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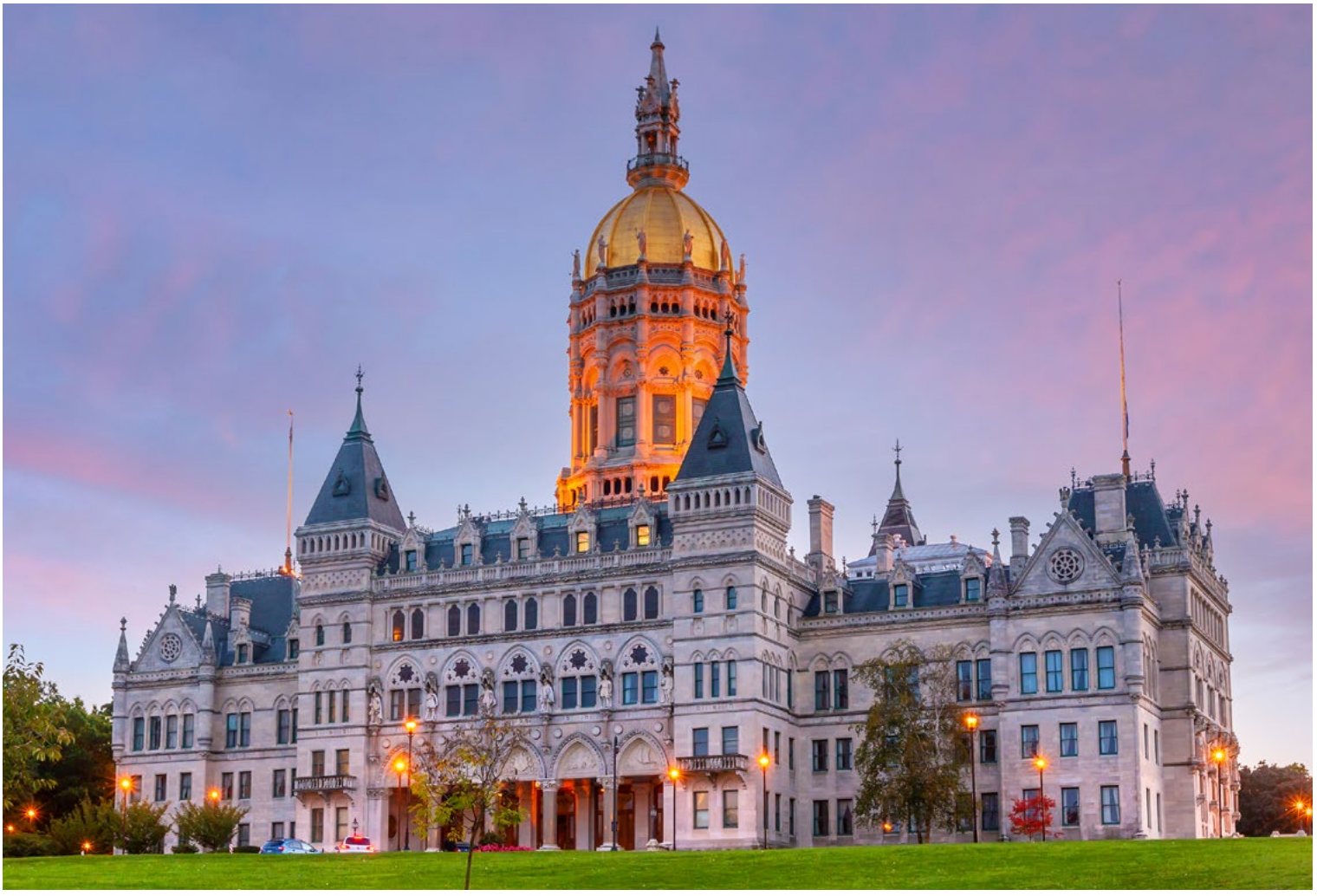
Connecticut Public Option:

Potential Ramifications on Provider Finances and Patient Access to Care



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As Connecticut lawmakers consider ways to improve health care during the 2021 legislative session, policy proposals to create a new public insurance option are up for consideration. While policymakers are floating a public option as a means to achieve increased coverage and lowered health costs, they should also consider the impact the policy might have on access to care in the state. Public programs typically reimburse providers significantly below commercial rates, meaning offering a state public option at a reduced premium might require significantly lower provider reimbursement rates to ensure solvency and achieve cost containment. As the number of Connecticut residents covered by the Connecticut Public Option and other public programs increase, the impact on provider finances could also have unintended yet significant ramifications for patients. Faced with an influx of patients on public programs, providers could be forced to reduce services or change the way they provide care to remain afloat, potentially threatening access to care in communities across the state.

The Connecticut Public Option

In 2021, Connecticut legislators introduced Senate Bill 842 (S.B. 842), which would create a new public coverage option ("Public Option") in Connecticut.[1] Modeled off the state's Partnership Plan for non-state public employees and employers, the Public Option would be managed and overseen by the Connecticut Office of the State Comptroller and administered in partnership with private insurers.[2] Connecticut's Public Option would be available to multiemployer plans (typically unions), nonprofits, and small businesses (50 employees or fewer). Policymakers introduced the Connecticut Public Option in an effort to provide an affordable coverage option for consumers and decrease health care costs. However, to ensure cost containment while holding down premiums for consumers, the Public Option will likely require reduced reimbursement rates, significant tax increases, or a combination of the two.

Connecticut Partnership Plan implies lower reimbursements for Public Option

The Connecticut Partnership Plan, currently available to non-state public employees such as municipalities and public libraries, would serve as the basis for the state's Public Option. Established in 2016, the Plan's persistent financial challenges raise questions aboutits long-term viability.[3]

Partnership Plan MLR and Projections*

SPAN	PREMIUMS	CLAIMS	MLR
Jul 1, 2017 - Jun 30, 2018	$140,669,124	$150,040,021	106.7%
Jul 1, 2018 - Jun 30, 2019	$358,398,841	$380,547,450	106.2%
Jul 1, 2019 - Jun 30, 2020	$512,762,495	$484,097,446	94.4%
Jul 1, 2020 - Dec 31, 2020 *(ACTUAL)*	$272,319,765	$236,120,985	86.7%
Jul 1, 2020 - Jun 30, 2021 *(PROJECTED)*	$557,890,338	$510,514,464	91.5%
Jul 1, 2021 - Jun 30, 2022 *(PROJECTED)*	$587,606,000	$567,853,000	96.6%

**Actual and projected MLRs between Jun 30, 2020 and Jun 30, 2021 were impacted by a drop in medical utilization due to COVID-19*

Source: Report on the Status of the Connecticut Partnership Plan. Office of the State Comptroller, March 2021.

In the first two years of the Partnership Plan's operation (plan year 2017-2018 and 2018-2019), the Plan paid out more for services than it collected in premium dollars.[4] This resulted in a Medical Loss Ratio (MLR) – or the percentage of premiums the Plan paid toward claims and expenses – of over 100 percent.[5] While that figure decreased in 2020 when medical utilization fell sharply due to the COVID-19 pandemic, actuaries expect the effect will be temporary.[6]

The Partnership Plan's precarious financial state, combined with policymakers' ambitious targets for constraining premium growth under the Public Option,[7] suggests that significant reductions in provider reimbursements will likely be necessary to ensure the new Connecticut Public Option remains solvent. Alternatively, policymakers would likely need to raise revenues to offer the Plan at a lower cost subsidized by taxpayer dollars, either in conjunction with or as an alternative to lower reimbursement rates. While policymakers proposed the Connecticut Public Option as an affordable coverage option to consumers that would reduce costs, the performance of the existing Partnership Plan indicates this may be an uphill battle.

The Impact of Lower Reimbursement Rates on Providers and Patients

The Public Option would change the payer mix for health care providers in Connecticut, which could have major implications for their finances. Public programs typically reimburse providers at rates that are significantly below commercial market rates. For example, according to the Medicare Payment Advisory Commission, Medicare reimburses hospitals at less than 60 percent of commercial insurance rates on average,[8] a rate that often fails to cover the cost of providing care. In 2019, hospitals' aggregate Medicare margin was -8.7 percent.[9]

As the number of patients on government insurance increases with the introduction of the Public Option, hospitals may be unable to withstand the likely revenue losses from reduced reimbursements, putting providers at risk of financial distress. Today, nearly one-third of hospitals in Connecticut – from Fairfield to Tolland Counties – operate with negative margins.[10] Health care providers that see a large proportion of patients enrolled in public insurance programs already face barriers to delivering the

full continuum of quality care,[11] and the financial changes resulting from the Public Option could ultimately impact the type and quality of care available to Connecticut's residents.

When providers struggle, so do patients. Providers that cannot absorb losses from the Public Option could be forced to change service lines to remain afloat, as evidenced by providers' responses to reduced revenues during the COVID-19 pandemic. During the public health crisis, hospitals reduced services, including emergency room (ER) services, to make up for the revenue loss.[12, 13] Some providers may increase the number of patients they see each day, resulting in shorter appointment times. Others may need to prioritize appointments with commercially insured patients, whose coverage reimburses at higher rates, to ensure a sustainable payer mix. As a result, there may be even fewer providers available to care for patients with public coverage. This could create a two-tiered system, where privately insured patients have better access to care than those with public insurance.[14] Further, research shows that when providers are faced with lower reimbursement rates, they are less likely to invest in resources that could improve care out of fear that they will never recoup the investment.[15]

In the worst case, some providers operating with negative margins that incur financial losses due to the Public Option may need to close entirely, impacting access to care and health outcomes in neighboring communities. If hospitals or doctors' offices shut their doors, patients may experience longer travel distances to reach the nearest health care facility. Even a slight increase in driving time to an emergency room increases the chance of death for patients suffering from an emergency issue like cardiac arrest.[16] Moreover, a closure in a local community could mean that residents lose their trusted or preferred source of care, placing a greater strain on them to find a reliable replacement that is financially secure under the new policy.

Building on the ACA: A potential solution for Connecticut's uninsured

The Connecticut Public Option targets specific populations in part because the uninsured rates for these groups are higher than average; however, a portion of these workers are already eligible for marketplace coverage under the Affordable Care Act (ACA). Many small business employees rely on the ACA health insurance exchanges or a government program such as Medicaid for coverage.[17] In fact, the ACA has been critical to bolstering coverage among Connecticut workers, including employees of small businesses. As of 2017, more than 80 percent of Connecticut residents who gained coverage due to the ACA were either full- or part-time workers.[18]

Connecticut lawmakers seeking to improve coverage might consider working with federal officials to leverage and build upon the ACA to increase coverage while maintaining a balanced payer mix for providers across the state. Today, 56 percent of Connecticut's uninsured population are already eligible for free or subsidized coverage through the state's exchange, and an additional 13 percent are eligible for employer-sponsored coverage.[19] Raising awareness of coverage options among disadvantaged populations and increasing investments in outreach to individuals and small businesses around the annual open enrollment period may help to increase enrollment in existing programs.

In addition, expanding ACA subsidies, as the federal government did on a temporary basis in April of 2021 through the enactment of the American Rescue Plan Act, could help the remaining uninsured population in Connecticut gain coverage. In 2020, when an estimated 3.5 million Americans lost employer-sponsored coverage due to COVID-19,[20] vital safety net programs, including the exchanges, prevented many individuals from becoming uninsured.[21] In fact, one million Americans signed up for the marketplace during this year's special enrollment period, most of whom purchased coverage after the expanded subsidies went into effect in April.[22]

Conclusion

Policymakers should consider the potential disruption to health care access and quality that could occur under the Public Option for communities in Connecticut. As the state's uninsured rate continues to decrease, it would be prudent to understand whether the introduction of the Public Option would improve the current system or disrupt existing programs that have proven effective during an unprecedented public health crisis and related economic challenges.

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Endnotes

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