HEALTH BENEFITS INSTITUTE
440 1st St. NW, Suite 430 | Washington, DC 20001
O: 202.808.8848 | thehealthbenefitsinstitute.org

Testimony of J.P. Wieske in opposition to SB 346

Senator Lesser, Representative Scanlon, Senator Kelly, Representative Pavalock-D'Amato and members of the committee, thank you for the opportunity to testify before you on behalf of the Connecticut Association of Health Plans in opposition to SB 346 An Act Concerning Public Options for 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 are many. Some issues are technical, and while not exciting, are important. Others are based on public policy reasons. Most important, however, is to keep our eye on the potential consumers impacted by this government-run plan.

My name is J.P. Wieske. I am the former Deputy Commissioner for the state of Wisconsin. In that role, I supervised the agency at the Direction of Commissioner Ted Nickel. 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 approximately $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 Wisconsin's Health Insurance Risk Sharing Pool (HIRSP) Board, and on the Group Insurance Board (GIB) which governs the state and local government employee insurance plan. I also served as the lead in creating Wisconsin's Healthcare Stability Plan, the state's reinsurance pool.

I was also active with the National Association of Insurance Commissioners where I chaired the Regulatory Framework Taskforce, Health Care Reform Alternative Workgroup, Network Adequacy Subgroup, Accident and Sickness Workgroup, and Prescription Drug Benefit Model Subgroup. I also served as a surrogate for Commissioner Nickel, who was serving as the NAIC President.

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 looking to establish good public policy in health care markets, and as a lead on the study of the North Dakota hospital and health insurance markets along with my colleague Jeff Lemiuex, a former CBO economist.

I apologize for my lengthy and detailed bio, but I thought it was necessary for you to understand my background to better understand my concerns.

At its simplest, insurance is a contract. Consumers agree to pay a premium. Insurers agree to cover their risk. And that is what SB 346 promises.

But what SB 346 proposes is not an insurance contract. It is run more like a government-run program like Medicaid. The basic financial requirements for an insurance contract are missing. It is missing key consumer elements that are typically part of today's insurance contracts. And the proposal creates new issues by further segmenting the risk pool, making it difficult for consumers to compare coverage, and making enrollment in the program and the market-at-large more difficult. In short, I believe the proposal

will significantly harm the Affordable Care Act (ACA) market in both the individual and small group market.

Consumer Issues

I worked on ACA implementation issues both in the state of Wisconsin, and while serving as committee chair at the NAIC. I've interacted with insurers, consumer groups, and medical providers. I've seen a number of major policy mistakes, and most of them leave consumers holding the bag. Many of the reforms listed below are intended to be minimum standards that apply to the whole market. They ensure a consumer is receiving a plan as promised. The requirements ensure consumers can understand the difference between the benefit plans and make the best choice for them. I find it suprising that SB 346 leaves these requirements out making consumer choices much much more difficult.

- **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 ConnectHealth make it easy for consumers to compare benefit plans.
- **There is no requirement that the fund offer a "qualified" plan**. There is no guarantee that consumers are buying comparable plans if ConnectHealth can not meet the minimum standards for a qualified health plan.
- **There is no network adequacy requirement**. In general, consumers should expect that that they can receive needed medical care. Without network adequacy requirements, the coverage is meaningless.
- **ConnectHealth is not required to meet benchmark plan requirements.** As a result ConnectHealth's benefit package may differ from private insurers making it difficult for consumers to compare plan designs.
- **The program is not required be sold on the exchange.** Access Health CT is the place where consumers are going to purchase coverage. If ConnectHealth is exclusively off-exchange, it is difficult for consumers to appropriately shop.
- **Licenses insurance agents do not appear to be able to sell the program.** Virtually every health reform not including agents has failed. From Community Health Purchasing Alliances, standardized benefit plans, and other state pooling mechanisms have had problems with consumer traction if agents are not part of the process.
- **Consumers are not promised loss ratio refunds.** The ACA promises consumer refunds if the loss ratio target is not met, there is no requirement for ConnectHealth to do the same in the legislation.

I will also note that most, if not all of these requirements, must be filed by insurers with the insurance department. This ensures consistent compliance and application. It ensures someone is looking out for the consumer. It ensures policy terms, and policy language are understandable to a consumer.

Financial Issues

I have learned through experience that financial integrity issues are not just important for good governance, but also for the protection of consumers and the market. Consumers rely on the financial promises of the insurer, that the money will be there when they pay a claim. Governments typically do

not have the same problem with ability to pay, but program integrity and taxpayer protection are important as well.

I have also learned of the importance of market integrity. A program that has the ability to forestall rate increases – for whatever reason – can damage the program permanently, but it can also wreak havoc on the market. It can lead to insurer market exit, and destabilize the entire market. Necessary high rate increases following pricing errors in a given year can put the program in a death spiral.

- **Premiums are set based on the state employee rates. E**ven a cursory analysis will tell you that the individual and small group risk pools operate very differently. Just ask Kentucky, who in 1998 allowed a buy-in to their state employee plan by individuals and small groups. The buy-in groups consistently had loss ratios exceeding 100%.
- **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.
- **There is no requirement that the fund maintain sufficient reserves.** Insurer are required to maintain minimum level of reserves or purchase reinsurance to protect against unexpected losses, for example in the case of a potentil pandemic like coronavirus. . Reserves can provide investment income and help smooth out high and low cost years.
- **There is no requirement that the fund use statutory accounting practices required of insurers.** Insurance companies have specific accounting rules to ensure costs are allocated correctly, there is no requirement for ConnectHealth to use statutory accounting let alone GAAP accounting. These rules not only tell you how to count expenses, but when expenses should be counted. It is often easy to move some expenses from one year to the next under GAAP.
- **There is no required audit of the program.** IIn my experience regular outside audits and reporting encourage good government, and sound policy. ConnectHealth does not appear it will ever be audited separately.
- **There is no requirement that the fund meet the ACA required loss ratio definition.** Promising to meet the loss ratio is meaningless. The Affordable Care Act has clear reporting requirements that could be used by ConnectHealth, and should be reported to the public. It is also important to understand whether the plan will be required to hit 90% annually, use the ACA's 3 year process, or target a lifetime loss ratio.

I appreciate the concerns that SB 346, the government-run insurance plan, are intended to address. Connecticut's concerns are not unique and I saw many of the same issues in my work with the NAIC. The truth is there is no easy answer, and I don't believe SB 346 will effectively address the problems.

Again, thank you for taking the time to hear my testimony. I am happy to answer any questions on SB 346 or other health reform topics.