Quality is Our Bottom Line

Connecticut Association of Health Plans

Testimony regarding

Connecticut Health Care Cabinet "Bailit" Draft Strategies

November 15, 2016

On behalf of the Connecticut Association of Health Plans (CTAHP), we respectfully offer the following testimony regarding the recommendations developed by Bailit for the Cabinet's consideration.

First and foremost, with the changing landscape in Washington we caution the Cabinet and the state against moving in any one direction too quickly. Doing so could unintentionally destabilize Connecticut's insurance market and have an adverse effect on the consumers that we all aim to serve. The Affordable Care Act (ACA) and the state's Exchange include many provisions that are reliant upon one another in order to create a functioning health care system. While Association members have long held that the ACA needs reform, any changes adopted in Connecticut must be done thoughtfully, based upon what is happening nationally, lest we do more harm than good.

We appreciate the energy and the effort that has gone into the development of the Bailit report. However, we remain concerned that the underlying cost of health care has yet to be addressed. Carriers, too, share in the concern around rising health insurance premiums. But, we can't forget that premiums are only a reflection of the underlying expense of health care whether they're related to claims, benefits or regulations etc. Many elements in this report, while well intentioned, may serve to increase as opposed to decrease those underlying costs depending upon how the various initiatives are to be funded.

Furthermore, the Association takes exception to the characterization that the Bailit recommendations model Massachusetts. The two states are very different in their markets and in their regulation and they are not easily pared for such comparison. We ask that the Cabinet be cognizant of the downside of such juxtaposition moving forward.

With respect to the report's specific recommendations, CTAHP wholeheartedly agrees with the statement under strategy 2B which states that HHS standards for value-based payment models ***"were developed out of recognition that the fee-for-service health care payment system***

rewards volume over value of services, leading to overuse, misuse and the devaluing of lower-priced services like primary care and mental health."

Health plans have been at the forefront of value-based insurance designs that reward quality efficient care; and carriers have pioneered many of the efforts that are now being modeled under SIM and elsewhere. As such, the industry finds it disheartening that insurers are the only entity singled out for corrective action under the report.

Likewise, Connecticut's carriers have been actively engaged with the state's All Payer Claims Database (APCD) working together on policy and data submission for the last three years. These efforts have been compromised of late by the Liberty Mutual Supreme Court decision which concluded that federal ERISA law preempts a State's ability to require submission of self-insured employer data that is maintained by carriers. **Connecticut is approximately 60% self-insured, including the state employee plan, meaning that the costs and burden of any legislation passed by the state is born by less than half of the market – the small employers who are least able to afford it.** We all are working through these issues together, via the APCD, the Exchange and the SIM process and we suggest that any further efforts to collect data be done within these current constructs as opposed to creating a new duplicative requirement that will undoubtedly face some of the same challenges.

With respect to **Strategy 3B** and incorporating consumer affordability into the Insurance Department's rate review process, we again believe the focus is misplaced. By virtue of recent state and federal legislation, Connecticut carriers are not only subject to rigorous rate review but they are also subject to specified Medical Loss Ratio (MLR) standards whereby they are ***mandated*** to issue consumer rebates if their premiums exceed medical costs by certain thresholds. Integral to consumer protection is the question of insurer solvency. Rates must be sufficient to cover anticipated claims. While the Department of Insurance has called on plans to lower their proposed rates at times, they have also called on plans to raise their rates when they've felt that the premiums proposed are insufficient to cover the probable patient costs. Protections are already in place to guard against purported excessive insurer profit. Connecticut needs to address the underlying costs. Allowing carriers to innovate around network and benefit design, which has shown promise in terms of delivering high quality affordable health care, is an important first step.

Bailit's pharmacy recommendations, that the Cabinet took under advisement late in the process without a full vetting, are of particular concern. Prescription costs are skyrocketing. Carriers need as many tools in their tool box as possible to combat pharmaceutical companies. Yet some proposals in the report may provide an advantage to the pharmaceutical manufacturers over the carriers by undermining an insurer's ability to manage the benefit on behalf of their members.

Cost containment is paramount to the sustainability of our health care delivery system. While the ACA has many positive attributes, it also has resulted in many challenges which one would expect to accompany such a large new initiative. Many of these challenges, such as the sunset of the stop-loss and reinsurance provisions, add appreciably to the costs here in Connecticut, but they are beyond state control and must be dealt with at the federal level.

We respectfully request that the Cabinet take the above comments into account when adopting the final report and recommendations.

Thank you for your consideration.