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REPORT 1

A Risky Plan: Connecticut's Public Option Proposal

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About The Author

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Executive Summary

Connecticut state officials have proposed entering the private health insurance business to assist residents who are either unable or struggling to afford coverage. Proponents hope to offer a "public option" insurance plan to small businesses, labor unions, nonprofit organizations, and potentially individuals, using the state employee healthcare program as the template, that would offer lower premiums and lower out-of-pocket costs than current insurance options.

Unlike other states that have experimented with public options, the Connecticut proposal would place risk on taxpayers instead of private insurers.

What's more, the state's track record in selling insurance, or otherwise managing insurance plans, raises serious questions about how a public option would be run.

Connecticut's Partnership Plan 2.0, the basis for the public option, is a health plan run by the state comptroller that piggybacks on the state employee health plan network to provide comparable benefits to local government employees. But premium and claims data show it has operated at a significant loss, engaged in predatory pricing to capture market share, and used premiums from new enrollees to conceal red ink. Had such unsavory tactics been attempted by a private insurer, the state Insurance Department likely would have shut down the plan years ago.

The state has a mixed record in other plan-management efforts. In running its own employee health plan, the state's attempts to save money from policy tweaks have overall fallen about 40 percent short of its goals—and the state comptroller is over a year late in producing the latest assessment. HUSKY, the state's Medicaid program, has previously come under fire from federal auditors for ignoring problems and failing to police fraud aggressively.

Rather than entering the insurance business, state officials should instead examine how existing state programs could be improved to cover more people—and how state policies should be changed to make coverage more affordable for others.

This undertaking should begin with scrutiny of the state's two primary efforts: HUSKY and Access Health CT, the health insurance exchange. More than a quarter of the state's uninsured population appears already to qualify for HUSKY but has not enrolled. Meanwhile, the number of people buying coverage on the exchange has decreased for the past three years.

Instead of getting into the health insurance business, state officials should work to reduce the extent to which state policies have increased healthcare costs through taxes and regulations on providers. They should draw lessons from the early days of the novel coronavirus pandemic, when Governor Lamont suspended various rules to streamline healthcare services that allowed residents to use telemedicine and authorized out-of-state doctors to treat Connecticut patients under their home-state licenses. And they should foster, not impede, innovation and competition among healthcare providers by reforming Connecticut's Certificate of Need rules.

Background: Covering Connecticut

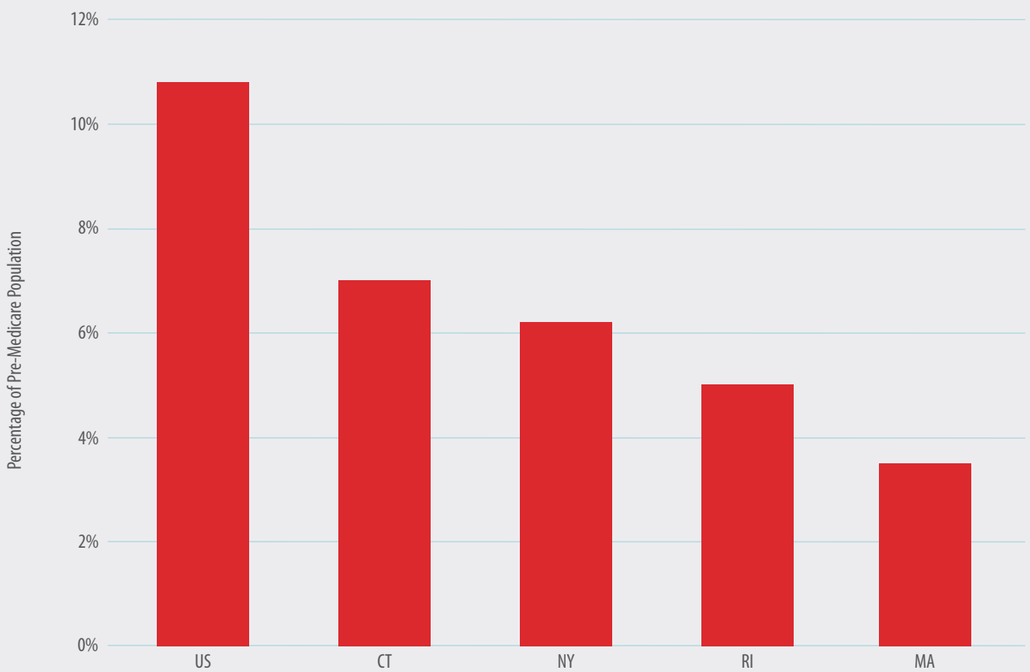
Considerable debate in recent years has focused on how the state and federal government can help more people access health insurance coverage.

The US Census Bureau estimates, as of 2019, just over 201,000 Connecticut residents did not have health insurance.[1] Statewide this was 7.0 percent of the population (+/- 0.3 percent) not yet old enough to qualify for Medicare, compared to 10.8 percent (+/- 0.1 percent) nationally. It ranged from 4.4 percent in Tolland County to 9.3 percent in Fairfield County.

Connecticut's uninsured rate in 2019 stood below the national average but still higher than all three of its neighbors **(figure 1)**.

Figure 1

Population (Age < 65) Without Health Insurance, 2019

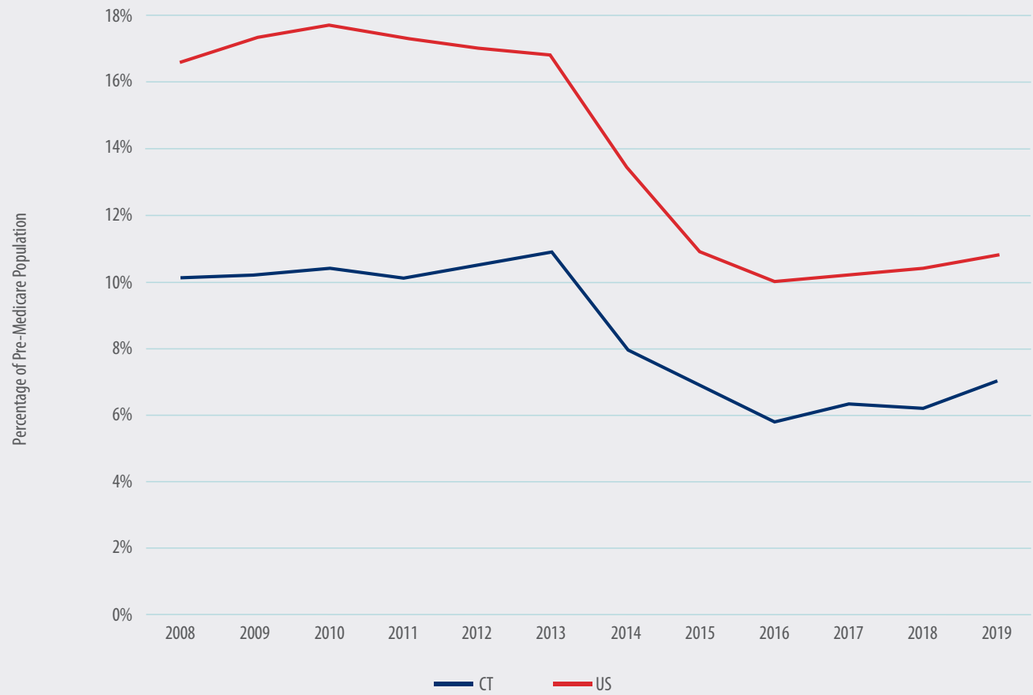


Source: US Census Bureau, Small Area Health Insurance Estimates

This marks an improvement from the prior decade. Between 2008 and 2013, Connecticut's estimated uninsured rate averaged 10.4 percent. From 2015 to 2019, it averaged 6.4 percent.

Figure 2

Population (Age < 65) Without Health Insurance, CT and US

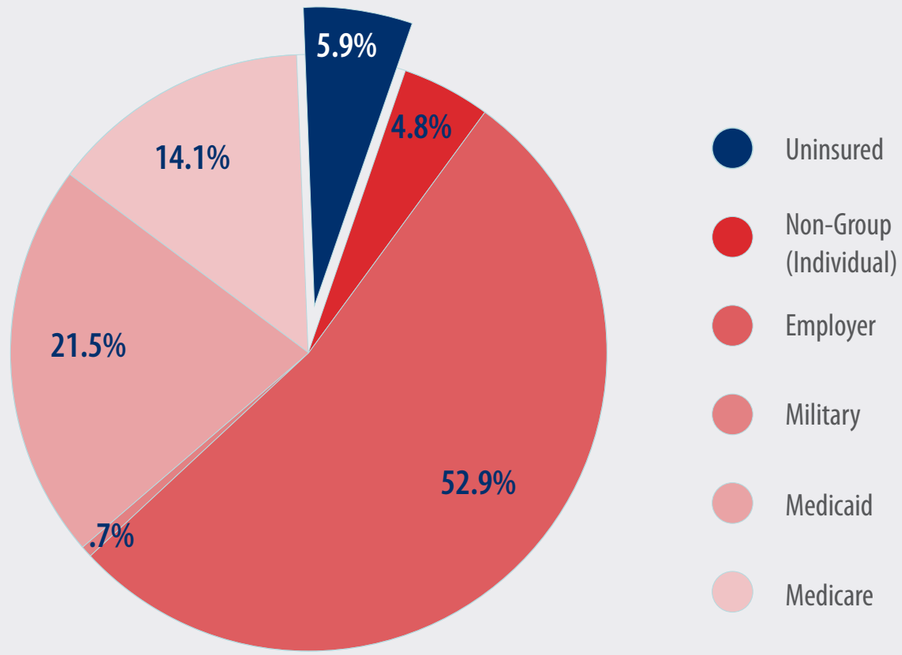


Source: U.S. Census Bureau

One notable trend is the drop in employer-provided health insurance. In 2008, 62.8 percent of all residents had insurance from an employer. By 2019, that had fallen to 52.9 percent **(figure 3)**.[2]

Figure 3

Source of Health Insurance Coverage, CT Residents, 2019



Source: Kaiser Family Foundation analysis of U.S. Census Bureau data

A portion of that decline is attributable to population aging. Medicare enrollment rose from 11.2 percent in 2008 to 14.1 percent in 2019. But it also bears noting that Connecticut's anemic recovery after the Great Recession was driven by job growth in lower-paying sectors less likely to provide employer coverage.

Employment in the leisure and hospitality supersector in late 2019 was 20,000 jobs (14.6 percent) above late 2007 levels.[3] By comparison, the financial activities supersector had shed a comparative number of jobs (20,500) over the same period, a 14.3 percent drop in the state's highest-paying area.[4]

This indicates some of the decline in private health insurance coverage likely flows from the state's weak job creation over the past decade.

State Policy & Healthcare

Connecticut regulates the health insurance market for employees with fifty or fewer employers, known as "small groups," and for individuals. Large employers or other large-group insurance plans, on the other hand, are largely regulated by the federal government.

State law controls much of the criteria insurers may use to calculate premiums and has rate-setting powers under which insurers must seek prior approval.

For people who can't afford health insurance, Connecticut partners with the federal government to fund HUSKY, the state's Medicaid program for low-income individuals and the disabled.

Connecticut in recent years has taken two major steps to reduce the number of people without health coverage.

In 2010, the General Assembly expanded eligibility for HUSKY, among other programs covering adults without minor children who earn up to 138 percent of the Federal Poverty Level.[5]

The state in 2013 launched Access Health CT, a healthcare exchange on which individuals and businesses can shop for health insurance and apply federal tax credits toward premiums.

But some Connecticut officials have proposed a different solution that would put the state government itself in the insurance business.

The Public Option

The "public option" concept of selling government-backed insurance coverage rose to national prominence in 2009, as Congress was considering what ultimately became the Affordable Care Act (ACA).

Public option advocates argued that the focus on share-holder value and executive compensation of private insurers translated into premiums costing more than necessary. The solution, they suggested, was for the federal government to stand up a health insurance plan with equal or better benefits and lower premiums that would create competitive pressure to force insurers to lower their rates.

Former state Comptroller Kevin Lembo captured much of the energy behind the push for a public option in a August 2021 testimony, urging state regulators to block rate increases sought by regulated state health insurers. The companies, Lembo argued, were either "not managing their plans responsibly" or "simply gouging Connecticut consumers because they know they can."[6]

The idea of getting state government into the healthcare market to compete with private insurers has circulated in Connecticut policy circles for decades.

As early as 1991, State Comptroller Bill Curry proposed a state-run health insurance plan through which individuals and businesses could buy the coverage provided to state employees.[7]

In 2009, Governor M. Jodi Rell vetoed a comprehensive bill that would have allowed the state comptroller to sell health insurance coverage to small employers through the state employee health plan.[8]

Among other concerns, Rell raised questions about the potential effect of this pooling on the state's costs, and about the possibility of "adverse selection," the situation that arises when rising premiums cause healthier people to drop their coverage.[9] Rell's own signature healthcare program for uninsured residents, the Charter Oak Health Plan, would ultimately face the same problem.

In 2011, lawmakers introduced HB 6308, which would have opened the state employee plan to small businesses and nonprofits in a manner similar to Curry's proposal. That provision was dropped before Governor Dannel Malloy signed the bill into law.

The legislation, however, created the first iteration of the "Partnership Plan," which let the state comptroller market the state employee health plan to local governments and provided the basis for recent public option proposals.

The comptroller's office launched a second program, Partnership Plan 2.0, in 2016. HB 7267, proposed in 2019, would have created the Connect-Health Plan, which would have had equal or greater benefits than plans sold on the state health exchange, and based premiums, deductibles, and cost-sharing on what each enrollee could afford to pay.[10] The bill passed in the House but died in the Senate.

In 2021, proponents took a narrower approach. SB 842 included a collection of policy changes, such as authorizing the state comptroller to sell Partnership Plan 2.0 coverage to small businesses and nonprofits—a "public option"—and charged private insurers a $50 million annual fee to provide additional subsidies on the exchange beyond the existing federal tax credits.

The bill was reported out of committee but did not get a vote in either chamber, after proponents decried an amendment that would have subjected the public option to the same state insurance regulations to which private carriers must adhere.[11]

Public option proposals that have circulated in Connecticut have been generally difficult to scrutinize because so much remains unknown about who would purchase such coverage and how large their claims would be compared to their premiums.

What's certain is that the public option concept under discussion in Hartford differs significantly, both from recent coverage efforts and also those pursued in other states, in that state and local taxpayers would incur risk.

In 2019, Washington state was the first to pass a public option law when it created Cascade Select plans, under which the state contracts with private plans to offer coverage with certain benefits at lower premiums.[12] The plans were first sold on the state's healthcare exchange in January 2021, though enrollment was lower than expected. That stemmed, in part, because plans were not available in every county and because the plans had higher premiums to offset their lower deductibles. The state notably had difficulty getting hospitals to accept the plans, for which reimbursement rates are capped, and in 2021 Governor Jay Inslee signed a law requiring them to do so.[13]

In Nevada[14] insurers doing business with Medicaid will be required to make a good-faith effort to offer public option plans at below-market premiums. In Colorado,[15] insurers will be required to offer lower-premium public option plans as a condition of selling coverage to individuals or small groups.

In all three states, taxpayers are shielded from the primary risk of claims outpacing premiums.

But under Connecticut's approach, taxpayers would have to absorb cost overruns—a concern proponents have suggested could be addressed by, ironically, purchasing stop-loss insurance from private companies.

To that end, the question of whether the state should enter the health insurance business turns significantly on how it has managed past efforts to provide healthcare coverage.

The answer? Not especially well.

The Wrong Treatment

Source: Office of the State Comptroller

Partnership Plan

Connecticut's state comptroller sells coverage under the state employee health plan under the state government-backed "Partnership Plan," which was first authorized by the General Assembly in 2011[16]. The program allows local governments to offer benefits similar to those enjoyed by state employees and to access the same network. In July 2021, the Plan was covering about 63,000 people through 150 groups of local government employees.

The Partnership Plan 2.0 is the template which public option proponents hope to use, allowing the state comptroller, who manages the Plan, to sell coverage to small businesses (and potentially individuals), in addition to local public employers.

To be sure, pooling healthcare costs for state and local government employees is not uncommon, and 22 states allowed it as of 2018.[17]

But the Partnership Plan 2.0 is unique because premiums and claims for local employees and their families are paid from an account separate from the state employee plan. Instead, the Plan piggybacks on the state's network with hospitals and other healthcare providers, and premiums are calculated based on their collective experience.

This arrangement has demonstrated how a public option might run—and it raises questions about both the state's capability to competently operate a plan and the extent to which incompetent operations could be concealed.

Healthcare plans can be expected to lose money in some months, and then to run surpluses in others. But the Partnership Plan 2.0 tended to lose more money than it collected over the long run.

After kicking off in January 2016 with just a handful of members, the Plan quickly added new local government employers, and by early 2017 it was covering over 13,000 employees and their family members.

But by June 2017, after 18 months of operations, the Plan's lifetime claims exceeded the revenues by about $900,000. By January 2018, the Plan was covering about 30,000 people—and the gap between lifetime revenues and claims had climbed to almost $10 million.

This shortfall peaked in July 2019, as enrollment topped 57,000 covered individuals, at more than $63 million.

Total Partnership Plan 2.0 premium revenues did not keep pace with claims during any six-month period between October 2016 and October 2019.

How could the Plan manage such a large deficit?

For starters, the constant addition of new members had the effect of boosting premium revenues faster than claims in the first few months.

Plan employers paid premiums immediately, while claims didn't hit the balance sheet right away. For instance, the Plan added 3,555 people in July 2021, bringing the total number of covered individuals to over 63,000. Roughly speaking, this would boost monthly premiums by 5 percent for the first few months without a corresponding increase in claims.

In a March 2021 report, Comptroller Lembo said "accounting for invoices received and awaiting payment" the Plan's account had a balance of $22.7 million.[18]

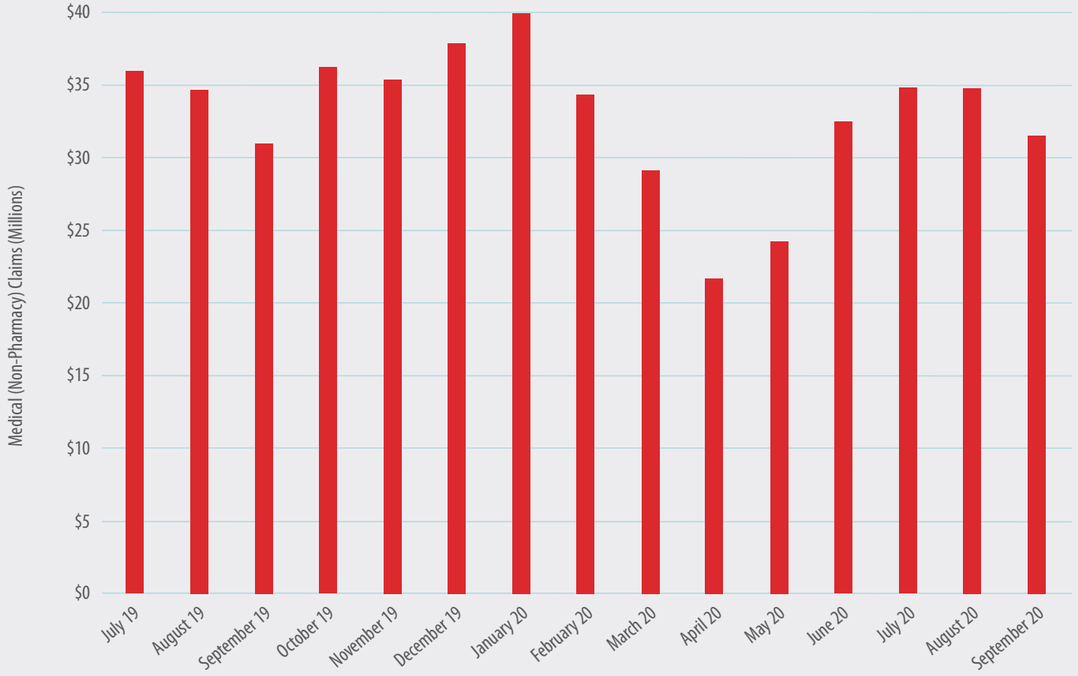
But here, Lembo was drawing a careful distinction. The Plan incurs costs each time someone visits a doctor or fills a prescription. Those claims go to an insurance company hired by the state in an administrative role, and then the administrator invoices the state. Only this final step—that is, the invoices, not the newly incurred claims—show up in Lembo's presentation of the Plan's balance sheet. Everything before it would be considered claims incurred but not reported (IBNR). To determine whether the Plan was collecting enough premiums to cover its claims, the complete picture—including IBNR—would be needed.

As it happens, a minor change to the Partnership Plan 2.0 in summer 2020 gave the public a rare glimpse into how the Plan was using lagged payments to avoid insolvency.

The state moved the management of the Plan's non-pharmacy medical claims from UnitedHealthcare to Anthem. United-Healthcare's last day administering medical non-pharmacy claims for the Plan was June 30, 2020.[19] But state payment records indicate the Plan paid UnitedHealth another $186 million in the months that followed, including $53 million that was paid more than three months later. By comparison, Plan participants incurred $182 million in medical non-pharmacy claims in the first six months of 2020.

Figure 4

Partnership Plan 2.0 - Medical (Non-Pharmacy) Claims



Source: Office of the State Comptroller

Meanwhile, the Plan did not begin paying Anthem until October—more than three months after it took over claim administration.

The Plan had a turn in fortune in 2020 when the coronavirus pandemic caused people to postpone medical procedures and office visits. This drop in utilization gave the Plan precious time to collect premiums without incurring as many liabilities as it previously had.

Medical (non-pharmacy) claims averaged $35.7 million from July 2019 to February 2020, the period during which coverage held steady around 57,500 covered lives. But from March 2020 to September 2020—the last month of published Partnership Plan 2.0 claims data—the claims were a total of $41 million less than they would have been if the Plan had incurred claims at the pre-COVID monthly average **(figure 4)**. In April 2020 alone, the Plan incurred more than $12 million less in medical claims than it had in February 2020.

The fact that the Plan experienced such a drop in costs and still reported (in March 2021) having only $23 million after paying some invoices, indicates the Plan was running in the red. If the Plan were a private health insurance provider, this would have likely triggered the state's administrative supervision rules designed to protect plan members and the public from "hazardous" financial conditions. If the Plan had not added employers aggressively during 2018 and 2019, and if utilization hadn't fallen in 2020, it would have likely faced insolvency.

But the Partnership Plan has operated for nearly a decade without the appropriate level of transparency for a program when taxpayers are potentially responsible for a half-billion dollars annually in healthcare claims. The incurred liabilities carried by the state have never been explicitly mentioned in its annual financial report. In short, it appears the comptroller's office was knowingly setting premiums at a level that could not support the claims it was incurring, operating at a loss, and using the delay in claims processing to conceal it.

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Overall, the Plan lacked uniform financial reporting, making it difficult for the General Assembly to monitor it.

Reporting around the Partnership Plan, and published reports from the comptroller's office, have failed to drill into key details, such as the cost of claims that have been incurred but not reported (IBNR).

For instance, the comptroller's office reported in papers submitted to the General Assembly that the Plan had $512.8M in premiums and $470.4M in claims during state fiscal year 2020.

But in presenting claims data to the state Health Care Cost Containment Committee just weeks prior, the comptroller's office showed a different data set ostensibly covering the same period. Premium receipts were nearly identical ($512.8M) but claims were $484.1M—more than $13 million greater than what lawmakers had been shown.[20]

It's not clear why the data differed, but the incident highlights the General Assembly's failure to put adequate safeguards on a program, which has put state taxpayers on the hook for considerable claims.

State lawmakers and Governor Malloy missed several red flags when the Partnership Plan was set up:

- The Partnership Plan was never seeded with reserves or other funds to cover the initial claims.
- The comptroller was allowed to cherry-pick the employers that joined, an improper delegation of legislative prerogative that could be used to conceal mismanagement.
- The Partnership Plan initially charged the same rate statewide, essentially allowing it to engage in predatory pricing by selling coverage at a loss in higher-cost geographic areas. After getting permission from the General Assembly to set rates by county—and after picking up most of its membership from Fairfield County—premiums for both single and family coverage there are 16.3 percent higher than those in Tolland County, the lowest-cost county.
- The Partnership Plan makes it difficult for municipalities to withdraw by imposing a financial penalty if they pull out with less than three years' notice.
- While private insurers must file detailed reports with the state Insurance Department showing, among other things, how long it takes them to pay claims, the Partnership Plan is exempt.

The state's experience with the Plan is a warning on multiple levels about the General Assembly's inability to craft or monitor an undertaking of this nature.

The entire matter highlights the peculiarity around how the comptroller's office is insulated from legislative oversight, ostensibly because it's led by an independently elected constitutional officer. But the office, over a decade, began what amounted to a half-billion-dollar side business largely outside the General Assembly's supervision and insulated from state insurance rules—with Connecticut taxpayers carrying an increasing amount of operating debt that would likely grow under current public option proposals.

SEBAC

The state in 2017 negotiated a ten-year healthcare and pension agreement with the State Employees Bargaining Agent Coalition (SEBAC), a consortium of the unions representing state workers. Gov. Dannel Malloy said the deal "comprehensively redesigns healthcare benefits" for employees and pre-Medicare retirees, "producing large annual savings for many years to come."[21]

However, reports examining the effect of healthcare benefit changes in fiscal 2018 and fiscal 2019 found every potential source of savings for which an estimate had been produced fell short.

The plan's changes, for which complete data is available, were meant to save $120 million but saved less than $72 million, a 40 percent shortfall.

State officials even underestimated the $300,000 cost of implementing policy changes to its own health plans, originally pegging it at $100,000.

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To make matters worse, the comptroller's office ignored state law and failed to release a report for fiscal year 2020, and ultimately missed the next deadline on December 1, 2021. As of mid-December 2021, the state was more than a year behind disclosing "savings" from the 2017 SEBAC deal.

HUSKY/Medicaid

Connecticut has taken considerable steps to cover its uninsured residents, expanding HUSKY eligibility and establishing a healthcare marketplace. But neither appears to be reaching the entire populations they set out to help.

In this regard, Connecticut is not unique. Nationally, the Kaiser Family Foundation estimates 26 percent of uninsured people already qualify for Medicaid coverage (and another 38 percent are eligible for federal marketplace subsidies).[22]

State-level census data indicate at least 53,000 residents, or more than one-quarter of the state's uninsured residents, already individually qualify for HUSKY. An additional portion of the uninsured may be parents or caregivers of HUSKY-eligible children who aren't aware they qualify themselves.

Reaching these eligible adults and children represents the lowest hanging fruit for Connecticut to improve coverage. The state has a strong interest in getting people covered because routine care can prevent more costly chronic conditions for which taxpayers will ultimately be responsible. The fact that Connecticut hasn't fully enrolled the people who qualify for free healthcare is a reminder that people with less immediate healthcare needs—who are the least costly to insure—will be less likely to enroll.

Some of this was visible in the populations covered by the state's HUSKY expansion: in 2019, adults covered by the HUSKY expansion had a higher average cost ($7,114) than already-eligible adults ($5,485), indicating that people with fewer health needs were less likely to seek and sign up for newly available coverage even when coverage is free.[23]

At the same time, Connecticut's HUSKY experience has highlighted shortcomings in the state's handling of health insurance for members of the public.

Federal officials scolded Connecticut agencies in the state's last major Medicaid audit in 2010, citing among other things "failure to adequately review credible allegations of fraud, and consider federally mandated payment suspensions."[24]

The Exchange

For many people with incomes too high to qualify for HUSKY, the 2010 Affordable Care Act provides federal tax credits to offset premium costs that can be used on Access Health CT, the state's insurance marketplace sometimes called "the exchange."

Connecticut is one of 21 states with a state-based exchange. These outfits almost universally endured growing pains. But Connecticut's exchange has notably struggled to expand, and the governor and General Assembly's hands-off approach to the exchange has translated into weak performance.

That's especially troubling because the ACA relies heavily on the state exchanges to advance its goal of building robust individual and small-group markets. A May 2021 study by the Urban Institute found, for a benchmark plan covering a 40-year-old non-smoker, premiums tended to be lower when more providers participated in the state exchange.[25]

The number of people buying individual coverage peaked in 2016 at 116,019 and has declined each year since 2018. In 2021, only 104,946 people purchased individual coverage from Connecticut's exchange and only two providers made plans available—significantly fewer than both Massachusetts and New York.

Access Health CT spent nearly as much in its 2020 fiscal year ($31 million) as New York's exchange ($37 million), which serves more than five times as many people.[26]

Charter Oak

Besides the Partnership Plan, the state's other major experiment in selling insurance was the Charter Oak Health Plan, which offered subsidized premiums to people who didn't qualify for HUSKY and had gone at least six months without insurance. Charter Oak, launched in 2008, covered individuals with incomes up to 300 percent of FPL and offered a capped deductible, among other things.

Charter Oak ran into difficulty building its network, which Rell hoped to piggyback on the HUSKY infrastructure. The program ultimately drew membership that was older and less healthy than anticipated. That, along with other issues, pushed premiums higher, and the General Assembly discontinued the program in 2013 as it was expanding Medicaid eligibility to some of the same groups Charter Oak had covered.

The Bottom Line

Looking at the state's Partnership Plan 2.0 experience, offering the Plan to businesses or individuals presents a significant financial risk for state and local taxpayers.

The Plan, simply put, does not appear to have collected enough premiums to cover its claims. Expanding its enrollment in its current form would increase the liabilities state taxpayers are carrying.

The most recent public option proposal (SB 842) would create a "risk fund" to purchase stop-loss insurance and give taxpayers some protection when claims exceed premiums. But this would do nothing to address the liabilities the Plan has already accrued by lagging payments, and would likely allow the comptroller's office to continue setting artificially low premiums.

The legislation would also require the Partnership Plan 2.0 to charge administrative fees to cover the cost of actuarial services and the state employees who work on the plan. On the one hand, this would shield taxpayers from having to absorb these particular costs. But it would do nothing to address the liability taxpayers incurred previously when the Plan paid out more in claims than it collected in premiums.

The creative accounting used by the comptroller's office to keep premiums low would likely become unavailable if businesses joined the Plan.

Accepting non-governmental employers would immediately put the Partnership Plan, and likely the State Employee Health Plan, under the federal government's jurisdiction. The 1974 Employee Retirement Income Security Act (ERISA) gives the U.S. Department of Labor broad authority over large, self-insured healthcare plans to ensure they have enough assets to cover promised benefits.

State and local governments are exempt from ERISA. But in 2012, DOL warned the Malloy Administration that selling coverage to businesses would "adversely affect" that exemption.

It's not clear how DOL would bring the Partnership Plan 2.0 into compliance, but it's not beyond reason to assume the Plan would be forced to increase premiums to a level commensurate with claims.

If this had happened in June 2019, when the Plan's lifetime receipts appeared to have lagged its claims by $64 million, the Plan would have needed to charge at least 11 percent more merely to avoid taking on more debt. If, at the start of that fiscal year, in July 2019, the Plan had needed to catch up entirely, premiums would have needed to be raised by 17.9 percent—even though the Plan consisted exclusively of cherry-picked groups of local government employees.

Extending the Plan to business customers would also cannibalize the state tax revenues Connecticut collects through a 1.5 percent tax on insurance company premiums.[28] It is reasonable to assume the General Assembly could increase the rate to offset these losses (prior to 2018, the rate was 1.75 percent).[29] The immediate impact would be small, but the General Assembly could potentially use the premium tax as a cudgel specifically to drive more businesses to purchase the exempt public option.

> *"The Plan, simply put, does not appear to have collected enough premiums to cover its claims."*

First Do No Harm

Rather than entering the health insurance market itself, state lawmakers should scrutinize the effectiveness of state programs meant to expand coverage and determine the extent to which state policy has undercut coverage goals by inflating healthcare costs.

One remarkable feature of the public option as proposed in Connecticut is the extent to which it would bypass the taxes and regulatory regime that drive up individual and small-group premiums. This itself is a tacit acknowledgment that the cost of health coverage reflects interference from Hartford.

At the same time, launching a public option plan would be a sizable undertaking that is premature given the state already has a new effort underway to expand coverage.

Over the next two years, the state will spend $23 million for Governor Lamont's "Covered Connecticut" initiative.[30] The program supplements federal tax credits with state subsidies to help people receive coverage on the exchange and covers co-pays and other out-of-pocket costs. Access Health CT CEO James Michel in December indicated 750 to 800 people had signed up, out of up to 40,000 eligible.[31]

But numerous opportunities for improvement remain and can be pursued in parallel with Covered Connecticut. This is not an exhaustive list, but rather the starting point for discussion about how to optimize the state's existing healthcare efforts—and identifying the instances where state government has needlessly, and sometimes inadvertently, inflated healthcare costs.

Improve HUSKY Enrollment

Roughly one-quarter of Connecticut's uninsured residents are already eligible for free care under HUSKY, the state's Medicaid program, but have not signed up. State officials must do a better job enrolling people in existing programs before considering expanding state government's role in healthcare coverage. Assuming there are no changes in eligibility, getting people covered and receiving routine and preventative care can help state and federal taxpayers avoid higher costs for acute and chronic care down the line.

Due to the pandemic, the state temporarily stopped dropping people from HUSKY when their eligibility changed. When this resumes, state officials should proactively notify anyone who no longer qualifies for HUSKY about the potential subsidies available to them on the exchange.

Strengthen the Exchange

Connecticut's health insurance exchange, Access Health CT, can be improved by policymakers to reduce regulatory red tape and encourage greater plan participation — which can increase options for residents and promote healthy competition.

Access Health CT, after a stronger early performance, has faced criticism for matters ranging from the quality of its phone center to its inability to properly interface with state agencies and insurance companies.

The decline in number of plans purchased on the exchange during the years leading up to the coronavirus pandemic demonstrates the need for the Lamont Administration and the General Assembly to take a more hands-on approach in directing the exchange.[32] Policymakers should reconsider everything from how the exchange markets itself, to uninsured people to the exchange's governance structure and practices, and should hold exchange leadership accountable to performance metrics.

It is noteworthy that nonprofit healthcare plans—which embody the public option's goal of removing profit motives from health insurance—have not found the Connecticut exchange an attractive market on which to sell coverage. Connecticut would not be the first state that has had to confront hiccups with its health exchange. But it's difficult to judge the effectiveness of state and federal policies unless the exchange operates under optimal conditions, which it arguably has not.

Reconsider Insurance Rules

Allowing companies flexibility in how they price and design plans could help get more people buying coverage. But federal law restricts what factors can be considered in setting premiums for individuals and small groups, limiting what the General Assembly can control.

That said, the General Assembly's Office of Legislative Research last year identified nearly 70 state coverage mandates that require insurance plans to cover specific conditions, treatments, or services as a condition of being sold in Connecticut, and the General Assembly continues adding more.[33] This approach reduces out-of-pocket costs for some enrollees, but it translates into incrementally higher premiums and more people forgoing coverage.

To the extent that federal law allows flexibility, the state should perform a cost-benefit analysis of each rule imposed on private insurance plans, especially the extent to which the state has increased the minimum package of benefits each plan must cover.

In other cases, the state has shifted the cost of certain public health initiatives, such as lead screenings and pediatric risk assessments, to private health insurance premiums by requiring insurers to cover costs instead of financing them through the General Fund.[34]

Taxes

The General Assembly should reject any proposal that would make coverage less affordable by levying what amounts to new taxes on health insurance, such as the $50 million "fee" considered as part of the 2021 public option proposal or the similar fee proposed by Governor Lamont in HB 6447.

Turning to the cost of healthcare itself, the state should scrutinize the extent to which its own policies inflate the costs of delivering care. Nowhere is that more visible than in the fact that Connecticut taxes hospitals.

Connecticut's hospital tax, like the provider taxes in 48 other states, is designed to pull down more federal reimbursement funding from Medicaid and Medicare and net a windfall for the state overall.[35]

The state collected a total of $909 million in hospital user-fee taxes from 26 hospitals in fiscal 2019, redistributing a portion back to some of the facilities.[36]

This approach can overall net more federal cash for the state, but patients with private insurance (and uninsured patients) are collateral damage. The cost is not insignificant: the effective tax rate on outpatient hospital services topped 12 percent during the past two years.[37]

Responsibility ultimately falls on Congress for allowing and even encouraging states to game the federal system, but the General Assembly should study the extent to which this structure translates into higher premiums and fewer people buying coverage.

Occupational Licensure Reform & Telemedicine

The widespread availability of smartphones and high-speed internet presents a new opportunity for people to use telemedicine and speak to healthcare providers from home.

But this advancement has limited benefit if the doctors and other medical professionals need special state permission

to provide virtual services—or worse, must be specially licensed to work in Connecticut.

In 2019, Arizona became the first state to broadly recognize medical licenses issued by other states, and Connecticut should do the same.[38] In April 2020, Governor Lamont issued an emergency order allowing healthcare providers to work under a license issued by another state as Connecticut scrambled to treat COVID-19 patients, and has generally extended this allowance for as long as the state remains under a pandemic-related state of emergency.[39]

In May, Governor Lamont signed legislation that allows certain providers to use telemedicine until 2023.[40] But permanent reforms are needed to create certainty for providers and their patients.

Certificate of Need Reform

Connecticut, like 34 other states, requires healthcare providers to obtain permission from the state—known as a Certificate of Need (CON)—before opening a new facility or in many cases even expanding the services they already offer.[41]

That stifles innovation, especially for outpatient surgical providers who would potentially compete with hospitals at a smaller cost and make new technologies more readily available.

Governor Dannel Malloy in 2016 convened a task force to review Connecticut's CON regime, and the General Assembly adopted modest reforms in 2018.[42] But the state's CON requirements still go so far as to bar healthcare facilities from "utilizing technology that has not previously been used in the state" without first getting the state's blessing.[43]

Governor Lamont in March 2020 issued an emergency order relaxing CON rules so hospitals could increase their bed capacity temporarily to meet COVID-driven demand.[44]

The Mercatus Center at George Mason University estimated that Connecticut's CON regime added $283 to the state's per-capita healthcare costs, based on 2016 data.[45]

Besides reducing costs and improving outcomes for Connecticut residents, allowing more healthcare facilities to set up shop in Connecticut would be an overall boost to the economy.

In 2019, the median wait time for an MRI in the Canadian healthcare system was 42 days, and 121 days for knee replacement surgery.[46] Canadians and other foreign citizens routinely visit the United States for medical treatment, and Connecticut is already well-positioned to capture a greater share thanks to existing direct flight service between Connecticut and both Quebec and Ontario.

Other State Policies

No single policy is responsible for making health coverage unaffordable for some Connecticut residents. But the state's healthcare sector is often negatively affected by broader state policies. Hospitals, for instance, are energy-and-manpower-intensive operations that are paying higher costs due to Hartford's interventions in the electricity market and minimum wage increases.

The state's 2020 experiment in easing regulations without any measurable degradation in care or outcomes, makes a compelling case for broadly re-evaluating more of what state government has done in the healthcare space—and where Connecticut must do less, not more.

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