Insurance and Real Estate Committee

PUBLIC HEARING

Tuesday, February 9, 2021

Connecticut Association of Health Plans

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Testimony in Opposition

to

S.B. No. 842 (RAISED) AN ACT CONCERNING HEALTH INSURANCE AND HEALTH CARE IN CONNECTICUT.

On behalf of the Connecticut Association of Health Plans and our member carriers -- Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim, and United Healthcare -- I respectfully urge your opposition to S.B. 842.

Access to quality, affordable health care coverage is core to the mission of all our carriers, and we remain committed to working with any and all stakeholders toward that end. Unfortunately, SB 842 doesn't achieve that goal.

As drafted, SB 842 is actually inclusive of two totally separate reform concepts that in many ways contradict one another.

Sections 1-3 allow individuals, unions, small employers, and nonprofits with up to 100 employees to purchase health care under the umbrella of the state employee health care plan. It's not really the state employee health care plan that's open for enrollment, however, it's the state Partnership Plan.

The Partnership Plan, by design, sits outside the scope of the state employee plan but it operates off the same rate structure that is used to underwrite the larger pool. As such, the rates collected for the Partnership Plan are insufficient to cover the claims incurred for its members and the result is a continuous state deficit.

Quality is Our Bottom Line

In 2018, the Partnership Plan finished the year with a $10M deficit. By the end of 2019, the deficit tripled to $30M. 2020 figures are still being finalized. While important, the 2020 figures are less likely to be relevant because COVID resulted in the shut-down of so many elective surgeries, treatments, and other procedures. As a result, we should expect to see lower claims experience. That said, once things return to normal post-pandemic, you will see a significant spike in claims as pent-up demand surfaces.

The concepts proposed under sections 1-3 of SB 842 are not new. In fact, they have been under consideration for over a decade. Previous versions of the proposal were known as Mega MEHIP, SustiNet, or just plain Pooling. Back in 2008, Governor Rell actually vetoed the original legislation. In 2012, Governor Malloy sought an advisory opinion from the Federal Department of Labor as to whether participation by nonprofits and small employers in the Partnership Plan would adversely affect the status of the state's ERISA exemption. In short - it would - exposing the state to significant potential liability.

Along the way, legislation did pass opening up the Plan up to municipalities and other non-state public employers like boards of education and libraries. Just two years ago, Public Act 19-117 made a number of significant changes to the underlying statutes, including to sections referenced under SB 842. One example relates to whether or not high-deductible health plans can be offered to Plan participants. The current statute says no, the new language says yes.

The 2019 act also requires the Comptroller to report to OPM on the total number of contracts, members, plan costs, premium payments and other revenues associated with his plans and the corresponding profit loss ratio for the previous calendar year -- distinguishing municipal health care plans from the state employee plan and demonstrating cost neutrality by individual municipal insurance plan across all municipal insurance plans. If the profit loss ratio demonstrates inadequacy in premium payments, the report is required to include a plan to ensure the fiscal adequacy of the premium rate structure and associated benefit design to eliminate any prior year financial loss and to prevent financial loss in the upcoming plan year.
To my knowledge, no report has been filed and/or analyzed as yet. A full review and rigorous analysis of that report should be undertaken before any new legislation is contemplated.

The approach outlined in SB 842 was a bad idea back in 2008 when Governor Rell vetoed the bill and it's still a bad idea now. Today, that same "pooling" concept has been rebranded as Connecticut's version of Public Option. Despite the new name, the underlying premise is the same and so is the result. The difference now is that we have the data to prove what we once only predicted -- that the concept doesn't work. It's unsustainable. Massive state deficits are the result.

Quality is Our Bottom Line

In the meantime, the Comptroller's program has undermined the private market by intentionally underpricing coverage. Plans in the private market, which are subject to state taxes and assessments as well as regulatory requirements that include guaranteed issue, rate review and approval, small group rate methodology, a medical loss ratio, and solvency standards among others, that the Comptroller is completely unburdened by, are put at an unfair competitive disadvantage. These private carriers can't compete with a program that gets to use state taxpayer dollars to cover built-in shortfalls. Private carriers operating in that manner would be put under immediate receivership by the Department of Insurance.

Now the Comptroller is proposing to add several new populations, under the same defective methodology, in a drive to establish a single-payer health care system. In truth, policy makers are being asked to embrace a government-run health care system that directly threatens Connecticut's flagship industry -- the economic output it generates and the jobs it supports -- in the name of a unique version of public option that offers only false promise.

Not only does the program undermine and threaten the private insurance market, it also undermines the ACA Exchange marketplace -- a marketplace in which the second half of the bill proposes to invest another $50M by way of a new surcharge on private insurance -- for purposes of establishing enhanced state subsidies among other measures. If the state chooses to move forward with the Partnership Plan, one of three things is sure to happen 1) premiums will increase drastically, 2) taxes will increase dramatically, and/or 3) provider rates will be slashed. Those will be the options afforded under the public option that is proposed by SB 842.

Subsidies, in and of themselves, are not a bad idea as proposed in SB 842. Any state subsidies, however, should be financed by the general fund and not at the expense of one market segment over another.

Any reform measures should also be accompanied by a focus on how to reduce health care costs which are what ultimately drive premium increases. SB 842 is completely silent on that accord. Until we have the hard conversations about why the underlying costs of care are what they are, and whether they are what they should be, we will continue to struggle with how to provide affordable coverage. That is where the answer lays. We ask you to oppose SB 842.

Thank you for your consideration.

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