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Testifying in Support of:

House Bill 5247: AAC Employee Health Benefit Consortiums

My name is Wyatt Bosworth and I am assistant counsel for CBIA, the Connecticut Business & Industry Association. CBIA is Connecticut's largest business organization, with thousands of member companies, small and large, representing a diverse range of industries from across the state. Ninety-three percent of our member companies are small businesses, with less than 100 employees. Thank you for the opportunity to testify in **support** of **HB 5247: AAC Employee Health Benefit Consortiums**.

Every day, small businesses struggle to attract and retain workers following the turmoil from the COVID-19 pandemic and the historic workforce shortage that has left more than 94,000 unfilled positions in the state. One of the only tools small employers have that can boost workforce and productivity is the ability to offer comprehensive benefit packages that include affordable and benefit-rich health plans. Unfortunately, due to volatile market conditions, the small group market is becoming more consolidated and less affordable every year.

Over the last few years, the Connecticut Insurance Department (CID) approved a wide range of premium increases in the on-exchange and off-exchange fully-insured small group markets.[1] According to a recent survey issued by NFIB in 2023, Almost all (94%) of small employers find it challenging to some degree to manage the cost of offering employer-sponsored health insurance, with almost half (48%) reporting it as very challenging.[2]

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[1] *See Health Insurance Rates for 2023*, Connecticut Insurance Department, (Sept. 2, 2022) https://www.catalog.state.ct.us/cid/portalApps/HCfiling2023.aspx (the average rate increase requested in the small group market, were reduced 47% from a requested average of 14.8%, resulting in an average increase of 7.9%); *see also Health Insurance Rates for 2024*, Connecticut Insurance Department (Sept. 8, 2023) https://www.catalog.state.ct.us/cid/portalApps/HCfiling2024.aspx (the average rate increase requested in the small group market, were reduced by 24% from the requested 12.4%, resulting in an average increase of 9.4%)

[2] *New Research About Small Businesses Offering – and Not Offering – Health Insurance,* NFIB (April 5, 2023) https://www.nfib.com/content/analysis/national/new-research-about-small-businesses-offering-and-not-offering-health-insurance/.

In Connecticut, between 2016 and 2022, the average annual single premium per enrolled employee for employer-based health insurance rose 25.9%.[3]

As a result of these increases, small employers are increasingly shifting away from the small group market to self-funded and level-funded products in order to control costs while maintaining competitive benefit plans. According to the Kaiser Family Foundation's 2022 Employer Health Benefits Survey, thirty-five percent of covered workers in small firms (3-199 workers) are in a level-funded plan.[4]

Recent state data for Connecticut from KFF also showed a 30% increase in small employers (2-50 workers) moving to self-funded and level-funded products between 2019 and 2022.[5] CBIA estimates the share of small employers in self-funded and level-funded products today is around 40%.

The increase in self-funding can be exemplified by examining the rapidly decreasing enrollment numbers in fully-insured products in the state. According to numbers provided by the Insurance Department last year, between 2017 and 2020, fully-insured lives in the small group market dropped from 235,337 to 110,003. In 2022, according to data provided to the Access Health Board of Directors meeting in January 2024, less than 80,000 lives remain in these markets.

Small employers are moving to self-funded products because they have (1) better control over plan designs; (2) access to important claims and utilization data; and (3) access to plan savings. According to AccessHealthCT, self-funded small employers are seeing up to 8%-10% in premium savings with "no material network or plan design differences.[6]"

However, despite being beneficial plans for many small employers, these self-funded plans are still out of reach for many of the smallest employers in the state. For example, according to AccessHealthCT, the average

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[3] State Health Facts, KFF (2024) https://www.kff.org/other/state-indicator/single-coverage/?activeTab=graph&currentTimeframe=0&startTimeframe=8&selectedDistributions=employee-contribution--employer-contribution--total-annual-premium&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] *2022 Employer Health Benefits Survey*, KFF (Oct. 27, 2022) https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/.

[5] *See Share of Private-Sector Enrollees Enrolled in Self-Insured Plans*, KFF (2022) https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?activeTab=graph&currentTimeframe=0&startTimeframe=9&selectedDistributions=firms-with-fewer-than-50-employees&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (2019: 14.5 vs. 2020: 19.3%; data from 2022 is forthcoming).

[6] AccessHealthCT January 2024 Board of Directors Meeting Presentation, Page 44 (Jan. 2024) https://agency.accesshealthct.com/wp-content/uploads/2024/01/January-2024-AHCT-BOD-Presentation.pdf.

employer size in these programs is 10 to 25 employees. Many smaller employers simply lack the cash flow and ability to actively manage their own health benefits to take advantage of these plans.

HB 5427, if enacted, will finally provide a platform for these small employers to take advantage of the self-funded arrangements that larger employers, the state, municipalities, and unions take advantage of today.

Self-Funded MEWA Trusts: Leveling the Playing Field for Small Employers

Recognizing the size and scale that Connecticut-domiciled chambers of commerce and trade associations possess in terms of small-employer membership, a number of states, including Virginia in 2022[7], paved the way for associations of significant scale to band their employer-members together to offer a self-funded health benefit plan, while being subject to rigorous financial and solvency oversight by the respective state's Department of Insurance as well as the federal Department of Labor.

While Connecticut has shared-jurisdiction over MEWAs with the Department of Labor, amendments to ERISA in 1983 provide policymakers near-unlimited authority to not only set up a regulatory structure for MEWAs, but set minimum requirements for plan design, benefits, consumer protections, and trust governance as well.[8] The provisions highlighted below showcase a unique and Connecticut-specific manner to appropriately regulate these plans and ensure they provide robust benefits for the employees that utilize them.

Insurance Department Regulatory Oversight

The regulatory structure of these MEWAs is robust and has direct buy-in from the Connecticut Insurance Department.

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[7] *Virginia small businesses seeking health care coverage get new option,* Richmond Times-Dispatch (April 7, 2023) https://richmond.com/news/state-and-regional/govt-and-politics/health-insurance-state-corporation-commission-virginia-chamber-of-commerce/article_7e98b3f2-d31b-11ed-8c63-67ac345feb39.html.

[8] *See* MEWAs under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation, U.S. Dep't of Labor at page 5 https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf ("Prior to 1983, if a MEWA was determined to be an ERISA-covered plan, State regulation of the arrangement would have been precluded by ERISA's preemption provisions. On the other hand, if the MEWA was not an ERISA covered plan, which was generally the case, ERISA's preemption provisions did not apply and States were free to regulate the entity in accordance with applicable State law. As a result of the 1983 MEWA amendments to ERISA, discussed in detail later in this booklet, States are now free to regulate MEWAs whether or not the MEWA may also be an ERISA-covered employee welfare benefit plan."); *see also* ERISA Section 514(b)(6)(A)(ii) ("[I]n the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title").

Under Section Three, a MEWA trust must apply and obtain licensure subject to Chapter 698 of the Connecticut General Statutes, as well as comply with all requirements under 38a. This ensures that the MEWA trust will be subject to the **same** licensure requirements that domestic insurance companies are subject to today.

The CID will also require each MEWA trust to establish a **minimum initial combined capital and surplus of $4 million**, as well as purchase and maintain a bond in an amount and form approved by the Commissioner. Both of these requirements ensure that the MEWA trust is financially healthy ahead of enrollment.

After a license is granted, the CID will continually examine the MEWA trust's finances in the same fashion the agency examines domestic insurance companies today. For example, Section Three mandates the MEWA trusts to be subject to (1) financial examinations and any resulting investigatory hearings; (2) visitation and affair examination at least once every five years; and (3) market conduct examinations with a requirement to pay the cost of such examinations.

This oversight will also ensure that the MEWA trust establishes and maintains reserves in accordance with any financial and solvency requirements applicable to health insurance companies.

Robust Consumer Protections

Because the federal government shares self-funded MEWA jurisdiction with the states, Connecticut is able to establish minimum-levels of consumer protections and benefits that are **stronger** than traditional single-employer self-funded arrangements.

For example, Section Three requires these MEWA trusts to **cover all ten federal Essential Health Benefits and all state health benefit mandates** under 700c of the General Statutes.

Contrary to the opposition's claim that the MEWA trusts will offer only "junk plans", Section Three requires these trusts to offer plans with an actuarial value of at least (1) 60%; (2) 68%; and (3) 78%. This ensures the plans offered by these MEWA trusts are actuarially equivalent to Bronze, Silver, and Gold plans offered in the fully-insured market today.

Section Three also codifies ERISA protections as it pertains to those with preexisting conditions. **Under no circumstance will these MEWA trusts be able to (1) discriminate against any individual based on a preexisting condition; and (2) establish discriminatory rules based on the health status of an individual related to health benefit plan eligibility, or rate or contribution requirements.**

Further, Section Three requires that **any** eligible company that applies for new or renewed coverage from the MEWA trust will be **guaranteed** a quote and an offer of coverage.

Section Five also designates the CID Consumer Affairs division to receive and review complaints from any policy holder under a MEWA trust plan. Policyholders will have access to the Office of Healthcare Advocate to resolve claim denials and other similar complaints as well.

Lastly, at the request of the Healthcare Advocate, the bill mandates that the notification requirements set forth in sections 38a-591c to 38a-591g (utilization review and benefit determinations of a benefit request or claim) apply to these self-funded arrangements.

Value-Based Insurance Design and APCD Data Reporting

Perhaps the most important aspect of this legislation is the mandate under Section Three to implement value-based health benefit plan design and value-based contracting. The bill requires the MEWA trust, which will possess great power to dictate terms of plan and benefit design, to administer programs like centers of excellence, wellness programs, health enhancement programs, alternative payment models, chronic disease navigation and patient-centered medical homes.

The MEWA trusts will follow the great progress the state of Connecticut and large employers have made for quite some time now. The Comptroller's Office has been a leader in this space by implementing value-based plan designs, as well as employers like (1) Stew Leonard's, which deployed high-value multi-system solutions that exclude high-cost systems that demonstrate no correlation to higher quality, and implemented affordable primary-care driven models, transparent PBM contracting, and traditional broad PPO options to ensure no forced disruption for members; and (2) JPMorgan, which recently opened three on-site advanced primary care centers for employees in the Columbus, Ohio area.[9]

The reporting requirements for these value-based programs also ensure that (1) the MEWA trust is held accountable to deploy these programs for the benefit of their employer-members; and (2) other self-funded plans around the state can use these best practices to deploy the tools themselves.

For example, under Section Three, the bill requires that the MEWA trusts report to CID (1) a description of the value-based plan designs and contracting programs; (2) the number of participating employees enrolled in these programs; (3) the percentage of dollars spent on these programs; and (4) a description of how these programs lowered costs for participating employees.

[9] *JPMorgan is launching primary care clinics,* Advisory Board (March 18, 2023) https://www.advisory.com/daily-briefing/2022/10/28/jp-morgan ("The three on-site advanced primary care centers will be located in Polaris, Easton, and Brooksedge, Ohio, and will serve more than 20,000 JPMorgan employees. The two near-site care centers will be located in Dublin and Westerville and will serve employees as well as more than 15,000 spouses/domestic partners and children enrolled in the company's benefit plan.").

Stop-Loss and Rate Methodology Review

The self-funded MEWA trusts will be subject to the **same** rate methodology review that large group fully-insured plans are subject to today. CID oversight for rating and renewal methodologies assures that the best practices are adopted for individual group participants thereby limiting the credibility of a group's experience relative to their rates and renewals.

Section Three also mandates that the MEWA trust establish an applicable pooling point that is consistently applied to all participating employers under the arrangement. The MEWA trust is required to utilize pooling or reinsurance for individual large claims to reduce the adverse impact on any specific participating employer's rates.

More specifically, the bill requires the MEWA trusts to (1) purchase and maintain stop-loss insurance for **each** health benefit plan with retention levels determined in accordance with actuarial principles from licensed insurers; and (2) purchase and maintain an aggregate stop-loss insurance policy with an attachment point of 125%. Both of these requirements ensure that volatile, unforeseen, or expensive claims will be appropriately spread out across the pool of employers with limited impact to the small employer who incurred the claim.

Trust Requirements

Every MEWA must establish and maintain a board of trustees with at least five trustees. These trustees will include employer-members who will design and implement benefit plans and rules for participation.

Trustees under the bill will also be required to discharge duties in accordance with generally accepted fiduciary standards, and purchase and maintain both commercially reasonable directors and officer's liability insurance, as well as fiduciary liability insurance.

Funds are required to be used to benefit the employers through (1) self-funding claims and reinsurance; and (2) defraying costs and expenses of operating the trust.

Lastly, the trust is **required** to use surplus in excess of an amount to be determined by the CID to reduce health benefit plan contribution amounts paid by participating employers and participating employees. This will afford each employer the opportunity to share in the plan's savings and build reserves which smoothes out increases and ultimately reduces rate volatility which is a prominent problem in today's small group market.

Existing Federal Protections

MEWA trusts are group health plans for purposes of Federal law. Like any other group health plan, they are subject to what is generally referred to as the ACA insurance market reforms or simply "market reforms."

These are the rules set out in Title XXVII of the Public Health Service Act (PHS Act) and Title I of the ACA. They are also incorporated by reference into ERISA and the Internal Revenue Code.

These market reforms include the ACA's rating reforms as well as the medical loss ratio, rate review, and risk adjustment programs, in the case of fully insured plans. While these rules don't apply to self-funded plans, other ACA market reforms do.

These include, among others: (1) dependent coverage for adult children up to age 26, (2) coverage of preventive health services without cost-sharing (grandfathered plans are exempt), (3) a bar on discrimination based on health status, (4) no rescissions of coverage, except in the case of fraud, intentional misrepresentation of material fact or non-payment of premiums, (4) no lifetime or annual dollar limits on essential health benefits, (5) improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt), (6) no waiting periods exceeding 90 days, (7) no pre-existing condition exclusions for any enrollees, (8) no discrimination against participants who participate in clinical trials (grandfathered plans are exempt), and (8) maximum out-of-pocket expenses for covered essential health benefits cannot exceed specified amounts (grandfathered plans are exempt).

The MEWA trusts will also be subject to a number of federal laws that apply to fully-insured and self funded plans today:

- HIPAA (ERISA Sections 701-703)
    - Limitations on a group health plan's ability to impose preexisting condition exclusions and provides special enrollment rights for certain individuals that lose other health coverage or who experience a life change;
    - Nondiscrimination rules that prohibit plans from establishing rules for eligibility to enroll in the plan or charging individuals higher premium amounts based on a health factor; and
    - Guaranteed renewable
- The Newborns' Act (ERISA Section 711)
    - If plan offers maternity hospital benefits for mothers and newborns, the plan must pay for at least a 48 hour hospital stay for normal birth and 96 hour stay for c-section
- Mental Health Parity Act (ERISA Section 712)
    - Parity in the application of annual and dollar limits on mental health benefits with annual lifetime dollar limits on medical and surgical benefits
- Women's Health and Cancer Rights Act (ERISA Section 713)
    - Protections for patients who elect breast reconstruction or certain other follow-up care in connection with a mastectomy
- Genetic Information Nondiscrimination Act (ERISA Part 7 of Title I)

    - Cannot base premiums for a plan or a group of similarly situated individuals on genetic information; and
    - Prohibits plans from requiring/requesting genetic testing and prohibits plan from collecting genetic information
- ERISA consumer protections (ERISA Title I):
    - (1) provide participants with plan information including important information about plan features and funding; (2) sets minimum standards for participation; (3) vesting; (4) benefit accrual and funding; (5) fiduciary responsibilities for those who manage and control plan assets; (6) grievance and appeals process for participants to get benefits from their plans; and (7) participant right to sue for benefits and bleachers of fiduciary duty

Conclusion

This bill gives small employers a voice. By clearing the way for trade and industry associations to aggregate their membership and become an active purchaser of health insurance, small employers will finally enjoy the same benefits that only large employers, municipalities, unions, and the state of Connecticut enjoy today.

For smaller trade associations, their small employers will finally be able to negotiate and work directly with a health insurance carrier to design a plan that is not only affordable, but meets the direct needs of their employees.

For trade and industry associations with significant scale, the allowance to offer a self-funded purchasing arrangement has the potential to move the needle by significantly bringing down healthcare costs while implementing plan features that prioritize **value over volume**. These larger associations will be able to replicate many of the successful models that larger employers are working with today: value based insurance design, wellness incentives, administrative efficiencies, care navigations, centers of excellence, investments in primary care, and more.

All of this while being rigorously subject to robust Insurance Department regulation and federal Department of Labor oversight. CBIA thanks the committee for raising HB 5247 and we urge your support. Thank you.