Insurance and Real Estate Committee
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PUBLIC HEARING
S.B. No. 842 AAC CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT

Testimony of
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Co-Chairpersons Lesser and Wood, Ranking Members Hwang and Pavalock-D Amato and members of the Insurance Committee, my name is Jeff Hogan and I am the Northeast Regional Manager for Rogers Benefit Group. Thank you for the opportunity to present some thoughts on S.B. 842 An Act Concerning Health Insurance and Health Care in Connecticut.

The proposed public option is NOT good for businesses or the economy in Connecticut. The underlying provider costs of coverage drive the cost of health coverage. Nothing in this bill addresses that. This bill fails to comprehend basic health economics and ignores the fact that most payers in the state have embraced and are implementing true value-based healthcare products that demonstrably reduce cost and increase the quality of outcomes. This legislation will destabilize existing provider and insurance markets while merely shifting costs. Good public policy would promote competition and the true move to accountable value-based healthcare.

Some facts:

1) The state contends that this legislation will reduce the cost of care to provide 'choices'. Cost of care can only be reduced if (1) Fees paid to health providers under the program are like those paid for Medicaid. (2) Taxes are raised to subsidize coverage. (3) Costs are directly shifted to insurance companies (and therefore other groups) with assessments. The state places artificial premium caps on premium increases that will make 1-3 inevitable.

2) The state's mechanism for forcing provider to accept lower costs will immediately cause those providers to shift costs to commercial insurers thereby INCREASING costs for employers not in the small group sector. BAD FOR BUSINESS. This will make CT unattractive for middle market and large employers.

3) The bill merely redistributes who pays what to cover the underlying costs of care, but the costs don't change. The bill aims to defy the primary principle of healthy insurance markets— the broad sharing of risks. This bill will destabilize markets by creating WINNERS and LOSERS via carved out populations. BAD FOR THE CT ECONOMY.

4) The bill basically exempts the entity from the rules, regulations, assessments and taxes that other legitimate health payers are required to pay to be compliant in CT thereby

permitting the regulatory body to be free from the burden and costs that it imposes on legitimate participants in the healthcare marketplace. BAD FOR THE CT ECONOMY.

National healthcare reformers and participants are completely focused on the supply side of healthcare and meaningful change in the health delivery system. Connecticut legislators should not be using force to interfere in a marketplace that is finally moving toward value-based healthcare solutions. Reform efforts should provide incentives to fundamentally change healthcare delivery to achieve true cost reduction and superior quality outcomes.

As one of the coordinators of the Connecticut Moving to Value Alliance and as a healthcare consultant working in the national healthcare eco-system, I ask you to reconsider this poorly designed legislation. It will not achieve the lower costs and superior outcomes it promises. The Comptroller's office has made laudable progress with its recent value-based offering to state employees, but glaringly absent in the program is participation from the two largest and most expensive health systems in the state. The state has small participation in this new offering and has not achieved demonstrable cost savings yet.

The Comptroller contends that the state must assert its massive purchasing power to provide lower cost healthcare plans for Connecticut's small businesses. Ironically, the state of CT employee health plan is one of the most expensive in the state. Further, if this massive purchasing power is and will be exercised, why must this legislation include provisions for the assessment of ever changing and likely ever-increasing fees upon "Each insurer and health care center doing health insurance business in this state, and each exempt insurer...." 234-238 ? Why would the state impose a regressive tax on successful plans with larger populations especially when many of these have created products and solutions embedding accountable value-based healthcare provisions producing demonstrably lower cost and superior outcomes? How will a new bureaucratic entity manage asymmetric risk? The state's other experiment, the State Partnership Plan is running year over year $30 million deficits.

COVID set off a chain of events that has caused consumers to distrust both the public and private healthcare system nationally. Missteps at the start of the pandemic led to a lack of adequate testing supplies and PPE. Providers, dependent upon fee for service volume, had to shut their practices down at the end of March unless they were directly supplying COVID services. Patients/consumers hid and are still hiding in their homes preferring not to expose themselves. Most providers quickly tried to stand up virtual care access for their employees but many of these services didn't coordinate care back to providers with interoperable access. Health providers have been under severe strain. The fragility of the healthcare system has been exposed.

Employers, trying to emerge from COVID financial pressures, have fewer or no discretionary dollars to invest in their health plans. They desperately want to have predictable costs and quality outcomes as they put their employees back to work.

Nationally, since COVID started, there's been a huge focus on value-based healthcare and the high-performance providers who embrace its principles. Value based healthcare demands a focus on cost and quality outcomes. In fact, it assumes that providers participating in the supply chain are at risk and have transformed their practices to give 24/7 access to care and that the provider

has the technology to coordinate care inter-operably and longitudinally (with the patient's specialists) and that the provider has invested in patient engagement features to meet the patient where they want to be treated. Further, providers can coordinate care via nuanced care paths to the highest performing providers and facilities at targeted prices that are warrantied. Traditionally, the health system in Connecticut has been characterized by fragmented and uncoordinated care with low investment in primary care. As such, our system is expensive and has variable quality outcomes.

The proposed legislation literally has no mechanism to incentivize or improve upon the provider supply chain in Connecticut. In fact, instead, the Comptroller claims that he will somehow magically extrude superior cost concessions from the system. Meanwhile, large employers, health systems and the largest payers in the state are investing heavily in value-based healthcare infrastructure, including technology and services which will make the health delivery system more competitive and accountable. They're focusing their attention on closed loop plan design that steer members to high performance providers.

In October, for the first time ever, Connecticut data was included in the illustrious Rand Hospital Transparency Report 3.0. This report points out variance between hospital systems relative to cost and quality. Those variances between and among hospitals in Connecticut are substantial. The report points out that it isn't clear what the exact cost of specific services are or should be. The report merely measures the variance in cost and quality.

How can the Comptroller tell us that he'll reduce costs by "X" when he has no idea what "X" is? Shouldn't the state be doing its due diligence first to determine what the cost of services are or should be before simply demanding a discount? Where is the whole issue of quality in this legislation? Who cares if you pay a low cost if you are also forced to pay for bad quality, complications and infections (bad outcomes)? Some of the most sophisticated provider groups and health systems in the state have committed to offering their services with targeted and transparent services including warranties to guarantee their quality. The state of Connecticut and its resources should be used to promote and incentivize this kind of transparency and competition between and among provider organizations for superior cost and quality across ALL health systems, especially the biggest and most expensive. This would be the highest and best use for directed healthcare policy.

Instead, via this legislation, the state feels that it should act as a bearer of risk and that it can do things that other payers can't. The state indicates that it will negotiate most favored nation pricing and that it will force providers to comply. It's fascinating and ironic to observe that the state wants to be both a regulator AND a payer, basically making its own rules without accountability. In the process, the state fails to consider the second order effects of intruding forcefully into the market without considering the obvious cost shift implications for other market segments and the likely opportunity for adverse selection in the small group market. It also ignores the huge contribution that national healthcare payers bring to the CT economy. Perhaps, most importantly, it fails to adequately consider and address the myriad ERISA and ERISA pre-emotion issues that the proposal creates. Also, simply stating that you're not a MEWA, doesn't mean that you're not one and therefore subject to Federal law.

It's clear that our legislators don't have a 'big picture' policy strategy for the reduction of healthcare costs and the improvement of quality in our market. Proposed healthcare cost benchmark legislation will likely be sacrificed because of this "my way or the highway" public option legislation. Why would hospital systems or payers trust the state and agree to the terms of a cost benchmark when it's clear that the state only intends to impose its will on them and force specious pricing concessions? Why would purchasers

consider creating captive insurance arrangements in Connecticut when the state effectively wants to compete against them as a payer using its own rules and mandates? This is BAD FOR THE CT ECONOMY.

This legislation is dangerous to our state and economy. It will not help to promote the necessary supply side health delivery reforms that will reduce cost and increase quality. Instead, it will merely serve to perpetuate the dysfunctional fee for service methodologies that have driven up costs and not improved quality. This is legislation that merely imposes force upon the marketplace. It does not encourage competition. Payers have been hard at work bringing strong value-based offerings to the market. This legislation will simply force competitors to pay for a government experiment that will ultimately be BAD FOR THE CT ECONOMY and not reduce costs. Thanks for considering my thoughts.

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