Health Care in Connecticut:

Sounding The Alarm

A Policy Brief

"Three years ago, my husband's job was outsourced and he became unemployed. We had the option of continuing our coverage under COBRA, but we couldn't afford it. We lived that way for quite awhile, and after he became an independent consultant we attempted to buy insurance. Because of preexisting conditions, we couldn't get coverage as a family. I paid for coverage for my school-age sons through HUSKY, but my husband, myself and our daughter in college were all uninsured.

Now, my husband is a self-employed consultant, and we have managed to purchase insurance through his consulting placement service, but it is entirely self-pay. It costs us nearly $16,000 a year for our insurance. Our coverage just went up $795 a year in January, and we were sent a list of the many things the insurance company will no longer cover! We scramble monthly to come up with the insurance premium, and then we have to pay our co-pays for office visits and prescriptions on top of that.

Do you think we have a reason to be angry?"
Harwinton, CT

Problems of Catastrophic Proportions Call for Bold Changes

Unfortunately, the Harwinton family's story is all too familiar, echoing across the country and in our state. It reflects the frustration and fear of hundreds of thousands of Connecticut residents worried about health care. People are worried about losing their health care, they're worried about paying for it, and they're worried about keeping it if they lose or switch their jobs. Connecticut, one of the wealthiest states in the country, can and must do better.

Nothing less than the health and well-being of our families and communities and the future of our state's economy are at stake. In the wake of our nation's protracted failure to fix the health care system, Connecticut is joining other states seeking comprehensive statewide solutions.

This brief outlines three health care policies for Connecticut to consider as alternatives over its current helter-skelter system of health care and coverage. The implementation of each strategy would result in a range of benefits over the existing system. However, only one of the three strategies fully meets the criteria of universal health care established by the Institute of Medicine (IOM). The Institute of Medicine is an independent, nonpartisan panel of health care providers and researchers who advise the United States Congress on matters of health and health care. The Universal Health Care Foundation of Connecticut endorses the IOM principles.

The strategies in this brief are meant to serve as an impetus for an informed and vigorous discussion among residents, their elected officials, business and health care providers. Clearly, the state's existing health care system is failing to meet the needs of not only residents, but also an increasing number of businesses. The question is no longer whether reform is necessary, but what are the most viable alternatives.

To that end, this brief discusses desirable as well as undesirable features of alternative health care policies measured against IOM principles. The main purpose of presenting these three policy strategies is to help focus the public discourse on realistic approaches Connecticut can take to create a health care system that better serves the needs of all of its residents. The strategies broadly discussed here are discussed in detail in the full report by the Economic and Social Research Institute titled *Health Insurance Coverage in Connecticut: Three Routes to Reform.*

Connecticut: Spending and Worrying More but Getting Less

In 2005, Connecticut spent a staggering $15 billion on health care, two-thirds of which was used for nonelderly residents,[1] but we are not getting our money's worth. Some 355,000 residents continue to lack any health care coverage, and that number is growing. Eighty percent of Connecticut residents without insurance are employed, and 75,000 are under age 18. Like the rest of the country, Connecticut relies largely on employer-based health insurance.

Health insurance premiums for a Connecticut family are the sixth highest in the nation; premiums for an employee plus a dependent rank second, and premiums for an individual rank twelfth.

Average daily hospital costs in Connecticut are sixth highest in the nation, exceeding the national average by 23 percent.

Those most likely to be uninsured earn too much to qualify for public programs but too little to pay for health coverage on their own. By the time the uninsured seek care, they are more often seriously ill, and more costly to treat. In 2005, $572 million was spent directly on health care for uninsured residents. The indirect toll of Connecticut's current level of uninsurance costs residents between $652 million and $1.3 billion a year, based on findings of the Institute of Medicine.

Today, Connecticut employers and their employees are spending an average of 13.3 percent of their payrolls on health insurance benefits. Facing unbridled health insurance expenses, employers, especially small businesses, are caught in a moral and economic bind, forcing many to choose between the health of their employees and their bottom lines. Businesses, families and communities in Connecticut all want the same thing: quality health care that is affordable, accessible and sustainable.

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Focusing on Economic Solutions for the Right Reasons

A team of leading health policy analysts and economists have developed three policy approaches for major coverage expansion in Connecticut, and projected each of their likely results.[2] Each approach would:

- Cover most or all of the state's uninsured;
- Modestly improve the state's economy, adding several thousand Connecticut jobs; and
- Lower employers' overall health care costs.

The two bolder strategies would significantly reduce health insurance costs for firms that cover their workers. These approaches would also significantly lower health care costs per insured resident. As a result, Connecticut residents would realize up to a billion dollars in extra income newly available for purposes other than purchasing health care. Under each alternative, the state would clearly be much better off than under the status quo, taking into account both financial well-being and access to essential health care.

To assess the three approaches to expanding coverage, we employed the Institute of Medicine recommendation that health care coverage should be based on the following principles:

- Health care coverage should be universal – it should cover everyone.
- Health care coverage should be continuous, portable from job to job, and between employed and unemployed status.
- Health care coverage should be affordable, especially to low-income individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

The first two public policy strategies come closer to fulfilling the IOM's requirements. The last approach described in this brief, which is based on policy models currently being tried in several other states, clearly does not meet these criteria.

When significant policy change occurs, trade-offs are inevitable. The compromises involved with each policy alternative should spur the informed and rigorous debate Connecticut needs for problem solving, decision making and developing responsible health care policy.

First, I feel sorry for the Connecticut children not covered by health insurance. I am in between jobs, meaning I quit a job and am working on finalizing a new job. It might take months. In the meantime, I need alternative coverage. Most of the insurances are expensive. I cannot afford an expensive plan. I always had medical and dental coverage, and never had a gap in job before now.

My condition prompts me to think seriously about all those who do not have insurance, especially the children. People must come forward to do something.

New Haven

Policy I

One Health Plan Serving All State Residents

Impact on Consumers

With all state residents under 65 in a single health plan sponsored by the state government, Connecticut would achieve 100 percent coverage while reducing total health care costs. By directly purchasing services from health care providers, the plan would provide benefits like those offered by typical private employers today. A standard benefits package would be available to all and would include the services covered by a typical benefits plan offered by the Connecticut employer now.

A new state commission would administer the plan either directly or through a private insurer. The commission would control costs by defining covered benefits and out-of-pocket sharing rules, setting a statewide budget for health spending, negotiating reimbursement levels with providers and setting standards for quality of care. Individuals and employers could purchase additional health care services or coverage.

State residents with incomes below $28,635 for a family of three and children above that level who qualify for HUSKY (Healthcare for Uninsured Kids and Youth) would receive supplemental coverage of additional benefits and protection against cost-sharing.

Who Pays for It?

The state plan would be financed through the following sources:

- Employers would contribute an amount equal to 7.7 percent of payroll, and workers would contribute an amount equal to 2.5 percent of gross wages and salaries. 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.
- State General Fund dollars now spent to provide coverage (through Medicaid, HUSKY and SAGA) would fund the single state plan to the extent that it provides services formerly covered through these public programs.
- Federal matching funds under Medicaid and the State Children's Health Insurance Program (SCHIP, known as HUSKY in Connecticut) would increase by $840 million.

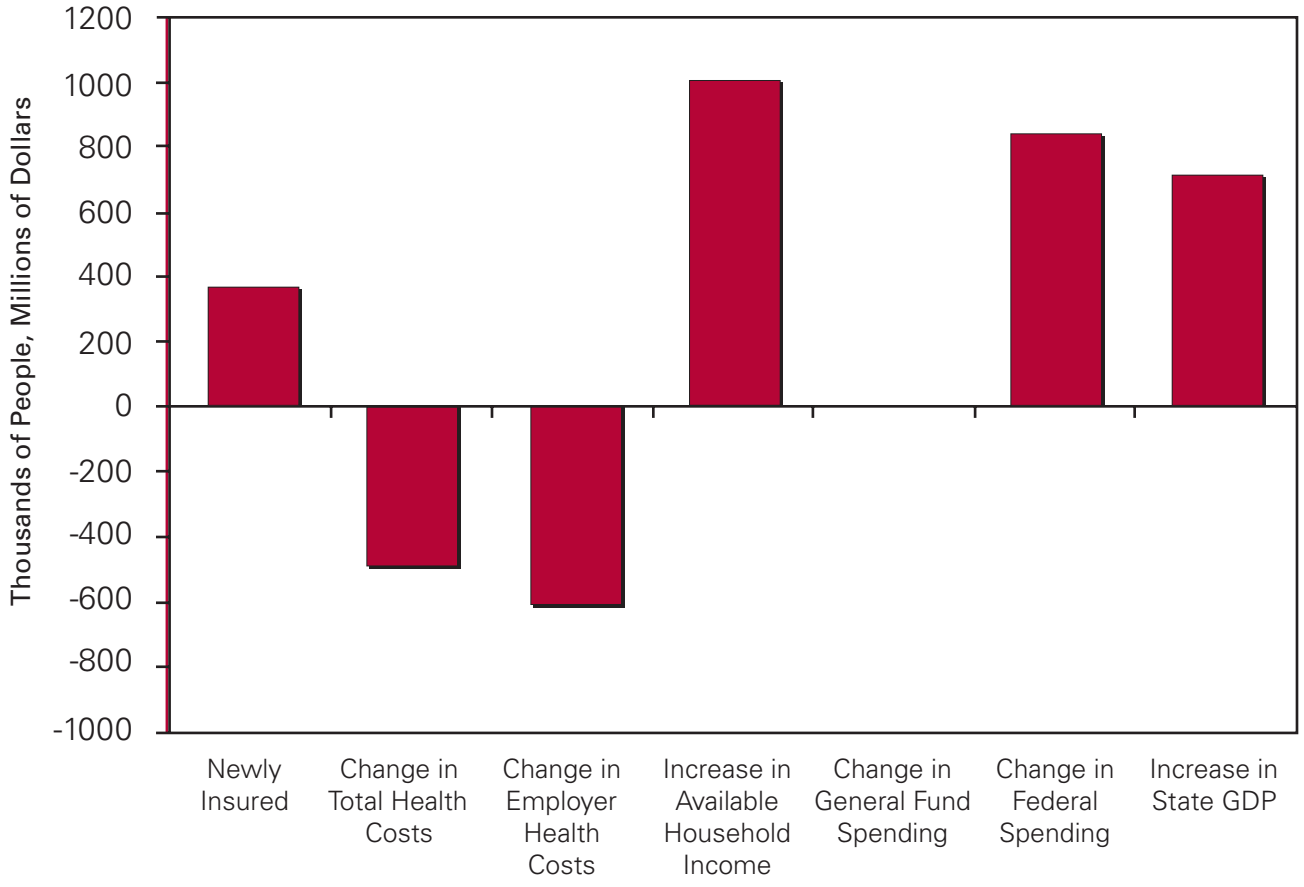

Figure 1. Impact of Single Health Plan

Figure 1 shows that while all residents would be insured[4], total health care spending on the nonelderly would fall by 5 percent.[5] Average health costs per insured would decline by 16 percent, from $4,121 to $3,447, in part because of reduced administrative costs incurred by insurers, health care providers and employers.

Total employer payments for health insurance would fall by $590 million or 11 percent. For companies that now offer coverage, health insurance costs would decline by $1.4 billion, or 26 percent. However, firms that did not previously insure their workers would contribute $820 million to cover their proportionate share of health costs. Accordingly, even through the business community as a whole would pay much less for insurance , some companies would spend more than they now pay and others would spend less, simply because all employers would be required to contribute.

Because of lower health insurance and health care costs, this approach would give Connecticut households $1 billion in new, net annual income available for purposes other than health care and health insurance.[6]

For all former Medicaid and HUSKY residents served by the state plan, health care providers who today serve patients through those programs would no longer receive lower reimbursement rates for plan-covered services. Providers not serving publicly insured patients today would receive lower reimbursement rates for some services, but their administrative costs would decline substantially with only one health plan providing the bulk of coverage for all nonelderly residents.

Employment in the state is estimated to increase by 6,000 to 11,000 jobs. State GDP would increase by $660 million to $830 million, or between 0.3 percent and 0.4 percent. The overall reduction in employers' labor costs accounts for this approach's mildly positive effect on the economy.

This policy alternative could fully meet the criteria articulated by the Institute of Medicine:

- Universal coverage can be achieved – 100 percent of residents would be covered.
- Health care coverage would be more continuous, with all nonelderly residents enrolled in the state plan.
- Coverage would be affordable to state residents.
- The health insurance strategy would be affordable and sustainable for society, although some firms not offering coverage today would experience new costs.
- The one state plan would have the capacity to implement measures that dramatically improve quality and efficiency, and eliminate disparities in access to and the quality of care among ethnic and racial minorities.

My husband and I are both self-employed. We own our own home, pay our taxes on time and are raising an 8 year-old boy who is my husband's from a previous marriage. His son is covered by HUSKY, but we are not covered by any health plan because of the cost.

Killingly

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Policy II

A State Pool with Competing Private Plans for Residents Lacking Employer-Sponsored Coverage

Impact on Consumers

Every state resident under age 65 who does not have employer-sponsored insurance (ESI) would be enrolled in their choice of private health insurance plans offered through a state insurance pool (similar to the Federal Employees Health Insurance Plan). With some exceptions, most publicly insured residents would also be enrolled. The state would negotiate with insurers for competitive plans offering choices ranging from comprehensive benefits to high deductible options (compatible with health savings accounts). A state agency or private entity would operate the pool, adopting measures to reduce costs and improve quality.

Medicaid beneficiaries who live in poverty ($19,090 for a family of three) or have severe disabilities may not get from the pool's "mainstream" plans the range of benefits and providers with special skills they may need. Instead, such beneficiaries could chose to get their care entirely through the state's Medicaid system.

Also, HUSKY-eligible children and nonelderly adults with incomes at or below $28,635 for a family of three would receive supplemental benefits and payment of certain out-of-pocket expenses through HUSKY, in addition to coverage through the state pool.

Residents with access to coverage through their employer would automatically be enrolled in their employers' plans.

Who Pays for It?

This new health insurance pool would be financed through several sources:

- Individuals pay up to 30 percent[7] of insurance premiums, depending on household income.
- Employers not offering coverage, whose workers therefore would be insured through the pool, contribute an amount equal to 8.7 percent of payroll.
- $220 million in new funds from the state General Fund would keep from rising above the 8.7 percent level the contributions required from employers whose workers enter the pool.
- For low-income individuals shifted into the pool, prior state Medicaid spending would continue.
- Federal matching funds for nonelderly individuals covered under Medicaid and HUSKY would increase substantially, from $470 million to $1 billion.

Employers offering coverage would be exempt from the 8.7 percent contribution requirement cited earlier. They would make payments, however, where the combination of employer and worker premium payments fell below 11 percent[8] of payroll.

For example, if such premium payments equaled 9 percent of payroll, the employer would make a payment to the pool equal to 2 percent of payroll. Accordingly, in firms offering coverage, total health insurance costs, including both premiums and pool contributions, could not drop below 11 percent of payroll. This would give employers strong financial incentives to let their workers receive coverage through the pool, since that would lower the employer's health insurance costs to 8.7 percent of payroll.

This level of employer responsibility would also protect the state pool from destabilization – caused by departure of firms with the healthiest workers – by providing resources that would keep pool premiums from rising significantly in the event of such departures. This employer responsibility would also ensure a level of parity between the benefits available to workers who get their coverage through their employers and benefits available to workers obtaining their coverage through the state pool.

Impact on Coverage and Cost

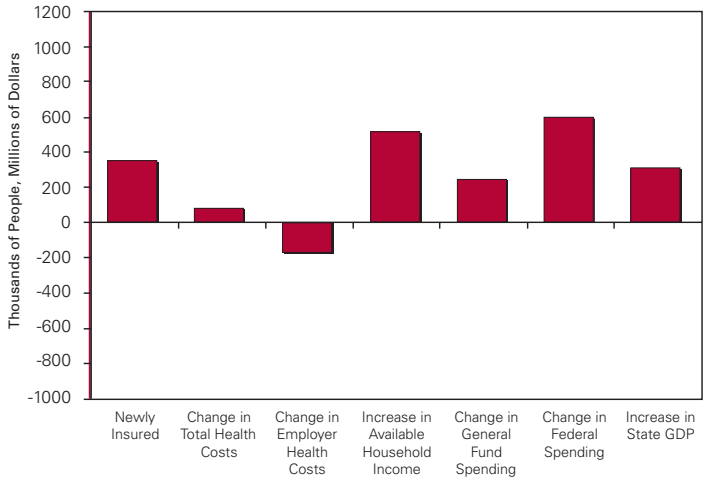

Figure 2. Impact of State Pool with Competing Plans

As Figure 2 shows, all of the state's residents would be covered. At the same time, total health care spending on the nonelderly would rise by $30 million, or one-fifth of one percent. Cost per insured resident would decline by 12 percent, falling from $4,121 to $3,629.

Approximately three-quarters of the companies that offer coverage would choose to save money by letting their employees receive coverage through the pool. As a result, 61 percent of nonelderly state residents would be in the pool, giving it the purchasing power to lower premiums substantially. In addition, consumers could lower their premium payments by choosing less costly coverage, providing an incentive for efficiency.

Because of lower health insurance and health care costs, this approach would provide Connecticut households with $640 million in new net annual income available for purposes other than health care and health insurance.

Total employer payments for health insurance would fall by $170 million, or 3 percent. Firms that presently offer coverage would see their health insurance costs decline by $990 million, or 18 percent. However, firms that do not presently offer coverage today would be required to contribute $820 million to cover their workers. Put differently, health insurance payments for employers as a whole would drop below current levels, but there would be a shift in what employers would pay. Some would pay more than they now pay and others would pay less, simply because all employers would be required to pay into the system.

This policy alternative would also have a positive impact on certain health care providers. Today, providers who care for publicly insured patients receive significantly lower reimbursement for services than they do for similar services provided to privately insured patients. Because a significant number of Medicaid, HUSKY and SAGA patients would form part of the pool, those health care providers would receive the same level of reimbursement for these patients that they receive for other patients covered through the private plans within the state pool.

On the other hand, for some providers who currently do not serve publicly insured patients, lower per capita health care costs, could translate into lower reimbursement rates than they currently receive. These lower rates would be offset to some degree by lower administrative costs, since the pool would have the leverage to require participating insurers to use common provider claim forms and procedures.

This approach would have a small, positive impact on the state economy. Employment would increase by 2,000 to 6,000 jobs, and the state GDP would increase by $320 million to $470 million, or approximately two-tenths of one percent. This modest improvement would result from two factors: employers' net labor costs would fall slightly; and health care spending directly benefits the local economy, unlike spending for other purposes, which often involves the purchase of goods produced elsewhere.

All of the state's residents would be covered.

This second policy alternative would satisfy some, but not all, of the Institute of Medicine's principles:

- Health care coverage would be universal.
- Health care coverage would be largely, but not entirely continuous. Most nonelderly residents would be covered through the pool, regardless of their employer. However, individuals might need to change health plans when they move between employers if at least one of those employers covers its workers directly rather than through the pool.
- Health care costs per insured resident would decline by 12 percent, and individual premium payments would be based on income, making coverage generally more affordable to individuals and families.
- The health insurance strategy would be more affordable and largely sustainable for society, but there would be increased costs for firms that do not cover their workers today. Such employers would need to be transitioned into the system. Poor people and people with disabilities who choose to stay outside the pool would receive their care through a health care system that does not serve others, which raises questions about sustainability. It also perpetuates the current two-tiered system that, in many ways, does not serve low-income people well.
- The pool's considerable leverage could be used to improve quality and lower cost, through negotiations with insurers. In addition, because each enrollee could choose any plan within the pool, insurers would have an incentive to compete by improving quality while holding down costs.

I had a full knee replacement. Less than a month later, my health insurance through COBRA ended. In April, I tried to get health insurance with all the major insurance companies and was denied because of a preexisting condition.

The only way I could get insurance was to go through HRA. Now I am paying almost $900 a month for good insurance that I know my doctors will carry. I could not believe in this country I was being discriminated against because of my knee.

We need affordable insurance for everyone.

West Haven

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Policy III

Expanding the Health Coverage Safety Net for Low- and Moderate- Income Adults and Insuring All Children

This approach has two major components: First, it would expand public subsidies, primarily to cover more adults; and second, it would require all parents to cover their children.

Impact on Consumers

The HUSKY program would expand to cover adults with annual incomes up to $38,180 for a family of three. Currently, HUSKY and Medicaid exclude (a) parents with incomes above $28,635 for a family of three and (b) childless adults, no matter how poor, unless they are pregnant, elderly, severely disabled, or currently caring for dependent children. In addition, HUSKY would cover, at state expense, income-eligible uninsured children whose immigration status disqualifies them from federal matching funds.

Uninsured adults with annual incomes between $38,180 and $57,270 for a family of three would receive a tax credit covering between approximately 85 and 20 percent of premiums. Within that income range, higher-income adults would receive smaller credits and therefore pay more for coverage. The state would provide this tax credit directly to insurers when monthly premiums are due, so people would not have to pay up front and later receive the credit when they file their income tax returns.

Adults with incomes above $19,090 for a family of three would enroll in employer-based coverage if that is available to them. The state would pay the worker's share of the premium and, through HUSKY, provide coverage of services and costs outside of the employer benefits.

Uninsured children would be automatically enrolled into health coverage at birth, upon starting school, and upon receiving health care. Children without proof of insurance would be enrolled into HUSKY, unless their parents purchased other coverage. As under current law, families with incomes at or below $57,270 for a three-person household would pay between $0 and $50 a month, depending on income and the number of children in the family. Families with incomes above $57,270 for a household of three would pay full HUSKY premiums (currently between $138 and $202 a month per family).

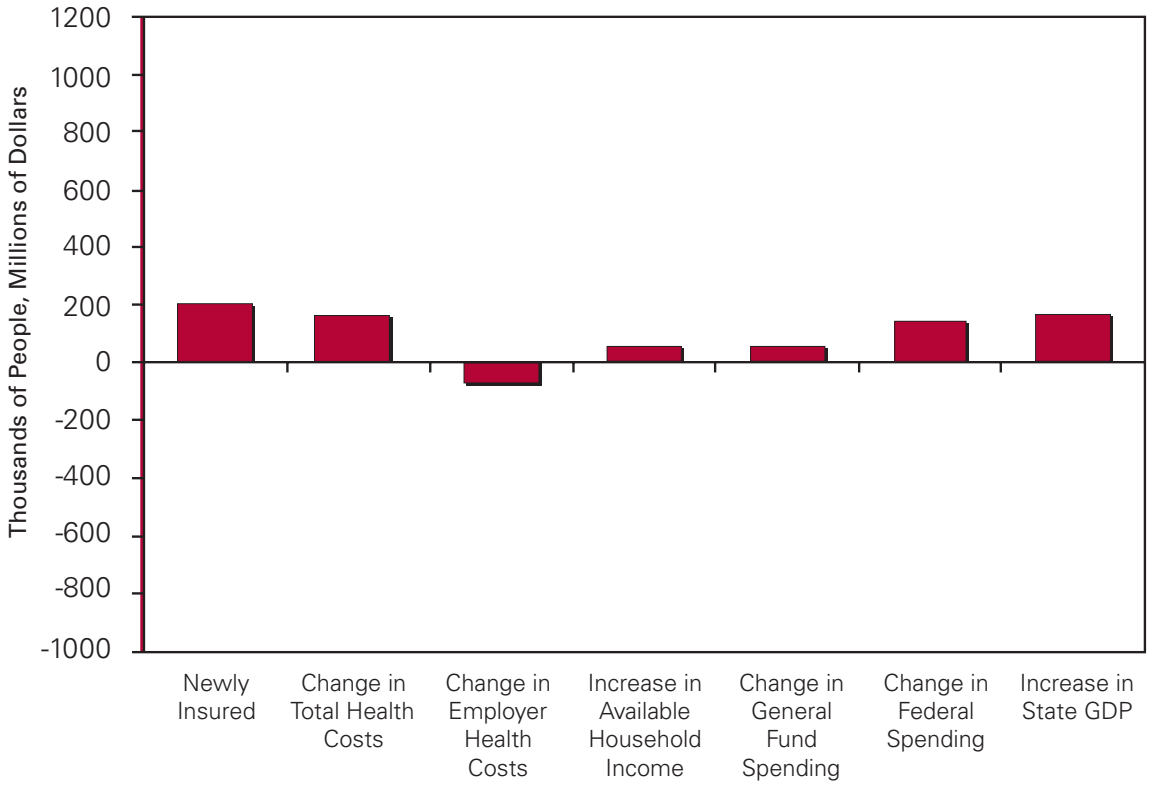

Figure 3. Impact of Public Program Expansion

Who Pays for It?

Under this expansion model, total health spending on the nonelderly in Connecticut would rise by $130 million, from $10.53 billion to $10.66 billion.

This coverage expansion would be financed from the following sources:

- Premiums paid by newly insured consumers.
- $45 million from the state General Fund, $40 million of which would fund the tax credits and $5 million of which would help pay new Medicaid costs.
- $135 million in increased Federal matching funds under Medicaid and SCHIP.

Impact on Coverage and Cost

Under this approach, the number of uninsured would decline by 66 percent, from 355,000 to 155,000. All 75,000 currently uninsured children would be covered, and the number of uninsured adults would drop by 125,000 people, from 280,000 to 155,000.

Health care costs for employers would decrease by $60 million, about 1 percent. Household income available for purposes other than the purchase of health care would increase by $20 million. Average annual health care costs per insured would drop by 6 percent, from $4,121 to $3,869.

Like Alternative II, this approach's net impact on the state economy would also be small but positive. Increased spending on health care in Connecticut directly benefits the local economy, whereas other spending often involves the purchase of goods produced out of state. Accordingly, increased health care spending would add between 2,000 and 6,000 jobs to the state's economy. The state's Gross Domestic Product (GDP) would increase by approximately $160 million, or less than one-tenth of one percent.

While this approach would cover a significant number of the uninsured at modest cost, it would not satisfy the criteria of the Institute of Medicine, for the following reasons:

- Health care coverage would not be universal. An estimated 155,000 (4 percent) of the state's residents would remain uninsured.
- Health care coverage would not be continuous. Changes in family circumstances would mean changes in systems of care. In some cases, adults would lose coverage if their incomes rose or their employment changed.
- Health care coverage would be affordable to low-income individuals. However, some moderate-income families would incur new expenses purchasing health insurance for their children.
- This health insurance expansion strategy would be affordable to the state. On the other hand, it may not be fully sustainable. Low-income people's coverage would be handled by publicly subsidized systems that do not serve the remainder of the population, continuing the current two-tiered system of health and health care. Accordingly, during economic downturns, when state-funded costs rise and state revenue falls, the low-income subsidies at the heart of this approach would be vulnerable to cutbacks.
- This strategy would not add any new mechanisms to promote quality of care or to lower health care spending. Disparate reimbursement rates for health care providers serving residents through Medicaid, HUSKY and SAGA would perpetuate inequities in access to care and quality of care.

Increased health care spending would add between 2,000 and 6,000 jobs to the state's economy.

Use Policy Models to Guide a Public Debate

No one individual policy alternative presented in this brief offers a flawless solution. Trade-offs are inevitable with major policy change. In commissioning the research that produced these policy alternatives, the Universal Health Care Foundation sought to generate a statewide discussion about the kind of health care system that Connecticut needs to maintain the health of its residents, grow and compete in a rapidly changing economy.

This policy brief not only lays out alternatives and their economic projections, but also offers a set of standards by which to measure their ability to achieve universal health care. Connecticut's ultimate goal should be to improve the overall system of coverage and care so that it works better for all. This includes ensuring every resident of the state has access to quality health care that is affordable.

Determining the right system of coverage for everyone, with the goal of improving the health and health care of our residents, will not be a simple or easy task. However, these three options provide a compass to point the state in the right direction. Some may be inclined to mix and match elements of each policy alternative and create yet another alternative for Connecticut to consider. Clearly, continuing to tinker with the current system will not fix what ails it. We need look no further than to residents like the family from Harwinton to see the urgent need for Connecticut to do better.

IOM Principles	Status Quo	One Health Plan for all Residents	Pool With Competing Private Plans	Expansion of Public Programs
Universal	10.9% uninsured	0% uninsured	0% uninsured	3.6% uninsured (155,000 adults still uninsured)
Continuous	Not continuous	Continuous	Largely, but not entirely continuous.	Not continuous
Affordable to individuals and families	$4,121 per-insured annual cost of premiums plus out-of-pocket spending	16% savings ($3,447 per-insured annual cost)	12% savings ($3,629)	6% savings ($3,869)
Affordable & sustainable for CT	Health care spending increased 221% between 1980 and 2004 (adjusted for inflation).	Generally affordable and sustainable. However, costs increase for firms not offering coverage today.	Generally affordable and sustainable. However, costs increase for firms not offering coverage today. People served by public programs vulnerable to cuts.	Low state costs, but low-income subsidies vulnerable to budget cuts.
Increases Quality and Controls Cost	Little coordination	Commission sets health spending budget and quality criteria.	Pool leverage and consumer choice improve quality and lower cost.	No new mechanisms to improve quality or control cost.

Table 1. Selected Trade-off Among Policy Alternatives

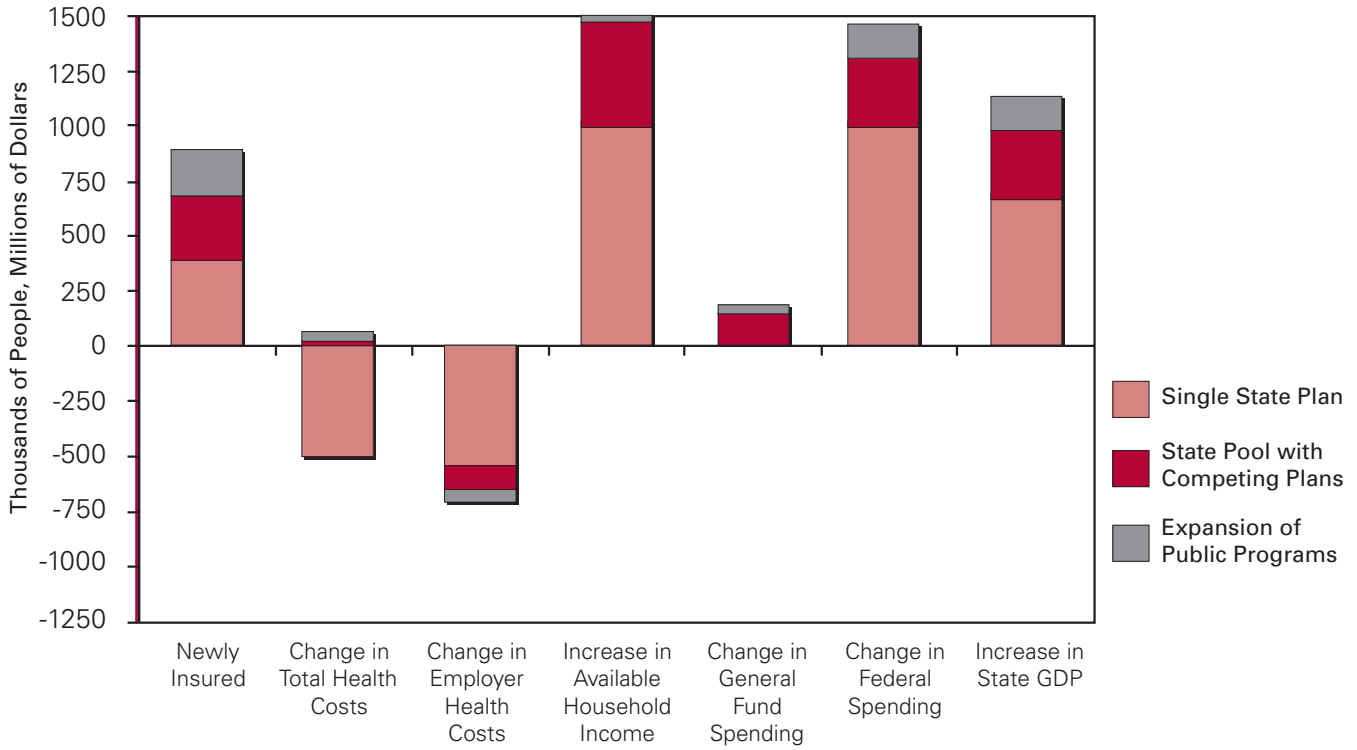

Figure 4. Comparative Impact of Each Policy Alternative

Endnotes

1) Most of the figures describing the status quo come from Mapping Health Spending and Insurance Coverage in Connecticut, J.A. Meyer and J. Hadley, prepared by the Economic and Social Research Institute, February 2006. The estimates of Connecticut coverage and health care costs contained in that report differ from those described here for several reasons: the prior estimates included elderly state residents, and the current estimates are limited to state residents under 65; the former estimates showed only spending to purchase health care, and the current estimates examine spending on health insurance premiums, which also include administrative expenses, profits and other costs to insurers. The two sets of estimates are based on somewhat different survey data and they categorize some minor coverage types differently. The percentage of state Gross Domestic Product (GDP) used for state-funded health coverage was updated from FY 2002 to FY 2003. Source: Kaiser Family Foundation, Statehealthfacts.org, "Total State Health Care Expenditures as Percent of Gross State Product, FY 2003," February 2006.

2) The figures and facts cited in this policy brief and in its companion report show the one-year impact of each alternative, as if its effects had been fully realized. In reality, new policies take some time to achieve their complete impact. Such delays could be more prolonged if policymakers choose to adjust these options to phase in particular policy elements. For example, employer contributions under the first two approaches could begin with larger firms and, over time, be phased in to reach smaller firms. Such a phase-in of financing might require a phase-in of coverage expansion as well.

3) The increase in federal Medicaid funding under Alternative I would be achieved without any increased investment of state General Fund dollars in Medicaid for several reasons: the state would use employer contributions to "draw down" federal matching dollars; parents with incomes up to 300 percent of the FPL would receive Medicaid coverage, most of which would benefit from employer contributions; and low-income, childless adults would be shifted from state-only SAGA to federally matched Medicaid, covering some of the resulting increase in federal spending with the state's unspent allocations of federal Disproportionate Share Hospital dollars and SCHIP funds. Most of these Medicaid policy changes could be accomplished by state plan amendment, without a waiver. Moreover, The required waivers would fall well within standard policies and practices of the Center for Medicare and Medicaid Services, which has granted comparable waivers to other states. A similar analysis of federal matching funds applies to the two other alternatives discussed below.

4) As with all coverage estimates presented in the accompanying report from the Economic and Social Research Institute, this estimate is rounded off to the nearest 5,000.

5) 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, it may cost the state roughly $83 million a year for fiscal intermediary services. This figure is not included in the estimates presented in the tables and text. Source: CMS, Durable Medical Equipment, Medicare Administrative Contractor (contract awards January 2006). Calculations by ESRI, March 2006. Of course, if a state agency directly provided those services that too would generate costs.

6) Estimates are limited to the nonelderly. However, the reduction in health care prices under this and the previous 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 the one state plan alternative, the average Medicare beneficiary could realize annual savings of up to $410 in out-of- pocket costs. For state pool with competing plans alternative, such savings could reach $220 per person.

7) 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.

8) The various employer payments comprise a single funding mechanism as follows. To fund health coverage offered by the pool, each employer starts with the obligation to make contributions equal to 11 percent of payroll (with adjustments for small and low-wage firms, as discussed in more detail in the accompanying report by the Economic and Social Research Institute). That obligation is reduced to take into account other payments made for health coverage received by the employer's workers and their dependents. Accordingly, if the firm offers coverage, the 11 percent payment obligation is reduced by the amount of employer and employee premium payments. In firms that do not offer coverage, whose workers are therefore insured through the pool, the employers' 11 percent obligation is reduced to 8.7 percent to reflect the poll's receipt of enrollee premiums and state and federal payments.

About the Researchers

The Economic and Social Research Institute (ERSI) is a nonprofit, nonpartisan organization that conducts research and policy analysis in health care and the reform of social services. ERSI 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.eresearch.org.

Jonathan Gruber, a health economist at the Massachusetts Institute of Technology developed the cost and coverage estimates used in the full report and this brief. The Urban Institute contributed to macroeconomic analysis to the report.

About the Foundation

The Universal Health Care Foundation of Connecticut is an independent, charitable grant making foundation dedicated to making the health care system work for all Connecticut residents. Its mission is to serve as a catalyst that engages people and communities in shaping a health system that provides universal access to quality health care and promotes health in the state. To learn more visit, www.universalhealthct.org. To learn more about the statewide campaign for universal health care, visit www.healthcare4every1.org.

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