HEALTH BENEFITS INSTITUTE

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Testimony of J.P. Wieske in opposition to SB 842

Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock- D'Amato and members of the committee, thank you for the opportunity to testify before you on SB 842 An Act Concerning Health Insurance and Health Care in Connecticut.

It is important to note that I am testifying against this bill for a number of reasons outlined in this testimony. My concerns and the concerns of my members are many. There are a number of fundamental design flaws that put Connecticut consumers, businesses, union members and state employees at risk. There are also important technical issues to consider. I am also concerned the public option violates the Affordable Care Act and ignores federal ERISA requirements. Finally, there are ongoing issues and concerns about the lack of transparency embedded in Connecticut's proposed government-run insurance option that exempts itself from both state and federal law.

My name is J.P. Wieske. I am the former Deputy Insurance Commissioner for the state of Wisconsin. My experience includes supervision of the regulatory and enforcement of the Wisconsin insurance market, as well as leadership on a number of health-related committees at the National Association of Insurance Commissioners. A more complete bio is included at the end of the document which may help establish my credentials in discussing these issues in this bill.

As a former regulator, I understand that details matter in insurance as much, and probably more than, just about any other industry. At its simplest, insurance is a contract. Consumers agree to pay a premium. Insurers agree to cover their risk. The agreement to cover a risk is a contract in two parts, it requires both the promise to pay and an ability to make that payment.

Senate Bill 842's Government-Run Plan Violates the Affordable Care Act

Most legal experts agree that later this year, the Supreme Court will again rule that the Affordable Care Act is constitutional, and the law will stay in place. This proposed government-run health care program violates the ACA in a number of ways:

1. ***Violates single risk pool requirements.*** The ACA requires each market – individual, small group, and large group – to be in their own single risk pool. SB 842 requires all risk, regardless of size, to be pooled into a single risk pool.
2. ***Violates guaranteed availability.*** The ACA requires guaranteed availability of coverage, but the bill does not "Require the Comptroller to offer coverage under the state employee plan to every multiemployer plan, nonprofit employer and small employer seeking coverage under the state employee plan pursuant to this section"
3. ***Violates guaranteed availability in the large group market.*** The ACA does not allow limited availability of coverage based on type of business. Since the pool requires coverage of non-profit employers over 50 employees, the ACA requires guaranteed availability of coverage of all large employers.
4. ***Violates renewability requirements.*** The ACA does not allow non-profit employers, many of whom qualify for small group or individual coverage, to be locked into an insurance contract for three years.

5. ***Violates loss ratio requirements.*** Coverage sold to individuals, small businesses, and large businesses are subject to the ACA's minimum loss ratio requirements. There is no promise to meet these requirements.
6. ***The public option will require its own separate 1332 waiver.*** In violating a number of ACA requirements – including the single risk pool requirement – the government-run insurance plan will require the state to apply for a separate 1332 waiver for the government-run plan. The Trump administration made the guardrails for a 1332 more flexible, but it is expected the Biden administration may tighten the guardrails. This makes approval by the federal government of the government-run option far from certain.
7. ***May be forced to operate a single-payer plan or shut down.*** Poor drafting creates a problem under the ACA. The public option is offering coverage in all markets, and guaranteed availability under the ACA will require the state to offer coverage to all applicants.
8. ***The New ACA subsidies may inadvertently harm consumers.*** Any state subsidies are treated as taxable income for federal tax purposes. This may change a consumer's eligibility for various programs, and may end up being offset by a reduction in their federal subsidy.

Senate Bill 842's Government-Run Plan Violates Insurance Laws and Principals

The proposed structure and requirements would not meet the minimum standards required in most state insurance laws.

1. ***Voids ERISA protections for Connecticut's state and local government plan***. Under ERISA, governmental plans, as defined in the law[1], are exempt from ERISA. Adding private employers to the pool voids the exemption.
2. ***Operates as a self-funded MEWA.*** Despite language in the bill that says it is not a MEWA, the plan does not meet the definition for an exception[2] from ERISA. Under ERISA, this is a multi-employer welfare arrangement. The reason the state of Connecticut and other states ban self-funded MEWA's is because of the significant financial risk and frequent insolvencies.
3. ***If it is not a MEWA, the government-run plan is operating as an unlicensed insurer.*** The proposed public option is selling insurance without an insurance license is treated as being outside of Connecticut insurance requirements.
4. ***The government-run plan does not appear to be required to offer COBRA or state continuation rights.*** Under state and federal law, when an employee changes their employment status, and as a result, involuntarily lose coverage, the employee if provided the option to continue with their current employer-based coverage. The federal COBRA law applies to employers over 20 lives and state continuation to groups at or under 20 lives. If the government-run plan is not a MEWA, and not an insurer, it does not appear to be specifically required by statute to offer continuation coverage when an employee involuntarily loses coverage.

[1] *a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing.*

[2] Section 4(b) of ERISA, 29 U.S.C. §1003(b), specifically excludes from Title I coverage the following plans: (1) governmental plans (as defined in Section 3(32)); (2) church plans (as defined in Section 3(33)); (3) plans maintained solely to comply with workers' compensation, unemployment compensation or disability insurance laws; and (4) certain plans maintained outside the United States.

5. ***The government-run plan will impose undisclosed fees.*** The bill allows the Comptroller's office to assess a variety of fees on member small employers without limits. Insurers are not allowed to include undisclosed fees under any insurance contract.
6. ***The government-run plan does not have any requirement to maintain minimum capital requirements.*** The Wisconsin Office of Commissioner of Insurance ran three separate insurance funds, a local government property fund, a life insurance fund, and the Injured Patients and Families Compensation Fund. All were required to meet minimum capital requirements and borrowing from the general fund was limited by statute. There is no limit here.
7. ***The government-run plan is not required to meet statutory insurance accounting requirements or any other standards.*** This plan is not subject to regular outside independent and public audits. It should be. Every state agency, and every state fund in the state of Wisconsin was required to submit to a Legislative Audit Bureau audit, and the results were made public.
8. ***The new mandated requirements for silver plans may put the state at financial risk.*** Under the ACA, any new mandate costs must be paid for by the state. Before passage of this section, the state should seek formal guidance from Center for Consumer Information and Insurance Oversight.

Senate Bill 842 Creates Potential Conflicts with President Biden's Priorities based on US. House Bill 1425

House Bill 1425 passed the U.S. House in June of last year, with no action taken by the Senate. With Democratic control of both chambers and the Presidency, a number of the changes included in the bill are likely to be acted on, especially because strengthening the ACA is seen as a priority by President Biden.

1. ***A Connecticut-only subsidy creates tax issues.*** As mentioned above, the proposed ACA subsidies contained in SB 842 may have their heart in the right place, but the subsidies will be treated as taxable income under U.S. tax law (short of Congressional action). The House passed legislation last year fixing this issue, and it is expected to be a priority.
2. ***Congress is expected to pass new exchange subsidy criteria.*** The current subsidies have created a number of issues inside exchanges but especially concerns surrounding affordability. House Bill 1425 modified those subsidies, and some form of change is expected to pass.
3. ***New plans for those ineligible for the exchange may create conflicts.*** It is expected that coverage for "Dreamers" will be included in any ACA expansion package.

Other Concerns with Senate Bill 1425

1. ***Pool pricing is opaque, and consumers can not compare prices.*** The legislation allows the Comptroller to impose fees after coverage is issued in amounts unspecified, a practice appropriately banned in the licensed insurance market. This makes cost of coverage wildly unpredictable to both employees, and their employers. Many of these assessments appear to come after the coverage year has been completed, making it even more confusing.
2. ***Once in the government-run pool, you can never leave.*** There is no requirement that would allow businesses access to their data to shop for coverage outside the pool. Under current procedures, it has been practically impossible for local units of government to leave, and even if they can, they are charged a significant administrative fee. This predatory behavior is banned in the private market.
3. ***If coverage is offered to the private market, the government-run plan should be subject to the same financial audit as insurance companies.*** Insurance companies are not allowed to move

money from one pocket to the other, and yet this is exactly what the Comptroller proposes to do, with no oversight.

4. ***There is no requirement that the plans meet actuarial value levels.*** Consumers have gotten use to comparing plans by metal level. There is no requirement that government-run plan make it easy for businesses to compare benefit plans.
5. ***There is no requirement that the fund offer a "qualified" plan.*** There is no guarantee that consumers are buying comparable plans if the government-run plan is not required to meet the minimum standards for a qualified health plan.
6. ***There is no network adequacy requirement.*** In general, consumers should expect that that they can receive needed medical care. Without specific network adequacy requirements, the coverage is meaningless.
7. ***Licensed insurance agents may be able to sell the program at the discretion of the Comptroller.*** This provision is meaningless. It provides no certainty to agents, and no set commission levels.
8. ***Businesses are not promised loss ratio refunds.*** The ACA promises consumer refunds if the loss ratio target is not met, there is no requirement for to do the same in the legislation. In fact, it promises to move money from one pocket to other if there is expected refund.
9. ***There is no requirement that the fund meet the ACA required loss ratio definition.*** The Affordable Care Act has clear reporting requirements that could be used by the government-run plan and should be reported to the public.
10. ***There is no requirement that a qualified actuary to certify the rates are adequate.*** This is a standard procedure for insurers to ensure the rates meet appropriate standards. The plan should be required to have a qualified actuary review the rates annually.
11. ***There is no requirement that the fund maintain sufficient reserves***. Insurer are required to maintain a minimum reserve level or purchase reinsurance to protect against unexpected losses, for example in the case of a potential pandemic like coronavirus. . Reserves can provide investment income and help smooth out high and low-cost years.

1332 Issues

SB 842 includes language allowing the state to create a 1332 Waiver to reduce costs for consumers. This is separate from what I believe will be different 1332 Waiver required for the government-run plan.

1. ***Retaliatory taxes will be an issue.*** The proposal includes issues surrounding retaliatory taxes. Connecticut has no basis to ban another state from imposing a retaliatory tax based on the actions of that state's legislature. State laws vary considerably. In my home state of Wisconsin, we always apply the higher tax regardless of whether or not one of our companies had to pay it. Other state laws vary. There could be as many as 50 state variations on this issue.
2. ***Paying for a 1332 with an assessment on insurers changes the impact.*** It is important to note that using an insurer assessment lowers the positive impact of a 1332 waiver. It raises the price of insurance to those who purchase it, and returns some of it back. Broad-based assessments like using general purpose revenue has a bigger positive impact.
3. ***Reinsurance has been used because it works.*** We support the concept of a 1332 waiver in order to make the market work better. Reinsurance has been a popular 1332 waiver because of the ease of administration – it is like a 1332 on training wheels. When funded without an assessment on the insurance industry, it substantially lowers insurance costs. However, even with substantially liberalized Trump rules, approval of a non-reinsurance 1332 waiver has been difficult for states. As noted above, it is expected the Biden administration will re-consider the Trump-era 1332 flexibility. This means some level of uncertainty of 1332 waiver approval unless further Congressional action clarifies the guardrails.

4. ***Studying 1332 waivers may yield new options.*** With legislative approval, Wisconsin studied our 1332 options. Allowing Commissioner Mais and his experienced staff to work directly with CMS to conduct a study – similar to what we did in Wisconsin – may yield new and innovative options that could be considered.

In closing, I wholeheartedly agree with the concerns that this legislation is intending to address. There is no question that employers are finding it increasingly difficult to offer coverage. Unfortunately, for Taft-Hartley plans, non-profits, and small employers this legislation will not provide a long-term solution. In fact, it is likely to make it worse. In the 1990's, Kentucky faced similar issues in their market, and expanded coverage through their state employee pool. By 1996, Kentucky Kare, the state's self-funded state employee plan, needed a 28% increase to stem the losses:

> In 1993, Kentucky Kare appeared to be so financially strong that a decision was made to leave rates unchanged until the reserve levels were reduced. However, by June 1996, the Department of Insurance began a financial examination of Kentucky Kare showing a loss of more than $30 million over a 20-month period.".[3]

Thank you again for your time. My bio is listed below. I'd be more than happy to answer any questions during the course of the public hearing or through email at jpwieske@horizondc.com or by phone at 920-784-4486.

JP Wieske Bio

My name is J.P. Wieske. I am the former Deputy Insurance Commissioner for the state of Wisconsin. In that role, I supervised the agency at the Direction of the Commissioner. The agency consisted of several functions including supervision of the over 3,000 licensed companies including over 250 domestic carriers, and over 100,000 licensed agents. We also ran three state funds – the Injured Patients and Families Compensation Fund with over $1Billion in assets, the State Life insurance Fund with about 24,000 consumers, and the Local Government Property Insurance Fund which was the largest mono line insurance carrier in the U.S.

I served on the Group Insurance Board (GIB) which governs the state and local government employee insurance plan and on Wisconsin's Health Insurance Risk Sharing Pool (HIRSP) Board which provided coverage to the uninsurable prior to the implementation of the Affordable Care Act.

I also served as the lead in creating a 1332 Waiver for the state of Wisconsin. Wisconsin's Healthcare Stability Plan, the state's reinsurance pool, continues to deliver lower health care costs to Wisconsin consumers in the individual market, and has led to increased consumer choice.

I was active with the National Association of Insurance Commissioners where I chaired the Regulatory Framework Taskforce which also supervised the NAIC's ERISA Subgroup, Health Care Reform Alternative Workgroup, Network Adequacy Subgroup, Accident and Sickness Workgroup, and Prescription Drug Benefit Model Subgroup.

In my current role, at Horizon Government Affairs, I am involved in a number of projects. They include work with the Council for Affordable Health Coverage (CAHC) a big tent organization that supports bi-partisan policy solutions, serving as the Executive Director of the Health Benefit Institute which is establishing good public policy in health care markets, and as a lead on the study of the North Dakota hospital and health insurance markets on behalf of the North Dakota Insurance Department.

[3] https://insurance.ky.gov/ppc/Documents/history.pdf