Connecticut Health Policy Project

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TESTIMONY to the Committee on Human Services

March 19, 2019

Re: Opposition to Raised Bill No. 7339, An Act Concerning a Public Insurance Option

Ellen Andrews, PhD, Board Chair

Thank you for the opportunity to share our strong opposition to this bill and a Medicaid buy-in proposal more generally. This September the CT Health Policy will mark twenty years working to expand access to high quality, affordable healthcare for every state resident. I have an even longer resume of working for decent, sustainable healthcare that is affordable for consumers, but also for taxpayers and employers. My experience includes serving as staff to, and now serving on, the Medical Assistance Program Oversight Council since its inception in 1994.

We hear every day from consumers who cannot afford Connecticut's very expensive insurance premiums. And things are getting worse; reversing four years of progress, in 2016 Connecticut's uninsured rate grew by 22,000 people. There are many good ideas floating around this Capitol that could help, but the public option based on Medicaid is not one of them. Instead of shifting people between pools chasing minimal administrative efficiencies or lowering provider payment rates, for real relief we need to address the underlying drivers of Connecticut's skyrocketing health costs. We must address the drug prices, which are the main driver of health costs in our state. We must reverse the consolidation of health care delivery, both horizontal and vertical, that is driving up prices and limiting consumer choice. We have to do something about Connecticut's serious problems with the quality of care. We need to get the right care to the right person when they need it, and only that care. Providers need to be able to communicate appropriately, so care is not fragmented or duplicated. We need more information and data so we can monitor, plan, and evaluate health policies with our eyes open. And we need to act on what we find, irrespective of politics or conflicted interests.

At first glance, Medicaid's appeal as a public option is understandable. Since 2012, when Connecticut fired private insurance companies from our program, per person costs are down, quality is up, more providers are participating, and consumer satisfaction is over 90%. This year, our Medicaid program is saving over $968 million over 2011 costs because of our focus on coordinating care, rewarding quality, and attention to high-need, high-cost members. If you stop here, it seems that opening that program to Connecticut residents who do not qualify makes sense. But after a closer look, it is clear that not only will it not work but it will likely compromise Medicaid's hard-won progress and significant savings we've achieved over the last seven years. The juice just isn't worth the squeeze.

In fact, Connecticut has tried this before, with miserable results. In 2008, piggy-backing on Medicaid, Governor Rell created the Charter Oak Plan as an affordable coverage option for people who didn't qualify for Medicaid. At first it was affordable but that didn't last long. Charter Oak attracted higher cost members because the Medicaid provider panel is designed to care for safety-net, high-need people. By 2013, Charter Oak ended in a death spiral as high-cost members disproportionately enrolled, causing premiums to double, causing healthier members to drop out. At its peak, Charter Oak covered only a tiny fraction of Connecticut's uninsured. It also harmed the underlying Medicaid program as providers were required to participate in both programs. Most providers are paid about half as much to care for Medicaid members as for privately insured patients. Many providers care for Medicaid members, despite losing money, because it's the right thing to do. Healing people is their reason to practice. But providing the same care to formerly-insured patients at much lower Medicaid rates, was too much. They fled both programs and Medicaid members suffered. In addition, the administration had dropped private insurers from Medicaid just before Charter Oak started, but brought them back to attract insurers into the new buy-in. For many reasons, a private capitated model makes the most sense for a buy-in but it would likely serve as a glide path back to that model for our larger program, as insurers are unlikely to accept risk for such a small population. The delay in firing insurers cost taxpayers hundreds of millions of dollars and cost Medicaid members with four more years of less care and lower quality. We can't make insurance affordable on the backs of Medicaid providers and we can't afford a return to capitated, private insurers for Medicaid.

No other state has yet implemented a Medicaid buy-in public option. Massachusetts considered this option but rejected it because of disruption to fragile individual insurance markets and massive liability to the state. And Massachusetts is not facing Connecticut's budget deficits. States considering this option still use the capitated, private insurance model that failed spectacularly in Connecticut. For many reasons, a private capitated model makes the most sense for a buy-in but it would likely serve as a glide path back to that model for the larger program, as insurers are unlikely to accept risk for such a small population, as happened with Charter Oak.

There are dozens more reasons why a Medicaid buy-in will fail both people desperate for affordable premiums as well as the 850,000 Medicaid members and the providers who care for them. But this futile exercise will also delay real cost control for all of us. That involves more than shuffling people between risk pools but requires lowering the underlying costs that are driving up premiums. Connecticut needs to stop repeating bad ideas that don't work. A Medicaid buy-in may be attractive at first, but it won't work.