ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

The Economic and Social Research Institute (ESRI) is a nonprofit, nonpartisan organization that conducts research and policy analysis in health care and the reform of social services. ESRI specializes in studies aimed at improving the way health care services are organized and delivered, making quality health care accessible and affordable, and enhancing the effectiveness of social programs. For more information, see www.esresearch.org.

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CONTENTS

Executive Summary

Universal health coverage can be achieved in Connecticut without a major increase in health care spending, while providing a small boost to the state's economy. In fact, by enrolling all residents in a single health plan that directly pays health care providers, policymakers could expand coverage while lowering costs for employers, households, and the state. Alternatively, with a small increase in spending, policymakers could cover all residents by offering a variety of private health insurance choices. A third option would cover 96 percent of residents, primarily through expanding existing insurance mechanisms rather than creating new ways to access health coverage.

Because policymakers can choose to do nothing, this summary begins with the status quo. It then describes three approaches to reform, using tables and charts to illustrate key results and trade-offs among these alternatives.

THE PRESENT SYSTEM [1]

- Coverage is divided between multiple, overlapping sources, including employer-based insurance, state-subsidized coverage of low-income households through HUSKY, SAGA, and Medicaid, and insurance that residents buy themselves.
- Approximately 11 percent of state residents are uninsured. Nearly $600 million a year is spent providing them with health care.
- Indirectly, Connecticut's cost for the uninsured ranges between $652 million and $1.3 billion a year, based on the findings of the Institute of Medicine of the National Academies of Science.
- Connecticut spends more per person on health care than most other states. For example, premiums for employer-based insurance rank between second – and twelfth-highest in the country, depending on the type of coverage.
- In fiscal year 2003, 3 percent of Connecticut's economy was spent on state-funded health care. This was the 16th-lowest percentage in the country. Out of the five states with highest per capita incomes, only one spent less than Connecticut.

[1] Most of the numbers that describe the status quo are taken from the prior report released for this project – J.A. Meyer and J. Hadley, *Mapping Health Spending and Insurance Coverage in Connecticut*, prepared by the Economic and Social Research Institute and the Urban Institute for the Universal Health Care Foundation of Connecticut, Feb. 2006. However, the percentage of state GDP used for state-funded health coverage was updated from FY 2002 to FY 2003. Kaiser Family Foundation, *Statehealthfacts.org*, "Total State Health Care Expenditures as Percent of the Gross State Product, FY2003," Feb. 2006. In addition, the percentage of Connecticut residents without insurance is taken from Census Bureau data. U.S. Census Bureau, *Current Population Survey, 2003 to 2005 Annual Social and Economic Supplements.* "Percentage of People Without Health Insurance Coverage by State Using 2 – and 3 – Year Averages: 2002 to 2004." August 2005.

APPROACH ONE:

One Health Plan Serving All Residents

- A single health plan would cover all state residents under age 65. Employers and individuals could purchase additional coverage. Contributions by employers and employees, current General Fund outlays, and federal Medicaid matching funds would pay for coverage.
- Providing everyone with the same plan and purchasing services directly from health care providers would lower administrative and health care expenses. Although all uninsured residents would gain coverage, total spending would drop 5 percent. Health costs per insured person would fall by 16 percent.
- Employers as a whole would see their annual health care costs fall by 11 percent, from $5.4 billion to $4.81 billion. However, employers that do not insure their workers today would begin paying for coverage. Those that now offer employee health coverage would experience a 26 percent drop in health costs.
- With less spending on health care and health insurance, Connecticut households would have an extra $1.03 billion a year to spend for other goods and services. Household health care and health insurance costs would fall by $750 million a year. Because employers would pay less for health insurance, they would increase wages, providing workers an extra $280 million in after-tax income.
- While state spending on medical coverage for low-income residents would remain at current levels, federal Medicaid payments would rise by $840 million.
- The state health plan would become the primary insurer for 92 percent of non-elderly Medicaid beneficiaries, eliminating most Medicaid reimbursement shortfalls for health care providers.
- Primarily because of employers' reduced labor costs, this option would add 6,000 to 11,000 new jobs to the state's economy. State GDP would rise by between $660 million and $830 million a year.

APPROACH TWO:

A Health Insurance Purchasing Pool with Competing Private Plans

- Under this option, most state residents could choose from multiple private health plans, which would be offered through a new health insurance purchasing pool. Employers could offer health coverage, but they would achieve significant cost savings by discontinuing coverage and letting their workers buy insurance through the pool. The pool would be financed by individual premium payments based on income and choice of health plan, employer contributions, federal matching funds, and state General Fund dollars.
- This alternative would cover all residents.
- An estimated 61 percent of residents under age 65 would enroll in the pool, giving it the leverage to hold down costs and improve quality. Cost increases would also be restrained because enrollees would save money by selecting less costly coverage. As a result of these two factors, total health care spending would increase by only $30 million, or one-fifth of 1 percent, even though all the state's residents would be covered. Health costs per insured person would fall by 12 percent.
- Employers as a whole would pay $170 million less for health insurance – a 3 percent savings. But employers that do not offer their workers health insurance now would begin paying for coverage. On the other hand, firms that previously covered their workers would experience an 18 percent reduction in health insurance costs.
- Net household income available to spend on goods and services besides health care would increase by $640 million a year, for two reasons: households' health care and health insurance costs would fall by $550 million; and with employers spending less on health insurance, after-tax earnings would increase by $90 million.

- State General Fund spending on subsidies for low-income residents would remain at current levels. However, to limit employers' cost for joining the pool, the state General Fund would contribute $220 million. At the same time, the state would receive an additional $530 million in federal Medicaid funding.
- The pool would become the primary insurer for 32 percent of non-elderly Medicaid enrollees, eliminating Medicaid reimbursement shortfalls for most services provided to these individuals.
- This option would add between 2,000 and 6,000 jobs to Connecticut's economy. The state's GDP would rise each year by $320 million to $470 million above current levels. That effect would be driven by declining labor costs and increased spending on goods and services in Connecticut. Spending for health care usually occurs within the state. Other spending is often devoted to buying items made outside the state.

APPROACH THREE:

Expanding the Health Coverage Safety Net While Requiring All Parents to Cover Their Children

- HUSKY would expand to cover adults with incomes up to 200 percent of the federal poverty line (FPL), including former SAGA enrollees. At state expense, HUSKY would also cover income-eligible children whose immigration status bars federal funding.
- Adults with incomes between 200 and 300 percent of FPL would receive fully refundable and advanceable state income tax credits (or vouchers) for partial payments of health insurance premiums. Subsidies would fall as incomes rise.
- The proportion of state residents with insurance would increase from the current 89 percent to 96 percent.
    - o The number of uninsured adults would drop by 45 percent, from 280,000 to 155,000.
    - o All children would be covered. Parents would be required to provide their children with health insurance. Uninsured children would be automatically enrolled into HUSKY at birth, at the start of school, or when they receive care. Parents whose income is too high to receive a subsidy would pay full premiums.
- Total spending on health care would rise by $130 million – approximately one percent. Costs per insured resident would fall by 6 percent.
- State General Fund spending on health coverage for low-income residents would increase by $45 million. Federal Medicaid funding would grow by $135 million.
- Employer payments for health insurance would drop by $60 million, or one percent.
- Households' net income available for purposes other than the purchase of health care would rise by $20 million. A $10 million increase in health costs would be offset by a $30 million increase in post-tax earnings because employers would pay less for health insurance.
- This option would add 2,000 new jobs to the state's economy. State GDP would rise by $160 million. As noted, health care spending stays within the state. By contrast, while state revenue collection would displace private spending, part of such spending purchases goods produced outside the state.

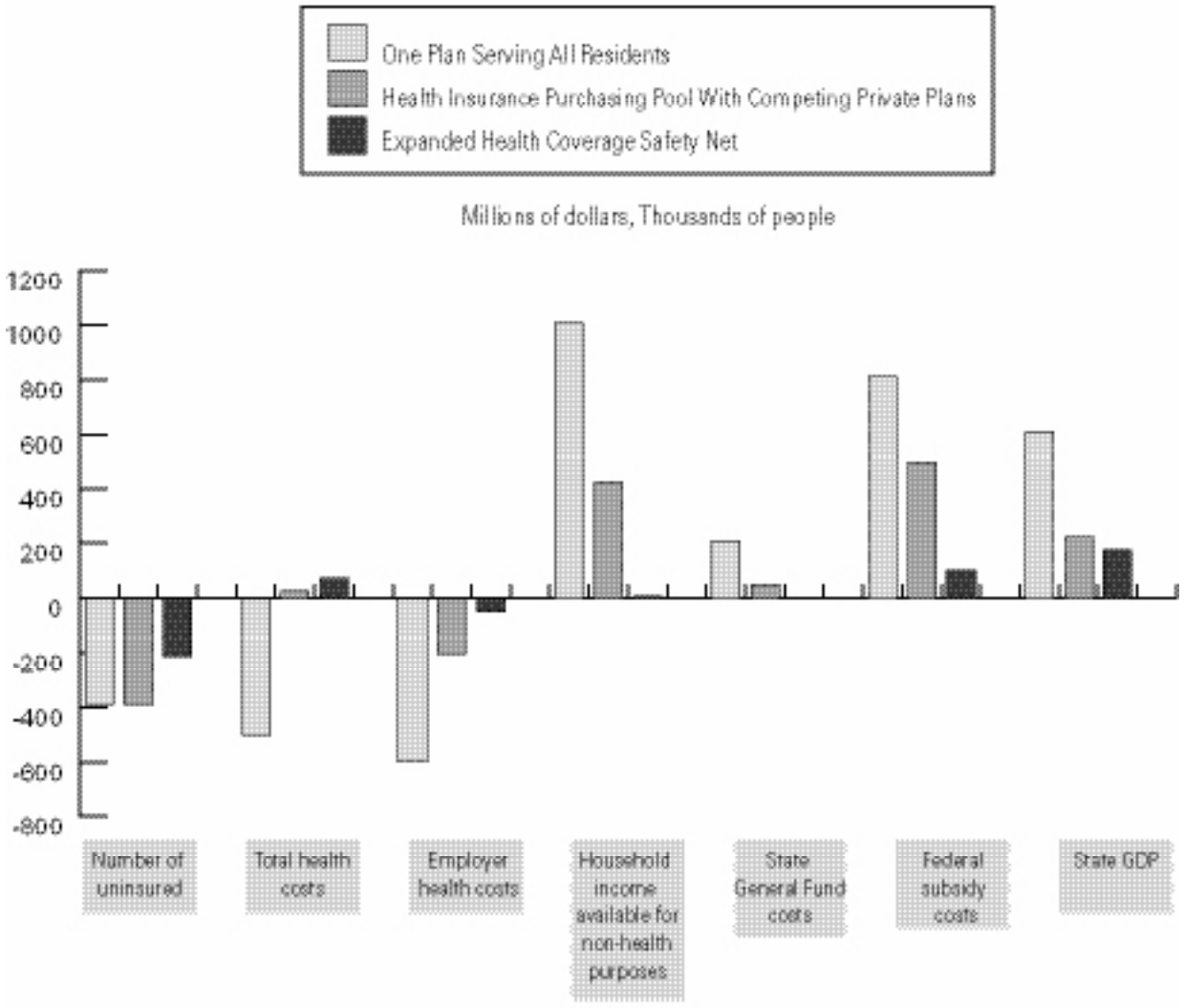
The following table and chart show these results in graphic form.

TABLE 1. PROJECTED IMPACT OF THREE POLICY ALTERNATIVES ON CONNECTICUT RESIDENTS UNDER AGE 65

	Status Quo	1. One Health Plan Serving All Residents	2. Health Insurance Purchasing Pool With Competing Private Plans	3. Expanded Health Coverage Safety Net
Percentage of state residents without coverage	10.9 %	0 %	0 %	3.6 %
Total spending on health care and insurance	$10.53 B	$10.03 B	$10.56 B	$10.66 B
Health spending per insured resident	$4,121	$3,447	$3,629	$3,869
Employer health insurance costs*	$5.4 B	$4.81 B	$5.23 B	$5.34 B
Household spending on health care and health insurance*	$4.06 B	$3.31 B	$3.51 B	$4.07 B
State General Funding spending**	$600 M	$600 M	$820 M	$645 M
Federal matching funds for Medicaid and SCHIP	$470 M	$1.31 B	$1.0 B	$605 M
Post-tax wages and earnings	$33.04 B	$33.32 B	$33.13 B	$33.07 B
Number of jobs	2.155 M	2.161 to 2.166 M	2.157 to 2.161 M	2.157 M
State GDP	$204.16 B	$204.81 to $204.98 B	$204.48 to $204.62 B	$204.32 B
Total personal income	$165.97 B	$166.70 to $166.73 B	$166.29 to $166.31 B	$166.1 B

Source: Gruber Microsimulation Model, Calculations by ESRI, March 2006; Urban Institute, REMI Macrosimulation Model, April 2006.
*The estimates for Approaches One and Two include both voluntary and required payments.
** These costs include SAGA, SCHIP, and Medicaid expenditures for the non-elderly as well as for Approach Two, state funding to lower the amount of required employer contributions.

Figure 1. Changes from status quo, by policy option: Projected impact on non-elderly residents of Connecticut

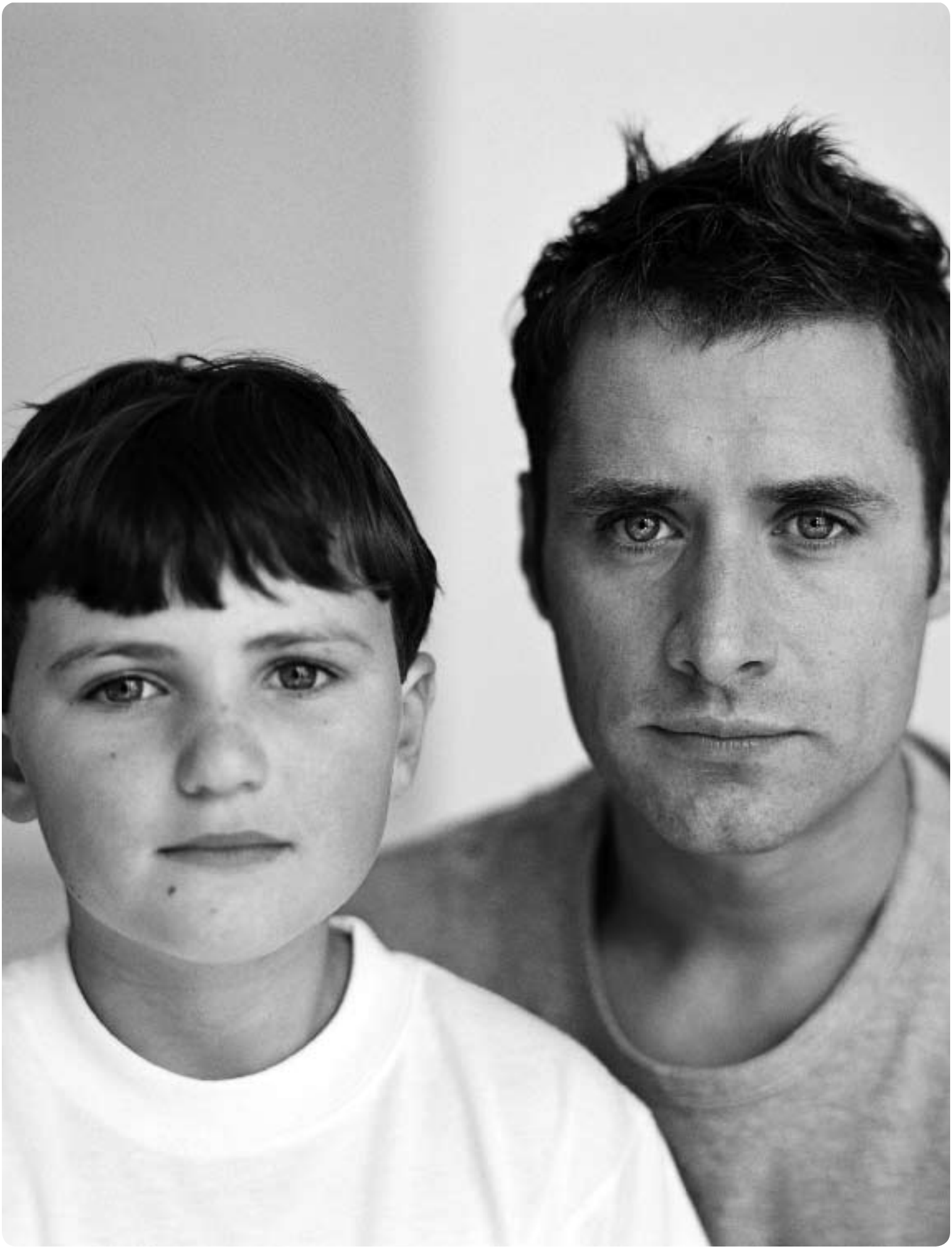


Source: Gruber Microsimulation Model, Calculations by ESPI, March 2006; Urban Institute, REMI Macrosimulation Model, April 2006. Note: the estimated changes to State GDP represent the lower end of each range.

How policymakers, members of the general public, and stakeholders view these approaches will depend on their policy preferences. The following table shows how each alternative compares in terms of various possible priorities.

TABLE 2: SELECTED TRADE-OFFS AMONG POLICY ALTERNATIVES

Policy Preferences and Factors	Status Quo	One Health Plan Serving All Residents	Health Insurance Purchasing Pool With Competing Private Plans	Expanded Health Coverage Safety Net, With Parents Required to Cover Their Children
Covering all state residents	10.9% uninsured	No uninsured	No uninsured	3.6% uninsured
Health care spending per insured non-elderly person	$4,121 per year	16% savings	12% savings	6% savings
Integrating low-income households into the same system that serves others	Separate HUSKY and Medicaid program	Integrated into state health plan	Partial and voluntary integration into pool	Very little integration – some HUSKY adults go into employer plans
New funding sources, other than federal funds and individual payments	_	Employers	Employers and General Fund	General Fund
Health insurance contributions from employers	Some firms contribute, others do not	All firms required to contribute	All firms required to contribute	Some firms contribute; others do not
Employer health costs	High and rising	Major savings	Significant savings	Minimal savings
Household health costs	High and rising	Major savings	Significant savings	Minimal savings
Markets where consumers choose from competing, diverse health plans	Choices mostly limited to large employers and non-group plans	All residents in a single plan with standard benefits, but supplementation is permitted	61% of residents in pool, with diverse private options	Some adults get tax credits to access purchasing pools
Comprehensive insurance vs. high-deductible plans with HSAs	Mostly comprehensive, except for a few employers and non-group plans	All state residents get comprehensive coverage; no high deductibles	61% of residents in pool, with diverse private options	Some adults get tax credits to access purchasing pools
New State General Fund spending	_	No increase	$220 million for employer subsidies	$45 million for individual subsidies
Change to state economy	_	Slight positive impact	Slight positive impact	Slight positive impact



Health Insurance Coverage in Connecticut:
Three Routes to Reform

INTRODUCTION

This report concludes nearly a year's work for the Universal Health Care Foundation of Connecticut. The goal of this project has been to help policymakers, opinion leaders, and the public understand the general state of health coverage in Connecticut as well as possible reforms. The report this project produced in February 2006 – *Mapping Health Spending and Insurance Coverage in Connecticut* – described the current system, which includes the following features:

- Approximately 11 percent of state residents are uninsured, and the number continues to rise. The largest group of uninsured consists of low-wage workers who earn too much for public assistance but too little to afford health insurance without an employer's help.
- Nearly $600 million a year is spent providing uninsured residents with health care.
- In terms of indirect costs, the absence of coverage for 11 percent of state residents costs the state between $652 million and $1.3 billion a year, based on the findings of the Institute of Medicine of the National Academies of Science.
- Health care spending per person is often higher in Connecticut than in most other states. For example, premiums for employer-based insurance rank between second – and twelfth-highest in the country, depending on the type of coverage involved.
- In fiscal year 2003, 3.0 percent of the state's economy was spent on state-funded health care. This was the 16th-lowest such percentage in the country. Out of the five states with the nation's highest per capita incomes, only one devoted less to state-funded health care.[2]

To help policymakers, stakeholders, and the public decide how to address the problem of Connecticut residents without health coverage, this report focuses on possible directions for reform. To develop options for coverage expansion, we began with a survey of what other states have done. The results are attached as Appendix A.

We then identified multiple options to address Connecticut's specific situation and "tested the waters" through conversations with two dozen experts and representatives of key public and private stakeholders in the state. They are listed in Appendix B. Based on the feedback we received, we chose for further analysis the three alternatives discussed below.

Professor Jonathan Gruber of the Massachusetts Institute of Technology then conducted a microsimulation to estimate each option's effects on cost and coverage. Those estimates were given to a team of analysts at the Urban Institute, who projected the resulting impact on the state's economy, based on a sophisticated, commercially available macrosimulation model. This report describes the results of those efforts.

Chapter 1 provides an overview of each approach and its anticipated effects on coverage and costs, based on Dr. Gruber's findings. Chapter 2 describes the macroeconomic estimates developed by the Urban Institute suggesting the likely impact of each option on the state's economy. Chapter 3 fleshes out each of the three policy options in detail, itemizing policy specifications and describing several alternative forms such options could take.

[2] That state was Massachusetts, which has since committed to spending additional resources on state-funded health care. Kaiser Family Foundation, Feb. 2006.

While it is possible that state lawmakers could combine a number of the policy elements explored here or adopt them in a modified form, those are not the goals of this report. Rather, our work has a more modest objective: namely, to illuminate public discussion in Connecticut about strategies for fixing a health care system that virtually everyone agrees is badly broken. We developed specific examples of three, qualitatively different approaches to reform:

- Using a single health plan to cover all residents, contracting directly with health care providers rather than purchasing traditional health insurance;
- Covering all residents through a more market-oriented approach, with a variety of private health plans and significant (though not unlimited) individual choice; and
- Increasing health coverage substantially by expanding public programs for adults and requiring all parents to obtain health insurance for their children.

We conclude that major progress is possible, using methods that leave the state as a whole better off, taking into account employers, households, state government, and the state economy. However, in any reform proposal, trade-offs are inevitable. Some stakeholders will experience losses, even if others realize much larger gains. By making explicit the trade-offs, gains, and losses in three contrasting options, this report provides the Foundation and, ultimately, Connecticut residents with information to help develop a reform plan on which consensus can be achieved.

Chapter One: Cost and Coverage Estimates

For each of the three policy options, this chapter estimates the number of people who would be newly insured, the total resulting cost, and the distribution of that cost among public and private stakeholders. Developed by Professor Jonathan Gruber of the Massachusetts Institute of Technology, these estimates also include potential effects on wages and earnings, federal and state income tax payments by state residents, and various state and federal costs. In some cases, Dr. Gruber's analysis includes a calculation of the size of various assessments that would be needed for full funding.

The first section of this chapter describes Dr. Gruber's general modeling methodology. The next sections examine each of the three policy approaches in turn, explaining key elements of each policy alternative and the results of Dr. Gruber's work.

Several initial caveats are important. First, to present clear policy choices to the public and to the state's leaders, the following estimates show the one-year impact of each alternative, as if all its effects had been fully realized. Typically, the effects of new policies are not fully realized for several years. Such delays could be even more prolonged if policymakers choose to adjust these alternatives to phase in particular policy elements.

For example, employer contributions under the first two options could begin with large firms and, over time, be phased in to encompass smaller firms. Such a phase-in of financing might require a phase-in of expanded coverage as well.

Second, the estimates below describe each alternative as if it were in effect in 2005. In choosing this time frame rather than a projection of future results, our goal was to illuminate key questions facing decision makers through more reliable estimates, framed to fit 2005, rather than more speculative estimates of future health spending and coverage.

Third, these estimates will necessarily differ from other, equally reliable findings that are based on different data sources or different methods of analysis. For example, *the estimates of Connecticut coverage and health care costs contained in the last report published as part of this project [3] differ from those described here. These differences have several causes: the prior estimates included elderly residents, while the current estimates are limited to residents under age 65; the former estimates showed only spending to purchase health care, whereas the current estimates also examine spending on health insurance premiums, which include, in addition to health care costs, administrative expenses, profits, and other costs to insurers; the two sets of estimates are based on slightly different survey data; and the two sets of estimates categorize some minor types of coverage differently.*

Fourth, as will become evident, the following estimates are based on models that reflect the best available academic research into the dynamics of health coverage, labor markets, and public financing. However, there are inherent uncertainties in forecasting future events. Policy implementation necessarily departs from even the most reliable projections. Accordingly, the following estimates should not be viewed as infallible predictions of what is sure to happen if the options described below were adopted. Nevertheless, they do constitute reasonable forecasts on which policymakers can rely in assessing the trade-offs that arise when considering major health policy changes.

DESCRIPTION OF THE MODELING PROCESS

An acceptable quantitative analysis requires a careful assessment of responses from individuals and businesses to health insurance changes. The Gruber Microsimulation Model provides the capability for such analysis. Dr. Gruber applied this model to three policy reform approaches to estimate the impact of each option on public – and private-sector costs and on insurance coverage in Connecticut.

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[3] Meyer and Hadley, February 2006.

Dr. Gruber used the type of "microsimulation" modeling that the United States Treasury Department, the Congressional Budget Office (CBO), and other federal "scorekeepers" employ. This method draws on the best evidence available in the health economics literature and real-world data to project how individuals and firms would respond to the changes in the insurance environment induced by changes in government policy.

The model takes as its base the February and March, 2001, Current Population Surveys (CPS) (updated to 2005). These data were used to compute the impact of each policy approach on the eligibility for, and price of, various types of insurance. These price and eligibility changes were then run through a detailed and integrated set of equations that relate them to behavioral responses by individuals, families, and firms. The model yielded estimates of the number of newly insured people, other shifts in coverage, the net effect on coverage of these responses, and the change in total health expenditures in the state (accounting for various substitution effects and savings offsets). The model also showed projected changes in costs for such entities as firms currently insuring their workers, firms not providing such coverage, and households.

Because the Gruber model begins with a baseline linked to current expenditures and accounts for offsetting savings associated with new expenditures to cover the uninsured, the model determines how much it would cost to cover the uninsured, relative to what is being spent today.

In analyzing these reforms, it is particularly important to understand employer responses to each policy change. Most microsimulation models are based on individual data, so analysis of employer responses is often weak. The Gruber model remedies this problem by using special data from the Bureau of Labor Statistics (BLS) on the composition of workers in firms. The model creates "synthetic" firms in the CPS by drawing for each worker other "co-workers" in the CPS based on that worker's wage, industry, firm size, and health insurance offering status. The selection of co-workers is governed by the special BLS data to ensure that firms are created appropriately. These synthetic co-workers are grouped together to form firms. Such firms' responses are modeled based on the average effects of policies on their workforce.

Dr. Gruber started by placing all non-elderly residents of the state of Connecticut in the insurance category where they are today – Medicaid, employer-based coverage, buying health care on their own (the non-group market), other public or private insurance, or uninsured.

Dr. Gruber then superimposed on this "status quo" each of the three reform alternatives to see, in effect, where people would land after the reform was implemented. He asked such questions as:

- How many people would move from the category of uninsured to insured?
- Would they get this new coverage through the workplace, on their own, or by enrolling in a public program?
- In response to new government subsidies, how many people would move from employer insurance to public coverage?
- How many would give up an insurance policy that they were purchasing on their own to enter a new or expanded government program?
- If a new coverage mechanism is set up for moderate-income people who do not qualify for HUSKY, how many people would use that mechanism?
- Of this group, how many would move from job-based coverage and how many from self-purchase in the non-group market?

Estimates of per capita out-of-pocket costs for each insurance category were then applied to the changed distribution of enrollees, with proportionate reductions for the first two options based on the anticipated decrease in total health care costs.

MODELING RESULTS FOR APPROACH ONE:

One Health Plan Serving All Residents

Key Policy Elements

This first option includes the following provisions:

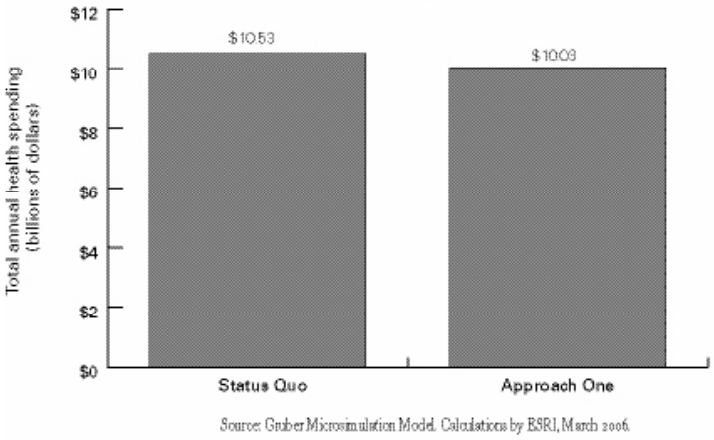
1. All non-elderly residents would be covered through a single health plan, which would purchase health care services directly from providers. Covered benefits would resemble what private employers typically provide today.[4] The plan would be administered by a new state commission,[5] either directly or through a contract with a private insurer serving as fiscal intermediary. Individuals and firms could purchase supplemental coverage.
2. Coverage would be financed through continuation of current state funding for low-income residents' health coverage, contributions from employers and employees, and federal matching funds under the Medicaid and SCHIP programs.
3. The commission would control costs by defining covered benefits and out-of-pocket cost-sharing rules, setting a statewide budget for health spending, negotiating reimbursement levels and other cost-related matters with providers, and setting standards for quality of care. In addition, administrative costs would be reduced by using one instead of multiple plans for most services provided to residents under age 65 and by directly paying health care providers rather than using insurers as intermediaries.
4. State residents with incomes below 150 percent of the federal poverty level (FPL) and children above that level who qualify for HUSKY would have supplemental coverage for cost-sharing and additional benefits currently offered by the HUSKY program. To promote appropriate use of care and to receive federal matching funds, auto-enrollment mechanisms would be combined with extending Medicaid eligibility to parents with incomes up to 300 percent of FPL.

Cost and Coverage Estimates [6]

This option would cover all state residents, including 355,000 people who otherwise would have been uninsured.

Despite that increase in coverage, *this alternative's vigorous cost controls and reduction in administrative expenses would lower total health care spending for the non-elderly by 5 percent*, from $10.53 billion to $10.03 billion.[7] Average health costs per insured, non-elderly state resident would decline by 16 percent, from $4,121 to $3,447.

Figure 2. Health spending for non-elderly residents of Connecticut: Status Quo vs. Approach One.



Source: Gruber Microsimulation Model. Calculations by ESRI, March 2006.

This 10 percent savings per insured resident is based on the assumption that statewide purchasing of health care, greatly reduced administrative costs, and resulting savings could cut

[4] As of 2004, the vast majority of employer-based plans in the U.S. covered adult physicals, prescription drugs, outpatient and inpatient mental health services, maternity care, oral contraceptives, well-baby care, and chiropractic services. In PPO plans, deductibles in 2005 averaged $679 for family coverage and $323 for single coverage. For HMOs, average deductibles were $141 and $71 for family and single coverage, respectively. Copayments per physician visit were $15 or less for 62 percent of HMOs and $20 or less for 77 percent of PPO enrollees using in-network providers. In 2004, average copayments for prescription drugs were $21 and $48 for preferred and non-preferred medications, respectively. Kaiser Family Foundation (KFF), *Trends and Indicators in the Changing Health Care Marketplace*, Publication No. 7031, Updated: Feb. 2, 2005. KFF/HRET, *Employer Health Benefits: 2004 Annual Survey*, September 9, 2004. Unfortunately, state-specific or even regional data showing covered benefits for employer-based coverage are not yet published, although the Bureau of Labor Statistics has announced plans to provide such information for each of the nine Census regions.

spending 20 percent below average premiums for employer-based coverage under the present system. If anything, that may understate the magnitude of likely savings. The U.S. health care system does not currently use the same kind of centralized cost-control arrangements employed by other developed countries. As a result, America's spending on health care, per insured resident, is much higher than in any other country in the Organization for Economic Cooperation and Development (OECD). In the median OECD country, health spending per insured resident is 64 percent below American levels; and the highest-spending country outside the United States pays 43 percent less than the U.S.[8]

Of course, a nation can achieve such efficiencies more effectively than can a single state,[9] in large part because patients and providers can cross state lines. Nevertheless, it seems reasonable to expect that a single state's efficiencies, through centralized cost-control, could realize one-fourth of the savings achieved by the average developed nation and slightly less than 40 percent of the efficiencies accomplished by the world's second-highest-spending country (Figure 3).

The level of savings we anticipate for Approach One could be achieved by reducing administrative costs, according to research conducted by Professor Kenneth Thorpe of Emory University. Dr. Thorpe found that, simply through reducing insurers' and health care providers' administrative costs, a single state health plan for Missouri would achieve almost identical per capita savings as the level estimated here for Connecticut[10] (Figure 3). To go beyond administrative savings in reducing health care spending would probably require trade-offs involving changes in provider practice patterns or compensation levels,[11] reduced distribution and utilization of new medical technology, or similar matters.

[5] Similar commissions have played important roles formulating health policy in states like California, Delaware, and Maryland.

[6] In addition to producing these estimates, one goal in modeling Approach One was to determine the level of employer and employee contributions required for full funding. Full funding for this alternative would result from assessments on employers of 7.7 percent of payroll and on employees of 2.5 percent of gross wages and salaries. As described more fully in Chapter Three these assessments would be reduced for low-income workers and small firms. They would also be capped to ensure that high-income individuals and their employers do not pay costs that exceed current levels.

[7] If policymakers decide to retain a private insurer to act as fiscal intermediary, and if the resulting cost (relative to total volume of claims) is comparable to what Medicare recently paid for such services, the state will need to pay roughly $83 million a year for fiscal intermediary services. This figure is not included in the estimates presented in Table 3, below, or the text. CMS, *Durable Medical Equipment, Medicare Administrative Contractor* (contract awards Jan. 2006). Calculations by ESRI, March 2006. Of course, if a state agency directly provided those services that would cost money as well.

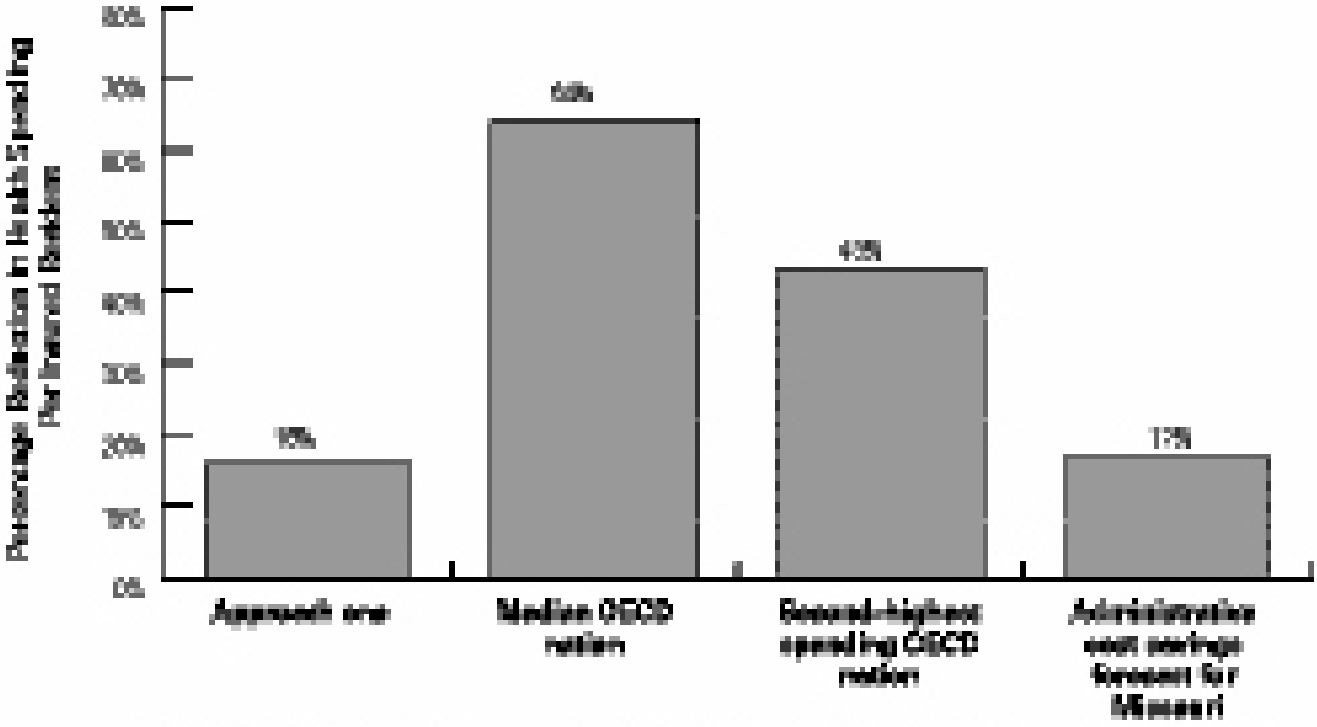
[8] G. F. Anderson, B.K. Frogner, R.A. Johns, and U.E. Reinhardt, "Health Care Spending and Use Of Information Technology In OECD Countries," *Health Affairs*, May/June 2006. Calculations by ESRI, May 2006. Note: the per capita averages found in Anderson, et al., were adjusted to compensate for a higher per capita GDP in the U.S. than in other countries, applying the formula in footnote 4 in Anderson, et al., op. cit. For information on per capita GDP, see *OECD Factbook 2006*: "Economic, Environmental and Social Statistics," ISBN 92-64-03561-3. More important, the U.S. per capita health care spending level for 2003 was translated into costs per insured person based on the Census Bureau's estimate that, in 2003, 15.6 percent of U.S. residents were uninsured. U.S. Census Bureau, Housing and Household Economic Statistics Division, *Health Insurance Coverage: 2003 Highlights*, Last Revised: December 07, 2004. Calculations by ESRI, May 2006.

[9] Small population size, by itself, does not preclude effective, centralized cost control. Two OECD nations – Iceland and Luxembourg – have fewer than half a million residents apiece and nevertheless provide universal coverage at a cost 53 and 45 percent, respectively, below U.S. costs per insured resident. Anderson, et al., op. cit.; EOCD Fact Book 2006, op. cit.; U.S. Census Bureau, 2004, op. cit. Calculations by ESRI, May 2006.

[10] Under the Missouri proposal, administrative savings realized by covering all state residents through a single health plan would cut total spending per insured by 17 percent – slightly more than the 16 percent savings found here. K. E. Thorpe, *A Universal Health Care Plan for Missouri*, prepared for the Missouri Foundation for Health, 2003; K.E. Thorpe, *Health Care Expenditures and Insurance in Missouri*, prepared for the Missouri Foundation for Health, 2003. Calculations by ESRI, May 2006. Slightly lower administrative cost savings might be realized in Connecticut than in Missouri, because Connecticut has a smaller proportion of its population enrolled in non-group coverage, which has particularly high administrative costs.

[11] An example is furnished by West Virginia's health coverage program for state and local employees. As Approach One would do for all Connecticut residents under age 65, West Virginia uses a single third-party administrator to pay provider claims for public employees. That state has leveraged its purchasing power to cut provider reimbursement levels 20 to 25 percent below private market rates – more than the 16 percent total cost savings per insured resident anticipated here. State Coverage Initiatives, *Profiles in Courage: West Virginia Small Business Plan*, Fall 2005. See also The Commonwealth Fund, *West Virginia Implements Small Business Plan*, October 2005.

Figure 2. Savings from Centralized Cost-Control: Approach One Estimates vs. Savings Realized in Other Developed Countries and Projected for Missouri



Because of this decrease in health costs, coverage of all state residents would be accompanied by overall financial gains for most stakeholders that currently fund health care – namely, employers, households, and state government. Only the federal government would spend more than under the present system. The following discussion examines each set of stakeholders, in turn.

Employers

Employers would no longer pay an estimated $5.40 billion in premiums. Instead, firms would pay approximately $4.54 billion in required contributions and $270 million in voluntary supplementation of the state plan. As a result, *employers as a whole would save $590 million, which translates into an 11 percent reduction in the amount they currently spend on health coverage.*

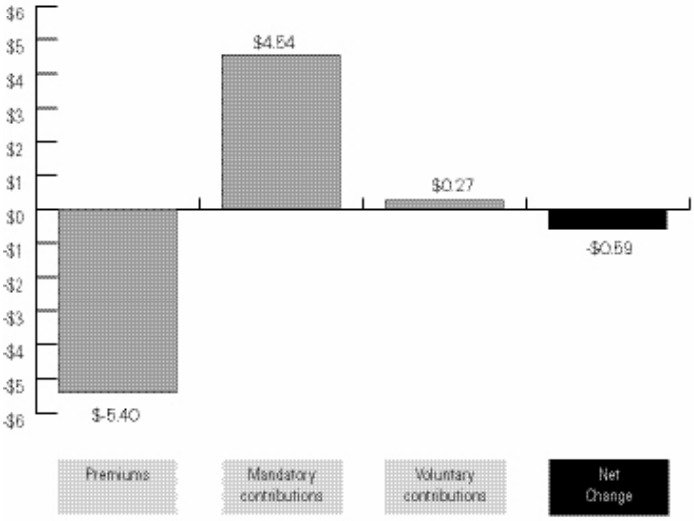
Two caveats are necessary here. First, although total employer spending would decline, it would change in character. Currently, all employer spending on health coverage is voluntary. Under this alternative, most such spending would be required by state law.

Second, while employers as a whole would spend less under Approach One than under the present system, firms that previously did not cover their workers would begin making payments. For them, this alternative would add approximately $820 million in new health care costs, which would be partially offset by a drop in wages of $620 to $650 million, [12] resulting in a net $160 to $200 million increase in labor costs. Conversely, the companies that purchase health coverage today would experience $1.4 billion in savings, a 26 percent drop in health care costs. That savings would be partially offset by a $1.1 billion to $1.13 billion increase in wages. As a result, total employee compensation would fall $280 million to $310 million below current levels. *Each set of companies – those that previously did not offer coverage and those that did – would experience net changes in labor costs equal to less than one-hundredth of one percent of such companies' total payroll.*

Households

Household savings would be significant. Health insurance premium payments would decline from $2.16 billion for both employer-based coverage and non-group insurance to $108 million for coverage that supplements the state plan. In addition, workers would make contributions to the state health plan totaling $1.48 billion. Out-of-pocket payments would decline by $180 million, from $1.9 billion to $1.72 billion. Accordingly, households would save $750 million in annual health care costs. At the same time, because employers would pay less for health insurance, total wages and salaries would rise by $470 million. As a result of increased earnings, federal and state income tax payments would likewise rise by roughly $190 million, resulting in after-tax income gains of $280 million. *Connecticut households' net income available for purposes other than the purchase of health care and health coverage would increase by $1.03 billion a year.* [13]

Figure 4. Changes in Employer Payments for Health Insurance Under Approach One

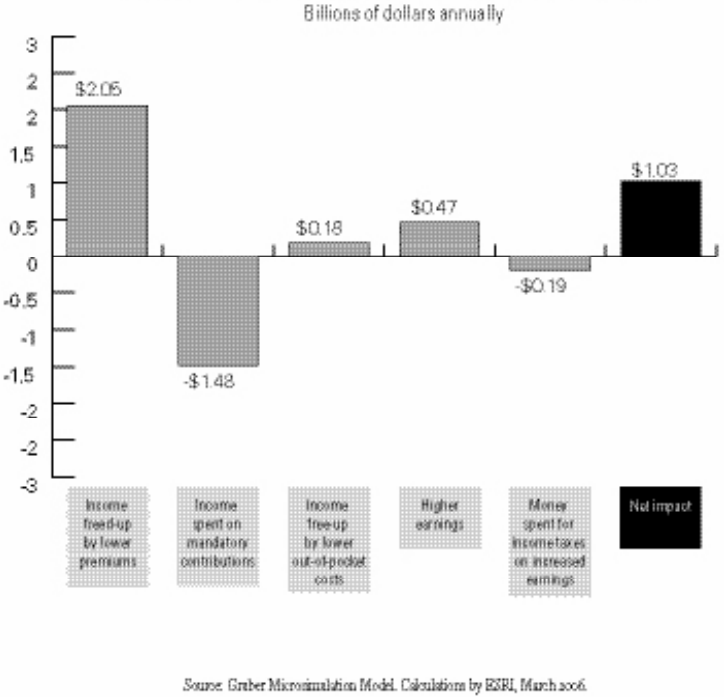


Source: Gruber Microsimulation Model. Calculations by ESRI, March 2006.

[12] A number of studies show that changes in employers' health insurance costs are offset by contrary changes to wages. J. Gruber, "Health Insurance and the Labor Market," chap. 12 in *Handbook of Health Economics*, vol. 1, ed. A.J. Culyer and J.P. Newhouse (Amsterdam: Elsevier Science B.V., 2000), 645–706.

[13] The estimates in the text are limited to the non-elderly. However, the reduction in health care prices under this approach would probably affect costs for the elderly as well. If either such "ripple effects" or a federal waiver allowed Medicare beneficiaries to benefit fully from the cost savings achieved by this option, the average Medicare beneficiary could realize annual savings of up to $410 in out-of-pocket costs.

Figure 5. Impact of Approach One on Household Income Available for Purposes Other Than Health Care



Source: Gruber Microsimulation Model. Calculations by ESRI, March 2006.

Government

Because this policy alternative greatly expands Medicaid eligibility for adults and automatically enrolls eligible individuals into Medicaid, federal Medicaid payments would increase substantially, from $470 million to $1.31 billion. That $840 million boost would be offset somewhat by a $150 million increase in federal income tax revenue, resulting in net federal costs of approximately $690 million.

This increase in federal Medicaid funding would be achieved without any increased investment of state General Fund dollars. That is because the state would use employer contributions to "draw down" federal matching dollars and because SAGA beneficiaries would be shifted from state-only SAGA to federally matched Medicaid. [14]

In fact, the state's net budget balance could improve by as much as $110 million. State income tax revenues would increase by roughly $40 million. As with other employers, the state could realize significant savings in the cost of covering public employees. If such employees participated in the single state plan without supplementation, the state would save approximately $70 million. [15]

Health care providers

For 291,000 people previously insured by Medicaid – or 92 percent of current beneficiaries under age 65 [16] – the state plan would be responsible for paying most health care costs, with Medicaid's role limited to "wraparound" coverage of out-of-pocket expenses and benefits. As a result, for services covered through the state plan, providers would no longer receive lower reimbursement for Medicaid patients than for others. On the other hand, lower health care costs, per capita, could translate into lower reimbursement rates for some providers, depending on the insurance status of their patients and the services they receive. Those losses would be offset, to some degree, through providers' lower administrative costs. Providers would need to deal with only one insurer for most services to the non-elderly, using a single statewide claims form and claims processing system.

Following is a table summarizing these estimates for Approach One.

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[14] The former provision in the text would likely pass muster under federal law . Since there would be no link between the employer furnishing contributions and the individuals receiving Medicaid, employer contributions should be able to qualify as legitimate state revenue for Medicaid purposes. The latter provision in the text may not run afoul of federal budget neutrality requirements that apply to Medicaid waivers under Section 1115 of the Social Security Act because, under longstanding federal policy, the state's unspent DSH allocations could be counted in the baseline for calculating the waiver's impact on federal spending, provided that enough qualifying hospital expenditures can be documented. As with the use of broad-based employer contributions to help pay the state's share of Medicaid costs, expanding coverage for parents could be implemented through a simple Medicaid State Plan Amendment and would not need a waiver. However, this precise combination of strategies is innovative, and it is certainly possible that federal officials could raise questions.

TABLE 3.
COST AND COVERAGE ESTIMATES FOR APPROACH 1

Health Coverage Estimates

	Thousands of Covered Individuals		
Major types of coverage	**Current Law**	**Approach 1**	**Change**
1. Total number of insured	2,555	2,910	355
a. Employer-sponsored insurance	2,070	-	(2,070)
b. Nongroup insurance	170	-	(170)
c. Medicaid*	315	30	(285)
d. New state plan	0	2,880	2,880
2. Uninsured total	355	-	(355)

Health Care Cost Estimates

	Millions of Dollars		
Major types of spending	**Current Law**	**Approach 1**	**Change**
1. Total health spending in Connecticut	$ 10,530	$ 10,030	$ (500)
2. Total premiums and payments for covered services	$ 8,630	$ 8,310	$ (320)
a. Employer payments**	$ 5,400	$ 4,810	$ (590)
b. Household payments **	$ 2,160	$ 1,590	$ (570)
c. State-share Medicaid and SAGA	$ 600	$ 600	-
d. Federal-share Medicaid	$ 470	$ 1,310	$ 840
3. Out-of-pocket payments for uncovered services	$1,900	$ 1,720	$ (180)

Tax and income estimates

	Millions of Dollars		
	Current Law	**Approach 1**	**Change**
1. Total wages and salaries of Connecticut residents	$ 62,100	$ 62,570	$ 470
2. Federal income taxes paid by Connecticut residents	$ 22,200	$ 22,350	$ 150
3. State income taxes paid by Connecticut residents	$ 6,860	$ 6,900	$ 40

*Current law estimates include Medicaid, SCHIP, and SAGA. Approach 1 estimates are limited to individuals for whom Medicaid is the primary insurer (mainly people with disabilities).
** Under Approach One, some of these payments are legally required contributions rather than voluntary premiums.
Notes:
(1) Totals may not add because of rounding. Coverage estimates are rounded to the nearest 5,000. Cost and income estimates are generally rounded to the nearest $10 million, except in some cases when only three digits of precision are available.
(2) All estimates are limited to the non-elderly.
(3) Federal Medicaid dollars rise without a corresponding increase in state General Fund spending, since (a) employer contributions are used to meet some of the state's financial responsibilities; and (b) receipt of federal matching funds for formerly state-only SAGA coverage frees up state resources to draw down federal match for new enrollees.

[15] In state FY 2004, expenditures on state employee health insurance totaled $317.1 million. *Annual Report of the State Comptroller Budgetary Basis, Fiscal Year Ended June 30, 2004*, "Statement of Appropriations and Expenditures." The estimates in the text assume the 7.3 percent national average increase in per capita private health insurance premiums in 2005. Center for Medicare and Medicaid Services, Office of the Actuary, *National Health Care Expenditures Projections: 2005-2015*, Feb. 2006. Depending on what supplemental coverage (if any) is purchased for state employees, the state may save less than the average private employer.
[16] Because of their need for specialized systems of care, people with disabilities would remain outside the single state plan.

MODELING RESULTS FOR APPROACH TWO:

A Health Insurance Purchasing Pool with Competing Private Plans

Key policy elements

Under this option, a single pool would cover most state residents. The pool could be administered by a public or private agency. In either event, the pool would offer residents a choice among *multiple private health plans*. Employers could offer health insurance. But employers could achieve considerable savings, without sacrificing their employees' health care, by discontinuing coverage and allowing their workers and dependents to be covered by a private health plan offered through the pool.

Additional features of this alternative include the following:

- All non-elderly residents of the state would be covered through the pool, with two exceptions: First, Medicaid beneficiaries who are elderly, disabled, or have incomes below the Federal Poverty Level (FPL) could choose either to remain in Medicaid's delivery system or to join the pool for most services. Second, individuals offered employer-sponsored insurance (ESI) would be enrolled in such coverage, rather than the pool.
- HUSKY children covered through the pool would receive supplemental coverage of out-of-pocket costs and benefits, as would adults with incomes at or below 150 percent of FPL. To provide coverage that takes into account the needs of low-income enrollees and to draw down available federal matching funds, enrollment of eligible individuals into Medicaid and SCHIP would be automatic, and eligibility for parents would extend to 300 percent of FPL.
- Each uninsured individual seeking health care would be enrolled in employer-based coverage, if offered, or in the pool, in all other cases. If the individual was enrolled in the pool and did not choose a plan within a certain period of time, one would be assigned.
- The pool would offer a range of comprehensive health plans typical of current employer-based coverage [17] as well as high-deductible options compatible with Health Savings Accounts. The pool would be modeled after the Federal Employees Health Benefits Plan (FEHBP). Individuals choosing expensive plans would be charged higher premiums, because, as noted below, they would pay a percentage of the total premium. Because individuals with more income would pay a higher percentage, the financial consequences of selecting costlier coverage would rise for those with more ability to pay. Individuals and firms could supplement the coverage available through the pool. The state agency (or its private contractor) operating the pool would take steps to lower costs, improve quality, and increase transparency, such as requiring participating insurers to use a common form for provider claims.
- The pool would be financed through:
    a) Individual premium payments, which would vary based on income, from 0 percent [18] to 30 percent of premiums;
    b) State General Fund dollars, including
        i) A continuation of prior spending for low-income individuals shifted into the pool and
        ii) A new subsidy to reduce the cost of pool coverage to employers;
    c) Federal matching funds under Medicaid and SCHIP; and
    d) Contributions by employers not offering coverage, to finance the remainder of pool costs. Based on Dr. Gruber's work, such contributions would amount to 8.7 percent of payroll (that is, of wages and salaries).

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[17] For information about typical employer-based coverage, see the corresponding footnote for Approach One.
[18] Very-low-income individuals would not pay premiums if they selected the least expensive plan with comprehensive benefits and limited out-of-pocket cost-sharing. They would make premium payments, however, if they chose more costly coverage.

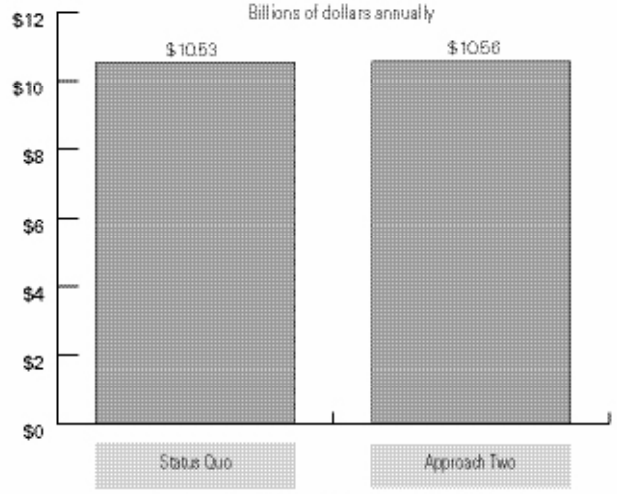
- Some employers may offer coverage that, including both employer and employee premium payments, costs less than 11 percent of payroll. Such companies would make "fail-safe" payments into the pool bringing the employers' total health insurance payments to the 11 percent level. [19] This would achieve three goals:
  a) Such payments would protect the pool from becoming a victim of adverse selection caused by an exodus of low-risk firms. Without such protection, the pool could destabilize. If a firm covering its workers had an unusually healthy workforce, its premiums might be much lower than the state average. Withdrawing those workers from the pool would raise the average risk level of the remaining people. That would cause premiums for the pool to rise, driving out additional companies with comparatively healthy workers, which would further increase premiums, further drive out the healthiest among remaining firms, etc.
  b) This provision would reduce the incentive for employers to avoid the payment of state-imposed health insurance costs by offering their workers token health coverage. Without specifying the details of employee benefits, the 11 percent minimum would provide at least some limited assurance of adequate coverage for individuals insured through ESI rather than the pool.
  c) This financing structure would give virtually all firms a strong financial incentive to have their workers covered through the pool, thereby lowering the employer's health insurance costs to 8.7 percent of payroll. Increasing the number of residents in the pool provides the leverage needed to lower costs, improve quality, and streamline administration.

Cost and coverage estimates

This option would cover all state residents, including 355,000 people who otherwise would be uninsured.

Despite this expansion in coverage, *total health care spending on the non-elderly would rise by only $30 million (one-fifth of one percent)*, increasing from $10.53 billion to $10.56 billion. [20]

Figure 6. Health spending for non-elderly residents of Connecticut: Status Quo vs. Approach Two



Source: Gruber Microsimulation Model. Calculations by EPRI, March 2006.

[19] This approach to funding may raise questions under federal ERISA law, which forbids states from regulating employer benefits, including health coverage. Careful drafting of statutory language could help defend against any claim of ERISA violation. The policy discussed here is quite different from the Maryland law that was recently struck down as violating ERISA. There, the state levied a nominal tax on employers so that employers would provide increased benefits rather than pay the tax. In effect, the Maryland law mandated the increased provision of employer benefits, and the mandate was cloaked in the guise of a tax. *Retail Industry Leaders Association v. Fielder*, Civil No. JFM-06-316 (D.Md. 2006), slip op. July 19, 2006. To the opposite effect is the approach discussed here, which encourages employers to pay the 8.7 percent payroll contribution. However, this area of law is unclear and unsettled, and the risk of a challenge must be acknowledged.

[20] An additional cost not included in the text or accompanying tables is the expense of administering the pool. The Federal Employees Health Benefits Program (FEHBP), after which the pool in Approach Two is modeled, spends approximately one-tenth of one percent of total pool costs on pool administration; claims processing, provider credentialing and the like are handled by insurers, not the pool administrator, under both FEHBP and Approach Two. K. Davis, B.S. Cooper, R. Capasso, *The Federal Employee Health Benefits Program: A Model For Workers, Not Medicare*, The Commonwealth Fund, November 2003. Because it would work with a relatively small number of local plans, the pool's administrative costs in Connecticut could be lower than under FEHBP, which manages transactions with more than 220 diverse health plans around the country. U.S. Office of Personnel Management, *Benefits Administration Letter* Number: 05-406, "2005 Federal Employees Health Benefits (FEHB) Program Open Season: Ordering and Distribution of Material," Attachment 2, October 28, 2005. On the other hand, with 8 million covered lives, FEHBP may achieve economies of scale not realized by the pool, which is projected to include slightly less than 2.2 million state residents. Statement of Daniel A. Green, Office of Personnel Management, before the Subcommittee on the Federal Workforce and Agency Organization, Committee on Government Reform, U.S. House of Representatives, June 13, 2006. If as a net result of these countervailing factors, the pool's administrative cost were twice FEHBP's level, such costs would amount to $12.5 million.

Costs per insured resident under age 65 would decline by 12 percent, falling from $4,121 to $3,629. This reduction primarily results from the assumption that the pool's insurance costs would be 10 percent below existing average employer-based coverage. Such savings would be achieved through two strategies: consumers in the pool would have financial incentives to select less expensive coverage; and, based on the estimated 61 percent of residents who would join, pool administrators would have the purchasing power to lower premiums. A secondary factor is the reduction in out-of-pocket costs that would result when some individuals gain coverage and others shift from non-group plans to pool coverage. Additionally, providers would not need to raise their charges to cover the costs of uncompensated care for the uninsured, further lowering per capita spending for the insured.

These savings would have generally (though not uniform[illegible] positive effects on stakeholders in the health care system described below.

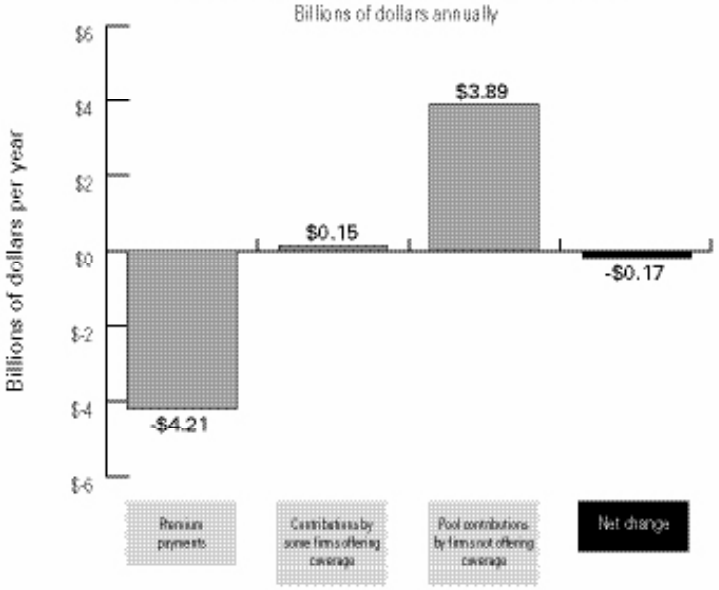
Employers

Employer payments would depend on whether their w[illegible] ers are covered through the pool or the employer purcha[illegible] coverage directly. Employers who do not offer coverage [illegible] whose workers accordingly would be covered through pool would make a pool contribution equal to 8.7 percen[illegible] payroll. Through the combination of fail-safe payments [illegible] employer and employee premium payments, firms that o[illegible] health insurance would need to spend an amount equal t[illegible] percent of payroll.

Today, most companies that offer insurance spend well ab[illegible] that amount. The average Connecticut firm's health in[illegible] ance costs, including employer and employee premiums, currently equal 13.3 percent of payroll costs, according to Dr. Gruber's research. On the other hand, even firms spending just 11 percent of payroll on health insurance could realize significant savings by dropping their premium contribution to 8.7 percent of payroll and letting their workers receive coverage through the pool. As a result, approximately 75 percent of employers that previously covered their workers would likely make this change.

Under this reform option, *total employer payments for health insurance would fall by $170 million, or 3 percent.* Because 75 percent of employers now offering coverage would no longer do so, companies' premium payments would decline from $5.4 billion to $1.19 billion. However, employers not offering coverage would contribute $3.89 billion to support the pool. In addition, some firms that continued to offer coverage would contribute $150 million in "fail-safe" payments. Figure 7 illustrates these effects on employers.

Figure 7. Changes in Employer Payments for Health Insurance Under Approach Two



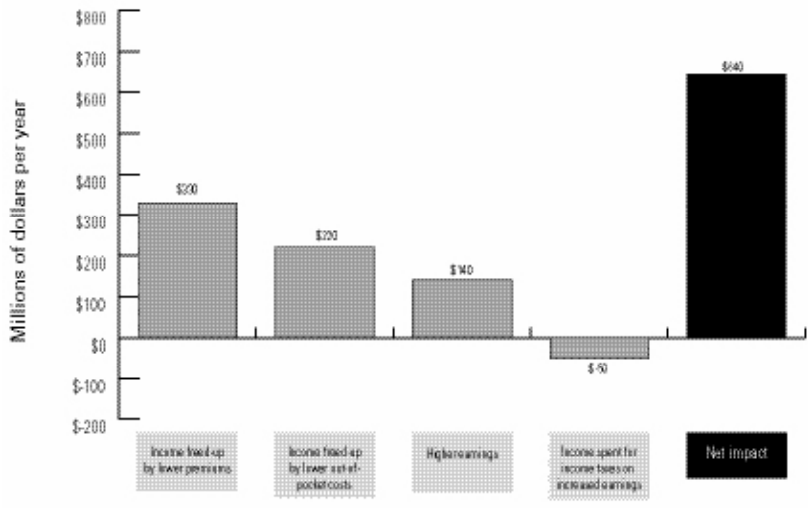
Source: Gruber Microsimulation Model. Calculations by ESRI, May 2006.

As with the first alternative, the employers that achieve savings would see their health insurance spending change in character. Some such spending would be required under state law, whereas all employer spending on health insurance is voluntary today. This option also resembles the first in that, while health insurance payments for employers as a whole would drop below current levels, some employers would pay more and others would pay less than in the past, simply because all businesses would contribute. Companies that currently cover their workers would realize an 18 percent savings, amounting to $990 million. That savings would be largely offset by $760 to $790 million in wage increases, with a net reduction of $200 to $230 million in total employee compensation. Conversely, firms that previously did not offer coverage would incur approximately $820 million in new costs for health coverage, which would be largely offset by an estimated $620 to $650 million reduction in wages. The result for these employers would be a net $160 to $200 million increase in labor costs. *Each set of companies – those that previously offered coverage and those that did not – would experience changes in labor costs that are less than one-hundredth of one percent the size of such companies' total payroll.*

Households

Households' net income available for purposes other than the purchase of health care and health insurance would increase by approximately $640 million a year. Household premium payments would fall by $330 million, dropping from $2.16 billion to $1.83 billion. Similarly, out-of-pocket payments would fall by $220 million, declining from $1.9 billion to $1.68 billion. [21] In addition, because firms would pay slightly less overall for health insurance, earnings would increase by an estimated $140 million. The wage gain would be partially offset by approximately $50 million in higher federal and state income taxes, resulting in residents' post-tax income rising by $90 million. Figure 8 illustrates the impact of Approach Two on households.

Figure 8. Impact of Approach Two on Household Income Available for Purposes Other Than Health Care



Source: Gruber Microsimulation Model. Calculations by EBRI, March 2006.

[21] The estimates in the text are limited to the non-elderly. However, the reduction in health care prices under this approach would probably affect costs for the elderly as well. If either such "ripple effects" or a federal waiver allowed Medicare beneficiaries to benefit fully from the cost savings achieved by this approach, the average Medicare beneficiary could realize annual savings up to $220 in out-of-pocket costs.

Government

Because this option greatly expands Medicaid eligibility for adults and automatically enrolls many eligible individuals into Medicaid, Federal Medicaid payments would increase substantially, growing from $470 million to $1 billion for the non-elderly. The impact on the General Fund would be limited, because (a) the state would use employer contributions to "draw down" federal matching dollars; and (b) SAGA beneficiaries would shift from state-only SAGA to federally matched Medicaid. [22] In addition, the state, like other employers, could realize gains from enhanced purchasing power and reduced cost-shifting that would lower premiums under Approach 2. If state employees shifted to the pool, the state's savings would amount to approximately $40 million.

This alternative does involve a new General Fund commitment of $220 million, which is used to lower the contribution required of employers whose workers are covered through the pool. As a result, most employers would have an incentive for their employees to be covered through the pool. Increasing the number of covered individuals in the pool accomplishes multiple objectives. It gives the pool the critical mass and leverage to reduce prices and improve quality and transparency; increases the state's receipt of federal matching funds for which Connecticut legitimately qualifies; increases the number of residents with a choice between competing private health plans; and raises the number of residents who can keep their health plan if they change jobs.

Health care providers

The new pool would become the primary insurer for 100,000 current Medicaid beneficiaries (or 32 percent of all such non-elderly individuals), with Medicaid's role limited to wraparound coverage. As a result, for services covered through the pool, providers would no longer receive lower reimbursement for Medicaid patients than for others. On the other hand, lower health insurance costs, per capita, could translate into lower reimbursement rates for some providers, depending on the insurance status of their patients and the services they receive. Such lower reimbursement would be offset, to some degree, by lower administrative costs, as a single insurance claim form could be used for the 61 percent of the state's non-elderly population

Following is a table summarizing the estimates for Approach Two.

[22] For a discussion of federal legal issues, see the earlier footnote on this point in the above analysis of Approach One.

TABLE 4.
COST AND COVERAGE ESTIMATES FOR APPROACH 2

Health Coverage Estimates

	Thousands of Covered Individuals		
Major types of coverage	**Current Law**	**Approach 2**	**Change**
1. Total number of insured	2,555	2,910	355
a. Employer-sponsored insurance	2,070	510	(1,560)
b. Nongroup insurance	170	-	(170)
c. Medicaid*	315	230	(85)
d. New pool	0	2,170	2,170
2. Uninsured total	355	-	(355)

Health Care Cost Estimates

	Millions of Dollars		
Major Types of Spending	**Current Law**	**Approach 2**	**Change**
1. Total health spending in Connecticut	$ 10,530	$ 10,560	$ 30
2. Total premiums and payments for covered services	$ 8,630	$ 8,880	$ 250
a. By employers**	$ 5,400	$ 5,230	$ (170)
b. By households **	$ 2,160	$ 1,830	$ (330)
c. By state Medicaid and SAGA dollars	$ 600	$ 600	-
d. By federal Medicaid dollars	$ 470	$ 1,000	$ 530
e. General Fund pool subsidies	0	$ 220	$ 220
3. Out-of-pocket payments for uncovered services	$1,900	$ 1,680	$ (220)

Tax and income estimates

	Millions of Dollars		
	Current Law	**Approach 2**	**Change**
1. Total wages and salaries of Connecticut residents	$ 62,100	$ 62,240	$ 140
2. Federal income taxes paid by Connecticut residents	$ 22,200	$ 22,240	$ 40
3. State income taxes paid by Connecticut residents	$ 6,860	$ 6,870	$ 10

*Current law estimates include Medicaid, SCHIP, and SAGA. Approach 2 estimates are limited to people with disabilities and the very poor who choose to keep Medicaid as their primary insurer.
** Under Approach 2, some of these payments are legally required contributions rather than premiums.
Notes:
(1) Totals may not add because of rounding. Coverage estimates are rounded to the nearest 5,000. Cost and income estimates are generally rounded to the nearest $10 million, except in some cases when only three digits of precision are available.
(2) All estimates are limited to the non-elderly.
(3) Federal Medicaid dollars rise without a corresponding increase in state General Fund spending, since (a) employer contributions are used to meet some of the state's financial responsibilities; and (b) receipt of federal matching funds for formerly state-only SAGA coverage frees up state resources to draw down federal match for new enrollees.
Source: Gruber Microsimulation Model. Calculations by ESRI, May 2006.

MODELING RESULTS FOR APPROACH THREE:

Expanding the Health Coverage Safety Net While Requiring All Parents To Cover Their Children

Key policy elements

The third option would primarily expand current coverage arrangements to achieve universal coverage of children and a substantial increase in coverage for adults. Altogether, 96 percent of the state's residents would be insured. Further, this option would create a platform on which a future system covering all state residents could be built. The approach includes new public subsidies, requirements that all parents cover their children, and greatly streamlined adult enrollment mechanisms. The following are this alternative's main features:

- HUSKY would cover adults with incomes up to 200 percent of FPL, including childless adults formerly insured through SAGA. Adults with incomes above 100 percent of FPL would be enrolled in employer-based coverage whenever it was available, with the state paying the worker's share of premiums and providing "wraparound" coverage of services and costs outside the employer package.
- Uninsured adults with incomes between 201 and 300 percent of FPL would qualify for fully refundable state income tax credits. Adults with incomes at the bottom end of this range would receive credits that pay approximately 85 percent of health insurance premiums. The subsidy amount would gradually fall as incomes rise, reaching 20 percent of premiums at 300 percent of FPL. The state would advance these credits directly to insurers when monthly premiums were due, without waiting for year-end filings of state income tax returns. Such credits could be used to purchase plans offered through the Municipal Employees Health Insurance Plan (MEHIP), the Health Reinsurance Association (HRA), or private pools certified by the state.
- Above 150 percent of the FPL, neither HUSKY nor the new tax credits would cover (a) adults who have access to employer-based coverage for which the firm pays at least 50 percent of premiums; (b) people who dropped coverage voluntarily during the past six months; or (c) workers whose employers dropped coverage during the past six months. These restrictions would be intended to prevent new subsidies from undermining current systems of employer-based coverage.
- When uninsured adults sought care, they would have an opportunity to request subsidized coverage. Rather than complete an application form, they could choose to have a Health Consumer Assistance program help them qualify.
- Uninsured children would be automatically enrolled into health coverage at birth, when starting school each year, or when receiving care. Unless the parents provided other coverage, such children would be enrolled into HUSKY. Parents would have an opportunity to apply for subsidies, which, as now, would be available to families making up to 300 percent of the FPL, or $60,000 a year for a family of four in 2006. Parents who declined to apply for subsidies or who were ineligible would be charged the full cost of coverage. For children who receive HUSKY without subsidies, monthly premium payments would be made, whenever possible, through withholding from parents' paychecks.
- So that all low-income children would have affordable options, HUSKY would include all income-eligible children whose immigration status makes them ineligible for federal matching funds. Subsidies for such children would be entirely state-funded.
- Federal matching funds and the state's General Fund would finance HUSKY and tax credits.

Cost and coverage estimates

The number of uninsured would decline by 66 percent, falling from 11 percent to 4 percent of state residents.

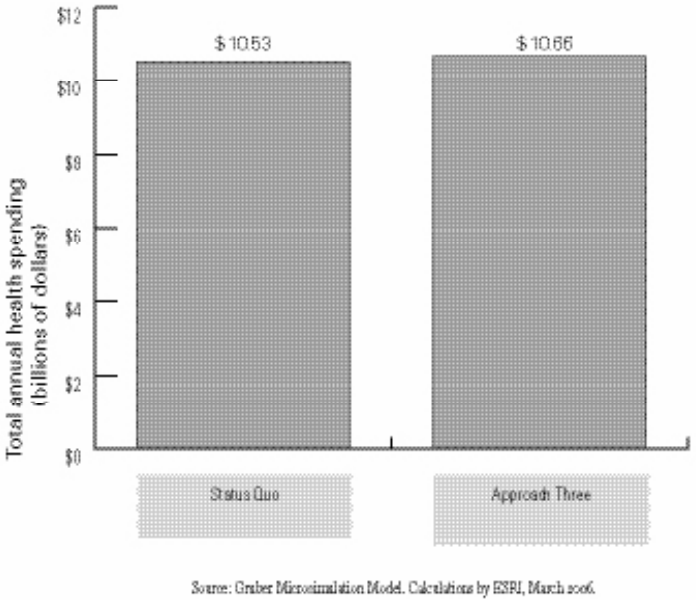
This alternative would cover all 75,000 children who lack health coverage today. [23]

It would also achieve a 45 percent reduction in the number of uninsured adults, which would drop from 280,000 to 155,000. [24]

Altogether, roughly 200,000 previously uninsured residents would receive coverage. HUSKY would cover 185,000, and tax credits would pay for 15,000 of these individuals' health insurance. In addition, a small number of insured individuals would change their form of coverage. [25]

Total health spending on the non-elderly would increase by $130 million, or 1 percent of all health care spending (Figure 9).

Figure 9. Health spending for non-elderly residents of Connecticut: Status Quo vs. Approach Three



Source: Gruber Microsimulation Model. Calculations by ESPI, March 2006.

Health spending per insured person would fall by 6 percent, from $4,121 to $3,869. The likely cause is that the previously uninsured would enroll primarily in Medicaid, raising the proportion of Medicaid enrollees among all insured from 10 to 15 percent; Medicaid's per capita costs for non-elderly and non-disabled enrollees are lower than per capita costs for other insurance coverage.

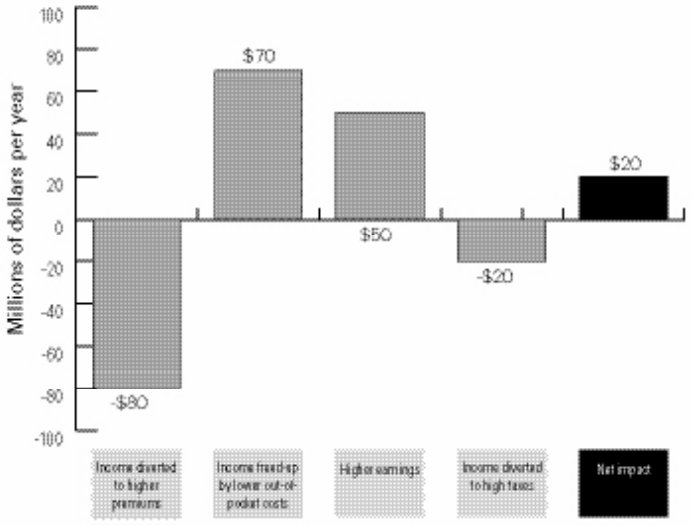
This expansion in coverage would require $45 million from the state General Fund. Federal Medicaid payments would increase by $135 million. Increased Medicaid spending from the state General Fund would be limited to $5 million, for two reasons: state Medicaid costs for enrollees with incomes above the FPL would be lowered through leveraging available employer-sponsored insurance (ESI); and federal matching funds would be received for former SAGA enrollees whose care, in the past, was funded entirely by the state. [26] However, in addition to $5 million in increased Medicaid costs, the state would need to fund an estimated $40 million in tax credits. [27]

Total business payments for health insurance would fall by $60 million, or 1 percent. These savings would be largely offset through expected wage increases of $50 million, resulting in overall labor costs $10 million below current levels.

[23] As with all coverage estimates presented in the text, figures, and tables, this estimate is rounded off to the nearest 5,000.
[24] Based on Medicare research, it would cost $8 million or less to administer a well-run telephone assistance program to accomplish this approach's start-up enrollment goals for adults. See Access to Benefits Coalition, *Pathways to Success: Meeting the Challenge of Enrolling Medicare Beneficiaries with Limited Incomes*, 2005. This expense is not included in this report's text and tables, because it is a one-time cost. After start-up, ongoing expenditures for enrollment assistance would drop significantly.
[25] The only such change involving at least 5,000 people would shift 6,000 people from non-group coverage into Medicaid.

Households' net income available for purposes other than purchasing health care or health insurance would increase by $20 million a year, as the net result of the following: household premium payments would rise by $80 million or 4 percent, growing from $2.16 billion to $2.24 billion; out-of-pocket payments for health care services not covered by insurance would fall by $70 million, dropping from $1.9 billion to $1.83 billion; and households would receive a $50 million projected increase in wages and earnings resulting from reduced employer payments for health insurance, offset by $20 million in higher state and federal income taxes, with a net increase of $30 million in post-tax earnings (Figure 10).

Figure 10. Impact of Approach Three on Household Income Available for Purposes Other Than Health Care



Source: Gruber Microsimulation Model. Calculations by ESRI, March 2006.

Following is a table summarizing estimates for this approach.

[26] For the latter approach to satisfy the federal budget neutrality requirement that applies to waivers under Section 1115 of the Social Security Act, Connecticut's otherwise unspent federal DSH allocations may need to be counted as part of the "baseline" against which federal waiver costs are compared, as discussed above in connection with Approach One.

[27] State policymakers could substantially reduce the latter cost by using HUSKY rather than tax credits to cover these somewhat higher-income adults. With HUSKY, the state could obtain federal matching funds to cover at least the custodial parents in this income group, and per capita costs would drop because of lower provider reimbursement rates under Medicaid. Of course, the use of Medicaid rather than private reimbursement involves serious trade-offs in terms of lower provider participation, less access to care, and reduced support for provider infrastructure.

TABLE 5.
COST AND COVERAGE ESTIMATES FOR APPROACH 3

Health Coverage Estimates

	Thousands of Covered Individuals		
Major types of coverage	**Current Law**	**Approach 3**	**Change**
1. Total number of insured	2,555	2,755	200
a. Employer-sponsored insurance	2,070	2,060	(10)
b. Nongroup insurance	170	160	(10)
c. Medicaid*	315	510	195
d. Tax credits	0	25	25
2. Uninsured total	355	155	(200)
a. Children	75	-	(75)
b. Adults	280	155	(125)

Health Care Cost Estimates

	Millions of Dollars		
Major Types of Spending	**Current Law**	**Approach 3**	**Change**
1. Total health spending in Connecticut	$ 10,530	$ 10,660	$ 130
2. Total premiums and payments for covered services	$ 8,630	$ 8,830	$ 200
a. By employers	$ 5,400	$ 5,340	($ 60)
b. By households	$ 2,160	$ 2240	$ 80
c. By state Medicaid and SAGA dollars	$ 600	$ 605	$ 5
d. By federal Medicaid dollars	$ 470	$ 605	$ 135
e. By tax credits	0	$ 40	$ 40
3. Out-of-pocket payments for uncovered services	$1,900	$ 1,830	($ 70)

Tax and income estimates

	Millions of Dollars		
	Current Law	**Approach 3**	**Change**
1. Total wages and salaries of Connecticut residents	$ 62,100	$ 62,150	$ 50
2. Federal income taxes paid by Connecticut residents	$ 22,200	$ 22,220	$ 20
3. State income taxes paid by Connecticut residents	$ 6,860	$ 6,860	$ -

*Includes Medicaid, SCHIP, and SAGA
Notes:
(1) Totals may not add because of rounding. Coverage estimates are rounded to the nearest 5,000. Cost and income estimates are generally rounded to the nearest $10 million, except in some cases when precisely three digits of precision are available.
(2) All estimates are limited to the non-elderly.
(3) Federal Medicaid dollars rise without a corresponding increase in state General Fund Spending, since receipt of federal matching funds for formerly state-only SAGA coverage frees up state resources to draw down federal match for new enrollees.
Source: Gruber Microsimulation Model. Calculations by ESRI, March 2006.

Chapter Two: Each Alternative's Impact on the State Economy

Note: this chapter was authored by Fred Blavin and Lisa Clemans-Cope of the Urban Institute. The chapter briefly explains these analysts' methodology and sets out their results.

OVERVIEW

To estimate the macroeconomic (economy-wide) effects of the three approaches to covering the uninsured in Connecticut, we utilize a dynamic simulation model–specifically, the Regional Economic Model Incorporated (REMI) Policy Insight. This model draws on econometric relationships and economic models to produce macroeconomic forecasts for Connecticut–that is, the model can show how the three reforms, if implemented, would affect such factors as state income and employment levels.

The three alternative strategies for achieving and financing coverage expansion would affect the cost of doing business and living in Connecticut, the demand for health care services, employment levels, overall economic activity, and personal incomes. The REMI model's econometric relationships reflect how these and other aspects of the economy interact.

The model's macroeconomic forecast of the Connecticut economy starts from a baseline estimate reflecting the economy in 2005 without any policy change. It then projects how the introduction of a policy change–that is, the implementation of one of the three options–would affect economic and demographic variables. The data used to represent the policy change result from the Gruber microsimulation, which was explained in the previous chapter. Some of the microsimulation results had to be adjusted from the pre-tax income totals provided by the Gruber microsimulation to post-tax estimates required for the REMI model.

The REMI model allows analysis of how policy changes would impact the state's economy by affecting household and employer health care spending and taxes. The model is flexible enough to allow each of these alternatives to be simulated under different assumptions, in particular, different assumptions about how new employer costs could be distributed over employers in different industries. To make clear the impacts of the assumptions regarding the distribution of employer costs, we present alternative simulations for Approach 1 and Approach 2 (see Table 6 and Table 7). Differing assumptions do affect the magnitude of the results. *However, the results shown in Tables 6 through 8 suggest that the economic impacts would be mildly positive under any of the three policy options.*

Further information on the macroeconomic modeling underlying this report is available from the Universal Health Care Foundation of Connecticut.

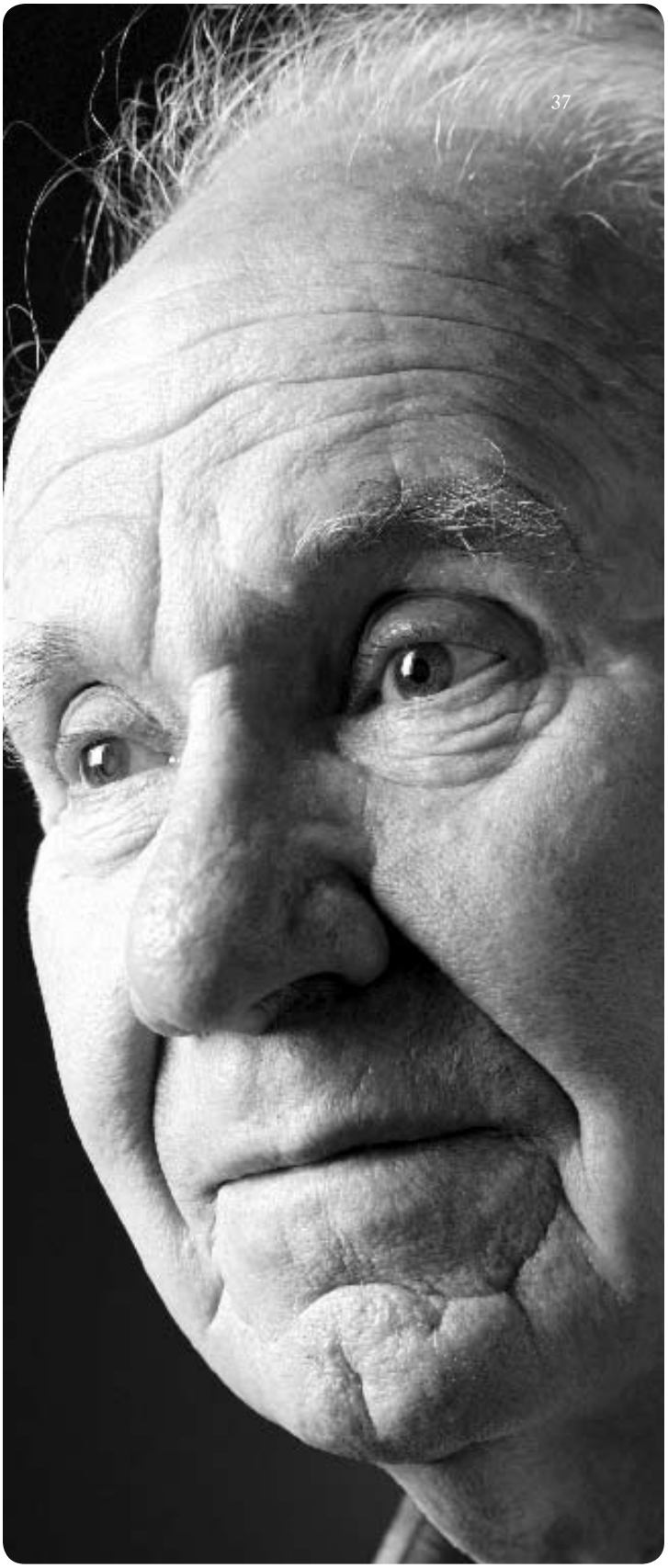
MACROECONOMIC MODELING RESULTS AND INTERPRETATION

In Tables 6 through 8, we present results from macroeconomic impact analysis for the three health reform options. The results presented in each table are differences in the levels and percent changes between the baseline and the reforms for important policy variables.

Approach 1 (one health plan serving all residents, shown in Table 6) increases employment by 6,000 to 11,000 workers, depending on what assumptions are used to distribute changes in employer costs. In addition, the state GDP would increase by 0.3 percent to 0.4 percent, and real disposable income (taking into account price changes) would increase by 0.4 percent to 0.8 percent, depending on which assumptions are made. Approach 2 (health insurance purchasing pool with competing private plans, shown in Table 7) has a relatively small impact on the state economy. Employment would increase by 2,000 to 6,000 workers, the state GDP

would increase by 0.2 percent, and real disposable income (taking into account price changes) would decrease or increase by 0.2 percent or less. Approach 3 (expanding the health coverage safety net while requiring all parents to cover their children, Table 8) likewise has a small, slightly positive effect on the economy.

The proposed reforms would impact employment, the state GDP, and personal income by a small amount–less than one percent under each scenario modeled. Approaches 1 and 2 have a slight positive effect on the economy through employers' overall reduction in labor costs. In addition, a second dynamic is at work with Approaches 2 and 3. The latter alternatives produce a generally mildly positive economic impact because of increased health spending. Most of that spending purchases goods and services in the state and thus strengthens Connecticut's economy. Of course, the state revenue financing some spending is subtracted from the private sector, lowering private sector consumption. But much of that consumption would have been for goods produced outside the state, so the net impact on the state's economy is positive. Put differently, increasing state revenue to spend on health care has the net effect of providing the local economy with Connecticut dollars that otherwise would have supported economic activity outside Connecticut. [28]



[28] Some observers have questioned the economic impact of job growth in the health sector at the expense of employment growth in other sectors. If the increased resources devoted to health care reflect low benefits because of high and unnecessary utilization due to moral hazard, moving more resources to the health sector may be economically inefficient. But the evidence suggests that people place a high value on health care and are resistant to strong cost containment efforts. This suggests that the value of increased health care output, including the benefits of medical technologies and pharmaceuticals, may well exceed the value of using these resources elsewhere. Thus job growth in the health sector at the expense of jobs in other sectors could improve economic well-being. At some point continuing to increase the amount of resources devoted to health care may begin to change this calculus. H.J. Aaron, "Should Public Policy Seek to Control the Growth of Health Care Spending?" *Health Affairs* web exclusive, January 8, 2003; M.V. Pauly, "Should We Be Worried About High Real Medical Spending Growth In The United States?" *Health Affairs*, web exclusive, January 8, 2003.

TABLE 6
2005 REMI PROJECTIONS FOR APPROACH 1:
One Health Plan Serving All Residents

	Baseline Levels	Levels Under Approach 1			Levels Under Approach 1, Alt Employer		
Variable	**State Totals**	**State Totals**	**Difference from Baseline**	**% Change**	**State Totals**	**Difference from Baseline**	**% Change**
Total Employment (Thousands of workers)	2,155.10	2,166.19	11.09	0.52%	2,161.44	6.34	0.29%
Total Employment as % of Nation	1.26	1.26	0.01	0.52%	1.26	0.00	0.29%
Total State GDP (Billions)	$ 204.16	$ 204.98	$ 0.83	0.41%	204.81	0.66	0.32%
Personal Income (Billions)	$ 165.97	$ 166.73	$ 0.76	0.46%	166.70	0.73	0.44%
Personal Income as % of Nation	$ 1.62	1.63	0.01	0.46%	1.63	0.01	0.44%
Disposable Income (Billions)	$ 140.30	$ 140.93	$ 0.63	0.45%	140.90	0.60	0.43%
PCE-Price Index (Nominal dollars)	$ 127.84	$ 127.45	-$0.39	-0.30%	127.88	0.04	0.03%
Real Disposable Personal Income (Billions)	$ 141.15	$ 142.21	$1.06	0.75%	141.72	0.56	0.40%
Same, Per Capita (Thousands)	$ 42.11	$ 40.37	$0.26	0.66%	40.25	0.14	0.36%
Population (Thousands)	3,519.61	3,522.78	3.17	0.09%	3,520.99	1.38	0.04%
Population as % of Nation	1.19	1.19	0.00	0.09%	1.19	0.00	0.04%

Source: Urban Institute analysis of REMI 2006.
Notes:
(1) All Income and GDP numbers are in 2005 dollars.
(2) The personal consumption expenditure (PCE) price index based is 100 for the nation in the current reference year for U.S. – based indices. If lower than 100, then prices in the state are less than the nation, if higher, then prices are higher than the nation. This is used to deflate real disposable personal income.
(3) The inputs in this table are based on the micro-simulation results described in Chapter One. In some cases, these results were adjusted from pre-tax to post-tax dollars. Inputs into REMI included $148M increased health spending; a $170M fall in non-wage labor costs; $432M increased consumer reallocation; wage bill increase of $136M; and personal tax increase of $220M.
(4) The Alt Employer projections disaggregate non-wage labor costs and wage bill among high-offer rate and low-offer rate industries.
(5) Sometimes, the nominal totals, differences, and percentage changes do not align because of rounding.

TABLE 7
2005 REMI PROJECTIONS FOR APPROACH 2:
State Pool With Competing, Private Plans

	Baseline Levels	Levels Under Approach 2			Levels Under Approach 2, Alt Employer		
Variable	**State Totals**	**State Totals**	**Difference from Baseline**	**% Change**	**State Totals**	**Difference from Baseline**	**% Change**
Total Employment (Thousands of workers)	2,155.10	2,161.28	6.18	0.29%	2,157.29	2.19	0.10%
Total Employment as % of Nation	1.26	1.26	0.00	0.29%	1.26	0.00	0.10%
Total State GDP (Billions)	$ 204.16	$ 204.62	$ 0.47	0.23%	204.48	0.32	0.16%
Personal Income (Billions)	$ 165.97	$ 166.31	$ 0.34	0.21%	166.29	0.32	0.19%
Personal Income as % of Nation	1.62	1.63	0.00	0.21%	1.63	0.00	0.19%
Disposable Income (Billions)	$ 140.30	$ 140.36	$ 0.06	0.04%	140.34	$ 0.04	0.03%
PCE-Price Index (Nominal dollars)	$ 127.84	$ 127.73	-$0.11	-0.08%	128.09	$ 0.25	0.20%
Real Disposable Personal Income (Billions)	$ 141.15	$ 141.33	$0.18	0.13%	140.92	-$ 0.23	-0.17%
Same, Per Capita (Thousands)	$ 40.11	$ 40.15	$0.04	0.11%	40.05	-$ 0.06	-0.14%
Population (Thousands)	3,519.61	3,520.33	0.72	0.02%	3,518.83	-$ 0.78	-0.02%
Population as % of Nation	1.19	1.19	0.00	0.02%	1.19	0.00	-0.02%

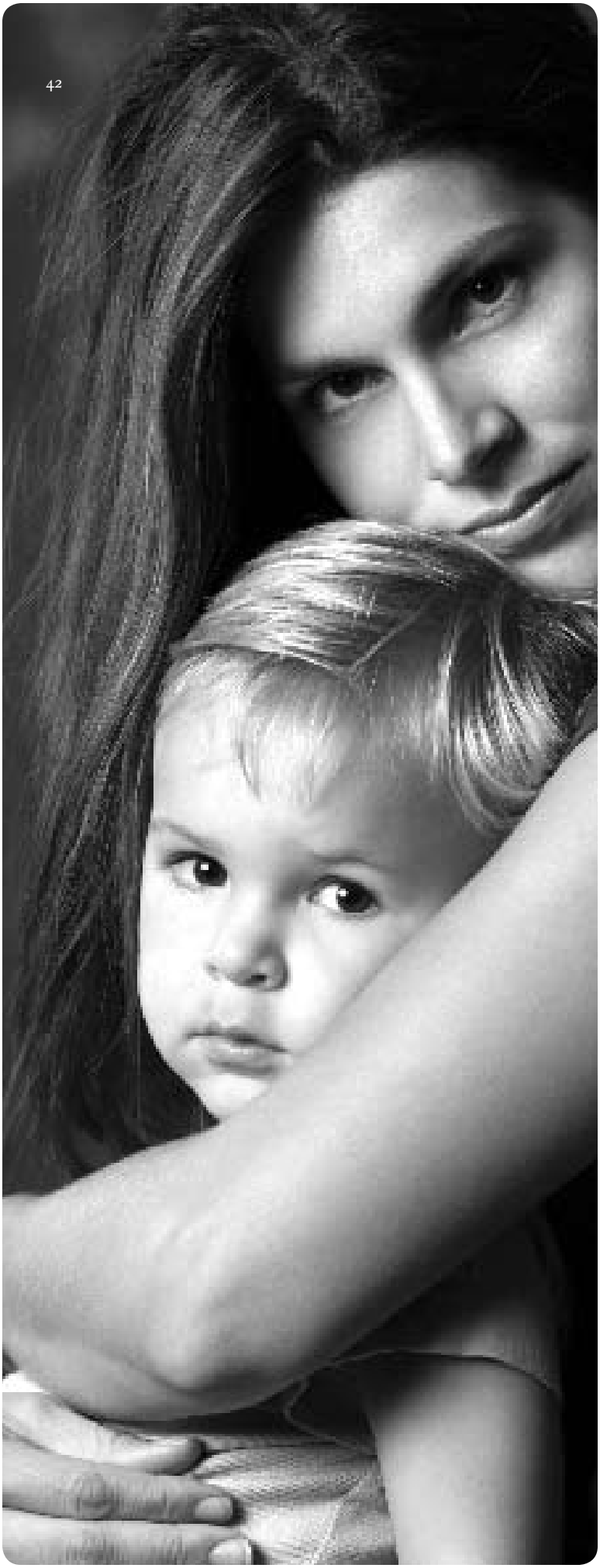
Source: Urban Institute analysis of REMI 2006.
Notes:
(1) All Income and GDP numbers are in 2005 dollars.
(2) The personal consumption expenditure (PCE) price index based is 100 for the nation in the current reference year for U.S. – based indices. If lower than 100, then prices in the state are less than the nation, if higher, then prices are higher than the nation. This is used to deflate real disposable personal income.
(3) The inputs in this table are based on the microsimulation results described in Chapter One. In some cases, these results were adjusted from pre-tax to post-tax dollars. Inputs into REMI included $148M increased health spending; a $170M fall in non-wage labor costs; $432M increased consumer reallocation; wage bill increase of $136M; and personal tax increase of $220M.
(4) The Alt Employer projections disaggregate non-wage labor costs and wage bill among high-offer rate and low-offer rate industries.
(5) Sometimes, the nominal totals, differences, and percentage changes do not align because of rounding.

TABLE 8
2005 REMI PROJECTIONS FOR APPROACH 3:
Expanding Health Coverage Safety Net for Adults and All Children

	Baseline Levels	Levels Under Approach 2		
	State Totals	State Totals	Difference from Baseline	% Change
Total Employment (Thousands of workers)	2,155.10	2,157.19	2.09	0.10%
Total Employment as % of Nation	1.26	1.26	0.00	0.10%
Total State GDP (Billions)	$ 204.16	$ 204.32	$ 0.16	0.08%
Personal Income (Billions)	$ 165.97	$ 166.10	$ 0.13	0.08%
Personal Income as % of Nation	1.62	1.62	0.00	0.08%
Disposable Personal Income (Billions)	$ 140.30	$ 140.36	$ 0.06	0.04%
PCE-Price Index (Nominal dollars)	$ 127.84	$ 127.80	-$ 0.04	-0.03%
Real Disposable Personal Income (Billions)	$ 141.15	$ 141.26	$ 0.10	0.07%
Same, Per Capita (Thousands)	$ 40.11	$ 40.13	$ 0.03	0.06%
Population (Thousands)	3,519.61	3,519.93	0.33	0.01%
Population as % of Nation	1.19	1.19	0.00	0.01%

Source: Urban Institute analysis of REMI 2006.
Notes:
(1) All Income and GDP numbers are in 2005 dollars.
(2) The personal consumption expenditure (PCE) price index based is 100 for the nation in the current reference year for U.S. – based indices. If lower than 100, then prices in the state are less than the nation, if higher, then prices are higher than the nation. This is used to deflate real disposable personal income.
(3) The inputs in this table are based on the microsimulation results described in Chapter One. In some cases, these results were adjusted from pre-tax to post-tax dollars. Inputs into REMI included $148M increased health spending; a $170M fall in non-wage labor costs; $432M increased consumer reallocation; wage bill increase of $136M; and personal tax increase of $220M.
(4) The Alt Employer projections disaggregate non-wage labor costs and wage bill among high-offer rate and low-offer rate industries.
(5) Sometimes, the nominal totals, differences, and percentage changes do not align because of rounding.

Chapter Three: Policy Specifications and Variations for All Three Options



This chapter provides fairly detailed specifications for the three alternatives analyzed above. In addition to explaining the specifications that were modeled, the following tables include examples of possible variations on each approach.

APPROACH ONE: ONE HEALTH PLAN SERVING ALL STATE RESIDENTS

GENERAL DESCRIPTION	Under this alternative, state residents under age 65 would be automatically covered in a single health plan. Funding would come from a combination of employer and employee contributions, federal matching funds, and continuation of prior General Fund payments for low-income residents' health coverage. Anyone could buy supplemental coverage.
Eligibility	1) All state residents would be automatically covered.[29] Even if people did not enroll and showed up for care, they would be enrolled at that time, and the cost of the care would be covered.
Administration	2) Final responsibility would be vested in a new, independent Connecticut Health Care Commission, which would be insulated from everyday political influences by having staggered, long terms of office, similar to terms for the Federal Reserve Board. 3) The Commission could contract with a health insurer to provide fiscal intermediary services, such as payment of provider claims for reimbursement.
Standard benefits	4) A standard benefits package (including consumer cost sharing provisions) would be defined by the Commission and provided to all state residents. The benefit package would include covered services and out-of-pocket cost-sharing typical of health insurance private employers now offer. The Commission would be responsible for updating the benefit package based on an annual review of population needs, new medical advances, and revenue constraints. The plan would not cover long-term care, which would continue to be provided through the Medicaid program for people who qualify.
Benefits for low-income people	5) Supplemental coverage for low-income residents would be based on current HUSKY benefits, with the expectation that federal matching funds would be available in most cases. (A waiver under Section 1115 of the Social Security Act would be needed for federal matching funds covering the full range of services to childless adults.) Current HUSKY coverage for children would remain in effect. Wraparound coverage of services and costs outside the standard plan would be provided to all HUSKY children and to adults with incomes up to 150% of the Federal Poverty Level (FPL). 6) Medicaid eligibility for parents would be extended to those whose incomes were at or below 300% of FPL. In addition, Medicaid would cover previously ineligible childless adults with incomes up to 150% of FPL. Federal budget neutrality requirements would be addressed by tapping Connecticut's previously unused allocations of funding for Disproportionate Share Hospitals (DSH).
Supplemental coverage	7) Anyone–individuals or employers–could buy supplemental coverage from insurers. Policies covering these supplemental benefits would be subject to generally applicable state and federal law, including state insurance regulations. a) As a variation on this approach, policymakers could either (i) limit supplemental benefits to services outside the standard package or (ii) forbid supplemental benefits altogether. As applied to employer-sponsored insurance, however, such restrictions could run afoul of federal ERISA laws that forbid states from regulating employee benefits.

[29] In some cases, residence, employment, and receipt of care can take place in different states. While this report cannot resolve these matters in detail, policy could not be implemented without taking these variables into account. For example, Connecticut health plans cover services obtained elsewhere when such services of adequate quality are not available within the state's borders. As under the present system, such access would need to be assured under all three options discussed in this report.

Financing	8) State General Fund dollars now spent to provide coverage–notably, Medicaid, SCHIP, and SAGA–would help fund the plan, to the extent the standard plan provides services formerly covered through these government programs. 9) Funding would also come from federal Medicaid and SCHIP dollars. 10) Contributions from employers and workers would also help finance the plan. a) Employers would contribute an amount equal to 7.7% of payroll. No assessment would be levied on the first $20,000 per year of aggregate payroll or on individual wage or salary income in excess of $200,000. Variations on this policy element include: i) Policymakers could phase-in this assessment. For example, during the first year, particularly vulnerable firms could pay an amount equal to 2% of payroll. This could rise by 2 percent annually until it reached 7.7% in the fourth year. Firm vulnerability could be defined in terms of size, worker wages, recent establishment, profits, or lack of coverage in the past. (Using the last criterion for identifying the firms receiving subsidies would raise questions of fairness, since otherwise similar firms would be assessed differently based simply on prior offers of insurance, and those that previously covered their workers would be penalized for such coverage.) ii) Alternatively, policymakers could substitute state General Fund dollars for some or all of this assessment. A reduced assessment could apply to all employers or to sets of employers seen as needing relief, such as those meeting the criteria for vulnerable businesses described above. Such relief could instead be financed by increasing employee payments or by raising contributions from firms not receiving relief. For example, firms with fewer than 10 workers could be made exempt from contributions if larger firms made contributions greater than 7.7% of payroll. b) Employees would contribute an amount equal to 2.5% of their wages. The first $10,000 of annual earnings would not be subject to the assessment, and income beyond $200,000 would be exempt. These contributions would be made via payroll deductions, to the extent possible. c) Employers could elect to pay their employees' contributions, effectively using the employees' pre-tax income. d) Self-employed people and non-employed people with household income above 150% of the federal poverty level would make contributions equal to 8% of income between 150% and 250% of FPL and 10.2% of income above 250% of FPL. Contributions would be capped at the maximum amount of employer and employee contributions for a full-time employee with $200,000 in annual earnings. 11) Another variation on this approach would structure companies' contributions as a fixed amount per worker, rather than as a percentage of payroll. Such a variation would seek to avoid incentives for companies to shift employment from high-wage to low-wage work.

New residents	12) Families that move to the state and that include someone with a full-time job in Connecticut would qualify for coverage as soon as they started working. Others would not be eligible for subsidized coverage for two years after moving to the state, if federal law permits such a waiting period. However, these new arrivals could buy into the state plan at full price, with a premium that takes into account applicants' individual health risks.
Cost control and quality improvement	13) The commission would set an overall budget. Commission members would establish a formal process for consulting with major stakeholders in Connecticut on a periodic basis to set and adjust this budget. Stakeholders would include business and labor organizations, health care providers, and consumer groups. While it could delegate some or all of the work to other entities, the commission would have final responsibility for negotiating rates with providers, consistent with the state's overall health care budget. Similar negotiations could be used for other cost-related matters, such as the distribution of new and capital-intensive medical technology. The method for establishing rates would ensure the viability of providers who make a good-faith effort to comply with best medical practices while reducing administrative costs and payments. In redefining the benefits package each year, the commission would consider affordability as well as evolving medical science. 14) The commission would promote quality improvement by collecting data on the health status of Connecticut residents in a form that safeguards confidentiality. The commission would also track utilization patterns and take steps to increase provision of timely, cost-effective primary and preventive care and to reduce inappropriate care. It would work with providers to improve patient safety and maximize effective use of information technology.

APPROACH TWO: A HEALTH INSURANCE PURCHASING POOL WITH COMPETING PRIVATE HEALTH PLANS

GENERAL DESCRIPTION	This alternative ensures universal coverage. Most state residents would be covered through a statewide, health insurance purchasing pool that contracts with multiple, private health insurance plans. Employers could offer coverage, in which case their employees and eligible dependents would be covered through the employer-sponsored plan rather than the state pool. The plan would be financed by individual premium payments, employer contributions, federal matching funds, and state General Fund dollars.
Eligibility	1) Except for individuals offered employer-sponsored insurance (ESI), all non-elderly residents of the state would qualify for coverage through a purchasing pool. 2) When an uninsured person without access to ESI sought care, that person would be automatically assigned to a plan participating in the pool. When an uninsured person with access to ESI sought care, such a person would be enrolled in the employer plan. [30] a) A variation on this approach would seek to prevent low-income individuals from being asked to pay unaffordable premium amounts for ESI. Policymakers could provide that individuals offered ESI would nevertheless be enrolled in the pool if that ESI failed to meet specified benchmarks for affordability, such as costs that fall below a specified percentage of income. Alternatively, Medicaid could pay some or all the worker's ESI premiums for low-income workers. (Under the latter approach, Medicaid would also provide supplemental benefits and protection from out-of-pocket cost-sharing.)
Administration	3) The pool could be administered by a state agency directly, such as the State Comptroller's office, which already purchases health insurance for state employees and operates a health insurance purchasing pool. Alternatively, the state could contract with a private entity to administer the pool. In either case, the administering entity would negotiate and contract with health plans, provide information to the public, transfer funds, collect and distribute premium payments, enroll individuals into health plans (which includes setting appropriate default enrollment rules), etc. Health plans would administer coverage for their enrollees as they do currently.

[30] If two parents were each offered employer-sponsored coverage but no one in the family enrolled, a parent seeking care would automatically be enrolled in his or her employer's plan, and the children would be assigned randomly to one of the parents' plans.

Sources of coverage	4) *Multiple private plans.* The state pool would contract with private health plans to provide a range of benefits on a community-rated, guaranteed-issue basis. These plans would include comprehensive coverage typical of plans private employers offer today as well as high-deductible options compatible with Health Savings Accounts. The pool administrator would contract with whatever number of health plans it determined would produce the greatest value. While providing a meaningful choice of options, the pool would keep options to a manageable number to avoid consumer confusion. 5) *Plan choice.* At least one comprehensive plan would be available at no premium cost to people with income below 150% of the federal poverty level. However, anyone enrolled in the pool could choose any plan under contract with the pool administrator. 6) *Benchmark coverage.* During the pool's first year, the administrator would set a benchmark for coverage equal to the actuarial value of average employer-based coverage. The benchmark would be adjusted annually for health care inflation. As detailed below, enrollees selecting plans above the benchmark would pay the difference in premiums. Note: the pool administrator would be permitted but not required to offer coverage above the benchmark level. 7) As a variation on this approach, policymakers could lower administrative costs by having the pool contract with insurers to provide third-party administrator services, rather than full health insurance.
Benefits for low-income people	8) SCHIP beneficiaries and many Medicaid beneficiaries would receive their primary coverage through the pool. They would retain supplemental coverage (sometimes called "wraparound coverage") that preserves current benefits and limits on premiums and out-of-pocket cost-sharing under Medicaid or SCHIP. Medicaid beneficiaries who are disabled or who have family incomes at or below the federal poverty level (FPL) could choose to stay with the current Medicaid program for all services, rather than receive their principal coverage through the pool. 9) Medicaid eligibility for parents would be extended to those with incomes at or below 300% of FPL. In addition, Medicaid would cover previously ineligible childless adults with incomes up to 150% of FPL. Federal budget neutrality requirements would be addressed by tapping Connecticut's previously unused allocations of federal DSH dollars.

Financing	*Approach Two* would be financed by a combination of household premium payments, employer contributions, federal matching funds for the Medicaid-eligible and SCHIP-eligible population, and state General Fund payments. *Premiums* 10) The premiums for households covered through the pool would be graduated based on income. People with incomes below 150% of FPL would pay no premiums, unless they chose a comprehensive plan above the benchmark level. [31] Those with incomes above 300% of FPL would pay 30% of the full costs of the premium for any plan at or below the benchmark level. The responsibility for premium payments by those between 150% and 300% of poverty would be graduated from 0% to 30%. Households selecting plans above the benchmark level would pay the full difference in premiums. 11) Households entering the pool would provide information about income, which would be used to determine eligibility for federal matching funds and to set each enrollee's premium, based on household income. 12) Employers could pay their workers' premiums. Presumably, this would lower wages. In effect, pre-tax rather than post-tax dollars would be used to pay worker premiums, keeping workers' new income tax liabilities to a minimum. Note: Alternative mechanisms could also be used to achieve this objective. *Federal Matching Funds* 13) For all individuals covered through the pool who qualify for Medicaid or SCHIP, the pool would receive federal matching funds. *Maintenance of Effort Payments from the State General Fund* 14) The State General Fund would make payments into the pool that reflect the state's previous cost for pool services that were formerly covered through Medicaid, SCHIP, and SAGA. *General Fund subsidies to limit employer costs* 15) To reduce the payments required from employers whose workers receive coverage through the pool, the General Fund would contribute $220 million to pay premiums for pool plans. *Employer Contributions* Employer contribution levels would be structured to achieve the following goals: • Employers that do not offer coverage and whose workers are thus covered through the pool would pay the balance of pool costs that are not covered by individual premium payments, General Fund dollars, and matching federal funds.

[31] HUSKY children would have the same premium obligations as under current law.

Financing continued…	• If employers with unusually healthy employees choose to cover their own workers, such employers would make small "fail-safe" contributions to compensate for the pool's consequently higher risk level. Without such compensation, the pool could destabilize. The increase in average risk level would cause premiums inside the pool to rise, driving out of the pool additional companies with comparatively healthy workers, which would further increase premiums, further drive out the healthiest among remaining firms, etc. • These fail-safe payments would reduce employers' incentive to avoid state-imposed health coverage costs by offering their workers token health coverage. • Without specifying the details of employer-based health benefits, this 11 percent minimum payment would offer some minimum assurance of adequate coverage for state residents ineligible for the pool because their employers offer insurance. • Most companies that now offer coverage would benefit financially by allowing their workers to join the pool. Increasing pool enrollment gives the pool the critical mass and negotiating leverage to lower costs and increase quality; allows the state to obtain more matching federal dollars; and increases the number of state residents with choices between competing health plans and access to coverage that is portable, regardless of job changes. • Employer contributions would be adjusted to reduce the burden on small, struggling firms. In more detail, employer contribution levels would be set as follows: [32] 16) Each firm would be nominally responsible for contributing a sum equal to 11 percent of payroll, which is the amount needed to fully fund coverage within the pool, without funding from any other source. However, payments for health insurance that covers a company's workforce would reduce the company's required contribution – potentially to $0 – as follows: a) A company that insures its workers would subtract from its 11 percent obligation all health insurance premiums paid by the company and its employees. Most firms that cover their workers would owe nothing because premiums for employer-based insurance now average 13.3 percent of payroll. The companies that do make payments under this reform option are likely to have unusually healthy workers for whom insurers charge very low rates. [33] b) If a company does not offer insurance and its workers are therefore covered through the pool, its obligation would be reduced by the firm's pro rata share of health insurance payments the pool receives from the state and federal government and from enrolled individuals. Based on Dr. Gruber's estimates, the resulting employer obligation would equal 8.7 percent of payroll.

[32] The pool needs to be structured so employers cannot wait until their employees get sick before they stop providing ESI and have their workers enter the pool. Accordingly, after the first several years of pool operation, a firm electing to cover its workers would have no access to pool coverage for three years. After that, the firm could make a different choice, which again would be binding for a three-year period.

[33] As explained above, one important goal of this provision is to protect the pool from destabilization through adverse selection. To accomplish that goal, employers need to be credited only for premium payments that purchase coverage comparable to that offered through the pool. Otherwise, employers with unusually healthy workers would have an incentive to take the money they would have spent making "fail-safe" payments and instead buy richer benefits for their employees. The resulting inefficient distortion of employer decisions would prevent the pool from receiving the resources needed to prevent destabilization. (Note: comparability to coverage within the pool could be determined based on actuarial value.)

Financing continued…	c) To reduce the burden on some employers, variations to this approach are possible. As noted in Approach One, required contributions could be either (a) gradually phased-in or (b) replaced, in whole or in part, by additional General Fund dollars. The amount of required employer contributions could also be limited by increasing the amount of employee premium payments. Alternatively, contributions could be restructured so some employers paid more and others paid less. For example, firms with 10 or fewer employees could be exempt if the remaining firms paid a higher percentage of payroll. 17) In determining a firm's contribution, the following would be excluded: the first $20,000 of payroll annually for the firm (to protect small, struggling firms); and any individual wage or salary in excess of $200,000 per year (to avoid extremely high per capita contributions from high-wage firms). 18) An employer could claim additional credit against the 11 percent threshold by demonstrating greater efficiency in purchasing coverage than that achieved by the pool. Such efficiency would be shown by comparing premium payments to the actuarial value of covered benefits, taking into account the age, gender, and geographic residence of covered enrollees. This would allow employers to retain the financial advantages of programs that encourage their workers to lead healthier lives, better purchasing for value than the pool realized, and other efficiencies. 19) Another variation on this approach would structure companies' contributions as a flat dollar amount per worker, rather than as a percentage of payroll. Such a variation would seek to avoid incentives for companies to shift employment from high-wage to low-wage work.
Insurance market rules	20) All insurers participating in the pool would offer coverage on a guaranteed-issue, community-rated basis. To protect insurers from the possibilities of adverse selection, a risk-adjustment mechanism would transfer funds from plans with below-average-risk enrollees to those with above-average-risk enrollees.
New residents	21) Families that move to the state and that include someone with a full-time job in Connecticut would qualify for coverage as soon as employment began. To the extent federal law permits, others would not be eligible for subsidies for two years after moving to the state. However, these new arrivals could buy into pool coverage at full price, with premiums based on applicants' individual health risks.

Cost control and quality improvement	22) Enrollees would save money by choosing less expensive coverage. Accordingly, plans would be in direct competition with one another to attract enrollees by covering services more efficiently as well as by providing services that consumers want. 23) Quality improvement would be addressed through several steps. In calling for bids from competing health plans, the commission would set quality improvement targets related to improving cost-effective preventive and primary care, reducing inappropriate care, and increasing appropriate use of information technology. The commission would publicly report progress toward these goals. Quality information would also be shared with consumers to inform their health plan choices. 24) In awarding default enrollment shares to comprehensive health plans, the commission would reward low cost and high quality. 25) The commission would also use its leverage to reduce administrative costs. For example, it could have all participating insurers use a single form for provider claims.

APPROACH THREE: EXPANDING THE HEALTH COVERAGE SAFETY NET WHILE REQUIRING ALL PARENTS TO COVER THEIR CHILDREN

GENERAL DESCRIPTION	This alternative would primarily use existing coverage mechanisms to cover more residents, as follows: • HUSKY would expand to include uninsured adults with incomes up to 200% of FPL and all low-income children whose immigration status disqualifies them from federal matching funds. • Fully refundable, advanceable state income tax credits would help uninsured adults with incomes between 201% and 300% of FPL buy coverage through Municipal Employee Health Insurance Program (MEHIP), the Connecticut Health Reinsurance Association (HRA), or private purchasing pools. • Parents would be required to provide their dependent children with health coverage. All uninsured children would be enrolled at birth, when they started school, or when they obtained health care.
Public program expansion	Connecticut would expand HUSKY as follows: 1) All otherwise eligible children whose immigration status disqualifies them from full federal matching funds would receive state-funded coverage. 2) Whether or not they are parents, adults with incomes at or below 200% of FPL would qualify. a) For each adult, monthly premiums would vary with income as follows: i) At or below 100% FPL, no premiums. ii) Between 101% FPL and 150% FPL, $25. iii) Between 151% FPL and 200% FPL, graduated premiums reaching, at 200% of FPL, 3% of income for a one-person household (currently $56). b) Co-pays for adults would vary with income as follows: i) At or below 100% FPL, none. ii) Between 101% FPL and 150% FPL, nominal. iii) Between 151% FPL and 200% FPL, amounts between nominal and typical commercial levels. 3) Adults with incomes up to 150% FPL would receive the standard Medicaid package of benefits. Certain Medicaid benefits (such as transportation) that are essential to indigent populations would not apply to adults earning above 150% FPL. 4) To ensure that new public dollars neither substitute for nor otherwise undercut employer-sponsored insurance (ESI), HUSKY would not be offered to the following adults with incomes above 150% FPL: a) Adults who are offered ESI where the firm pays 50% or more of the premium; and b) Adults who have voluntarily dropped private coverage or whose employers have dropped coverage during the past six months. **Exception:** Adults with access to ESI could obtain subsidies for the worker share of premiums if such premium costs would otherwise exceed a designated percentage of household income.

Tax credits (vouchers)	5) Connecticut would establish fully refundable, advanceable health insurance tax credits (or vouchers) to help pay premiums for adults with incomes between 201% and 300% of FPL. The state would directly pay those credits to qualified health plans when monthly premiums are due. Eligibility for tax credits would be determined by the same agency that determines eligibility for HUSKY. If possible, the state would obtain federal matching funds for such credits, through Medicaid and SCHIP waivers. 6) To prevent tax credits from substituting for or otherwise undercutting ESI, tax credits would have the same restrictions described above for HUSKY adults with incomes above 150% FPL. 7) The few credit beneficiaries with access to ESI could use their credits only to purchase ESI. Other beneficiaries could use their credits only to buy insurance through MEHIP, HRA, or a state-approved, private purchasing pool that wishes to serve tax credit recipients. a) As a variation on this approach, if an employer's coverage failed to meet certain minimal standards, policymakers could provide that employees' tax credits would be used to buy insurance from MEHIP, HRA, or an approved private pool, rather than from the employer. 8) To qualify for tax credits, plans would charge recipients age-based premiums that reflect current practice. That is, individuals in their 20s would be charged one premium; those in their 30s would be charged a higher premium; etc. 9) Set each year, the tax credit amount would vary by household income and age of enrollee. For each combination of income and age, the credit would be sufficiently large that, to enroll in the least expensive, comprehensive plan available through MEHIP (the "reference plan"), enrollees would pay as follows: a) In households with incomes at 201% FPL, each adult, regardless of age, would pay the minimum amount required of HUSKY adults at 200% FPL. [34] b) Between 201% and 300% of FPL, payments in each age range would gradually rise so that, at 300% of FPL, each enrollee would pay 80% of the plan's age-adjusted premium. 10) When a credit recipient chose a plan other than the reference plan, the household would be responsible for the difference between the chosen plan's premium and the credit. Regardless of the choice, to prevent high-deductible plans from having an essentially coercive marketing advantage among lower-income residents, the enrollee payment could not drop below 3% of household income.

[34] As explained above, each such adult would make a monthly payment equal to 3% of income for an individual at 200% of FPL.

Tax credits (vouchers) continued...	11) While the premiums tax credit recipients pay would vary based on age, income, and choice of health plan, the actual tax credit payments to the insurance plans would also be adjusted for other individual risk factors. a) To lessen the risks that health plans would face from enrolling tax credit beneficiaries on a guaranteed-issue basis, the state would subsidize reinsurance. This would cover a percentage of costs for the most expensive cases (e.g., above $100,000 per case). 12) To serve tax credit recipients, a private purchasing pool would have to meet reasonable state requirements. For example: a) The pool would need to offer the same plans (on a guaranteed-issue basis) to all tax credit beneficiaries. b) The pool would need mechanisms to educate enrollees about health plan choices and to prevent fraudulent marketing and enrollment by insurers. 13) To lessen the risk of adverse selection, and to ensure that tax credit beneficiaries do not wait to enroll until they get sick, tax credits would be available for use only within defined time periods. Potentially eligible individuals would be notified that they may qualify for tax credits. If they did not attempt to enroll within 60 days of receiving such notice, they would be ineligible for credits until the next open enrollment period.
Automatic enrollment	14) Children whose parents or guardians could not show proof of coverage would be enrolled automatically into HUSKY at birth, when school begins each year, or when they receive medical care. a) Parents would be charged full premiums, unless they applied for and received subsidies. As under current law, those would be available for families making up to 300 percent of FPL, or $60,000 a year for a family of four in 2006. i) Some parents with incomes too high for HUSKY subsidies may find the full cost of HUSKY for their children unaffordable. If such parents lacked access to dependent coverage through work, in most cases they could cover their children with non-group coverage that is less costly than HUSKY. ii) One variation on this approach would address possible fears that some families with incomes above 300 percent of FPL could not afford to cover their children. State policymakers could extend HUSKY subsidies above its current income ceiling for children. Alternatively, families could be excused from covering their children if they show such coverage is unaffordable, given their individual circumstances. b) When children receive unsubsidized HUSKY, the following would apply: i) Payment of regular, monthly premiums would be automated via regular payroll withholding, whenever possible. ii) If parents did not pay HUSKY premiums, their children would remain covered. Unpaid balances (plus a penalty, in appropriate cases) would be collected from the parents through state income tax surcharges or other mechanisms.

Automatic enrollment continued…	15) Adult enrollment would be facilitated as follows: a) When an adult obtained health care without showing proof of insurance, the adult would be asked to complete a form that would provide an opportunity to seek help paying for health care costs, including charges for that particular visit. The form would include a request to be contacted by a health consumer assistance program. It would also include a waiver of confidentiality of information in the hands of state or federal agencies that could indicate possible eligibility for HUSKY or tax credits. b) Funds would be available for consumer assistance programs to conduct telephone follow-up for adults who request coverage and who might be eligible for HUSKY or tax credits. c) Adults who request coverage but who are not contacted by a consumer assistance program would be mailed application forms for HUSKY and tax credits. d) As variations on this approach, policymakers could increase the number of adults receiving coverage by adding one or both of the following policy mechanisms: i) Uninsured adults seeking health care could be enrolled by default into health coverage unless such adults affirmatively declined insurance. After receiving an opportunity to apply for subsidies, default enrollees would be charged full premiums unless they had incomes at or below 300 percent of FPL and qualified for assistance. ii) All state residents could be required to purchase health insurance, unless they were unable to afford coverage.
Financing	16) The state General Fund would be tapped to fund the HUSKY expansion and tax credits. 17) Federal matching funds would also be used, including Connecticut's currently unused allocations of federal DSH dollars.
Cost Control	18) HUSKY enrollees would be offered choices among health plans. For adults with income above a certain level (perhaps 100% of FPL), those who had several options and selected the more expensive plan would pay some of the extra premium cost. This would establish an incentive to choose less expensive plans. 19) Similarly, tax credit beneficiaries who choose a comprehensive plan other than the least expensive such coverage would pay the extra cost, creating an incentive for cost-conscious choice of plan. 20) Adults in HUSKY who have incomes above the FPL and who have access to employer coverage would be required to use employer coverage as their primary insurer. While this would lower costs to the state, it would increase costs to employers by increasing the number of workers who accept employer offers of coverage. To safeguard beneficiaries, HUSKY would furnish full wraparound coverage, including payment of employee premiums, out-of-pocket expenses, and supplemental benefits.

CONCLUSION

This paper analyzed three approaches to health reform in Connecticut:

- Placing all residents (other than Medicare beneficiaries) into a single health plan;
- Except where employers decide to continue offering insurance, covering non-elderly residents through a purchasing pool that offers diverse private insurance policies; and
- Requiring all parents to provide their children with health insurance, while expanding the state's current system for subsidizing low – and moderate-income adults.

These options share important common elements. Each would greatly expand health coverage and modestly improve the state's economy. To varying degrees, each would lower employers' overall health care costs, reduce health care spending per insured individual, and leave Connecticut residents with more income to spend for purposes other than buying health care. Each would also increase the state's receipt of available federal matching funds under Medicaid.

Of course, the three alternatives also differ in important ways. Key differences include:

- The percentage of state residents receiving coverage.
- Changes in the state's overall health spending.
- The integration of low-income residents into the same health care system that serves others.
- The role of employers and the state General Fund in providing new funding.
- Requirements for employers to contribute to health coverage.
- Households' ability to make choices about their health coverage.
- Reimbursement levels and administrative savings for providers.

This analysis is a sobering reminder that all reform options involve trade-offs. Even if "winners" greatly outnumber "losers" and gains far outweigh losses, some stakeholders are likely to experience financial setbacks, no matter which approach state policymakers take to reform. At the same time, this analysis is an encouraging demonstration that health coverage can be significantly expanded using policies that leave the state as a whole much better off in terms of the health of Connecticut residents and their financial well-being.

The need for health care reform is urgent. Fortunately, viable reform is possible. To achieve such reform will require state leaders with courage, wisdom, and persistence. Such traits will be essential to reaching consensus on policy changes that provide the people of Connecticut with the health coverage they need to lead healthy, productive lives.

Appendix A

A Review of State Coverage Expansion Strategies And Lessons for Connecticut

A report prepared for

The Universal Health Care Foundation of Connecticut

By:

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CONTENTS

Appendix A

A REVIEW OF STATE COVERAGE EXPANSION STRATEGIES AND LESSONS FOR CONNECTICUT

SUMMARY

As states are grappling with rising lack of health insurance and escalating health care costs, many are trying to expand coverage through incremental reforms. A few are considering or have passed more comprehensive or sweeping solutions. Reviewing their experiences – both positive and negative – reveals lessons for Connecticut as it explores options for change.

We examine two other New England states that have passed comprehensive health reform, which may be considered possible models for Connecticut:

- A multi-pronged strategy passed in Massachusetts and supported by the governor, legislative leaders, and many in the advocacy, business, and health industry communities; and
- Maine's multifaceted Dirigo Health Plan.

We then examine attempts to expand coverage through requirements on employers:

- Hawaii's long-standing employer mandate; and
- California's "play or pay" employer mandate and universal children's coverage program (both passed by their state legislatures but later rejected and vetoed, respectively).
- Besides the few states pursuing universal coverage, many states are exploring or implementing reforms that target specific uninsured populations, taking a more incremental approach. These efforts generally fall into two categories:
  - Expanding public coverage programs, particularly Medicaid and the State Children's Health Insurance Program (SCHIP) through:
    - Enhanced outreach and enrollment of already eligible individuals;
    - Raising income-related eligibility levels, often with cost-sharing requirements;
    - Opening eligibility to additional populations, frequently with limited benefits, such as adults without dependent children;
  - Building on employer-based coverage, through such strategies as:
    - Premium assistance toward existing employer plans;
    - State-funded reinsurance of private insurance;
    - Direct subsidization of a new public-private plan;
    - Allowing employers to buy into state-negotiated health plans;
    - Relaxing certain insurance rules – e.g., allowing more limited benefit packages, or permitting a dependent-only option for small businesses.

Cost control is integral to serious coverage expansion efforts. State attempts to contain health expenditures in recent years generally have involved reducing the growth of Medicaid spending by cutting provider payments, eligibility, and/or benefits for certain populations; or imposing or increasing cost-sharing by beneficiaries. Yet some states are making efforts to contain costs while *improving* quality, access, efficiency and/or outcomes, through such strategies as care and disease management, a uniform public/private purchasing strategy, multi-state pharmaceutical purchasing, and administrative streamlining.

Based on other states' experiences, following are some lessons for Connecticut as it considers strategies for moving toward universal health care:

- There is no perfect health reform solution; all state strategies involve tradeoffs, winners and losers, and "growing pains." State planners must be flexible and be willing to make adjustments along the way.
- It is critical to consider and be prepared to address potential unintended consequences, such as attempts to circumvent new rules (for example, employers converting full-time employees to part-time workers to avoid an insurance mandate).
- Built into any reform plan must be significant efforts to educate and garner support from state leaders, major stakeholders and the public. For example, invite them into the planning process at an early stage.
- Planners should explore potential legal challenges from ERISA or impediments from the federal government, and incorporate as many safeguards as possible into the reform legislation, regulations, and/or waivers.
- Assessing and educating the public about the true costs of uninsurance can mobilize public and political will for reform; foundations and advocacy groups can play a major role in this area.
- Developing a critical mass of support for further reform may result in multiple reform proposals on the table, underscoring the need for dialogue and compromise among stakeholders.

INTRODUCTION AND STATEMENT OF PURPOSE

Through a grant from the Universal Health Care Foundation of Connecticut, the Economic and Social Research Institute is conducting a comprehensive study to develop workable proposals to cover Connecticut's uninsured. This project's objective is to inform the state's leaders about possible policy options to provide affordable health coverage for all residents, estimating the number of people that would be newly insured under each reform, the total resulting cost, and the distribution of costs. To help inform and provide context for this work, we have prepared this briefing paper that reviews other state approaches to expanding health coverage, and presents some important lessons from these experiences for Connecticut. **Particularly at a time when comprehensive *national* health system reform is not on the horizon, and many states are under severe pressure to *contain* or *cut back* their public health programs, it is critical to acknowledge and assess the options some states are pursuing to battle the interrelated crises of rising uninsurance and skyrocketing health costs. Although there is no perfect solution, and all state reform strategies involve trade-offs and "growing pains," policymakers are realizing that the long-term costs of *neglecting* to act are far too great. The best and most feasible strategy for each state depends on its specific economic conditions, culture, politics, and other circumstances. But much can be learned from the experiences – both positive and negative – of other states that are leading the way.**

This report begins with descriptions of more "sweeping" reform approaches by two other New England states, Massachusetts and Maine. These states were selected both because they are among the very few that have implemented or are seriously considering comprehensive approaches to universal coverage, and because, as New England states, they share many of the pressures and opportunities that Connecticut faces.[35] This similarity also suggests that Connecticut could "join forces" with some of its innovative regional neighbors.

[35] Since the initial preparation of this report (Appendix A), Vermont has also passed legislation that will significantly expand coverage. The reforms in other neighboring states of Rhode Island and New Hampshire are informative, though more incremental in nature. Given the scope and timing of this project and its special focus on comprehensive reforms, we do not provide detailed descriptions of these states' initiatives.

We then profile Hawaii and California because of their success and near-success, respectively, with implementing expanded coverage by requiring employers to provide coverage for their workers.

The report then summarizes more common, incremental approaches to coverage expansion by numerous states. Given the dynamic nature of state policy, we must acknowledge that the examples cited are "point in time" descriptions and that proposals and movements quickly change in both detail and direction. But the efforts described illustrate the wide range of options being pursued. While each option has strengths and weaknesses, and cannot by itself achieve universal coverage, these approaches could be considered potential building blocks in a more comprehensive strategy.

Reviewing state experiences over many years reveals that successful reform requires leadership; a clearly defined mission; reliable facts about the current health care system, its strengths, and deficiencies; dialogue, input and buy-in among stakeholders (for example, many coverage expansions begin with advocacy groups, but then the banner is taken by a governor or other "champions"); creativity; and flexibility to learn from mistakes and make mid-course corrections.

Further, state reform often requires that planners pursue parallel tracks: legislative, regulatory, and administrative changes at the state level; and federal government approval or support. For example, state coverage expansions that use Medicaid funding often require "1115 waivers" or "HIFA waivers." [36] Waiver requests generally involve extensive negotiations between the state and the Centers for Medicare and Medicaid Services (CMS). Waivers give states flexibility to modify the way they deliver services and provide coverage to low-income individuals in ways not generally permitted under federal statutes – while retaining federal Medicaid contributions. Coverage expansions through this mechanism are limited, however, due to a requirement that the changes must be budget neutral for the federal government. [37] More recently, states (including Connecticut's neighboring state of Vermont [38]) have been working with the federal government to get greater flexibility in covering low-income residents in exchange for a cap on federal Medicaid contributions. These arrangements, however, may result in coverage restrictions rather than expansions due to capped resources over the long term.

Because serious health care reform must address escalating health costs in addition to coverage issues, we briefly review some cost containment efforts by states (while acknowledging that other reports devoted to cost containment provide a more extensive discussion). We present examples of state strategies for containing costs while improving quality, access and/or health outcomes.

Besides illuminating creative strategies and important lessons for other states, state-level coverage initiatives provide potential models for *national* reform in the long term. This could involve the entire nation adopting one successful model, or the federal government supporting multiple approaches adopted and administered at the state level. Even in the short term, the federal government could actively promote state experimentation and leadership in coverage expansions through financial, regulatory, and political support.

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[36] Section 1115 of the Social Security Act permits the Secretary of the Department of Health and Human Services (DHHS) to waive certain portions of the federal Medicaid Act, if the demonstration project is budget neutral to the federal government. The waivers are generally granted for five year period, and can permit changes in eligibility, benefits, and payment mechanisms. The Health Insurance Flexibility and Accountability (HIFA) initiative was established by the Bush administration as an additional waiver mechanism to grant states greater flexibility in their Medicaid programs to expand or alter coverage for low-income individuals using existing resources.

[37] For more information about the waiver process, see: Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/medicaid/1115/default.asp), and *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Artiga & Mann, Kaiser Commission on Medicaid and the Uninsured, Policy Brief March 2005, http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf).

[38] Vermont recently made an agreement with the federal government to cap federal Medicaid contributions in exchange for flexibility to administer Medicaid through a state-wide managed care organization.

EXAMPLES OF STATE EFFORTS TO APPROACH UNIVERSAL COVERAGE

MASSACHUSETTS

In April 2006, the Massachusetts legislature overwhelmingly passed, and the governor signed, a bill containing mechanisms for nearly all of its residents to obtain health coverage. [39] This was the result of months of wrangling among the House, Senate, governor, and various stakeholders. The key features of the plan, based on principles that span the political spectrum, include the following:

- A requirement that all state residents obtain health coverage by July 1, 2007; individuals who can afford insurance but do not purchase it by that date will be penalized on their state income taxes;
- A new "Commonwealth Health Insurance Connector" that will certify and offer insurance products of high value and good quality, connect individuals and small businesses with health insurance products, and allow for portability of coverage from one job to another;
- The Commonwealth Care Health Insurance Program, providing public subsidies to families with income up to 300 percent of the FPL toward the purchase of private insurance plans through the Connector;
- Expansion of Medicaid coverage for children with family income from 200 percent to 300 percent of the FPL;
- An increase in Medicaid reimbursement to providers, with rates tied to specific performance goals;
- An assessment of up to $295 per worker per year on companies with 10 or more employees and which do not provide coverage, with the money helping to pay the costs of the uninsured;
- A Free Rider surcharge imposed on employers who do not provide health insurance, when an employee uses free care more than three times, or whose employees receive free care more than five times in a year; the surcharge will range from 10% to 100% of the state's costs of services provided to the employees, with the first $50,000 per employer exempted;
- Ability of individuals to buy insurance with pretax dollars;
- Incentives to insurance companies to offer low-cost 'basic' insurance plans to individuals aged 19 to 26;
- Insurance market reforms including the merging of the non-group and small-group markets, expected to reduce premiums by nearly 25 percent;
- A restoration of all MassHealth benefits that were cut in 2002, including dental and vision services; and coverage of legal immigrants;
- A phasing-out of the state's Uncompensated Care Pool by October 1, 2007, replacing it with the Health Safety Net Fund, run by a new division within Massachusetts' Medicaid office.

[39] Governor Romney line-item vetoed eight sections of the bill, including the employer assessment, the restoration of dental, vision, and other benefits in Medicaid, and coverage of legal immigrants; the Legislature overrode the vetoes in late April, however.

Legislators expect the plan to cover 515,000 uninsured people – about 95 percent of the uninsured – within three years. The program is estimated to cost $1.2 billion over that period, with only $125 million in new state money. Most of the financing will come from federal funds through the renewal of the state's 1115 (a) MassHealth demonstration waiver (including a shift from supporting individual hospitals to funding health insurance coverage for uninsured individuals), and existing state health funds. Legislators expect that no new state money will be required after the three years. The bill was developed with input from multiple stakeholders, and appears to have the support of many representatives of the business community, health care industry, and consumer advocates.

It is noteworthy that the final bill contains elements that were introduced in various plans over the past year or two. The chart below illustrates the various components of health reform plans proposed by Governor Romney, the state Senate, the House, Health Care for All (a coalition of advocates for universal coverage), and the Blue Cross Blue Shield of Massachusetts Foundation in conjunction with the Urban Institute ("Roadmap" proposal).

FIGURE 1: COMPARISON OF HEALTH REFORM PROPOSALS IN MASSACHUSETTS, 2005

	Romney	House	Senate	Health Care for All	Roadmap (w/ Options)
Medicaid Coverage Expansion		✓	✓	✓	✓
Subsidies for Private Coverage	✓	✓	✓	✓	✓
Reinsurance for High Cost Claims			✓	✓	✓
Non-group & Small Group Market Reform	✓	✓	✓	✓	✓
Group Purchasing Vehicle	✓	✓			✓
Surcharge on Employers/employees for Free Care Pool Use		✓*	✓		
Employer and/or Individual Mandates	✓	✓		✓	✓

* Employer contributions would fund Commonwealth Care Fund, which would help finance subsidies for purchase of private health insurance; contributions would be offset by a credit for employee health expenses.
Note: The Romney, Senate and House descriptions are based on revisions as of Fall 2005; the Health Care for All and Roadmap descriptions are based on Spring 2005 versions.
Sources: BCBS of Massachusetts Foundation, Roadmap to Coverage presentation, 12th Annual Princeton Conference, May 19, 2005; An Act to Increase the Availability and Affordability of Private Health Insurance to the Residents of the Commonwealth (H4279, 2005), and An Act Promoting Access To Healthcare
(Redraft of H.2777, October 31, 2005), The Commonwealth of Massachusetts, 2005, and personal communications.

Considerations for Connecticut: The final set of reforms passed and now being implemented in Massachusetts did not come easily, but rather resulted from long and difficult debate and compromise. Importantly, there was agreement across political lines that comprehensive reform was needed. This sentiment appears to be driven by a public that values health care, a strong existing coverage base, supplemented by a state-wide pool for uncompensated care, growth in the number of uninsured, and the acknowledgement that the state is already paying a substantial sum for the uninsured. The widespread concern resulted in multiple comprehensive reform proposals on the table. To move forward, the parties had to acknowledge that there is no one "right way" to fix the problem, and that to be successful they needed compromise and bipartisan agreement.

Like its northern neighbor, Connecticut has traditionally been relatively generous in providing public coverage to its low-income residents, though many remain under – or uninsured. By estimating the current costs to state taxpayers, employers, and other stakeholders of having a significant number of people without adequate health coverage, and by educating the public about these "hidden costs," Connecticut may be able to build comparable support for reform. Also, early interest in the Blue Cross Blue Shield of Massachusetts Foundation's "Roadmap for Coverage" indicates the ability of a foundation to play an important role in documenting the problem (through timely research on the number of uninsured, the costs borne by the state and the private sector, and the state's economy), identifying options and tradeoffs for expanding coverage, and developing a plan for moving toward universal coverage.

MAINE

In 2003, Maine passed the Dirigo Health Plan, a multi-faceted set of reforms designed to move toward universal coverage over a period of five years through a public/private partnership. The Maine plan combines expansion of MaineCare (Medicaid) with a new DirigoChoice insurance plan for small firms, the self-employed and other individuals. Maine's plan also develops a series of measures to improve quality of care and contain costs. The state hoped to provide coverage to over 189,500 uninsured and underinsured individuals over the first five years of operation. There have been some difficulties and "growing pains," but program officials assert that Dirigo will adapt and move forward.

Key components of the Dirigo Health Plan are the following:

- Public program expansion: Authority granted under a Health Insurance Flexibility and Accountability Act (HIFA) waiver [40] permits the state to expand MaineCare to adults without dependent children, whose incomes are up to 125% of the FPL [41] , and to expand MaineCare eligibility for families earning from 150% of the FPL to 200%. (Note: Due to budget constraints, the state has kept eligibility for adults without dependent children at 100% of the FPL, and limited some benefits for this group in order to stay within the allowed federal cap.)
- DirigoChoice: Maine's health plan designed to help small businesses and uninsured individuals obtain affordable, quality health coverage, DirigoChoice is a collaborative between Maine's Dirigo Health Agency and Anthem Blue Cross Blue Shield of Maine. Coverage for small businesses and the self-employed took effect January 1, 2005 and benefits for individuals without access to job-based coverage began April 1, 2005. DirigoChoice [42] offers comprehensive benefits with full coverage for preventive care services. Enrollees with family income up to 300% of the FPL ($28,000 a year for an individual and $56,000 a year for a family of four) receive discounts (up to 100%) on premiums and deductibles, based on a sliding scale. Larger businesses may join the Dirigo system at a later phase.
- Cost containment: Cost containment depends primarily on voluntarily limits on revenues and prices by hospitals, providers, and insurers, as well as some limits on Certificate of Need-related projects.
- Quality improvement: The program establishes the Maine Quality Forum as a watchdog group to promote evidence-based medicine, best practices, and electronic technology (e.g. moving toward electronic medical records for patients). It has launched the Safety Star Recognition Program that will award a "Safety Star" to hospitals meeting or exceeding thresholds established for 28 specified safe practices.

The state has also allowed for more stringent cost containment measures, including a capital expenditures budget and premium regulation, if voluntary measures are not adequate. Financing comes from individuals and businesses who volunteer to join DirigoChoice, newly available federal matching funds, an assessment (up to 4% of premiums) on insurers beginning in year two (to capture savings from reductions in uncompensated care), and an initial infusion of $53 million in state funds during the first year of enrollment. The state planned to make this program "budget neutral" after this start-up outlay.

DirigoChoice had approximately 8,500 members in October 1, 2005. Membership included 711 small businesses (50 or

[40] Maine's HIFA waiver proposal to use unspent Disproportionate Share Hospital (DSH) funds to help finance Medicaid coverage for low-income adults without dependent children with income up to 125 % of the FPL was approved by the Centers for Medicare and Medicaid Services (CMS) in September 2002. Approval may have been facilitated by the fact that the proposal was uncomplicated, and it was submitted soon after the release of the HIFA initiative, when CMS may have been especially motivated to approve waivers. For more detail about Maine's Medicaid expansion, see Childless Adult Coverage in Maine (Alteras & Silow-Carroll, , Economic and Social Research Institute, August 2004, http://72.14.207.104/search?q=cache:7q30GoPieKAJ:www.kff.org/medicaid/loader.cfm%3Furl%3D/commonspot/security/getfile.cfm%26PageID%3D46180+maine+childless+adults&hl=en).

[41] A previous Medicaid expansion granted eligibility to childless adults with incomes up to 100 % of the FPL.

[42] DirigoChoice did not require federal approval; the section 1115 waiver (extending MaineCare coverage to childless adults, etc.) applies to all individuals eligible for MaineCare, regardless of whether they enroll in MaineCare through DirigoChoice. DirigoChoice members who are eligible for MaineCare receive wraparound services for MaineCare benefits not included in the DirigoChoice package.

fewer employees), over 1,300 sole proprietors and approximately 1200 individuals. [43] About 80% had household income under 300% of the FPL and received discounts. [44]

The program is experiencing some growing pains. For example, enrollment expectations for the "working poor" have proven overly optimistic. Since employer contributions for such individuals (who are eligible for MaineCare) draw federal matching dollars, under representation of this group means that federal contributions are lower than anticipated. Meanwhile, the plan caps the number of 'individual' members in DirigoChoice to 4,400, due to concerns about adverse selection – i.e., that high-risk individuals would disproportionately enroll in the subsidized program. The cap was reached in June 2005, much earlier than expected.

A 2005 independent ruling by the state's Superintendent of Insurance estimated that the Dirigo Health reforms such as voluntary spending caps by hospitals and limits on hospital expansion have resulted in nearly $44 million in savings over the past year. [45] Although this is significantly less than earlier estimates by the governor's administration, the savings will allow the program to continue. The state's health insurance companies will be assessed an amount (expected to be close to the $44 million) under the premise that the savings should have trickled down to insurers. These "Savings Offset Payments" will help fund the premium discounts and quality initiatives.

Since Dirigo Health was passed, legislators and administrators have made a number of changes to address new concerns and circumstances. Plan officials emphasize that adjustments will continue in the future. For example, there will be greater legislative oversight. Also, the membership cap is being lifted, allowing people on the waiting list and other individuals and sole proprietors to sign up for coverage in 2006.

Considerations for Connecticut: Maine illustrates that it is possible to use a "building blocks" approach that maintains and adds to existing systems (Medicaid and the employer-based insurance system) to move toward universal coverage. As with other models, the reforms must be phased in; for example, in the first year, Maine expected to cover about 31,000 people of the 140,000 individuals in the state who are uninsured. It is not clear, however, whether the mixture of strategies will allow the state to reach its long-term "universal" coverage goals. The reasons include the fact that participation in DirigoChoice is voluntary, and even subsidized coverage may seem unaffordable to some workers and employers. In fact, the under-representation of businesses and "working poor" in the plan's early experience indicates that the goals may not be reached.

It will be important to monitor whether the planned assessment on insurers in Maine will be adequate, and whether that cost will just be passed on to consumers in the form of higher premiums – exacerbating rather than reducing the cost shift to those privately insured. It will also be important to assess whether the voluntary limits on provider charges will sufficiently contain future costs. Maine has sensibly prepared a "back up" plan by allowing a newly established forum to institute stronger cost control measures if necessary.

Overall, the Dirigo plan has generated less political opposition than either an employer mandate or a single payer system requiring a large tax increase or stronger, immediate cost controls. Connecticut may have taken a step in this direction by strengthening the MEHIP buy-in. [46] By allowing small firms to purchase coverage through the state employee sys-

[43] Personal communications with Adam Thompson, Maine Governor's Office of Health Policy and Finance, November 4, 2005.
[44] Maine Governor's Office of Health Policy and Finance.
[45] News release, October 29, 2005, Maine Office of State Policy and Finance, http://www.me.gov/governor/baldacci/healthpolicy/news/10_29_05.htm
[46] The Municipal Employees Health Insurance Program (MEHIP), sponsored by the office of Connecticut's State Comptroller, was created to make affordable managed health insurance coverage available to all municipal employers in Connecticut. It has been extended to Community Action Agencies, fire districts, transit districts, and not-for-profit organizations, and small businesses (firms with 50 or fewer employees). Participation allows each employee to select from the state-negotiated health plans. In 2004 the state passed a bill allowing MEHIP to pass on administrative savings to participating small firms. In 2005, additional legislation allows pooling and other changes expected to save small businesses about 15% on average on health insurance costs. See http://www.mehip.org/snoDefault.aspx.

tem, and making recent changes to make that coverage more affordable, Connecticut is improving access using existing structures and programs. There is potential to build on this strategy by providing subsidies to low-income workers, as Maine does. Yet Maine's experiences so far underscore that significant changes to the health care system will invariably hit some "snags" (described above), and that flexibility and creativity is critical to address new problems.

Additional lessons from Maine's experience were delineated by one of Dirigo's principal architects, Trish Riley, director of the Governor's Office of Health Policy and Finance, in a profile by State Coverage Initiatives: [47]

- Political will is an essential element of success–health reform is hard work and it requires vigorous and persistent political leadership.
- Even compromises like Dirigo Health do not fully bridge the ideological divide–advocacy for high-risk pools, AHPs, HSAs, and a roll back on insurance mandates continues.
- Employer skepticism is real–the product must be sustainable.
- Do not underestimate the level of risk aversion in private insurance.
- Support from the public, press, advocates, and elected official is key to success.
- Everybody wants lower premiums–but not the tough choices that go with reducing health care cost growth.
- Sustained leadership is essential–keep an eye on and political will to the task.
- Providing comprehensive health care coverage is hard work and requires vigilance and the capacity to change and revise as needed.

HAWAII

Hawaii was the first state to enact an employer mandate in 1974 (Massachusetts and Washington enacted ones but never implemented them). The state required employers to offer their full-time workers health insurance through either indemnity plans or HMOs. In 1983, Congress granted Hawaii a waiver to exempt the state from ERISA [48] and locked in 1974 mandated benefits and cost-sharing levels. According to data from the Kaiser Family Foundation, 83% of the non-elderly in Hawaii living in households with at least one full-time worker had employer coverage in 2000-2001, compared to 74% for the United States as a whole. The corresponding rates for part-time workers were 46% and 35% while for non-workers, 32% had employer coverage (for example, through a spouse) in Hawaii, compared to 27% in the country.

Thus, while the employer mandate has put Hawaii well ahead of the U.S. average, a significant proportion of workers and their families remain uninsured. In part, this seems to stem from the fact that companies do not have to cover employees working less than 20 hours per week, and that the number of these jobs has grown (some would say in response to the law's flexibility for employers on this point).

Considerations for Connecticut: Hawaii provides the lesson for other states that an employer mandate may require overt federal authorization and participation because of ERISA considerations. It also shows the pitfalls of exempting firms from making pro rata contributions for part-time workers.

CALIFORNIA

In 2003, California enacted SB 2, which required medium-sized and large businesses to pay a fee into a public health

[47] State Coverage Initiatives, an initiative of the Robert Wood Johnson Foundation, *Profiles in Coverage: Maine Dirigo, 2005* (http://www.statecoverage.net/maineprofile2.htm).

[48] The federal Employee Retirement Income Security Act of 1974, (ERISA) contains federal standards and requirements intended to address fraud and mismanagement of private-sector employer pension and other benefit plans. Its "preemption clause" states that that ERISA supercedes all state laws that "relate to" employee benefit plans sponsored by private sector employers or unions; this has been interpreted to exempt private employer self-funded health plans from state rules and mandates.

coverage program ("pay"), or provide health insurance to their workers ("play"). The bill was repealed after a narrow rejection in a public referendum in 2004.

The Health Insurance Act of 2003, or SB 2, and a companion bill AB 1528, included the following provisions:

- Employers would pay 80% of the fee and employees would pay 20%.
- In an attempt to insulate small firms from sudden, new financial burdens that may threaten their viability, the law exempted companies with fewer than 20 workers.
- For firms with 20 to 49 workers, the required fee or proof of coverage would not take effect unless the legislature first enacted a tax credit for those firms equal to 20% of the employer's net cost for the fee.
- Companies with 50 to 199 workers would have been required to "pay or play" only for their workers, not for their dependents. But these companies would also be subject to certain provisions of California insurance law, such as rate bands and guaranteed issue, previously affecting firms with fewer than 50 workers.
- Eligible employees were defined as those who have worked for an employer for three months and work at least 100 hours per month.
- A State Health Purchasing Fund would be created, administered by California's Managed Risk Medical Insurance Board (MRMIB). The latter organization already manages Healthy Families, California's version of the SCHIP program.
- Employers who decide to offer and fund health coverage would apply to the state's Employment Development Department for a credit against their fee.

SB 2 was highly controversial, with many vocal supporters and opponents. The consumer advocacy community, along with labor and the medical association, played a major role in promoting the plan. Changes were made to make the proposal more palatable to businesses before it was passed by the legislature and signed into law. But strong opposition by certain employer groups and others led to placing SB 2 on the ballot for a referendum vote. Even without that rejection by a narrow margin, the new law would have likely been subject to an ERISA legal challenge. [49]

Following SB 2, there was considerable interest in various comprehensive reform plans in California. A proposal for universal coverage for children, called "The California Healthy Kids Insurance Program," was also heavily promoted by the advocacy community, with much support by California foundations. This plan called for:

- Conversion of California's Medi-Cal program and the Healthy Families program (SCHIP) into one seamless, subsidized program for children with family income up to 300% of the FPL.
- Automatic enrollment of children if they are receiving assistance under any of several other programs such as Food Stamps, WIC, or the National School Lunch Program.
- Public/private partnerships at the local level all around the state to facilitate enrollment in the new program as well as to support employer-sponsored coverage for children.

The plan (in bills AB 772 and AB 1199) was passed by the state legislature, but vetoed by Governor Arnold Schwarzenegger in October 2005. But continued support for children's coverage, and success in expanding coverage at the county level,

[49] According to Patricia Butler, "Had the [SB 2] law survived the November 2004 referendum, it probably would have been challenged in court. Opponents might have argued that ERISA preempted the credit against the employer fee, both because SB 2 referred to ERISA plans and because conditioning the credit on covering certain health benefits and requiring employers to pay 80 % of the premium had a significant impact on plan structure and benefits" (Patricia Butler, *Insurance Markets – ERISA Implications for Employer Pay or Play Coverage Laws*, California HealthCare Foundation Issue Brief, March 2005, p. 3).

has brought the issue back to the table. In the May 2006 revised state budget, the governor proposed state financial support for outreach, enrollment, systems improvements and transitional premium support for local Children's Health Initiatives. And in November, California voters will determine the fate of a new tobacco tax. If approved, that funding would be available in 2007 for a statewide California Healthy Kids program.

Considerations for Connecticut: Passage of SB 2 and Healthy Kids Insurance by the state legislature illustrates the potential role that advocates and the foundation community can play in developing and garnering support for health reform.

Although neither bill was actually implemented, California's experience in developing bills that passed the legislature illustrates that compromise is essential. For example, SB 2 exempted small firms from the pay-or-play system, despite the fact that the feature would have reduced the potential impact on the uninsured. The law would have covered at most one of four uninsured people in California.

If any state embarks on a pay or play system, it needs to give very careful thought as how to avoid a successful ERISA challenge. In addition to using the term "fee" instead of tax, this tactic may involve giving ground on specifying key features of health insurance, such as the requirement that employers contribute at least a certain percentage of the cost of the premium. [50] Further, states may find that this type of program may actually generate some budgetary gains because the state would receive employer contributions for significant numbers of low-wage workers and their children who are now enrolled in Medicaid. The employer payments for these employees would often exceed the state's portion of the federal-state match.

The popularity of the California Healthy Kids Insurance Program proposal indicates that widespread support could be garnered for universal coverage of certain segments of the population. Children, more than other groups, are considered "deserving" and are an attractive target politically. If there is inadequate support for true universal coverage in Connecticut, advocates might consider beginning with a drive toward universal coverage for children, and building from there. The Governor's veto despite bipartisan support in the legislature is a reminder that all major leaders in the state must be brought into the process and their support ensured.

INCREMENTAL STATE COVERAGE EXPANSIONS

Most states are not planning the kinds of major reforms seen (or considered) in Massachusetts, Maine, Hawaii, or California. Budgetary and/or political barriers have led many states to focus on maintaining current coverage and access programs (and trying to avoid cut-backs), or planning incremental reforms to expand coverage. Most of the incremental reforms being explored or implemented involve either expanding public coverage or building on employer-sponsored health insurance.

EXPANDING PUBLIC COVERAGE

Many states have increased access to existing public coverage programs through enhanced outreach and enrollment of already-eligible individuals. And some states are expanding eligibility for Medicaid or SCHIP (using 1115 or HIFA waivers) by raising the income threshold and/or by adding new populations such as adults without dependent children (for example, Maine, Oregon, Pennsylvania, New York). One of the most generous and longstanding programs is in Washington State, which covers childless adults with incomes up to 200% of the FPL. Minnesota covers childless adults up to 175% of the FPL.

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[50] For full discussion, see Patricia Butler, *ERISA Implications for SB 2: Full Report*, March 2004, California HealthCare Foundation, www.chcf.org/topics/sb2/index.cfm.itemID=21470.

To control public expenditures during very difficult fiscal times, however, many state public coverage expansions have imposed enrollee premiums, caps on enrollment, and/or limited benefit packages for certain groups of enrollees. The reduced benefit packages vary across states, ranging from elimination of non-emergency transportation and limits on mental health visits, to a primary care-only benefit package in Utah's Primary Care Network. Proponents argue that some coverage is better than none, while consumer advocates are concerned that reduced benefits provide inadequate protection that may actually increase costs in the long run.

BUILDING ON EMPLOYER-BASED COVERAGE

In order to share the burden of coverage expansion, many states are pursuing ways to make private, employment-based health insurance more affordable to lower-income workers. Strategies include:

- **Premium assistance toward existing employer plans –** States subsidize private premiums for people eligible for Medicaid, SCHIP, or new populations; mechanisms include Health Insurance Premium Payment program (for example, Pennsylvania, Iowa), 1115 or HIFA waivers [51] (for example, Rhode Island, Maine), three-share models [52] (Michigan, Illinois). Also, states are making federal health care tax credits available to those who are eligible according to the federal Trade Act of 2002. Take up has been very slow, however [53];
- **Reinsurance [54]** – Through this indirect public subsidy, states pay insurance claims in an otherwise "private" health plan that exceed a certain amount or fall within a designated corridor (for example, annual claims for a given individual that fall between two, specific dollar amounts), thereby protecting the private insurer and helping to keep premiums lower (New York, Arizona);
- **Direct subsidization of new public-private plan –** States work with private insurers to develop a new health plan that targets small firms, low-income workers, or other vulnerable groups, and the state provides direct subsidies tied to income and family size (for example, Maine's DirigoChoice described above);
- **State-negotiated health plan –** States use their purchasing power from their state employee plan and other state programs to negotiate with insurers on behalf of small businesses (West Virginia, Connecticut);
- **Relaxation of certain coverage rules –** This may include waiving state-mandated benefits to permit a 'basic' or 'bare bones' insurance packages (e.g., excluding or strictly limiting mental health or prescription drug coverage) while establishing minimum standards. As noted above, there is a tradeoff between affordability and adequate protection. Another model involves allowing a dependent-only option for small businesses; Oregon's Children's Group Plan allows small business owners to provide comprehensive coverage for children of their workers even if they cannot afford to cover their employees.

Of course, numerous states combine strategies. For example, Connecticut's neighboring state of Rhode Island maintains a low uninsurance rate through generous Medicaid and SCHIP coverage: RIte Care covers families with income up to 250% of the FPL, with those above 150% of FPL contributing a monthly premium; and its RIte Share program provides premium assistance for RIte Care-eligible persons who have access to employer-based health insurance.

[51] See footnotes 34 and 35.

[52] Under a "three-share" model, health coverage premiums are shared among the employer, worker, and an outside funding source. Three-share coverage programs were developed at the community level (e.g., see http://www.ebri.org/pdf/briefspdf/0605ib.pdf for description of Access Health three-share program) but some states are considering this model on a state-wide basis.

[53] The Tax Credits created through the Trade Act of 2002 pay 65 % of the cost of health insurance premiums for a small group (approximately 200,000-300,000) of displaced workers and early retirees, and their dependents. For more information see http://www.cmwf.org/publications/publications_show.htm?doc_id=311250&#doc311250 and http://www.cmwf.org/usr_doc/dorn_tradeact_ib_721.pdf.

[54] Reinsurance is insurance bought by insurance carriers to limit their exposure to financial risk. It can take the form of: 1) individual stop-loss insurance, which limits or caps an insurer's exposure for any covered individual over a certain period of time; or 2) aggregate stop-loss insurance, which limits an insurer's total risk exposure over a group of specific risks. In New York and Arizona, the state provides reinsurance to certain private health plans in an effort to keep premiums affordable for small businesses and uninsured persons.

Building on the employer-based health insurance system has much appeal. That approach targets the large number of working uninsured, and spreads the burden of premium costs across the state, federal government, employers, and employees. But there are also serious challenges.

To date, many such state efforts have had only limited success. Premium assistance programs and early experience with reinsurance (Healthy New York) have resulted in much lower enrollment than expected. [55] Obstacles have included: need for very large subsidies to make coverage truly affordable, lack of interest and formidable barriers to employer participation, administrative complexity and cost (for example, determining cost-effectiveness, obtaining information from individual employers, coordinating Medicaid wraparound benefits with private insurance, coordinating with private health plans' narrow open enrollment periods), and the need for significant marketing efforts including working with insurance brokers. Rather than abandoning these politically popular approaches, however, states are exploring variations of past efforts to address and minimize the obstacles.

COST CONTROL EFFORTS

Nearly all stakeholders have realized that cost control is integral to serious coverage expansion efforts. Skyrocketing health costs have led to erosion of employer-sponsored health insurance and to states cutting existing public coverage programs or struggling to maintain current levels. Clearly, any efforts to *expand* public or private coverage require strategies for containing or slowing expenditure growth. It is beyond the scope of this report to present a full discussion of state cost-control options, but we mention a few key options below. [56]

States are hindered from imposing global health budgets or strong statewide cost controls by an existing "hodgepodge" of public and private provider and payer systems (which also significantly raises administrative costs), political pressures, and ERISA rules that limit state control over private businesses' self-funded health plans. [57] And not since the 1980s have some states tried to contain costs statewide through "all-payer" rate setting systems (MA, NY, NJ, MD). [58] Use of all-payer rates to control hospital costs met with strong opposition from certain stakeholders, and this mechanism was eventually abandoned.

[55] Private insurance reform is another mechanism states have used to encourage private coverage, also with mixed results.

[56] Other readings on state-level cost containment efforts include: State Health Care Cost Containment Ideas (National Conference of State Legislatures, July 2003 http://www.ncsl.org/programs/health/healthcostsrpt.htm); Rising Health Care Costs: State Cost Containment Approaches (Schneiter, et. al. National Academy for State Health Policy, June 2002, http://www.nashp.org/Files/GNL46.pdf); Stretching State Health Care Dollars During Difficult Economic Times (Silow-Carroll & Alteras, Commonwealth Fund, October 2004, http://www.cmwf.org/publications/publications_show.htm?doc_id=243623).

[57] See footnote 47 for description of ERISA.

[58] Under all-payer systems, multiple private and public payers pay the same rates for specified hospital services, rather than individual payers negotiating with hospitals, setting payment rates, or accepting billed charges.

The introduction and growth of managed care in the 1990s offered promise of cost containment, and costs did moderate temporarily, but then returned to high growth patterns. The backlash against managed care has further dampened the more effective cost control strategies under tighter managed care arrangements. A new movement toward high-deductible or catastrophic insurance plans combined with "health spending accounts" is viewed as a way for employers to reduce their health benefit burden, though many consumer advocates and others have strong concerns about this model. [59]

States do have more responsibility, and therefore more control, over spending for Medicaid and SCHIP than for private health expenditures. The economic downturn in the early 2000s brought the troubling mix of reduced state revenues, growth in Medicaid enrollment, and continued escalation of health care costs. As noted in a previous section, many states have had to reduce Medicaid spending growth by cutting reimbursement to providers, tightening eligibility, and/or cutting benefits for optional populations; or imposing or increasing cost-sharing by beneficiaries. The Deficit Reduction Act of 2005 gives states greater flexibility to impose premiums and cost-sharing and to change benefit design for certain Medicaid beneficiaries.

The risks (and documented outcomes, in many cases) of these actions, however, are reduced access to health care for vulnerable populations. Further, cutting back in some areas (e.g., Medicaid eligibility) tends to lead to cost shifting – greater costs in other areas (e.g., uncompensated care costs passed on to private payers).

Some states have been trying to contain costs while *improving* efficiency, quality, access and/or outcomes. That is, they have tried to stretch their limited health care dollars – and thereby help to protect or expand coverage levels – through changes in the way they deliver, administer, or purchase care. Examples include the following:

- **Care and disease management –** Some states (e.g., Colorado, North Carolina, Washington, Kentucky) are trying to reduce costs while improving health outcomes through targeted care/case management and disease management for Medicaid or high-risk pool populations. These efforts are generally showing modest savings, with the main benefit being improved quality and access to services; the programs are expected to result in improved health outcomes over time.
- **Uniform purchasing strategy –** Minnesota has joined with private business and labor groups in a "Smart-Buy Alliance" to drive quality improvements and efficiencies in the health care delivery system. While Alliance members continue to purchase health care individually, they have agreed to set uniform performance standards, cost/quality reporting requirements, and technology demands on health plans and providers and to favor providers and health plans that are certified for highest quality. [60]

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[59] For more information on this topic, see: Sally Trude and Leslie Jackson Conwell. Rhetoric vs. Reality: Employer Views on Consumer-Driven Health Care, Center for the Study of Health System Change, Issue Brief No. 86, July 2004, http://hschange.org/CONTENT/692/#ib4; High Deductible Health Plans and Health Savings Accounts: For Better or Worse? Presentation by Karen Davis, President, The Commonwealth Fund, at the National Academy of Social Insurance, January 27, 2005; and Christianson, Jon, Stephen T. Parente and Ruth Taylor. "Defined Contribution Health Insurance Products: Development and Prospects," Health Affairs 21(1), January/February 2002.

[60] For more information see: Silow-Carroll & Alteras, *States in Action: A Quarterly Look at Innovations in Health Policy*, The Commonwealth Fund, Spring 2005, http://www.cmwf.org/publications/publications_show.htm?doc_id=276919#featured

- **Multi-state pharmaceutical purchasing –** By joining together, some states hope to enhance their negotiation power to obtain better deals on prescription drugs. A group of "Rx Issuing States" (West Virginia, Missouri, New Mexico, Delaware, and Ohio) contract with a single pharmacy-benefits management firm to negotiate and purchase pharmaceuticals for certain groups and agencies within the states. Also, a number of states (Illinois, Wisconsin, Missouri, Kansas, and Vermont) have joined together, through the I-SaveRx program, to allow residents, regardless of income, to purchase lower-cost pharmaceuticals from more than 60 approved pharmacies and prescription drug wholesalers in Canada, the United Kingdom, and Ireland. [61]
- **Administrative efficiencies:** In 1999, Georgia consolidated its major health care purchasing and regulatory entities under one umbrella, the Department of Community Health. This was intended to streamline state administered health plans, as well as enhance program effectiveness and increase access to care. In Connecticut, the Municipal Employee Health Insurance Program, which administers health insurance to municipal workers, has been extended to make state-negotiated health plans available to additional groups including not-for-profit organizations and small businesses. Administrative efficiencies from using an existing marketing and billing structure, and forgoing expensive advertising, may be passed on to small businesses in the form of lower premiums. [62]

[61] For more information on pooled and evidence-based pharmaceutical purchasing, see http://www.cmwf.org/usr_doc/782_Silow-Carroll_stretching_pooledRx.pdf
[62] For more information about MEHIP, see http://www.mehip.org/snoCsgWelc.aspx.

CONCLUSION

Despite an upturn in the economy, states are still concerned about rising numbers of uninsured and underinsured residents, escalating health care costs, and the prospect of reduced federal contributions toward Medicaid. They are experimenting with a wide range of reform strategies to address these crises. Policymakers have learned that there is no "magic pill," and each approach entails tradeoffs. Incremental reforms that try to make the system more efficient while leaving the basic system essentially intact are worthwhile, but limited in their long-run impact on coverage and costs.

Yet sweeping health care reforms entail trade-offs as well. There is greater potential to move closer to universal coverage and to gain control over escalating health costs. But such reforms face major challenges such as: opposition to significant tax hikes necessary to finance new coverage; strong lobbying by powerful stakeholders who fear that they would be negatively affected; the risk of attracting chronically ill and high-risk people from other states; the need to persuade the federal government to continue to finance care for Medicare and Medicaid populations; and legal barriers posed by ERISA's prohibition on state regulation of employer benefit plans.

As described in this report, there are a few states trying to forge paths toward more comprehensive health reform. Despite the challenges mentioned above, policymakers are realizing the true costs of the current system – in terms of direct and indirect costs of treating the uninsured and underinsured, cost-shifting to private payers, inefficiencies, lost productivity, and human suffering. These efforts generally involve a combination of strategies to target different groups of under – and uninsured, improve stability of coverage for those who have insurance, while trying to impose cost containment and quality improvement on the health care system.

APPENDIX B

To guide their development of health policy options, ESRI researchers interviewed the following Connecticut experts and stakeholders:

Ellen Andrews, Executive Director, Connecticut Health Policy Project

David Benfer, President, Hospital of St. Raphael

Jerry Brown, President, SEIU

Chris Bruhl, President & CEO, The Business Council of Fairfield County (SACIA)

Rose Ciarcia and Patricia O'Hagan, Department of Social Services

Spencer Cain and Neil Ayers, Office of Fiscal Analysis

Marilda Gandara, President, The Aetna Foundation

Alta Lash and Jack Mimnaugh, United Connecticut Action for Neighborhoods

Mary Alice Lee, Senior Policy Fellow, Connecticut Voices for Children, Lecturer at the Yale University School of Medicine, Department of Epidemiology and Public Health

Mark Masselli, Executive Director, Middletown Community Health Center

Roy Occhiogrosso, Principal, Global Strategies Group

David Parrella, Director, Medicaid Program

James Rawlings, President, NAACP (New Haven Chapter), Community Relations Manager, Yale-New Haven Hospital

Tom Swan, Executive Director, Connecticut Citizen Action Group

Fredericka Wolman, MD, MPH

Nancy Wyman, State Comptroller

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