HEALTH BENEFITS INSTITUTE

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Written Public Testimony of JP Wieske, Executive Director of the Health Benefits Institute

Thank you for the opportunity to provide public testimony on the proposed rate increases in the individual and small group markets in the state of Connecticut. I am writing in support of the open process used by the Connecticut Department of Insurance to review these rates and against efforts to politicize the rate-making process.

My name is J.P. Wieske and I am representing the Health Benefits Institute (HBI) where I serve as the Executive Director. In my prior role, I served as Wisconsin's Deputy Insurance Commissioner where I supervised Wisconsin's rate review process. My comments today are reflective of my experience nationwide, across many states, that are all struggling with similar issues.

The Affordable Care Act has two separate but related processes to control health insurance. The first requires insurers to meet a minimum loss ratio. Consumers are guaranteed that the insurer will spend at least 80 percent of premiums on direct medical expenses (with much of the employer market requiring an even higher minimum loss ratio). Insurers not meeting the minimum loss ratio MUST refund premiums back to policyholders.

But the Connecticut Department of Insurance has an additional second layer of review and is the subject of today's hearing. The Connecticut staff – among the best in the country – conducts their own comprehensive assessment of each rate filing. This review examines the actuarial assumptions and projections made by each insurer. Because Connecticut comprehensively examines all insurer filings AND conducts a public hearing to gather public input, the state has not just an understanding of a specific rate filing but a much deeper understanding of the market at large.

Unfortunately, insurers are facing significant issues in the health insurance market. These issues include:

COVID

COVID has deeply impacted the health insurance market in a variety of ways.

Direct Cost: Insurers are directly financing this country's efforts to fully vaccinate the entire population. Including ongoing costs for multiple booster shots.

Testing: Despite access to "free" tests provided by the federal government, insurers continue to see increased utilization of COVID testing. In many cases, employers encourage employees to continue to undergo COVID testing even when not strictly necessary for an individual's health. While many employers provide these tests through the workplace, many smaller employers may utilize their insurance benefit. This is obviously of value to the employer and important for population health purposes, but it is not usually an expense borne by health insurance, and

may not be necessary for an individual's health in an asymptomatic individual. Testing continues to be done without collecting cost-sharing from the individual.

Behavioral Health: The pandemic has left many Connecticut residents in an extremely vulnerable position. The net result has been an increase in cost for many behavioral health services and a direct rise in prescription drug utilization in this space.

Indirect Costs: In our testimony last year, we highlighted the impact COVID has had on the overall health of the country. Insurers are continuing to see negative consequences caused by delayed and deferred care from the pandemic. We know that many heart attacks, and strokes were left untreated. We know consumers delayed treatment for chronic conditions like diabetes, and hypertension that will lead to larger problems in the future. We know individuals with chronic medical conditions have not had their treatment plans updated. By some estimates, this could lead to double digit increases over the next several years as the consequences continue to emerge. One private study estimated the cost could be at least a 16% increase in morbidity.

Delayed Care: Consumers are continuing to drive up utilization looking to catch-up with the care they delayed as a result of the pandemic. These services are all necessary, but it means insurers continue to see high utilization.

Prescription Drug Costs

Insurers continue to spend more and more on prescription drug costs. As supply chain and other issues continue to increase overall costs, prescription drug costs have been and will be impacted by those same trends. According to one source, over 850 common prescriptions increased their prices earlier this year. But cost is just one component. Insurers are also facing higher utilization costs as consumers continue to increase the number of prescription drugs they take. Over time, this will lead to better patient health but it will not necessarily lower costs.

Medical Costs

Medical costs have continued to outpace inflation over the years. In the current inflationary environment insurance will have to absorb these increased costs. Insurers will face not only increased medical costs, but economists continue to expect increased utilization. This results in an increased number of services at even higher rates.

Mandated Benefits

The cost of mandated benefits disproportionally impact the small group and individual market because those markets spread costs over a smaller population and have higher adverse selection issues. Policymaker efforts that mandate specific treatments, limit cost sharing, or other changes impact the cost of health insurance.

Regulatory Uncertainty

The American Rescue Plan significantly increased subsidies in the individual market and that positively impacted risk assumptions by the insurers. Unfortunately, Congress has continued to take its time in passing an extension of the subsidies. The Inflation Reduction Act, which passed the House and will be signed into law, will likely (finally) extend the subsides. Unfortunately, the insurers have no level of certainty of passage at the time of filing. Each insurer made some assumptions but likely were forced to hedge based on Congressional action or inaction. A number of states are expecting to allow for additional time for insurers to revise their filings. The Biden administration has also significantly changed some market rules for 2023. For example, some low-income consumers will now be able to change plans on monthly basis creating adverse selection issues.

Taxes and Assessments:

States have consistently looked at "sin" taxes on products like cigarettes to discourage their use. By making a product more expensive, consumers are expected to use it less.

While many heavily regulated industries pay for their own regulation, these costs rarely exceed more than the cost to regulate the industry. Taxes and fees on health insurance consistently exceed any cost to regulate. Policymakers have consistently looked to insurance as a piggy bank, and that has been an unfortunate burden on consumers.

Assessments and taxes on insurance are used as a general source of revenue. As a result, assessments continue to be a major driver in overall insurance costs for individuals and small businesses. 2021 data acquired from the health carriers shows that fully-insured plans incur $359.6 million in assessments, taxes, and fees annually; self-insured plans incur $74 million annually. This results in a per member cost in the fully insured market of $591 annually, and $54 annually for the self-insured market.

These increased costs impact insurers in two ways. First, it forces them to increase premiums to cover the cost. Second, it results in fewer insured persons exacerbating adverse selection issues.

For context, Connecticut citizens who are fully-insured in 2022 will pay $202 million assessments on top of their health insurance costs. Those assessments are used to pay for many initiatives in Connecticut including the operations for the Health Insurance Exchange ($32 million), Access Health; programs in the State Public Health Department ($11.8 million); and Health and Welfare Assessment/Immunization program ($71 million). While these goals are noble and certainly have industry support, wouldn't general revenue be better allocated rather than taxing a product you'd like consumers to buy?

Closing

In closing, HBI would again like to thank Commissioner Mais and the Department for holding this hearing. We fully support your work in this process and appreciate your efforts to review and understand health insurance rates. This process ensures consumers that their insurance department continues to work for them.

We expect that policymakers will continue to hold the entire health care ecosphere accountable for cost increases. Everyone should make an effort to sharpen their pencils and find any means to cut health care costs and as a result premiums. However, the high premium

increases insurers are forced to offer their consumers are largely out of their control and reflect larger medical cost trends.

When insurers are forced to artificially lower their rates by policymakers looking to politicize the process, those who are ultimately harmed are the consumers. During my time in Wisconsin as Deputy Commissioner, we faced significant market exits largely caused by federal rules that did not understand the Wisconsin market or our insurer needs. The greater Green Bay region saw rate increases in excess of 100%, and market exits that left only one carrier. Ultimately, we worked through the policy – including establishing a state-funded reinsurance pool -- and rates have actually moderated significantly and competition has returned across the state.

Thank you again for providing an opportunity to comment. Please do not hesitate to contact me if you have further questions at jpwieske@thehealthbenefitsinstitute.org or (920) 784-4486.

Sincerely

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