HEALTH COVERAGE IN CONNECTICUT: THE COSTS AND BENEFITS OF MAJOR REFORM

A report prepared for
The Universal Health Care Foundation of Connecticut

By

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About the Urban Institute

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Acknowledgements

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Executive Summary

Most Americans believe that the health system needs major reform. One question facing policymakers is whether such reform can be achieved in Connecticut without incurring unsustainable costs. To address that question, this report describes two policy options that would cover all state residents while increasing state General Fund expenditures by $85 million a year or less.

Both approaches would replace the current fragmented health insurance system with a simpler health coverage system that promises to allow better cost-control and quality improvement. Such a system would also provide complete portability, with residents keeping the same insurance plan, regardless of job changes. The first comprehensive reform approach, called "Connecticut Self-Insurance," would enroll all residents in a single, self-insured health plan that directly pays health care providers, providing the same kind of coverage purchased by most large employers. With the resulting savings, policymakers could expand coverage while lowering total health care spending within the state. Under the second approach, called "Select Care Choices," a health insurance purchasing pool would offer residents a variety of private health insurance choices, and people satisfied with their choice could keep it, regardless of job changes.

Both options use the same basic financing sources – namely, responsibility is shared between employers, employees, and the state and federal governments. Employer payments are based on payroll, exempting the smallest firms from any required contributions. Worker contributions are based on income, exempting the lowest-income residents from required payments. While the state General Fund contribution would rise by $85 million or less, federal matching funds would increase by more than a billion dollars, greatly lowering the costs that, without such federal support, would be imposed on Connecticut taxpayers, businesses, and households. As other states have done, Connecticut would aggressively tap federal resources to finance health coverage.

The cost and coverage estimates in this report were developed by Dr. Jonathan Gruber of the Massachusetts Institute of Technology, based on the health economics literature and data about Connecticut from the U.S. Census Bureau. They show the "steady state" achieved after several years of program implementation, albeit framed in terms of 2007 dollars and population totals. Accordingly, they include some savings that may take time to achieve, and they exclude one-time spending on start-up costs.

Approach One: Connecticut Self-Insurance

- A single, self-insured health plan would provide state residents under age 65 with health coverage typical of employer-based insurance at private companies in New England. Employers and individuals could purchase additional coverage. Contributions by employers and employees, General Fund outlays, and federal Medicaid matching funds would pay for coverage.
- Providing everyone with a single health plan that can be proactively managed and purchasing services directly from health care providers, as is done by most large companies, would lower administrative and health care expenses. Although all uninsured residents would gain coverage, total spending would drop by 4.3 percent. Total health costs per insured person would fall by 15.6 percent.
- Employers as a whole would see their annual health care costs fall by 16 percent, from $7.93 billion to $6.63 billion. Firms with annual payroll under the average for companies with 10 employees ($265,000 a year) would not have to pay for coverage. However, larger employers that do not insure their workers today would begin paying for insurance. Companies that now offer employee health coverage would experience a 23 percent drop in health costs.
- With less spending on health care and health insurance, Connecticut households would have an extra $1.81 billion a year to spend for other things, averaging $1,544 per household. Household health care

and health insurance costs would fall by $915 million a year. Because employers would pass on some of their health insurance savings in the form of higher wages, workers would receive an estimated $895 million in extra after-tax income.

- While state spending on medical coverage for low-income residents would rise by $85 million, federal Medicaid payments would increase by $1.5 billion, thanks to a combination of using employer dollars to "draw down" matching federal payments, taking advantage of various federal allotments that Connecticut now allows to revert to the U.S. Treasury, and converting SAGA from a state-funded program to federally-matched Medicaid.
- The state health plan would become the primary insurer for non-elderly, non-disabled Medicaid beneficiaries, eliminating most Medicaid reimbursement shortfalls for health care providers serving the non-elderly.

Approach Two: Select Care Choices

- Under this option, state residents under age 65 could choose from several private health plans, which would be offered through a new health insurance purchasing 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.
- Households selecting more expensive coverage would pay more in premiums. Between the resulting incentive to economize and the purchasing pool's ability to leverage good premium prices from insurers, this approach would cover all the state's residents while increasing state health care spending by $395 million, or 2.7 percent. This would represent less than a third of the 8.5 percent average annual increase in Connecticut health spending during the past 24 years. Total health costs per insured person would fall by 9.4 percent.
- Employers as a whole would see their annual health care costs fall by 10 percent, from $7.93 billion to $7.175 billion. Firms with annual payroll under the average for companies with 10 employees ($265,000 a year) would not have to pay for coverage. However, larger employers that do not insure their workers today would begin paying for insurance. Companies that offer coverage today would save an average of 20 percent on health insurance costs.
- With less spending on health care and health insurance, Connecticut households would have an extra $1.375 billion a year to spend for other things, averaging $1,173 per household. Household health care and health insurance costs would fall by $585 million a year. Because employers would pass on some of their health insurance savings in the form of higher wages, workers would receive an estimated $790 million in extra after-tax income.
- While state spending on medical coverage for low-income residents would rise by $70 million, federal Medicaid payments would increase by $1.67 billion, thanks to the same combination of factors described above in connection with the first option.
- Health plans in the purchasing pool would become the primary insurers for non-elderly, non-disabled Medicaid beneficiaries, eliminating most Medicaid reimbursement shortfalls for health care providers serving such individuals.

Impact on the State Economy

Based on prior macroeconomic modeling using the commercially available REMI model of the state economy, either approach would probably add to the state economy approximately 6,000 to 11,000 jobs and $660 million to $830 million in GDP. Increased economic growth would result primarily from employers' lower labor costs.

Office of Fiscal Analysis (OFA) projections

In recent months, OPA's Fiscal Notes have identified a range of significant costs resulting from various health reform bills. While those bills share important common features with the proposals discussed here, their financing mechanisms are quite different. In fact, the Fiscal Note receiving the most public attention concerned a bill that had all revenue mechanisms taken out in committee. With the revenue mechanisms described here, which are similar (but not identical) to those in the original legislation, each policy option's cost to the state General Fund is $85 million or less.

When these and other policy design differences are factored out, the estimates presented here are generally consistent with those described by OFA. Both with health coverage costs and revenue (although not with administrative costs), the methodologies used by Dr. Gruber and by OFA yield estimates in the same range.

In some ways, the key difference between OFA's analysis and the approach taken here concerns the role of state government. OFA's Fiscal Note ascribes to the state all health care costs for individuals enrolled in the state self-insured plan. By contrast, the approach in this report divides financial impact based on how much is paid by various groups. Accordingly, this paper allots General Fund costs to the state, employer costs to employers, household costs to households, and federal costs to the federal government.

In addition, OFA's analysis has flagged important issues that health reform proposals need to address with specificity, issues that were not fully developed in prior legislation. For example:

❖ To ensure that the state receives the anticipated level of federal matching funds, legislation needs to make clear that the state will be providing Medicaid and State Children's Health Insurance Program (SCHIP) coverage through the self-insured plan in the Connecticut Self-Insurance option and the health insurance purchasing pool in the Select Care Choices option. Such specification can make clear that those coverage systems *are* Medicaid and SCHIP, rather than outside coverage to which Medicaid is secondary.

❖ Legislation may need to specifically allocate funding for various administrative costs.

The following figure summarizes the projected cost and coverage results of these two reform options.

Figure 1. Changes from status quo, by policy option: Projected impact on non-elderly residents of Connecticut, 2007 (thousands of people, millions of dollars)
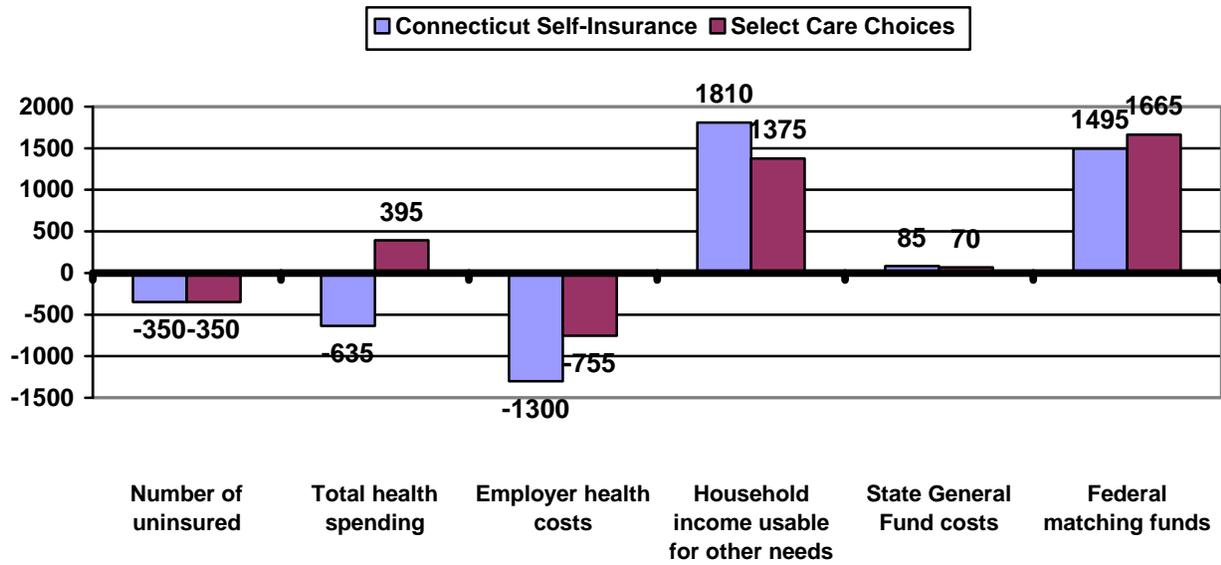
Source: Gruber Microsimulation Model.

Health Insurance Coverage in Connecticut: The Costs and Benefits of Major Reform

Introduction

According to recent public opinion research, 80 percent of Americans believe that the health care system needs major change.[1] It is thus no surprise that, in December 2006, Connecticut residents reported to pollsters that their top priority for state action – more important than reducing taxes, strengthening education, or improving the economy – was making health care more affordable and accessible.[2] Connecticut's leaders face a number of important questions in responding to this public need, including how to make health care reform affordable and sustainable.

To help answer some of those questions, this report examines two options[3] for major reform and estimates the resulting public and private sector costs. These estimates were developed by Dr. Jonathan Gruber, a Professor of Economics at the Massachusetts Institute of Technology and one of the country's leading health economists. The final section of this report analyzes some of the concerns raised by the Office of Fiscal Analysis in connection with health reform bills that have already been approved by various committees of the Connecticut General Assembly.

The goal of this report is not to support any particular health reform. Other approaches not described here are equally sound, and any policy ultimately enacted in this state is likely to bear only passing resemblance to the policies discussed below. Rather, this paper seeks simply to show that it is possible, without imposing a large burden on the state's taxpayers or employers, to craft reforms that would cover all of the state's residents while offering the potential to promote quality improvement and cost control more effectively than does the state's current fragmented health care system.

The policies described below share important common features. Each changes the health care system from current, fragmented approach, which disperses responsibility among multiple health plans and regulatory authorities, into a much simpler system with more focused responsibility and integrated systems of care. According to many analysts, such systems offer the potential of increased capacity for significant quality improvement and cost control.

The simpler systems described below also allow state residents to continue with an ongoing source of health coverage, regardless of job change. That is because health coverage is no longer furnished through employers. At the same time, these reform models continue employers' financial contributions, albeit at a lower aggregate level than today. With each option, financial responsibility is shared between employers above a certain size, based on payroll; households above a certain level of income, based on ability to pay; state government; and the federal government.

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[1] L.A. DiVall, R. Gutermuth, and N. Nelson. *Health Coverage Passport Survey*. Conducted by American Viewpoint for the Federation of American Hospitals. February 5-7, 2007.

[2] Spectrum Associates Market Research. *Final Report*. Prepared for the Universal Health Care Foundation of Connecticut. January 29, 2007.

[3] These approaches build on earlier work done by the author and colleagues. See S. Dorn, J.A. Meyer, and E. Wicks. *Health Coverage in Connecticut: Three Routes to Reform*. Prepared by the Economic and Social Research Institute and the Urban Institute for the Universal Health Care Foundation of Connecticut, November 2006.

1. Cost and coverage estimates for comprehensive reform options

A. Basic perspective

For both policy options, this section of the paper 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, tax payments by state residents, and state and federal spending. Dr. Gruber's analysis also includes a calculation of the size of various assessments that would be needed for full funding of these two reform approaches.

The first section of this chapter describes Dr. Gruber's general modeling methodology. The next sections examine each of the 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. These estimates seek to show the "steady state" result of each policy proposal, without describing one-time costs or initial lags in implementation.

Second, the estimates below describe each alternative as if it were in effect in 2007, using 2007 dollars and population estimates. Of course, a sensible transition period to new coverage systems would require an effective date in 2008 or later, but showing these results in a time frame closer to the present reduces somewhat the inevitable uncertainty surrounding both descriptions of the "baseline" present system and the two policy approaches described below.

Third, these estimates will necessarily differ from other, equally reliable findings that are based on slightly different data sources or different methods of analysis. To the extent that researchers apply different models for projecting costs and coverage, the most that can be expected is general correspondence, not precise agreement.

Moreover, even with the same basic model, estimates can vary. For example, the current estimates differ from those contained in the earlier, "Three Routes" report, described above, for the following reasons:

❖ These estimates are put in terms of 2007 dollars, rather than the 2005 estimates in the earlier report. Health costs increased during the intervening two years.

❖ With the policy options described here, funding is structured differently than in the prior report. Among other differences, the current options do not impose costs on employers with annual payroll at or below $265,000, which is the average for a ten-employee firm in Connecticut.

❖ There is another important difference between the second option described below and the second option in the earlier report. Both options involve health insurance purchasing pools, but the current approach would place all employed state residents under age 65 into such a pool, lowering total health care costs below the amount estimated for the prior policy option.

❖ The current set of estimates for HUSKY, Medicaid, and SAGA costs are more accurate. They reflect a more thorough analysis of state budget documents.

❖ Projected federal funding levels under reform options are higher, since they assume more robust auto-enrollment mechanisms. Those funds were used to reduce the contribution required from employers.

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 inevitably arise when considering major health policy changes.

B. 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 a basis for such analysis. Dr. Gruber applied this model to two policy reform approaches to estimate the impact of each option on public- and private-sector costs and on insurance coverage in Connecticut.

Dr. Gruber used the type of "microsimulation" modeling that the U.S. 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 Current Population Surveys (CPS) conducted by the U.S. Census Bureau, updated to 2007. 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, state taxpayers, 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 every non-elderly resident of the state of Connecticut in the insurance category where they are today — publicly subsidized coverage, 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 alternative 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?

Derived from both state-specific data in the CPS and national and regional data in the Medical Expenditure Panel Survey (MEPS), estimates of per capita out-of-pocket costs for each insurance category[4] were then applied to the changed distribution of enrollees, with proportionate reductions based on the assumed decreases in per capita health care costs stemming from various cost-control strategies.

C. Modeling Results for Connecticut Self-Insurance

1. Key policy elements

This first option includes the following provisions:

❖ All non-elderly residents would be covered through a single self-insured health plan. Covered benefits would be based on what private employers typically provide in New England.[5] The plan could be administered through a contract with a private insurer serving as fiscal intermediary or by a state agency. Individuals and firms could purchase supplemental coverage to augment the standard benefits package.

❖ Coverage would be financed through a slight increase in state funding for low-income residents' health coverage, contributions from employers and employees, and federal matching funds under Medicaid and the State Children's Health Insurance Program (SCHIP).

❖ Exempted from contributions would be employers with annual payroll below the average for firms with 10 employees ($265,000 a year for 2007).

❖ Each employer would contribute an amount equal to 13.6 percent of its annual payroll (if any) above $265,000, excluding any individual employee's earnings above $200,000 a year.[6] Those amounts would be updated after 2007 based on annual changes in average state earnings.

❖ Costs would be reduced in part because the plan would be self-insured. Also, the plan would work with physicians and other health care providers to agree on reimbursement levels, evolving coverage rules, and standards for quality of care. In addition, administrative costs would be reduced for providers by using one instead of multiple plans for most services provided to residents under age 65. State seed grants for

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[4] This analysis updated to 2007 the out-of-pocket cost estimates contained in J. A. Meyer and J. Hadley, *Mapping Health Spending and Insurance Coverage In Connecticut*, prepared by ESRI and the Urban Institute for the Universal Health Care Foundation of Connecticut, February 2006.

[5] The actuarial value of covered benefits – that is, the claims costs projected by actuaries for an average-risk population – would equal the average actuarial value of employer-based medical coverage and employer-based dental coverage offered by private firms in New England.

[6] In 2007, the median employer offering coverage pays an amount equal to 12.2 percent of payroll, according to Dr. Gruber's analysis. Taking into account both employer and employee payments, median employer-sponsored insurance costs an amount equal to 15.3 percent of payroll.

information technology and clear standards for interoperable systems of electronic health records would allow the plan to carefully monitor data about utilization and outcomes to identify and respond to emerging problems with cost and quality.

❖ Children and parents with income up to 300 percent of the federal poverty level (FPL) would qualify for federal matching funds through Medicaid and SCHIP, as would (with a federal waiver) childless adults up to 185 percent of FPL. The self-insured plan would be the vehicle through which the state provided Medicaid and SCHIP.

❖ Adults with incomes at or below 185 percent of the federal poverty level (FPL) and children with incomes at or below 300 percent of FPL would receive, in addition to benefits otherwise available through the self-insured plan, supplemental coverage for cost-sharing and additional benefits currently offered by the HUSKY program.

❖ Above 300 percent of FPL, enrollees would make a premium contribution equal to 30 percent of the per capita cost of care. Adults with incomes between 185 and 300 percent of FPL would contribute between 0 and 30 percent of such costs on a sliding scale, based on income. Premium payments would be made automatically, through payroll deductions, whenever possible.

❖ Uninsured individuals would be identified and enrolled into coverage when they seek health care, file state income tax forms, or fill out W-2 forms establishing wage withholding at work.

❖ Personal responsibility discounts would go to individuals who either avoided obesity and tobacco use or who participated actively in programs to address those problems.

2. Cost and coverage estimates

This option would cover all state residents, including approximately 350,000 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 4.3 percent*, from $14.71 billion to $14.08 billion. Average health costs per insured, non-elderly state resident would decline by 15.6 percent, from $5,626 to $4,747.

Figure 2. Health spending for non-elderly residents of Connecticut: Status Quo vs. Connecticut Self-Insurance (2007 dollars)
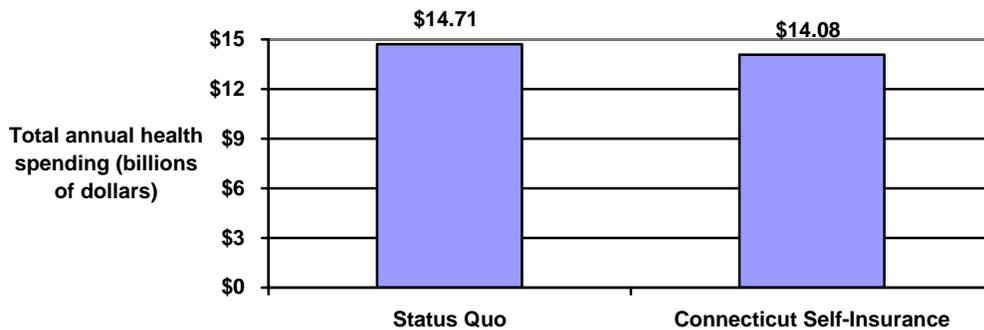
Source: Gruber Microsimulation Model.

If anything, this 15.6 percent estimate may be based on assumptions[7] that understate the magnitude of likely savings. Simply eliminating the cost-shift resulting from uncompensated care provided to the uninsured would lower Connecticut premiums by 5.3 percent, according to one analysis.[8] Even without such an elimination of cost-shifting, Massachusetts has achieved savings this April as high as 45 percent through the first round of health coverage offered through that state's health insurance exchange.[9] Without eliminating the cost-shift from uninsurance, West Virginia's public employee coverage has likewise lowered costs by 20 to 25 percent through using a self-insured plan.[10]

Of course, each of these comparisons has its limitations. The true extent of cost-shifting is controversial in the literature; the Massachusetts savings described above is limited to one health plan and may not persist; and the West Virginia savings from reduced provider payments may be more difficult to realize in a health coverage system that includes all non-elderly residents. But the broader point seems clear. 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.[11]

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[7] The estimates assume a 20 percent reduction from the average price of employer-sponsored insurance in Connecticut, increased by 4.7 percent to reflect administrative costs comparable to those documented for private insurers participating in Medicare.

[8] Data analysis by K. Thorpe, Rollins School of Public Health, Emory University, "Appendix Tables," in K. Stoll, *Paying A Premium: The Added Cost of Care for the Uninsured*, Families USA, 2005.

[9] In Boston, before implementation of the new Connector option a 37-year-old man could buy a non-group policy with a $5,000 deductible and without prescription drug coverage for $335 a month. When Connector coverage became available, a more generous policy with a $1,000 deductible, and including prescription drug coverage, was offered to 37-year-old Bostonian men at a cost of $175 a month. J. Kingsdale, personal communication, April 24, 2007.

[10] 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 15.6 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.

[11] 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 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

Of course, a nation can achieve such efficiencies more effectively than can a single state,[12] in large part because patients and providers can cross state lines. Nevertheless, it seems reasonable to expect that a single state's efficiencies through more centralized care management could realize one-fourth of the savings achieved by the average developed nation and 37 percent of the efficiencies accomplished by the world's second-highest-spending country (Figure 3).

The level of savings this paper anticipates 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 self-insured plan for Missouri would achieve identical per capita savings as the level estimated here for Connecticut.[13] 72 percent of the administrative savings projected by Dr. Thorpe were realized by providers, based on a comparison of providers' administrative costs in Canada and the U.S. The modest administrative savings projected for insurers resulted from comparing private insurance under Medicare with commercial insurance. Accordingly, the latter savings reflected streamlined claims processing, elimination of underwriting expenses, and reduced marketing and commission costs, not cuts in quality assurance or cost containment activities.

Since Dr. Thorpe published his study, new research has documented the difference between health plan administrative costs under Medicare and in the commercial marketplace, concluding that, in California, commercial insurers spent an average of 9.9 percent of premiums on administrative costs, compared to 4.5 percent for insurers contracting with Medicare.[14] The estimates presented here accordingly assume that administrative costs will consume 4.5 percent of costs to operate the self-insured plan, or $470 million, divided proportionately among employers, households, the state General Fund, and federal matching funds.

The latter study provided one additional finding suggesting that a 15.6 percent per capita cost savings estimate is quite modest. Researchers divided administrative costs for providers and insurers between those related to billing and insurance and those serving other purposes, such as provider credentialing, quality assurance, and customer service. The study concluded that, in California, billing- and insurance-related administrative costs consumed between 20 and 22 percent of all privately insured acute health care. If between 73 percent and 80 percent of such costs could be squeezed out of Connecticut health care by shifting to a single, self-insured plan, the savings projected here could be achieved by reducing administrative costs without sacrificing essential administrative functions that would need to be performed in any viable, modern health care system.

One final comment here is important. As noted above, these cost and coverage estimates assume a steady state of program operation, after several years. It seems highly likely that, in such a steady state, per capita savings greater than 15.6 percent could be achieved. However, that level of savings is less certain during the first few years of program implementation.
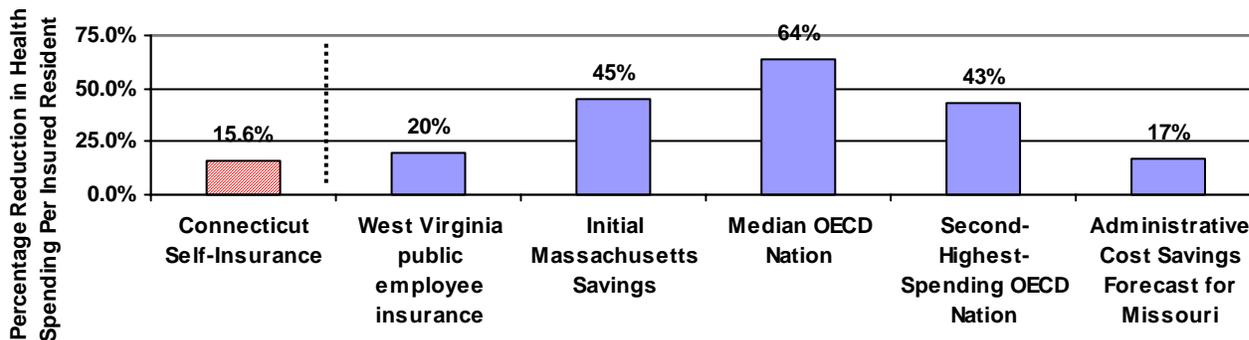
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costs per insured person based on the Census Bureau's estimate that, in 2003, 15.6 percent of U.S. residents were uninsured. U.S. Census Bureau, Housing and Household Economic Statistics Division, *Health Insurance Coverage: 2003 Highlights*, Last Revised: December 07, 2004. Calculations by ESRI, May 2006.

[12] 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.

[13] Under the Missouri proposal, administrative savings realized by covering all state residents through a single, self-insured plan would cut total spending per insured by 17 percent – slightly more than the 15.6 percent projection 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.

[14] J. G. Kahn, R. Kronick, M. Kreger, and D.N. Gans. "The Cost Of Health Insurance Administration In California: Estimates For Insurers, Physicians, And Hospitals." *Health Affairs.* Vol. 24, No. 6. November/December 2005.

Figure 3. Savings from centralized cost-control: estimates for Connecticut Self-Insurance vs. savings realized or projected in other states and developed countries

Because of this decrease in health costs, coverage of all state residents would be accompanied by overall financial gains for employers and households. While state General Fund spending would increase by less than $100 million, the federal government would spend appreciably more than under the present system. The following discussion examines each set of stakeholders, in turn.

Employers

Employers would no longer pay an estimated $7.93 billion in premiums. Instead, firms would pay $6.23 billion in required contributions and $400 million in voluntary supplementation of the state plan. As a result, *employers as a whole would save $1.3 billion, which translates into a 16 percent reduction in the amount they currently spend on health coverage.*

Figure 4. Changes in employer payments for health insurance under Connecticut Self-Insurance (2007 dollars)
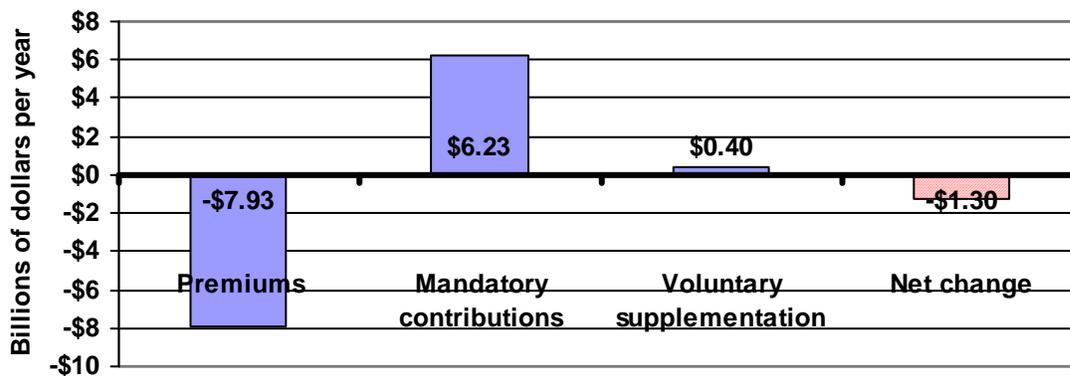
Source: Gruber Microsimulation Model. Note: totals may not add to 100 percent because of rounding.

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.[15]

Second, while employers as a whole would spend less than under the present system, many firms that previously did not cover their workers would begin making payments. For them, this alternative would add approximately $780 million in new health care costs, which would be offset to some degree by a drop in wages.[16] Conversely, the companies that purchase health coverage today would experience $1.8 billion in savings, a 23 percent reduction in health care costs.

That savings would be largely offset by an increase in wages. *Each set of companies – those that previously did not offer coverage and those that did – would experience small net changes in labor costs, taking into account both health insurance and wage effects. But the overall result would lower employers' labor costs.*

Households

Household savings would be significant. Annual health costs directly paid by state residents would decline by 20 percent, from $4.585 billion to $3.67 billion. Instead of spending $2.65 billion on health insurance premiums, households would spend a total of $2.27 billion for the combination of income-based contributions to the self-insured plan and estimated payments for coverage that supplements the state plan. Out-of-pocket payments would decline by $540 million, from $1.94 billion to $1.4 billion. At the same time, because employers would pay less for health insurance, total wages and salaries would rise by $1.31 billion. As a result of increased earnings, federal and state income tax payments would likewise rise by roughly $415 million,

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[15] This should not pose a major problem under Employee Retirement Income Security Act (ERISA), which bars states from regulating employee benefits. Under both this and the next option, employers are subject to revenue requirements that are completely independent of any arrangements for employee benefits. That said, it is difficult to predict how ERISA statute will be interpreted, so even this facially neutral revenue measure could be challenged.

[16] 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. For some firms that do not offer coverage today and that principally have low-wage workers, minimum wage laws and other factors would limit the extent to which wage reductions could offset the cost of required contributions to health coverage costs.

resulting in after-tax income gains of $895 million. *Connecticut households' net income available for purposes other than the purchase of health care and health coverage would thus increase by $1.81 billion a year.*[17] Distributed among all non-elderly residents, increased resources would average $1,544 per household.[18]

Figure 5. Impact of Connecticut Self-Insurance on household income available for purposes other than health care (2007 dollars)
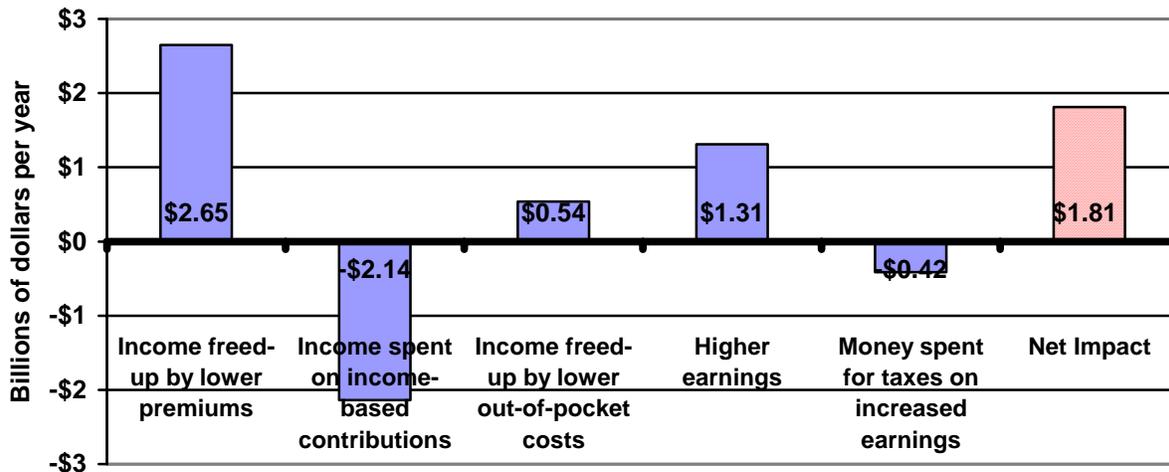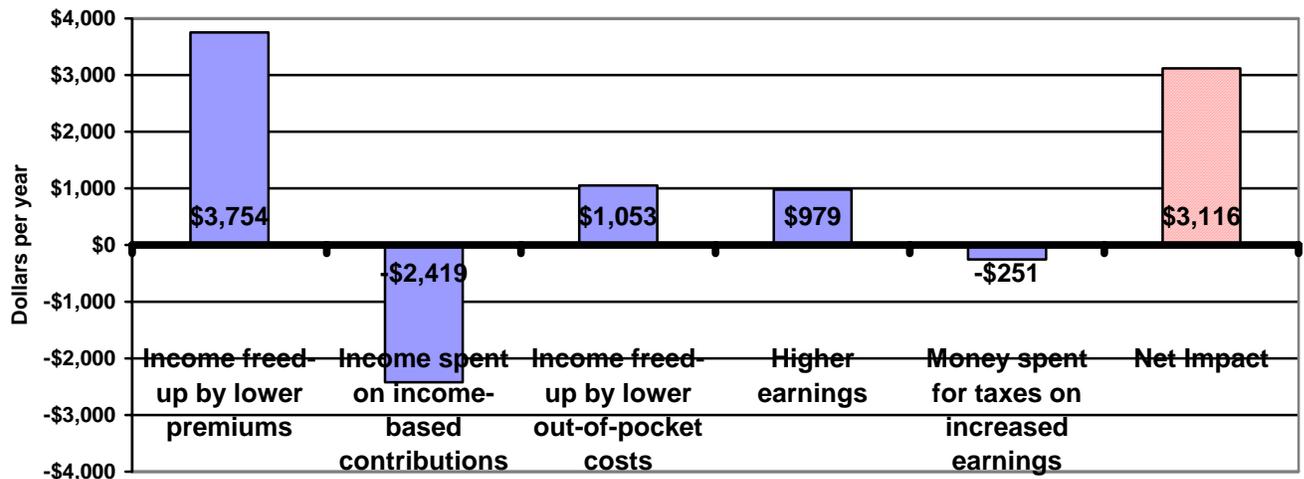

Source: Gruber Microsimulation Model.

For example, consider a family of four with two minor children and two working parents who earn $51,625 a year, or 250 percent of the federal poverty level (FPL); the family receives employer-sponsored insurance from a 50-employee company. Today, such a family's share of premiums averages $3,754. On average, out-of-pocket costs not covered because of deductibles and copayments reach $2,688 for the year. Under Connecticut Self-Insurance, such a family would see its post-tax income rise by $728 a year, because of lower health insurance costs to the employer. The family's premium payments would decline by $1,335 and out-of-pocket costs would fall by $1,053, in part because the children would receive subsidies, based on family income below 300 percent of FPL. As a result of all these factors, the family would realize approximately $3,000 in direct financial gains. Higher-income families without subsidies would also realize benefits, albeit smaller in amount.

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[17] 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.

[18] This estimate is based on the U.S. Census Bureau's estimate of average household size in Connecticut, included in *2005 American Community Survey, Data Profile Highlights: Connecticut Fact Sheet.*

Figure 5A. Impact of Connecticut Self-Insurance on an Average Four Person Family that Currently Has Income at 250 Percent of FPL and Insurance From a 50-Employee Company (2007 Dollars)

Source: Gruber Microsimulation Model.

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 $1.03 billion to $2.52 billion. That approximately $1.5 billion boost would be offset somewhat by a $285 million increase in federal income tax revenue and a $110 million increase in federal payroll taxes, resulting in net federal costs of approximately $1.1 billion.

This increase in federal Medicaid funding would be achieved with an increased investment of only $85 million in state General Fund dollars. That is because the state would use employer dollars to "draw down" federal matching dollars, the state would tap into federal allotments for Disproportionate Share Hospitals and SCHIP that now revert to the federal government, and because SAGA would change from a state-funded program to federally matched Medicaid.[19]

In addition, the state budget would realize some offsetting gains. State income tax revenues would increase by $20 million, which Dr. Gruber's estimates assume would be used to help pay for coverage. And as with other employers, the state could realize savings in the cost of covering public employees.

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[19] The provisions 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. While a waiver would be needed to cover childless adults, federal budget neutrality requirements may be satisfied since, 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. 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. Finally, the estimates in this paper assume a shift of the state-only costs of SAGA to federally-matched coverage. They assume no such change to the DSH funding that currently pays for some SAGA services.

Health care providers

For 315,000 people previously insured by Medicaid or SCHIP – that is, all beneficiaries who are neither disabled nor elderly[20] – the state self-insured plan would pay most health care costs. The state self-insured plan, along with supplemental services and cost-sharing limits available only to low-income residents, would constitute Medicaid and SCHIP coverage in Connecticut. As a result, for services covered through the state self-insured 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. In addition, whatever administrative structure is established to guide policy development would need to institutionalize a strong voice of physicians and other health care providers to ensure that coverage policies fit the evolving medical science as well as the state's changing health care infrastructure.

Following is a table summarizing these estimates.

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[20] Because of their need for specialized systems of care, people with disabilities would remain outside the single state plan unless they chose to enroll.

Table 1. Health coverage estimates for 2007 (under age 65): Connecticut Self-Insurance

Major types of coverage (thousands of persons)	Thousands of Covered Individuals		
	Current law	**CT Self-Insurance**	**Change**
1. Total number of insured	2,615	2,965	350
A. Employer-sponsored insurance	2,075	-	(2,075)
B. Nongroup insurance	175	-	(175)
C. Medicaid and SCHIP as primary insurer	365	50	(315)
D. New state plan	0	2,915	2,915
2. Uninsured total	350	-	(350)
Health care cost estimates			
	Millions of Dollars		
Major types of spending (millions of dollars)			
1. Total health spending in Connecticut	$ 14,710	$ 14,075	(635)
2. Total premiums and payments for covered services	$ 12,770	$ 12,675	(95)
A. Employer payments**	$ 7,930	$ 6,630	(1,300)
B. Household payments**	$ 2,645	$ 2,270	(375)
C. State payments	$ 1,170	$ 1,255	85
D. Federal-share Medicaid, SCHIP	$ 1,025	$ 2,520	1,495
3. Out-of-pocket payments for uncovered services	$ 1,940	$ 1,400	(540)
Income and tax estimates			
	Millions of Dollars		
1. Total wages and salaries of CT residents	$ 72,510	$ 73,820	1,310
2. Federal income taxes paid by CT residents	$ 11,250	$ 11,535	285
3. Federal payroll taxes paid by CT residents	$ 7,740	$ 7,850	110
4. State income taxes paid by CT residents	$ 2,820	$ 2,840	20

Source: Gruber Microsimulation Model.

**Under Connecticut Self-Insurance, employer and household payments include both voluntary and required contributions to health coverage. Under the status quo, all such contributions are voluntary.

D. Modeling Results for Select Care Choices

1. Key policy elements

Under this option, a health insurance purchasing pool would give state residents under age 65 a choice from among a number of private health insurance plans, offering varying benefits that employers and individuals could supplement. The pool could be administered by a public agency or by a private entity contracting with the state. Financing, assistance to low-income households, and most other policy details would be the same as under Connecticut Self-Insurance, with exceptions that include the following:

❖ The level of contribution required from employers would be higher, since this approach would be somewhat less effective in controlling costs. Firms would contribute 14.8 percent of payroll (if any) above $265,000 a year in 2007 dollars, excluding individual earnings above $200,000 a year.[21]

❖ The pool would offer a range of comprehensive health plans typical of current employer-based coverage. The pool would be modeled after the Federal Employees Health Benefits Plan (FEHBP). At least two benchmark plans would be offered that provide the same level of coverage furnished by average private employers in New England, as described in connection with the first option, above. Individuals choosing comparatively expensive plans would be charged higher premiums, since they would pay a percentage of the total premium, based on income. 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.

❖ 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 and submission system for provider claims.

2. Cost and coverage estimates

This option would cover all state residents, including 350,000 people who otherwise would be uninsured.

Despite this expansion in coverage, *total health care spending on the non-elderly would rise by only $395 million, or 2.7 percent*, increasing from $14.71 billion to $15.105 billion. To place this in context, the Center for Medicare and Medicaid Services of the U.S. Department of Health and Human Services estimates that the average annual increase in Connecticut's health spending from 1980 through 2004 was 8.4 percent.[22] Accordingly, the increased health care costs for covering all the uninsured, using this approach, would represent less than a third of the average annual increase in Connecticut health spending during the past 24 years.

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[21] As noted above, the median employer offering coverage now pays an amount equal to 12.2 percent of all payroll, including the first $265,000 per firm.

[22] Center for Medicare and Medicaid Services. *Health Expenditures by state of provider: Summary Tables, 1980-2004* (Final, February 2007).

Figure 6. Health spending for non-elderly residents of Connecticut: Status Quo vs. Select Care Choices (2007 dollars)
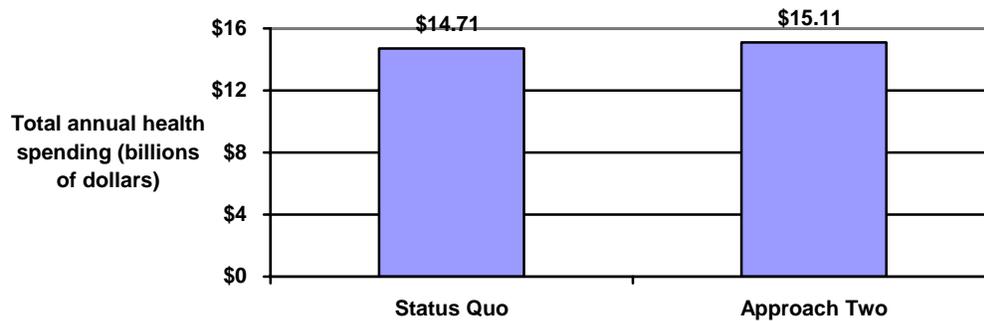
Source: Gruber Microsimulation Model.

Costs per insured resident under age 65 would decline by 9.4 percent, falling from $5,625 to $5,094. Such savings reflect economies assumed to be achieved through two strategies:[23] consumers in the pool would have financial incentives to select less expensive coverage; and with almost all non-elderly residents in the pool, administrators would have the purchasing power to obtain favorable premium bids from insurers. Using similar strategies, FEHBP has moderated cost increases in recent years much more effectively than have private employers. From 2002 to 2007, FEHBP premiums increased by an average of 7.3 percent, compared to 10.5 percent among all employers nationally.[24]

Secondary factors in limiting costs are 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 premiums.

These estimates include $225 million in administrative costs to run the health insurance purchasing pool, an amount equal to 2 percent of pool premium costs. For the federal health insurance purchasing pool that serves federal workers, on which this approach was based, the Office of Personnel Management spends less than one-tenth of one percent of health care costs on administration.[25] Accordingly, the administrative cost estimates included here assume more than a twenty-fold increase above the level experienced by the federal model, reflecting the additional responsibilities assumed by the pool administrator under the Select Care Choices plan. Under this approach, state administrative costs would be much lower than under the self-insurance option, since private health insurance plans would perform many administrative functions, the cost of which is included in premiums.

These per capita savings would have generally (though not uniformly) positive effects on stakeholders in the health care system, as described below.

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[23] The level of savings assumes premium costs that are 90 percent of average ESI in Connecticut in 2007, adjusted upwards to reflect 2 percent administrative costs for pool operation.

[24] U.S. Government Accountability Office. *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies among Participating Plans.* December 2006. GAO-07-141.

[25] K. Davis, et al., *The Federal Employee Health Benefits Program: A Model For Workers, Not Medicare.* The Commonwealth Fund. November 2003.

Employers

Under this option, *total employer payments for health insurance would fall by $755 million, or 9.5 percent.* Instead of paying $7.93 billion in premiums, employers would make $6.78 billion in required contributions, based on payroll, along with an estimated $400 million in payments for supplemental coverage. Figure 7 illustrates these effects on employers.

Figure 7. Changes in employer payments for health insurance under Select Care Choices (2007 dollars)
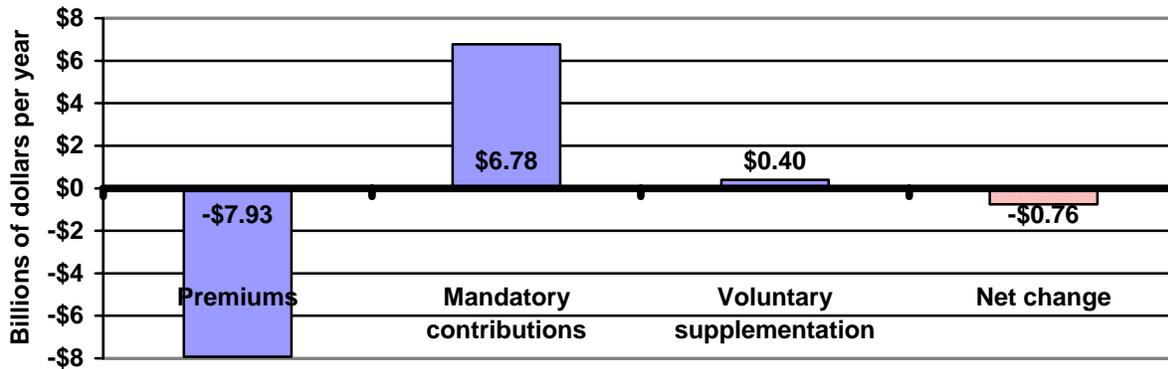
Source: Gruber Microsimulation Model.

As with the first option, the employers that achieve savings would see their health insurance spending change in character. Most 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 a 20 percent savings, amounting to $1.57 billion. That savings would be partially offset by wage increases, as noted above in conjunction with the first approach. Conversely, firms that previously did not offer coverage would incur approximately $811 million in new costs for health coverage, which would be offset to some degree by a reduction in wages. *Each set of companies – those that previously offered coverage and those that did not – would experience small changes in labor costs. But on balance, employers would see their labor costs decline modestly.*

Households

Household savings would be significant. Annual health costs directly paid by state residents would decline by 13 percent, from $4.585 billion to $4.0 billion. Instead of spending $2.645 billion on health insurance premiums, households would spend a total of $2.475 billion for the combination of income-based contributions and estimated payments for supplemental coverage. Out-of-pocket payments would decline by $415 million, from $1.94 billion to $1.525 billion. At the same time, because employers would pay less for health insurance, total wages and salaries would rise by $1.065 billion. As a result of increased earnings, federal and state income tax payments would likewise rise by roughly $275 million, resulting in after-tax income gains of $790 million. *Connecticut households' net income available for purposes other than the purchase of health care and*

health coverage would thus increase by $1.375 billion a year.[26] Distributed among all non-elderly residents, increased resources would average $1,173 per household.[27]

Figure 8. Impact of Select Care Choices on household income available for purposes other than health care (2007 dollars)
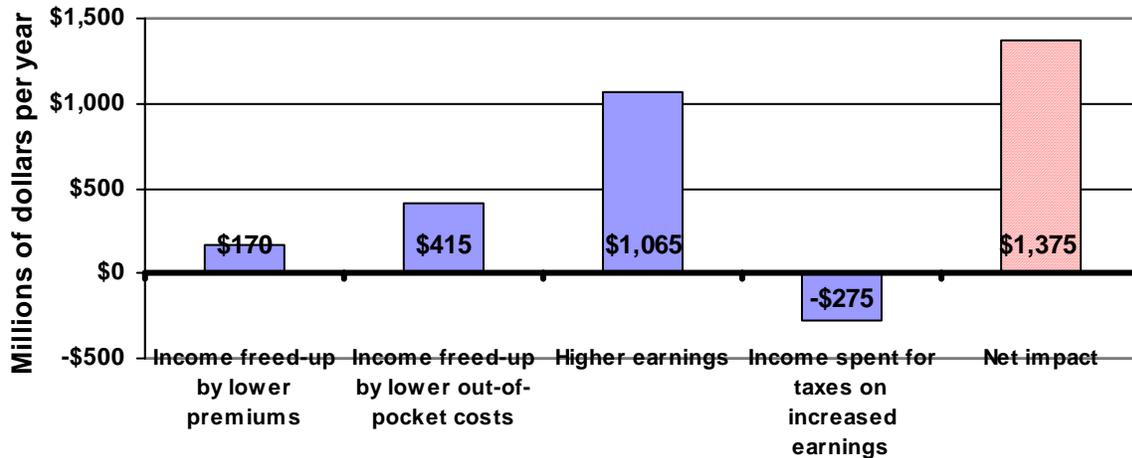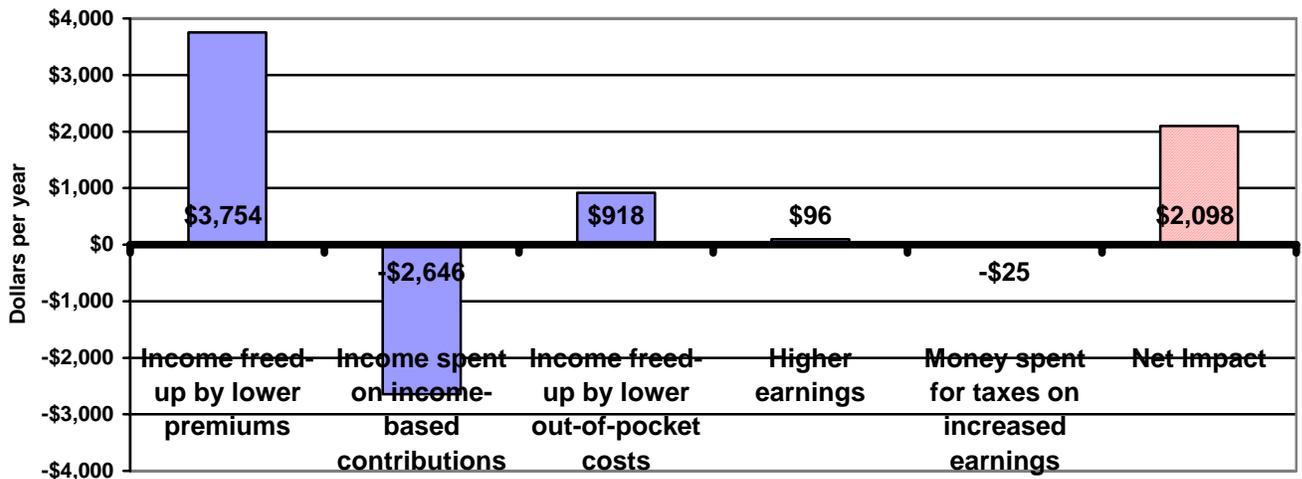

Source: Gruber Microsimulation Model.

For example, consider a family of four with two minor children and two working parents who earn $51,625 a year, or 250 percent of the federal poverty level (FPL); the family receives employer-sponsored insurance from a 50-employee company. Today, such a family's share of premiums averages $3,754. On average, out-of-pocket costs not covered because of deductibles and copayments reach $2,688 a year. With Connecticut Self-Reliance, that family would see its post-tax income rise by a small amount ($72 a year). The family's premium payments would decline by $1,108 and out-of-pocket costs would fall by $918, in part because the children would receive subsidies, based on family income below 300 percent of FPL. As a result of all these factors, the family would realize approximately $2,000 in direct financial gains. Higher-income families without subsidies would also realize benefits, albeit smaller in amount.

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[26] 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.
[27] For the basis of this estimate, see the discussion of the first option, above.

Figure 8A. Impact of Select Care Choices on an Average Four Person Family that Currently Has Income at 250 Percent of FPL and Insurance From a 50-Employee Company (2007 Dollars)

Source: Gruber Microsimulation Model.

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 $1.025 billion to $2.69 billion for the non-elderly. Federal cost increases would be modestly offset by a $275 million increase in federal income and payroll tax revenue. The increased cost to the General Fund would be limited to $70 million, since (a) the state would use employer contributions to "draw down" federal matching dollars; (b) the state would access more of the federal Medicaid and SCHIP allotments targeted to Connecticut; and (c) SAGA beneficiaries would shift from state-only SAGA to federally matched Medicaid.[28] In addition, the state, like other employers, could realize some savings from enhanced purchasing power and reduced cost-shifting that would lower premiums under this approach.

Health care providers

Select Care Choices would become the primary insurer for 315,000 current Medicaid beneficiaries. 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 vast majority of services provided to the state's non-elderly population. In addition, whatever administrative structure is established to guide policy development for all plans participating in Select Care Choices would need to institutionalize a strong voice of physicians and other health care providers to ensure that coverage policies fit the evolving medical science as well as the state's changing health care infrastructure.

Following is a table summarizing the estimates for Select Care Choices.

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[28] For a discussion of federal legal issues, see the earlier footnote on this point in connection with the self-insured plan.

Table 2. Health coverage estimates for 2007 (under age 65): Select Care Choices

Major types of coverage	Thousands of Covered Individuals		
	Current law	Select Care Choices	Change
1. Total number of insured	2,615	2,965	350
A. Employer-sponsored insurance	2,075	-	(2,075)
B. Nongroup insurance	175	-	(175)
C. Medicaid and SCHIP as primary insurer	365	50	(315)
D. Select Care Choices (pool)	0	2,915	2,915
2. Uninsured total	350	-	(350)

Health care cost estimates

Major types of spending	Millions of Dollars		
1. Total health spending in Connecticut	$ 14,710	$ 15,105	395
2. Total premiums and payments for covered services	$ 12,770	$ 13,580	810
A. Employer payments**	$ 7,930	$ 7,175	(755)
B. Household payments**	$ 2,645	$ 2,475	(170)
C. State Payments	$ 1,170	$ 1,240	70
D. Federal-share Medicaid, SCHIP	$ 1,025	$ 2,690	1,665
3. Out-of-pocket payments for uncovered services	$ 1,940	$ 1,525	(415)
			-

Income and tax estimates

	Millions of Dollars		
1. Total wages and salaries of CT residents	$ 72,510	$ 73,575	1,065
2. Federal income taxes paid by CT residents	$ 11,250	$ 11,485	235
3. Federal payroll taxes paid by CT residents	$ 7,740	$ 7,780	40
4. State income taxes paid by CT residents	$ 2,820	$ 2,820	-

Source: Gruber Microsimulation Model.

**Under Select Care Choices, employer and household payments include both voluntary and required contributions to health coverage. Under the status quo, all such contributions are voluntary.

E. Impact of reforms on the state's economy

The effect on the state's economy of the previous iteration of these reform options was projected using the REMI model, a commercially available macrosimulation model of each state's economy.[29] Those earlier versions were found to have modest, positive effects on employment and economic growth in the state (Table 3).

Table 3. Macroeconomicprojections for previous reform options

	Increased number of jobs	Increase to state GDP
Single health plan serving all state residents	6,000 to 11,000	$660 million to $830 million
Health insurance purchasing pool serving residents not offered employer-sponsored coverage	2,000 to 6,000	$320 million to $470 million

Source: Dorn, Meyer, and Wicks 2006. Urban Institute analysis using REMI macrosimulation model for Connecticut.

The two options discussed in this paper would probably have a net positive impact on the state economy comparable to the first option portrayed above, which was forecast to improve the state's economy primarily because firms that previously covered their workers would experience a 26 percent reduction in health coverage costs. That effect outweighed the harmful economic effects of requiring health insurance contributions from firms that formerly did not cover their employees.

As noted above, the two policies analyzed in the current paper would achieve slightly smaller savings for firms that currently cover their workers (23 and 20 percent savings, respectively, for Connecticut Self-Insurance and Select Care Choices). However, these two policies impose a smaller burden on the firms that do not cover their workers. That is because, unlike the earlier proposals that were subjected to macroeconomic modeling, the proposals discussed here spare the smallest firms from required contributions, and such firms are disproportionately likely not to cover their workers under the present system. As a result, while the "single state plan" policy modeled in 2006 was projected to have 18 percent of required employer contributions come from firms that did not previously offer coverage, the proposals discussed here lower that proportion to 12 percent. Put differently, the financing structure in the current set of proposals has been revised to lessen the harmful economic impact on small firms that did not previously cover their workers while still extending large savings to firms that currently offer insurance, which in all likelihood would result in an equal or greater net positive effect on Connecticut employment and state GDP (albeit still an impact of modest proportions, given the overall size of the Connecticut economy).

One caveat is important. While the above analysis seems reasonable, greater certainty could be achieved with a new round of macrosimulations applicable to the current set of proposals.

Some have suggested that proposals like those described here would, by greatly reducing profits from the sale of health insurance in Connecticut, cause significant harm to the state's insurance industry, with resulting loss of employment. While more than 67,000 Connecticut residents were employed by insurers in 2004, health insurance was responsible for 22,096 jobs, or less than a third of the insurance industry total, according to one analysis released by the insurance industry.[30] But insurers based in Connecticut are national in scope, in most

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[29] Dorn, Meyer, Wicks, op cit.

[30] Connecticut Economic Resource Center, Inc. *Connecticut's Insurance Industry: Economic Impacts & Contributions* (slide 10). December 2006.

cases. Based on Census Bureau data for 2004 and 2005, only 1.3 percent of U.S. enrollees in health insurance live in Connecticut.[31] Even a major reduction in the relatively small number of insurance policies sold in Connecticut is unlikely to have a major impact on any nationwide insurer, including those headquartered in Connecticut.

2. Issues raised by the Office of Fiscal Analysis

In recent months, the Office of Fiscal Analysis (OFA) has published Fiscal Notes analyzing SB 1371 and HB 7314. While these bills share important elements with the proposals discussed in this paper, there are important differences, including those that involve financing. While SB 1371, like the first approach discussed here, would enroll non-elderly residents into a single self-insured plan, the version of the bill analyzed by OFA had its financing mechanisms removed by the Insurance and Real Estate Committee before it favorably reported out the bill. By contrast, both approaches discussed here have specific financing mechanisms. As a result, the cost to the state General Fund is only $85 million for Connecticut Self-Insurance and $70 million for Select Care Choices.

Similarly, while HB 7314 would place non-elderly residents into a health insurance purchasing pool much like that in the Select Care Choices approach described here, HB 7314 would have all employers contribute an amount equal to 11 percent of payroll. By contrast, the financing mechanism discussed here would exempt the smallest firms and exclude certain earnings of the highest paid employees, as explained above.

Notwithstanding those differences, the OFA Fiscal Notes are important to the current analysis for two reasons. First, many of the key estimates by OFA and Dr. Gruber are in the same range. Second, OFA's analysis highlights gaps and questions involving the pending legislation that are essential to clarify in any future iteration of similar proposals.

A. Overlap between cost and revenue estimates

In estimating the impact of proposed reforms, one central question involves the cost of expanding coverage. Dr. Gruber's analysis suggests that, for the self-insured plan described above, the premium[32] per insured, non-elderly resident will average $4,275, which is at the lower end of the $4,000 to $6,000 range that OFA projects for SB 1371.

Parenthetically, it seems clear that the upper end of the OFA range would not apply to the proposals discussed here, which base benefits on average-cost private employer coverage. According to Dr. Gruber's analysis, premiums for employer-based insurance in Connecticut now average less than $4,000 per enrollee, even including public employee coverage, which tends to be more costly than insurance offered by private firms. While adding non-disabled Medicaid beneficiaries into the mix would raise premiums, both because of extra services and somewhat higher average levels of risk, it is hard to envision premiums reaching anything like $6,000 per enrollee in the near-term, at least for the covered benefits encompassed here.

An equally central question involves revenue. OFA forecasts that the employer assessment in HB 7314 would raise approximately $8 billion and that the proposal's individual, income-based assessment would generate

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[31] Estimates from Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of March Current Population Survey data, available from www.statehealthfacts.org.

[32] The full $4,747 cost per insured person described above includes out-of-pocket costs. The number at this point in the text, like the OFA range, concerns premium costs only.

$2.9 billion. Dr. Gruber's analysis concludes such assessments would raise $6.691 billion and $2.3 billion, respectively.[33] These estimates are in the same general range as but slightly lower than the OFA analysis.

However, with administrative costs, the estimates are substantially different. OFA estimates that, for HB 7314, administrative costs of running the health insurance purchasing pool and performing the other functions assigned to the comptroller would equal between 5 and 15 percent of total health insurance costs, or between $590 million and $2.655 billion. These costs would be in addition to administrative costs incurred by health insurers in marketing and advertising, enrolling and disenrolling individuals, processing claims, credentialing providers, assisting members, etc. (It is not clear whether such estimates would have been changed by more specific administrative appropriations in the bill.)

By contrast, the estimates in this paper assume administrative costs of $470 million and $225 million for Connecticut Self-Insurance and Select Care Choices, respectively. The former estimate assumes that the state would pay 4.5 percent of all spending for administrative costs, the level of administrative costs incurred by private insurers contracting with Medicare, as documented by the California study described above. As further explained above, the administrative cost estimate for Select Care Choices assumes that the Comptroller would pay, proportionately, more than twenty times what the Office of Personnel Management spends to administer the Federal Employees Health Benefits Program (FEHBP), the health insurance purchasing pool after which Select Care Choices was modeled.

One important characteristic of the cost estimates in this paper is that they are ongoing operational expenses. As noted above, the cost estimates do not include one-time expenses, such as the cost to build the administrative infrastructure required for a comprehensively reformed, statewide health system, which would be well above the operational level. To provide one example of how such start-up costs can exceed annual operating expenses, the Health Coverage Tax Credit, which was enacted in 2002 and represented an unprecedented, nationwide innovation in using the federal income tax system to cover the otherwise uninsured, eventually reached ongoing administrative costs of $20 million a year after spending $83 million during an 18-month start-up process.[34] Even if such infrastructure development costs are eventually recouped through more efficient provision of coverage, a significant administrative investment may be required in transitioning to a new system.

B. Legislative gaps and issues flagged by OFA

OFA's Fiscal Notes perform an important service in highlighting gaps in the current legislative bills, in addition to the absence of specific funding mechanisms. One such gap concerns federal matching funds. OFA rightly notes that Medicaid is the payer of last resort. OFA accordingly concludes that federal matching funds may be claimed only for the "wrap around" provision of supplemental benefits outside the coverage offered to state residents in general under both SB 1371 and HB 7314.

For the state to benefit from federal matching funds to the maximum degree possible under federal law, this issue must be squarely addressed in future iterations of these reform proposals. Accordingly, the approaches discussed in this paper would have Connecticut Self-Insurance and Select Care Choices comprise part of the Medicaid and SCHIP benefits package. Just as HUSKY today obtains full federal matching funds for a given beneficiary's enrollment in both a general capitated plan and a separate, "carved out" plan focused on

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[33] These estimates are not in the tables above, since they apply to the policy in HB 7314, not the two reform options on which the current paper focuses. However, the general correspondence between OFA's and Dr. Gruber's cost and revenue estimates for the policy in HB 7314 suggests that the same methodologies as applied to other policies could also yield results in the same general neighborhood.

[34] S. Dorn, *Administrative Costs for Advance Payment of Health Coverage Tax Credits: An Initial Analysis*, prepared by the Urban Institute for the Commonwealth Fund, March 2007.

behavioral health services, so under, for example, the first approach discussed in this paper, a given beneficiary would receive Medicaid through a combination of Connecticut Self-Insurance and supplemental coverage. State General Fund payments and employer contributions would both count as the state share in drawing down federal matching funds to cover, not just "wrap around services," but also the baseline, state-provided health care services for Medicaid- and SCHIP-eligible individuals.

A second issue raised by both Fiscal Notes involves collective bargaining agreements. As OFA rightly points out, such agreements need to be taken into account in designing proposals to place state and municipal employees into new coverage systems. Accordingly, the approaches discussed here would give employers (including public employers) the ability to purchase supplemental coverage. State and municipal employers may be able to meet the terms of their collective bargaining agreements by purchasing such supplemental coverage. If not, such agreements could be renegotiated or the workers could be enrolled in these new systems of coverage at the expiration of each bargaining unit's current agreement.

A third issue involves screening for potential Medicaid and SCHIP eligibility. OFA flagged the potential administrative cost in conducting such screening for all of the state's non-elderly residents. Accordingly, future proposals need to be explicit that population-wide screening would be limited to automatically matching and processing state-accessible income data. Additional assistance would go only to individuals identified by such matching as potentially qualifying for subsidies or individuals who request assistance or apply for aid.

Finally, OFA identified legislative gaps involving staffing and funding. Some of the legislation analyzed by OFA did not specifically provide for agency staff and compensation for commission members. Likewise, OFA identified various required appropriations that were not included in the bill, such as funding for reinsurance and IT development. These functions and staffing issues need to be addressed in future iterations of reform proposals.

Conclusion

At a cost of $85 million or less to the state General Fund dollars, all the state's uninsured could receive coverage through either of two comprehensive health reforms that would also yield large savings to most of the state's households and employers and, in all likelihood, provide a modest boost to the state's economy. Other carefully designed comprehensive reforms could no doubt accomplish similar results.