that today's supporters of SB 842 won't like.

**Fact:** SB 842 will provide more control, not less, for individuals and businesses over their health insurance choices. Individuals and small businesses in Connecticut have never had significant influence over the nature of the insurance they can purchase. If the new public option is implemented and proves popular enough to endures for even several years, we the people of Connecticut for the first time in the approximately 100-year history of health insurance in this country will have the ability to influence – and if needed replace – the people responsible for incredibly important healthcare coverage policy and operational decisions that affect all our families. Currently, Connecticut individuals and small businesses rely for their health coverage exclusively on private insurance companies. Those insurance companies all utilize a typical American Chief Executive Officer-driven corporate governance structure in which all segments report to a CEO, who is formally if not always in fact accountable to a board of directors. None of the health insurance companies currently operating in Connecticut has any mechanism for the state's consumers to influence company policy or the selection of either the board members or the executives. The table below illustrates the number of times that the people of Connecticut have had input in the selection of the state Comptroller and the policies adopted by that office, compared to the number of times the people of Connecticut during that same period have been able to influence insurance company policies or the selection of insurance company CEOs and board members.

| Insurance Decisionmaker Consumer Accountability Moments 1980-Present* *(since the beginning of the U.S. Healthcare Cost Crisis circa 1980)* | | |
|---|---|---|
| **Number of Times Connecticut Residents & Small Businesses Have Had Input Into the Selection of the State Comptroller *vs.* Number of Times Connecticut Residents & Small Businesses Have Had Input Into the Selection of Any Insurance CEO in Connecticut** | | |
| **Year** | **Consumer Input on Selection/Retention of Comptroller** | **Consumer Input on Selection/Retention of Insurance Company CEO** |
| **1982** | 1 | 0 |
| **1986** | 1 | 0 |
| **1990** | 1 | 0 |
| **1994** | 1 | 0 |
| **1998** | 1 | 0 |
| **2002** | 1 | 0 |
| **2006** | 1 | 0 |
| **2010** | 1 | 0 |
| **2014** | 1 | 0 |
| **2018** | 1 | 0 |
| ***Total:*** | **10** | **0** |

As the above table illustrates, the insurance industry objection that a public option will be less responsive to the needs and desires of Connecticut health insurance consumers than insurance companies currently are, is incorrect. There are provisions in the state Constitution that provide for the election of the state Comptroller every four years, whereas Connecticut at present has literally no consumer accountability moments for the private-sector health insurance leaders responsible for providing all individual and small group coverage in this state. [2] In a related vein, some members of this honorable Assembly will have had occasion over the years of their service as elected officials to seek to influence policy at both the Office of the State Comptroller as well as the office of one or more insurance companies, and will be able to judge from their own personal experience whether OSC was more responsive and accessible, less responsive and accessible, or about the same. But as to the ability of ordinary individuals in the state to influence policy direction or leadership regarding commercial health coverage policy and operations, the public option would mean a ground-breaking upgrade from almost nothing to something.

[2] This is the case because unfortunately there are no longer any health insurance companies in this state operating under a mutual corporate structure.

The public option opposition's key talking point that leadership changes at OSC may bring unwanted policy changes simply fails to take into account the key reality that right now, individual and small group consumers have effectively no voice with their health insurance company leadership. They take what's offered, if they can afford it. Giving an elected state official a key policy-making and operational decision-making oversight role in the new public-private partnership that the public option bill proposes will create some reasonable consumer accountability where none exists currently, and the opportunity to provide Connecticut consumers with some unprecedented and new consumer accountability levers is a key reason to support a well-designed public option. If the public option passes, and consumers of Connecticut decide that the Comptroller is not providing the policies and leadership they need, they can work to influence or replace him or her -- they have no such accountability leverage with respect to insurance company leadership.

2. **Myth: The people of Connecticut will be left holding the bag if the Public Option fails.** One bad year where claims exceed revenues, and bingo, the State of Connecticut will have to fund a massive bailout.

**Fact:** This is one objection that if voiced a generation ago, may have had validity, but it fails to take into account the progress the insurance industry has made over the past several decades perfecting new ways payers can use to insulate themselves from the financial risk of high claims years – sophisticated and powerful tools which a state instituting a public option is itself free to use. Bad years in which claims exceed revenues used to be a constant threat to the solvency of insurance companies, but not so much anymore. The first and most obvious tool is the ever-increasing deductibles and other out-of-pocket charges that are designed to make sure that patients bear the brunt of illness or injury well before the company does. But an even more important tool to protect insurance companies from the risk of high claims years has been the development and perfection in the health insurance industry of a financial risk-shifting tool called "stop-loss policies." Put simply, an insurance carrier itself buys coverage against high claims years. Stop-loss policies are available at the individual level (*i.e.,* the insurance company buys a policy that will reimburse the insurance company for any claims it has to pay for any specific individual over a specific amount for the year, say $50,000), but are also available at the entire membership level (*i.e.,* insurance against the risk that claims for the entire membership turn out to be higher than the company

expected).

The insurance companies aggressively and astutely use the new stop-loss strategy to protect themselves against high claims years. There is nothing stopping the State of Connecticut from limiting – or even for the right price completely eliminating – its risk from high claims years. And in fact, the proposed bill explicitly authorizes the Comptroller to use stop-loss strategies. Now, like all insurance, stop-loss policies cost money, and the more protection one seeks, the higher the price for the policy.
The point is the insurance industry itself has provided this honorable Assembly with all the tools it needs to assess how much or how little financial risk it wishes to expose the taxpayers of the state to (down to and including a risk of $0), and to instruct and authorize the Comptroller accordingly. If the public option is designed carefully, there need be no surprises from bad claims years, except to the extent you as representatives and senators are willing to accept on behalf of your constituents, the taxpayers of the state. It is entirely up to you to decide if the state is to be left "holding the bag" for a bad claims year, and if so, to what extent.

**3. Myth: This is a job-killer for Connecticut.**

**Fact:** Major healthcare reforms in the United States consistently produce large numbers of solid middle-class jobs, almost all in the private sector. There is no reason to believe that this public option proposal if enacted would be any different. The Affordable Care Act is estimated to have produced at least 500,000 jobs across the United States, or an average 10,000 per state.[3] While Connecticut only composes about 1% of the national population, which would imply 5,000 ACA-sourced jobs in our state, the real total here is probably disproportionately greater because of our status as the Insurance Capital, and the continued disproportionate presence in this state of major health insurers such as Aetna, Cigna and a significant United Healthcare presence.

Providing health insurance requires large numbers of highly skilled professionals such as actuaries, IT staff, and anti-fraud experts, to name just a few. It also employs large numbers of lower-skilled or entry-level jobs, such as call center workers. These job types and many more are required by every health plan, public or private. If the

[3] This 2017 estimate comes from Goldman Sachs. https://www.cnbc.com/2017/03/23/500000-jobs-added-to-health-sector-under-obamacare-goldman-sachs.html

public option is successful, hundreds and perhaps eventually thousands of new jobs will be created. The General Assembly may wish to explore if it can require that a certain percentage of these new jobs remain in Connecticut.

**4. Myth: This is an attack on the insurance industry, and will hurt the insurance industry.**

**Fact:** It is true that the current high-cost state of healthcare in our country has been good for the insurance industry, and the insurance industry's stocks, revenue and income are as high as they have ever been. Retaining the gold-plated status quo certainly is the best thing that could happen to the insurance industry. However, as OHA has previously explained elsewhere, the second-best thing that could happen to the industry is health care reform like a strong public option. [4]

That is because in the U.S., almost all major government-sponsored healthcare programs are in fact public-private partnerships, funded and to some extent overseen by the government, but actually delivered by private industry and private employees. There are only a few government health programs that rely to any significant extent on government employees, such as the Veterans' Affairs system, and the Indian Health Service, both with 19th century roots, and there are no modern examples. All of the major titularly government programs (all types and parts of Medicare, almost every state Medicaid program, and the ACA) rely for the vast majority of their actual implementation on vendors and contractors, very much including the insurance industry.

All the major insurance carriers have strong, rapidly growing, and highly profitable government segments where they are making good money running Medicare, Medicaid and ACA programs. The public option proposal set forth in SB 842 closely follows this typical American public-private partnership model for the delivery of government-sponsored health coverage. The SB 842 proposal is clearly that the Office of the State Comptroller will select and oversee private vendors to implement the new public option. This places SB 842 squarely amongst the plethora of healthcare reform proposals built around Medicare's public-private partnership model. To the best of OHA's information and belief, all major federal or state health reform efforts, including

[4] See https://www.courant.com/opinion/op-ed/hc-op-doolittle-medicare-for-all-0126-20200126-zz3q3gs5mzhqpdeccw4a3gttrm-story.html

those put forth by Sen. Bernie Sanders of Vermont and Rep. Pramila Jayapal of Washington and usually considered the most far-reaching of the major proposals, incorporate Medicare's 55-year old public-private partnership business model, and thus effectively contemplate major new responsibilities and business opportunities for the insurance industry and other private firms, albeit under government oversight that can be geared toward insuring that these private firms are fairly compensated, but not overcompensated. [5]

Again, OHA understands that the insurance companies do not want to upset the *status quo*, and that the companies believe that continuing on without a public option is the best thing from the perspective of their shareholders and for the community. But nevertheless, far from harming the insurance companies, reform proposals like the public option will prove to be a solid business opportunity for them, just as turned out to be the case with the Affordable Care Act, and senior private insurance leaders have on occasion confirmed this publicly. [6] OHA has every confidence that Connecticut's insurance firms will be able to compete for and win their fair share of this new business, and once they develop expertise in delivering state public option coverage, they will be able to use this expertise to pursue similar business with other states or at the federal level.

[5] To be clear, this kind of expansion of the typical American healthcare reform model relying on private industry rather than public employees, such as is contained in SB 842, is only one of several viable healthcare reform strategies. In our opinion, the exclusive American focus on public programs that are delivered by private industry is regrettable, because a few of the best healthcare systems in the world do use much more government employee-oriented business models. It is too bad that these admirable and successful structures appear to be functionally off-limits for serious healthcare reform discussion in America and in Connecticut. OHA would certainly consider supporting any well-designed more fully public proposals. But it simply is a fact that such proposals do not exist, and the public-private partnership model exemplified by traditional Medicare is viable. Until the menu of politically feasible healthcare reform strategies expands, measures like SB 842 that seek to create new healthcare marketplace and price negotiation dynamics within the public-private partnership framework are worthy of consideration.

[6] https://www.courant.com/opinion/op-ed/hc-op-doolittle-medicare-for-all-0126-20200126-zz3q3gs5mzhqpdeccw4a3gttrm-story.html ; see also https://thehill.com/opinion/healthcare/466576-want-to-expand-medicare-youll-need-to-hire-the-insurance-companies-not ; https://thehill.com/opinion/healthcare/457248-private-sector-vs-medicare-theyre-basically-the-same-thing

**5. Myth: The public option is socialized medicine.**

**Fact:** The public option proposed in SB 842 does nothing more than provide another source for small businesses and individuals to buy their insurance. Any system that requires a consumer to use their own money to purchase a good or service for a fair price is literally the opposite of socialism. The SB 842 concept of individuals and small businesses continuing to buy their own insurance coverage, albeit from a new government-sponsored entity, is a completely market-oriented, capitalist model.

Moreover, while giving Connecticut individuals and small businesses another option for where to continue buying insurance is classic market capitalism, it bears repeating that even behind and beyond the clearly capitalistic insurance-purchasing transaction between individual consumers and the new public option, the public option proposes behind the scenes to hire and pay private, for-profit companies to manage and provide every aspect of the new coverage. As OHA has explained elsewhere in detail, virtually all healthcare reform proposals current in the U.S. contemplate that any new plan be largely delivered by for-profit companies, just as Medicare and Medicaid currently are, and SB 842 clearly falls into this category. [7]

SB 842 takes certain key elements of the highly successful Medicare public-private partnership model – utilizing private sector vendors under oversight by politically accountable officials – but quite carefully entirely omits the taxpayer-funded nature of Medicare. SB 842's funding does not come at all from taxpayers or the general fund, but rather will come, directly and indirectly, from only one source: the businesses and

[7] Again to clarify, OHA is merely describing the current state of Medicare and Medicaid systems, and also is characterizing the federal Medicare for All and other more ambitious reform proposals as they exist. With the exception of the Veteran's Affairs and Indian Health Service, which both have their roots in the 19th century, the fact of the matter is that in this country all government-sponsored health coverage systems are delivered in the main by private, for-profit companies. And while some Medicare for All supporters do not enjoy learning this, it is also the case that all the major healthcare reform proposals at the state and federal level contemplate using private, for-profit companies to administer the new plan, and SB 842 is no different. This testimony is simply describing for the General Assembly's edification in considering the new SB 842 proposal the nature of current government-sponsored healthcare systems like Medicare and Medicaid, so that the Assembly can put the SB proposal into its proper context. The fact that OHA is here describing how Medicare and Medicaid are currently structured should not be construed as an endorsement of this public-private partnership model, nor as OHA somehow denigrating Medicare for All proposals. Many critics of the current healthcare system would like to see all profit motive taken out of healthcare. That is not what SB 842 does, nor is that what even the most far-reaching Medicare for All proposals do; but in the future if proposals for actual socialized medicine were to emerge in either DC or in Hartford – or even proposals that did not rely on for-profit entities to provide and administer health coverage – OHA would evaluate any such proposals on the merits. It is certainly the case that such systems operate with great success elsewhere in the world.

individuals who buy coverage from the public option. OHA's preliminary understanding of this proposal is that to the extent there is funding proposed for the plans available under the new public option, these monies will be collected not from the state's general fund, but from the insurance companies that will provide the public option plans. Presumably, this will increase premiums, which ultimately come from policyholders as part of the expense of the insurance coverage. A system where individuals and businesses are purchasing a service in a voluntary, arms' length transaction using their own money is by definition not socialist.

# Conclusion

Starting around 1980, healthcare costs in this country began to deviate from medical costs in our overseas economic peer group, resulting in America's current internationally abnormal cost structure where individuals and small businesses have to pay anywhere from two to three times as much as our direct overseas economic competitors pay for healthcare. This is why Warren Buffett has called medical costs the "tapeworm of American economic competitiveness." [8] Our medical cost structure is not a little out of whack. It is dangerously and unsustainably out of control.

Dramatic change is needed to level the playing field between American small businesses and individuals and their opposite numbers overseas. Fixing this cost disparity compared to our wealthy economic peers would help with almost all of the problems in American healthcare, from health disparities and concerns about equity, to issues of quality and access – all these important problems could be made better if we could only lower the underlying cost of healthcare in America and Connecticut. Turning to the commercial health insurance market where individuals and small businesses get their coverage, the major players in the current healthcare price negotiation dynamic include hospitals, insurance carriers, the pharmaceutical industry, and to a much lesser extent small employers.

Our skyrocketing cost performance since 1980 shows us that the insurance carrier/hospital/pharma dynamic is not producing the end result that our individual families and small businesses need and deserve – quality healthcare that is affordable. While the reasons for the failure of the commercial health coverage marketplace to produce affordable healthcare are complex and multi-factorial, one key bottom line is that

---

[8] https://www.businessinsider.in/BUFFETT-ON-HEALTHCARE-Medical-costs-are-the-tapeworm-of-American-economic-competitiveness/articleshow/58555447.cms . *See also, e.g.*, Peter G. Peterson Foundation, *Per Capita Healthcare Costs – International Comparison*, https://www.pgpf.org/chart-archive/0006_health-care-oecd (2018) (chart showing U.S healthcare costs twice the OECD average); The Commonwealth Fund, *U.S. Healthcare From a Global Perspective*, https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-global-perspective (2015) (including discussion of lower U.S. utilization, including lower physician visits and hospital admissions); Kaiser Family Foundation, *How Do U.S. Healthcare Prices and Use Compare to Other Countries?*, https://www.kff.org/slideshow/how-do-the-use-and-price-of-healthcare-in-the-u-s-compare-to-other-countries/ (2016) ("In general, people in the United States use the health system less than people in comparable countries, and services in the U.S. are consistently more expensive ….").

the commercial healthcare insurance marketplace has not been able to negotiate the internationally appropriate and sustainable prices that individuals and small businesses in Connecticut need in order to thrive.

Given a clear 40-year track record of the carrier/hospital/pharma price negotiation dynamic's inability to deliver the healthcare affordability needed to preserve American economic competitiveness and to insure affordable healthcare as a human right, it is well past time for this General Assembly to acknowledge that our commercial health insurers need strong, immediate assistance in their efforts to keep the cost of healthcare from continuing to rise on its current relentless and unsustainable path. The framework set forth in SB 842, which places the government strongly side-by-side with the private sector in a way that is reminiscent of the highly successful Medicare model as well as overseas models involving some sort of government presence in price negotiation, is worthy of consideration as a rather moderate way to keep the insurance companies in a key role, while empowering them to negotiate the price improvements that are needed to bend the cost curve in the right way. The system that has been in place since 1980 has not gotten the job done for Connecticut families and businesses. We need to change the price negotiation dynamic in our state. If the Comptroller is able to create a strong new public option in partnership with the private sector and with the carriers, this new dynamic over a period of years of sustained effort, could well result in improvements in healthcare affordability.

And, we also should remember that the risk here is low. As we understand it, the new public option is in addition to, and not instead of, all current options for individuals and small businesses to purchase insurance in Connecticut. Individuals and businesses will vote with their feet, and if the new plan does not pick up enough buyers to sustain itself and develop heft as a purchaser, then nothing has been lost. If on the other hand, the Comptroller's new public-private partnership empowers the private sector to develop and deliver a product that Connecticut businesses and individuals respond to and want to buy, then there is a good chance of creating an altered dynamic that over a period of years could deliver more affordability.

Thank you very much for your consideration of this testimony. If you have any questions concerning our position on this issue, please feel free to contact me at Ted.Doolittle@ct.gov.