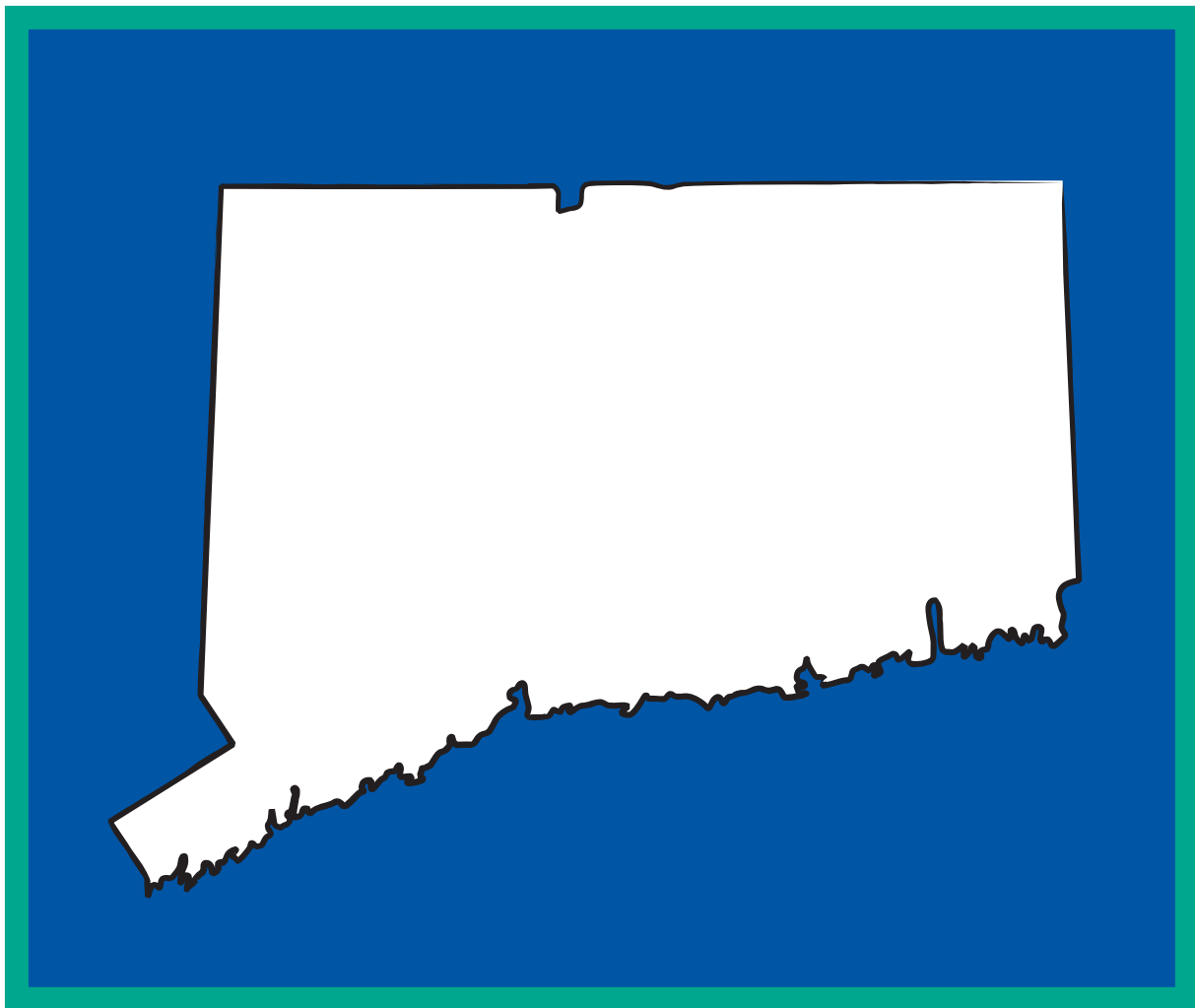


A Framework for Health Care Reform for Connecticut



from The Connecticut Health Insurance Policy Council, Inc.

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*Aetna made the decision not to support the Council's final report primarily because it did not recommend a limited individual coverage mandate in Connecticut. See page 21 for a discussion of this issue.

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A Framework For Health Care Reform For Connecticut

Executive Summary

The Connecticut Health Insurance Policy Council came together in July of 2006 to analyze issues and make recommendations for action on health care reform.

The importance of the undertaking to the participants is reflected in the fact that the membership of the Council is composed of senior executives of all of Connecticut's leading commercial health plans and business associations, as well as several of the state's leading employers. No group like this has been assembled in recent years in this state. The Council is a private, not-for-profit policy organization whose members have funded this project themselves and worked diligently for six months to fashion this report. We are indebted to Xerox Corporation for the production and printing of the document.

This report presents analyses of several problems associated with health care and health insurance, suggests broad goals for corrective action, and proposes a policy framework for the development of specific proposals.

1. Introduction

Our study has convinced us that health care reform must involve simultaneous and sustained action on three related challenges:

- improving the health status of our residents, particularly with regard to lifestyle-based diseases;

- improving the cost-effectiveness and quality (the "value") of health care services; and
- securing access to health insurance for those who lack it.

Mere health insurance reform is not enough, and lack of health insurance is not even the largest of these challenges in terms of the number of people affected. Because different parts of the health care system are managed by each of the public and private sectors, action is needed by both sectors to effect the needed changes. While the state needs to make some changes, so do employers, health plans, providers, and consumers. Moreover, these should not be viewed as discretionary matters. They are vital to the state's economic competitiveness, to the continued availability of our hospital and physician system, and to the well-being of consumers at all income levels.

2. Understanding the Problems

A. Health Status and Unhealthy Lifestyles

Connecticut ranks fifth from the top in a comprehensive ranking of the states in terms of health status, and has been moving up. But this comparative good news should

not mask either the importance of lifestyle factors to the overall health care cost issue, or to the health of many people in our state. For example:

- Nationally, 75% of health care spending is on diseases caused at least in part by unhealthy lifestyles;
- 16.5% of Connecticut residents smoke, and 20% are obese. These are probably the most important initial targets for action.
- Almost 10% of our adult residents have asthma, putting us near the bottom of the state rankings on that factor.
- We lag or have been dropping in several other areas that are probably impacted by our relatively high rates of urban poverty, including the incidence of infectious disease, the adequacy of prenatal care, and infant mortality.

B. The Cost and Quality of Insurance and Health Care

About \$22 billion was spent on health care services of all kinds in Connecticut in 2004. We know from decades of health services research that a material portion of this spending was wasted or is of questionable validity – more than enough wasted money than is needed to provide health insurance coverage for all.

The difficulty is that both nationally and in Connecticut we are sadly lacking in the means of measuring the cost-effectiveness and value of health care services. Consumers and employer-payers cannot easily compare the efficacy or quality of providers and therapies against the fees being charged, and, in fact, consumers don't typically know what the costs of services are until well after the point of service, if then.

Providers themselves often lack scientific bases for judging efficacy, and many do not have easy access to practice guidelines that codify what is established best practice.

An extensive effort on data collection, measuring and reporting results, establishing clinical guidelines and implementing them, and developing standards and rules for the deployment of information technology and electronic medical records must be central to health care reform. Information made available to the public should include data on both cost and quality in a consumer-friendly format. In short, health care reform has to address the need to put in place the information and technology infrastructure to manage cost and quality.

Further, Connecticut costs in a number of areas are unusually high compared to other states: for example, costs associated with mandated benefits (among the states, Connecticut is tied for third in the highest number of mandates), hospital costs (where we are 6th highest), nursing home costs (where we rank #1), and medical malpractice costs (where we rank #3 in average claims paid). Our state's private payers also experience heavy cost-shifting from Medicaid due to its inadequate levels of reimbursement for medical services. As a result of this, many participants cannot get access to physicians, which leads to overuse of expensive hospital emergency services.

Some people argue that if we could only lower the administrative costs of insurance, by moving to a so-called single-payer government-run system for example, we could solve the cost problem. But 86% of the average insurance premium dollar is spent on underlying health care costs, not on administration. Of the remaining 14%, most goes to necessary programs aimed at wellness promotion, consumer support, fraud detection, and cost containment, and

to costs associated with government regulation, taxes and cost shifting.

C. Lack of Insurance Coverage

Over 91% of Connecticut residents now have health insurance, with almost two-thirds of them gaining coverage through Employed-Sponsored Insurance (“ESI”). But there are important pockets of Connecticut residents who lack insurance, comprising about 300,000 people in total, whose needs should be addressed through targeted solutions. Special analyses of this uninsured population, prepared for the Council by the Lewin Group (“Lewin”) of Falls Church, Virginia, reveal several important groups to focus on for coverage expansion:

- 46% are among the “working poor” – those with household incomes from 100–300% of the Federal Poverty Level (“FPL”). (The 2006 Poverty Guidelines published by the U.S. Department of Health and Human Services, set the FPL at \$9,800 for a single person, and \$20,000 for a family of four.) Getting insurance to these people will require some kind of subsidy.
- 22% of the uninsured may be financially eligible for Medicaid but have not enrolled, and most of these are children under age 18.
- 66% of the uninsured have a working family member, but over 80% of those have no access to ESI either because their employers do not offer health care insurance or they are not eligible for it.
- About 37,000 workers and dependents declined coverage, presumably because it was too expensive.
- Another important and difficult subgroup of the uninsured is the 17%

(50,000 people) who are part-time employees but have no access to coverage from any non-Medicaid source (such as a plan covering a working spouse).

- 52% of uninsured workers and dependents are in small businesses – firms with less than 50 employees. Small business needs to be a key target of any reform.
- 41.5% are young adults, ages 19-34. Many of those choose to go without coverage rather than spend the money for insurance.

3. Goals for Health Care Reform

We need to set aggressive goals for a comprehensive health care reform effort. We see this effort as central to the ongoing competitiveness of our business community and the health of our citizens. Our overall goal should be to make Connecticut’s health care and health insurance systems a competitive advantage for businesses and residents. We suggest three goals, all of equal importance:

1. Connecticut should strive to become the healthiest state in the country by 2020, and should reach top three status overall and be in first place in lowest rates of obesity and smoking within five years.
2. High quality and affordable health care should become a source of economic vitality and a competitive advantage for Connecticut compared to other states. We should put systems in place so that our health care and insurance costs trend below the average of other states, and that make us leaders in deploying

data and technology to measure and improve health care cost-effectiveness and quality in a way that is meaningful to consumers.

3. It should be unacceptable for anyone to be unable to obtain health insurance coverage in our state. A proximate goal should be to reduce the number of uninsured by half in three years.

4. Policy Framework

We offer ten key principles to guide the development of specific policies and programs. They emphasize a coordinated approach of driving for improvements in health status, cost-effectiveness and quality, and insurance coverage.

1. We must expand and improve Connecticut's health care data and technology infrastructure. This means an improved shared-use health care data system, development and implementation of clinical guidelines, provision of cost and quality information to consumers, and deployment of electronic medical record systems.
2. We should build upon, not replace, the current ESI-based financing system. It is the system in place for almost two-thirds of our residents, and it provides most of the leadership in areas of wellness promotion, cost containment and quality enhancement. It should be strengthened, not replaced, and the private sector should take the lead.
3. Employers and the health insurance industry, working together, need to take more aggressive steps to achieve health care reform goals through creative plan design and benefit management. The private sector needs to take concerted action to generalize the use of wellness, cost containment, consumer information and other tools in model plan designs that have been shown to work, and should also take steps to help low-wage and part-time workers purchase coverage.
4. Individuals should be encouraged to take personal responsibility in making proper use of the health care and insurance systems. Consumers and Medicaid participants need to be given incentives to maintain healthy lifestyles and to use the health care system efficiently. The Council could not come to a consensus on whether upper income people who can afford health insurance should be required to have it.
5. The state needs to facilitate the offering of more affordable policies. This means that the state should allow and encourage health plans to offer customized and more affordable plans to special groups that lack coverage, and may include selective relaxation of benefits mandates.
6. The state should develop a new subsidy program to lower the cost of insurance for certain groups and individuals. Provision of new state subsidies should come with the condition that model plan design elements are used.
7. The state should re-examine public policies that drive health costs higher. Certain of our legal, regulatory and legislative requirements add unnecessary health care costs and should be re-examined. This should include consideration of special health courts to handle malpractice disputes.
8. The state should expand efforts to enroll eligible people in Medicaid, especially children in HUSKY where federal matching funds are going unused.

9. The state should reform the structure and financing of Medicaid. The state could stretch Medicaid funds further by using them to support participants through employer-sponsored health insurance plans and by bringing the benefit package more in line with commercial coverage. Reimbursement rates to providers must be improved to assure access to services and reduce cost shifting to the private sector.
10. We should create an authority with dedicated funding to encourage healthy lifestyles. We need a single purpose, public-private agency to mobilize effort on key healthy lifestyle and public health initiatives.

5. A Program Example

While the Council is not making specific program recommendations at this time, we want our proposed policy framework to be tested against the state's financial realities. Accordingly, the Lewin Group has priced out a specific set of program assumptions – not Council recommendations as such – to test their impact on state costs and coverage. Here are the assumptions:

- Health plans and the Department of Insurance, working together, will be able to fashion customized lower-cost policies for special groups that lower the cost of coverage by 15% below average commercial rates in Connecticut;
- The state will provide a 25% refundable tax credit to small employers who start to provide coverage for their workers;

- The state will provide a premium subsidy to previously uninsured individuals between 100–300% of FPL to help them buy into the lower cost private plans;
- People in households with incomes above 500% of FPL will be required to have coverage or pay a fine equal to the cost of insurance;
- HUSKY outreach programs will succeed in enrolling one-third of the eligible but not enrolled population;
- The SAGA program will be expanded to cover all those below 100% of FPL, solely through added state funding (though federal matching would be sought);
- The Medicaid benefit plan will be revised to be comparable with those provided under typical private coverage, but with no change in Medicaid's nominal co-payments; and
- Medicaid payments for hospitals, doctors, and other health professionals will be increased by 10%.

Using the Lewin Health Benefits Simulation Model (HBSM), the results of this hypothetical scenario in terms of reduction of the uninsured and cost to the state are shown on the next page.

Estimated Cost and Reduction in the Uninsured Population in Connecticut by Policy Provision			
	Reduction in Uninsured	State Cost (millions)	Federal Costs (millions)
<i>Overlapping Estimates of Program Impacts</i>			
Cover one-third of Medicaid/SCHIP not enrolled	22,000	\$18.6	\$21.8
Increase the income eligibility level under the State-Administered General Assistance (SAGA) program to 100 percent of the FPL for all single adults and married couples without children	11,220	\$29.2	--
Reduce private insurance premiums by 15%			
Individual coverage	10,700	--	--
Employer Coverage	16,900	--	--
25% employer tax credit for small firms that start to offer insurance	31,800	\$26.9	--
Premium subsidies for individuals between 100% and 300% of the FPL	27,750	\$72.3	--
Redesign Medicaid benefits for hospital, physician and other health professional health services	--	(\$65.0)	(\$65.6)
Increase Medicaid reimbursement by 10% for hospitals, physicians and other health professionals	--	\$101.2	\$103.0
Mandate for people living above 500% of the FPL to have coverage	49,000	(\$4.0)	--
<i>Non-Overlapping Total</i>			
Non-Overlapping Total	157,440	\$167.4	\$59.2

In addition, an estimated \$10 million would be needed in the first year to support initiatives in the areas of cost containment, quality improvement, and healthy lifestyles, consistent with the Council's Policy Framework, for a total cost to the state of about \$177 million.

Policy Report

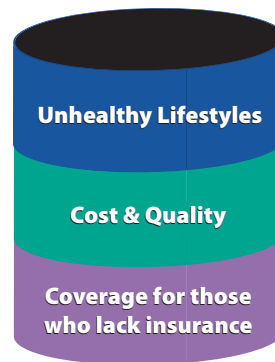
1. Introduction

In what many regard as a positive development, the focus of health care and health insurance reform has moved in recent years from the federal to the state governments. At least 20 states have enacted health reform initiatives of varying degrees of breadth, with our neighboring state of Massachusetts being one of the most recent and the most extensive to date. It is time for Connecticut to take up that challenge.

A first step in that effort is to define the problem we need to address. After six months of work, the Council has come to the unanimous view that the problem is not just the lack of health insurance coverage, though that is certainly a very real issue. Instead, there are three closely related challenges that must be addressed simultaneously:

- The need to improve the health status of a large portion of the state's population, particularly with regard to lifestyle-based disease factors;
- The need to improve the cost-effectiveness and quality of our health care system, so that the dollars that are spent are buying a better value product; and
- The lack of health insurance coverage for many of our citizens to assist them in gaining access to care.

It is useful to think of these issues in the form of a cake with three layers – all part of the same overall problem as shown in the graphic to the top right. If our population were healthier, and/or if health care were delivered in a truly cost-effective and measurably higher quality manner, there would be more than enough money already available in the system to deliver affordable health insurance to everyone.



We have also concluded that this report cannot only be about what the state government should do about health care reform. Since the financing and operation of our health care system is shared between the public and private sectors, it needs to be about what all of us in both sectors, including employers, providers and consumers, must do to help fix the problems.

The Council is convinced that actions that produce steady, meaningful, and comprehensive improvements in Connecticut's health care system are critical to the state's economic competitiveness and vitality. Failure to make such improvements will seriously jeopardize our economic future, undermine the financial stability of our hospitals, discourage talented professionals from opening and maintaining health care practices, ensure an increase in the gap between the haves and have-nots of our society, and reduce our ability to grow jobs and to sustain our premier quality of life. In short, we cannot choose between action and inaction. Our choice is between acting on a planned and orderly basis now or reacting in an ever more crisis-oriented fashion in the future.

Our report begins with background on the public and private health insurance structure in Connecticut as an introduction to analysis of the issues central to health care reform.

2. Background on Health Insurance in Connecticut

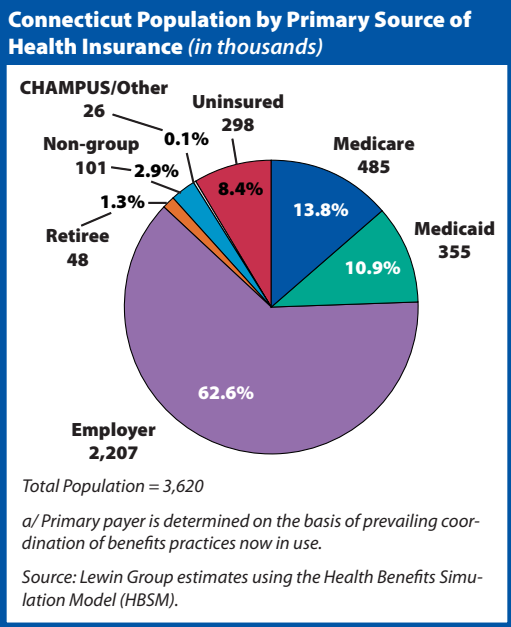
Over 91% of state residents are currently insured by either public or private programs (see the chart to the right). This is a record that Connecticut’s citizens should take pride in – and it should not be overlooked while focusing on solutions for those state residents who are not currently insured.

To elaborate on this chart:

Employer-Sponsored Insurance (“ESI”) including both workers and retirees covers 64% of the Connecticut population, one of the highest proportions among the 50 states.

- Of this number, 52% of enrolled employees in Connecticut are covered by so-called “self-insured” plans.¹ These plans, because they are self-insured (the employer is taking the risk) and are not covered by a policy of insurance issued by an insurer or a health plan that is subject to state insurance law, are governed by the federal Employee Retirement Income Security Act of 1974 (ERISA). This puts them beyond the reach of state insurance regulation and any state coverage or benefit mandates that might be imposed on state-regulated insurance plans. This fact becomes very important when considering state-level solutions to coverage problems.²

Insurance for individuals and their dependents is available from a variety of health insurers and health plans in Connecticut, though it is inherently more expensive than group coverage due to, among other things, the lack of economies of scale, tax advantages, and employer contributions. Health insur-



Important Conclusions From This Data:

- 64% of the insurance coverage for Connecticut’s population is employer-sponsored – one of the highest among the 50 states
- 52% of that employer-sponsored group are covered by self-insured plans, which are governed by ERISA and are beyond the reach of state coverage or benefit mandates
- Almost 25% are covered under public programs – Medicare, Medicaid and CHAMPUS
- Only 2.9% receive coverage through the individual market

ers and health plans can “medically underwrite” (adjust rates or exclude from coverage) individuals in our state, but low-risk individuals may actually find individual coverage less costly than employer-based coverage. Without such medical underwriting, the cost of individual coverage in Connecticut would be substantially higher.

- Because medical underwriting can result in high-risk people being unable to get coverage in the regular market, the health insurance industry worked with the state to establish the nonprofit Health Reinsurance Association (HRA) in 1975. The HRA is a high-risk pool that offers comprehensive health insurance benefits to eligible individuals and their families. HRA rates may vary by age and gender, but by statute premiums must be at least 125%, and no more than 150%, of the average rates for Connecticut employers with 10 employees. For example, the monthly HRA premium in 2006 for an individual (non-conversion) PPO plan for a husband and wife in their early 40s with one child would be \$1,294. There are lower rates for low income people – in the above example if household income were below \$32,160, the monthly rate would fall to \$902. But this cost is close to \$11,000 per year and would be unaffordable for a low income family with after-tax income below \$32,000. Clearly, for the high-risk pool to be a viable option for lower income people, it needs some additional, sustainable, broad-based source of premium subsidy. In 2005, 2,487 people were covered through the HRA in Connecticut.³

Employer-based or “group” coverage is available for small groups with one to 50 employees. Medical underwriting is not permitted and pricing variation is permitted only according to age, gender, family size, and a few other non-medical factors. (Note: an individual applicant bears the burden of proof to show that he or she is an employed group of one (a “sole proprietor”), and many simply prefer to access the individual market.)

Public health insurance programs are also critical to providing coverage for some Con-

necticut residents. As the chart on the previous page shows, 10.9% of the state population is covered by the Medicaid program.

- Most of Medicaid in Connecticut is administered by managed care companies under contract with the state, and this part of the program is called “HUSKY”. “HUSKY A” is managed Medicaid covering children under 19 years old and parents, or a relative caregiver living with such children, where household income is no more than 150% of the Federal Poverty Level or FPL;⁴ and pregnant women and children under 19 years old where household income is no more than 185% of FPL.⁵
- “HUSKY B” is the name for the federal-state program known as “SCHIP” (State Children’s Health Insurance Programs), extending coverage through managed care arrangements for children up to 300% of FPL.
- There also remains a category of people in fee-for-service Medicaid, administered directly by the state, covering those who for various reasons are exempted from the managed care plans as well as the aged, blind and disabled (“ABD”) program operating pursuant to the federal law.
- While the Lewin Census-based figures from March, 2006 show an estimate of 355,000 people in Medicaid, the state’s actual current count is approximately 305,000 people in the HUSKY programs (15,000 of whom are children in HUSKY B), and another 101,000 in fee-for-service Medicaid, for a total of about 406,000. In addition, about 31,000 single individuals or childless couples are covered under the State-Administered General Assistance program (SAGA), which is funded only by the state.

- An additional 13.8% of the state’s population, or 485,000 people, are covered by the federal Medicare program.

3. Understanding the Problems

Fortunately, there have been several recent reports written on health care issues in Connecticut from which we can draw. Among those we will cite are the following:

“Snapshot: Connecticut’s Health Insurance Coverage,” based on 2004 data and released in January, 2005 by the Connecticut Office of Health Care Access, and *“Health Insurance coverage in Connecticut: Executive Summary of the 2006 Household Survey,”* released by OHCA in December, 2006 (hereinafter, “OHCA”).

“Mapping Health Spending and Insurance Coverage in Connecticut,” February, 2006, by the Universal Health Care Foundation of Connecticut (hereinafter, “Foundation”).

“Connecticut Health Scorecard, 2006,” developed by the Business Council of Fairfield County (hereinafter, “Business Council”).

In addition, the Connecticut Health Insurance Policy Council has contracted with The Lewin Group of Falls Church, Virginia (“Lewin”), a health care consulting organization recognized nationally for its experience and expertise in statistical and economic analyses of state and federal health insurance reform proposals. Lewin has prepared extensive analyses of the uninsured population in Connecticut and of various policy proposals that were considered in the development of this report.

A. Health Status

Beginning our analysis with the top layer of the three layered cake, clearly a great potential impact can be gained from improving the health status or “wellness” of our residents through the promotion of healthy lifestyles. This is not to suggest that Connecticut does badly when compared to other states. In fact, in 2006 we rank fifth – up from seventh in 2005 – in “America’s Health Rankings,” a compilation of state rankings produced by the United Health Foundation, the American Public Health Association, and the Partnership for Prevention.⁶ We were ranked behind only Minnesota, Vermont, New Hampshire and Hawaii. The summary on Connecticut in the most recent ranking is attached as Appendix 1.

Despite this comparatively high ranking, we cannot be complacent. Research shows the striking impact on health care costs from lifestyle-related factors: 75% of health care spending is on diseases caused at least in part by unhealthy lifestyles.⁷ For example, there was an estimated \$37 billion in private health care spending related to obesity in 2002.⁸

Some of the best and most recent comparative health status data for Connecticut are found in the Business Council and America’s Health Rankings reports. There is much to be both pleased and concerned about in these studies:

- 16.5% of Connecticut adults smoke and 20% are obese – even though in both cases, we rank as the third best state.
- 9.7% of our adult residents have asthma, and Connecticut is ranked 47th (50th being worst) in the nation on this factor.
- We rank #1 in rate of childhood vaccinations, but we rank 16th in infant deaths per 100,000 live births.

- In oral health, we rank #1.
- In cancer incidence per 100,000 we are 38th.
- We rank 39th in the number of infectious disease cases per 100,000 population.
- We are 14th in adequacy of prenatal care, down sharply from 5th in 2005.
- We are 18th in per capita public health spending.
- We have dropped from 1st in 1990 to 10th place in 2006 in the percentage of the population without health insurance.

We have attached the Business Council's summary "Health Scorecard" as Appendix 2. This succinctly presents a large amount of health status information on our state population.

Effective work by both the private and public sectors on prevention and wellness programs, especially those oriented to reduction of lifestyle-related health risks, needs to be central to any health care reform. The fact that these risks are rooted in pervasive national and global behavior patterns that are hard to change does not mean that we cannot make progress.

B. The Cost & Quality of Health Insurance and Health Care

While still the mainstay of insurance coverage in the United States, ESI is being stressed by a variety of factors, mostly having to do with rising costs. Health benefit premiums have risen an average of 7.7% per year from 1997–2006, substantially outstripping the general rate of inflation.⁹ Nationally, employment-based coverage for the

non-elderly population dropped by about 5 million people from 2000 to 2004, to 159.5 million.¹⁰ At the same time, the cost burden of health coverage on consumers is increasing. The percentage of families spending more than 10% of family income on out-of-pocket health care costs increased from 8% in 1996-97 to 10% by 2001-02; and when consumer premium costs are included, that figure rose to 18%.¹¹

Approximately \$22 billion was spent in Connecticut in 2004 (the most recent year for which comprehensive statistics are available) on health care services of all kinds.¹² We know from decades of research that a significant portion of this money is spent unnecessarily – on therapies and services with little or no benefit for the patient.¹³ Consumers and even doctors often have to make decisions based on imperfect information, and some of this extra spending is inevitable. But much of it is not, and health care reform initiatives need to put in place systems and incentives that help consumers and providers of all kinds to make better and more cost-effective decisions.

Health care spending is heavily concentrated on the sickest people: studies have shown that during the last quarter of the 20th century, the sickest 5% of the population consistently accounted for more than half of health spending, while 10% accounted for more than two-thirds. The healthiest 50% of the group accounted for less than 5% of costs.¹⁴ Efforts to improve the efficiency and effectiveness of health care need to focus therefore on the sickest people, addressing quality of care and cost containment issues.

Any health care reform initiative cannot focus only on cost but must also ask whether we are getting value for our investment in terms of quality of service and good outcomes. Compared to a few other states, Connecticut has not been a leader

in assembling information about quality of care as delivered by our resident health care providers, but such information is critically needed to permit payers and consumers to make informed choices. We can and should work to lower the cost of health care itself by managing it better. In so doing, we can improve the quality of care by avoiding such things as unnecessary procedures, adverse drug reactions and defensive medicine, and by employing practice guidelines and evidence-based medicine techniques, deploying electronic medical record systems, and increasing efforts on prevention and wellness.

A recent study which lays out a comprehensive long-term program for reform of health care delivery is “Redefining Health Care: Creating Value-Based Competition on Results,” by Michael E. Porter and Elizabeth Olmsted Teiberg¹⁵. Among many other factors, it is notable that the authors place special emphasis on the need to develop greater individual accountability for participation in health care (e.g., meeting a reasonable set of individual obligations such as personal responsibility to participate in healthy living practices and compliance with medical treatment advice).

Health care costs have a direct bearing on insurance cost and affordability. Premium

increases closely follow health care cost increases – between 1993 and 2003, premiums grew nationally at an annual rate of 7.3%, paralleling closely the 7.2% annual growth of health care costs. The principle contributor to this growth in health care costs is increased utilization.

Some people argue that if we could only lower health insurance administrative expenses, we could solve the cost problem. But, as the graphic on page 7 shows (“Where Does Your Health Insurance Dollar Go?”), on average 86 cents of the commercial health insurance premium dollar is spent on direct health care services (i.e., hospital care, physician care, medical devices, and prescription drugs); only 14 cents is spent on all other costs, including administration. Three cents comprises the health insurance carrier’s profit margin. Of the remaining eleven cents, five cents goes to other consumer services, provider support and marketing (including wellness promotion and disease prevention, disease management, care coordination, investments in health information technology, fraud protection, and health support). An estimated six cents goes to government payments, regulation and administrative costs (e.g., claims administration).¹⁶

Where Does Your Health Insurance Dollar Go?



* Includes prevention, disease management, care coordination, investments in health information technologies and health support.

**Includes the inpatient costs of hospitals and the outpatient costs of hospitals and free-standing clinics.

Based on a PricewaterhouseCoopers' analysis. *Factors Fueling Rising Healthcare Costs 2006.*
© 2006 America's Health Insurance Plans



This graphic is used with the permission of America's Health Insurance Plans.

Moreover, the administrative expenses incurred by health insurers must be weighed against the value provided by those services. Private sector health plans and insurers have been responsible for developing many innovative benefit programs that have resulted in improving consumer health outcomes through more efficient and effective health care delivery.

For instance, health insurers provide work-site wellness programs that impact lifestyle behaviors to improve enrollees' health status and reduce the inappropriate use of health care resources and absenteeism while increasing productivity. As another example, a health insurer's coronary artery disease

management program may save enrollees pain and suffering and an employer-provided benefit plan considerable health care expense if a heart attack can be prevented. Health insurers also incur expenses in curbing unnecessary and inappropriate utilization of health care services, and in negotiating discounts off full charges from providers. The savings from these activities are generally passed back to employers and consumers. In short, we have to spend money on wellness initiatives and other cost containment programs in order to improve our health status and save money elsewhere.

Any comparison of an employer-sponsored insurance system to a single-payer system must take into account these fundamental

differences, as the single-payer system by itself is unlikely to develop the cost-saving characteristics described above.

Since the cost of health care and insurance is high everywhere in the United States, perhaps the best way to gain perspective on Connecticut is to determine where our health care and insurance costs and our regulatory structure are out of line compared to other states. The following are some examples:

- In 2003, ESI premiums in Connecticut for family, employee-plus-one, and single coverage were 6th, 2nd, and 12th highest respectively among the states.¹⁷ Premiums for very small Connecticut employers, those with 10 or fewer employees, were 2nd highest in the nation in 2006.¹⁸
- With 46 mandated benefits, Connecticut is tied for third place among the states having the highest number of benefit mandates imposed on insured group plans. It is outranked by only Maryland and Virginia.¹⁹ Since these mandates only affect insured as opposed to self-insured employers, they fall primarily on plans offered by smaller employers who generally are not large enough to self-insure their plans. These mandates are estimated to constitute as much as 30-40% of the cost of coverage, but since most commercial insurance would in any case include many of the mandated benefits, the true incremental cost of the mandates is estimated at 15-20%.
- In 2003, our average daily hospital costs were 6th highest among the states.²⁰
- Overall Medicaid costs per enrollee were 2nd highest, but there are huge differences within participant groups: Connecticut was 1st in costs for the elderly, 36th in costs for children,

and 46th in costs for non-disabled, non-elderly adults.²¹ Connecticut's Medicaid benefit plans are among the richest (and, therefore, most costly) in the country.

- Nursing home costs account for 14.5% of health care spending in Connecticut, making the Nutmeg State 1st among all the states in this category.²²
- Connecticut ranks 3rd in average medical malpractice claims paid, behind only Illinois and Hawaii.²³ Nationally, the cost of medical liability and defensive medicine consumes 10% of the premium dollar.²⁴
- According to data published by the American Health Planning Association²⁵, Connecticut has one of the most extensive Certificate of Need (CON) programs in the country, although certain improvements were made in the last session of the Legislature.²⁶ The costs and benefits of our CON process need to continue to be examined.

Further, under the heading of health care costs and quality, there is an important area where we may not be spending enough. Our Medicaid programs are widely acknowledged as under-funded. The Council strongly believes that policymakers need to confront the fact that these programs, which serve Connecticut's neediest population, are negatively impacting the commercial insurance marketplace due to their low reimbursement levels which have the effect of shifting costs to private and commercial patients. This cost shifting creates higher premiums for private payers and employers and contributes to cost escalation which forces some employers to drop coverage. [Note that because Council members Anthem and HealthNet are participating plans in the HUSKY program, they cannot take any position regarding the need for added

funding for the program and have recused themselves from voting on these sections in this report.]

Medicaid underfunding of its providers is well documented and leads to the inability of many Medicaid participants to access physicians' services other than through costly emergency room visits. In the case of the state's hospitals, reimbursements are set at 62.5–75% of hospital costs.²⁷ In the case of physicians, the Council was able to gather data on Medicaid fees paid to over 300 family practitioners, pediatricians, internal medicine specialists, and ob/gyns throughout the state. For the family practice/pediatric/internal medicine physicians, the state's fee schedule for the key evaluation and management (E&M) and preventive service codes was 26% below what managed Medicaid pays and 47% below what commercial plans pay. Similar patterns apply in the case of obstetricians/gynecologists.

These fee shortfalls have a predictable impact on physician willingness to see Medicaid patients. For the family practice/pediatric/internal medicine group, 75% of the physician practices were closed to new Medicaid patients. We're confident that the access problems are even worse in certain higher-cost specialties such as neurology, dermatology, and orthopedics. Much of the overuse of emergency rooms can be traced to the fact that this entry point into the system is the only way many Medicaid participants can see a doctor. The reimbursement structure is also negative for the HUSKY managed care operators in Connecticut who are constrained in terms of the reimbursements they can pass through to providers and the care management programs they can bring to bear.

The cost shift produced by the state's under-reimbursement of medical providers together with the cost of unreimbursed charity care is further magnified by the

impact of the federal Medicare program, which is beyond the scope of this report.

Effectively addressing inadequacies in government reimbursement of participating health plans and providers, and the consequent impact on physician participation and hospital financial stability, must be part of any attack on the problem of the uninsured. At the same time, more money should not be spent in an unmanaged fashion in Medicaid. The managed Medicaid providers are already applying a range of cost-saving technologies in their programs, and they must be encouraged and funded to do even more. The HUSKY program and the Medicaid fee-for-service program need to be financially stabilized and funded based on sound actuarial principles in order for an adequate provider network to be achieved and to prevent the cost-shifting to the commercial market that is currently occurring. This should be coupled with benefit redesign to more fairly replicate average commercial benefits in the HUSKY program and to maximize federal dollars for the program.

There is another side to the issue of high health care costs – health care as a generator of employment. This issue cuts two ways. On the one hand, high health care costs are typically listed as the number one issue for the business community in annual surveys by the Connecticut Business and Industry Association (CBIA) on the factors inhibiting job growth. On the other hand, the health care industry produces large numbers of jobs and is a major driver of the national and Connecticut economies. In September of 2006, *BusinessWeek*²⁸ reported that health care represents 12% of the total national workforce, and that since 2001, the health care industry has added 1.7 million jobs nationwide while the rest of the private sector taken as a whole had negative job growth.²⁹ This pattern certainly

applies in Connecticut where health care (as defined by BusinessWeek) is responsible for 212,000 jobs or 18% of the Connecticut workforce.³⁰ Further, the health care sector is attractive as an economic engine in that it offers a wide range of jobs for people of all skill levels. Any proposal for health reform in Connecticut needs to model its varying impacts on employment as an important consideration.

Growth in demand for health care as “boomers” age and the simultaneous reduction in the number of health care professionals caused by retirements will create inflationary pressures and serious challenges to quality. The State of Connecticut should develop a strategy to retain professionals beyond currently anticipated retirement dates, recruit professionals from other states, and “grow our own” by building the capacity of the higher education system to graduate more qualified health professionals. Curriculum, teaching and guidance changes K-12 will also be necessary to produce qualified candidates for these expanded educational resources.

There is one final cost issue which, while not dealt with in this report, is one of the largest facing the state – the need to deal with the problem of unfunded state employee retiree health programs. These liabilities will be reflected in footnotes to the state’s financial statements under new Government Accounting Standards Board (GASB) accounting rules starting in FY 2008, and will likely negatively impact the state’s bond ratings.

C. Lack of Health Insurance Coverage

Unfortunately, there is no single authoritative estimate of the uninsured population in our state. Based on 2005 Census data

reported in 2006, Connecticut ranks 10th among the states with the lowest percentage of people who are uninsured. 11.3% of the population or 393,944 people did not have health insurance.³¹ The Census data purports to track people who were uninsured for the previous year, but given the way people respond to the question the Census has said recently that its estimates are more closely in line with so-called “point-in-time” estimates.³²

By contrast, according to the most recent OHCA data 6.4% of the population or about 223,000 people lacked insurance at the time of its 2006 survey (a point in time estimate). OHCA’s telephone surveys arguably undercount the uninsured by being unable to reach those who lack telephones. OHCA estimates that 10% of the population or about 347,000 people lacked coverage at any point in the preceding year, a number closer to the Census figure.

Lewin uses the Census data but applies a correction factor to take into account widely accepted views about the undercounting of Medicaid participants in the Census data. The Lewin estimate is 297,700 people in Connecticut who were uninsured, or 8.4% of the population.³³ These figures all include undocumented residents (non-citizens). Any of these estimates can be used for analytic purposes and all should be understood to be approximate.

We generally use the Lewin estimates since they lie midway between the estimates of OHCA and the Census Bureau.

The Council believes expanding coverage for the uninsured requires careful analysis of the different segments of the uninsured population, since needs vary widely. Different types of initiatives will likely be required for different groups. We have looked at the composition of the uninsured population across several critical categories: family income, Medicaid eligibility, connection to

the workforce, employer firm size, and by age, race, and citizenship. Many important conclusions emerge which form the basis for a policy framework.

1. Analysis by Family Income

Figure 1 below segments the uninsured in Connecticut by family income and income as a percent of the Federal Poverty Level (FPL). The U.S. Department of Health and Human Services 2006 FPL Guidelines set the FPL at \$9,800 for a single person and \$20,000 for a family of four (with two children).

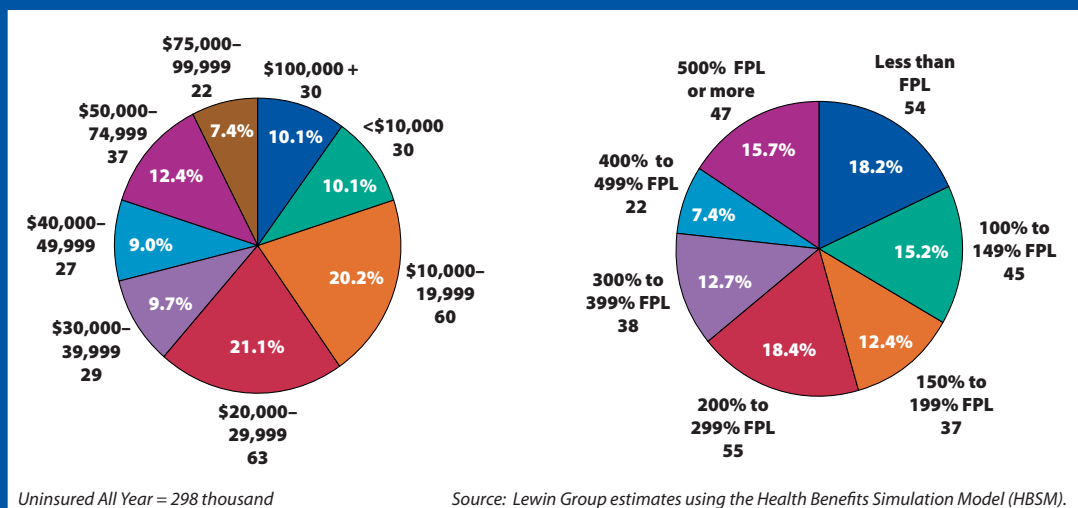
Analysis of this data shows that:

- While 18.2% are “poor” (under 100% of FPL)³⁴, a significantly larger 46% are

the so-called “working poor” (100-300% of FPL) who have a regular connection to the workforce. Whether ESI can be a more accessible solution for this group needs to be examined.

- A surprisingly high 15.7% of the uninsured are in households at 500% of FPL (a little over \$50,000 for a single person and a little under \$100,000 for a family of four) or higher. These people should be able to afford private insurance. Some members of this group presumably chose to self-insure or “go bare” because they think they do not need insurance, raising the question as to whether they need stronger incentives to get coverage and, if so, what types of incentives would be effective.

Figure 1: Uninsured in Connecticut By Family Income and Income As A Percent Of The Federal Poverty Level (FPL) (in thousands)



Important Conclusions From This Data:

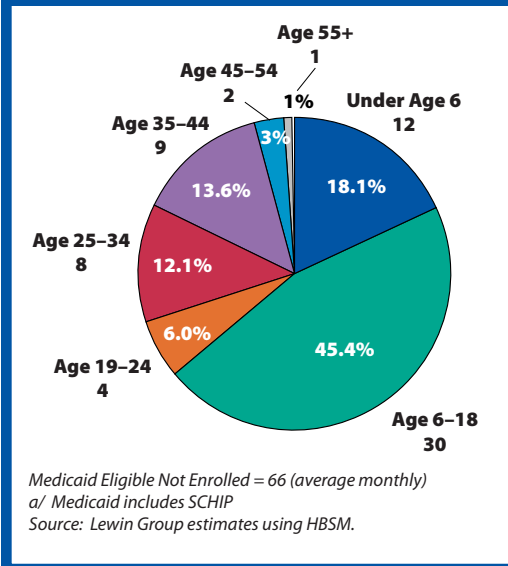
- 46% are the so-called “working poor” (100-300% of FPL) who have a regular connection to the workforce.
- A material 15.7% (those at 500+% of FPL) can afford insurance but choose to self-insure or “go bare” because they think they don’t need it.

2. Analysis by Medicaid Eligibility

The Connecticut Medicaid program serves a valuable function in providing coverage for over 400,000 people. While over 80% of Medicaid eligibles are enrolled in the program, Lewin estimates that 22.2% of the uninsured, or 66,000 people, may be financially eligible for Medicaid but not enrolled in the program. This clearly illustrates the need for improved outreach programs. As we see from Figure 2:

- Almost two-thirds (63.5%) are children under age 18, reflecting the higher income eligibility thresholds for children under HUSKY B and the program’s limited penetration.
- The low percentage of adults age 35 and over reflects the lack of eligibility under Medicaid for adult households without children. This group is only partially eligible under SAGA.

Figure 2: Uninsured Eligible For Medicaid But Not Enrolled, By Age



Important Conclusions From This Data:

- 66,000 of the uninsured may be financially eligible for Medicaid but are not enrolled – calling for improved outreach programs.
- Almost two-thirds (63.5%) of this group are children <18 – meaning that HUSKY B is not adequately reaching its target.

3. Analysis by Connection to the Workforce

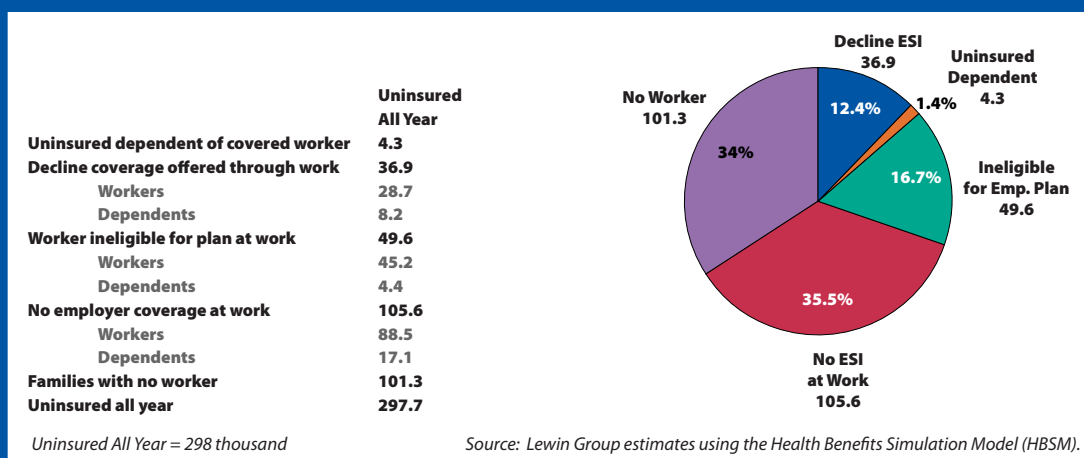
Figure 3 below illustrates that:

- Two-thirds of the uninsured (66%) have a working family member. But 53.6% of that 66% – over four-fifths – have no access to ESI, either because their employer did not offer any coverage or they were ineligible because the employer did not offer coverage for part-time employees and/or dependents. We need to target those employers to encourage them to offer insurance, or we must find other solutions for those workers. A particularly important subgroup is the people who are employed part-time and are not

covered from any other non-Medicaid source (for example, neither under the HUSKY program nor through coverage under the benefit plan of a full-time employed spouse). Lewin estimates this group at 50,000 or about 17% of the state’s uninsured.

- 12.4% of the uninsured have declined employer-based coverage, presumably because of cost. This points to a need for assistance for lower-wage workers in companies that do offer health benefits.
- 34% have no connection to the workforce, so for most of them improved Medicaid outreach must be stressed.

Figure 3: Uninsured in Connecticut By Connection To The Workforce (in thousands)



Important Conclusions From This Data:

- 66% of the uninsured have a working family member, but 53.6% of that group has no access to ESI. We need to encourage those employers to offer insurance or find other solutions for their employees.
- 50,000 uninsured are part-time employees with no access to coverage from any source.
- There is a need for assistance for lower-wage workers who cannot afford to enroll in their employers’ programs.
- 34% have no workforce connection, so improved Medicaid outreach must be stressed.

4. Analysis by Firm Size

Figure 4 shows that:

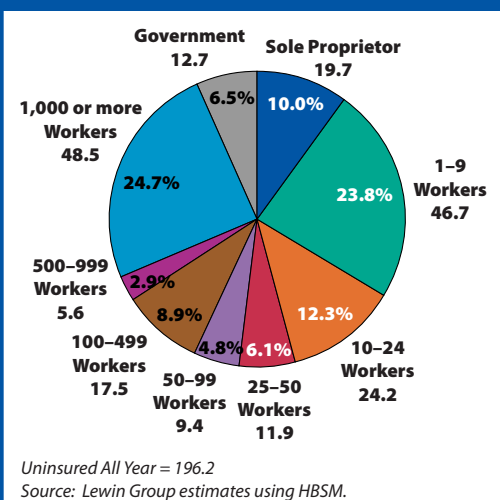
- 52.2% of uninsured workers and dependents are in firms with less than 50 employees – confirming the conventional wisdom that the problem is focused on the small employer category. But a surprisingly large 24.7% are in firms of 1,000 or more. These are mostly the part-time workers, again pointing to the need for a solution for this group.

5. Analysis by Age

In Figure 5 below:

- It is interesting that only 18.3% of the uninsured are children – a much larger group, at 41.5%, is young adults ages 19–34.
- Since only 18% are children under age 18, it is unlikely that meaningful health insurance reform can be achieved by focusing solely on children.

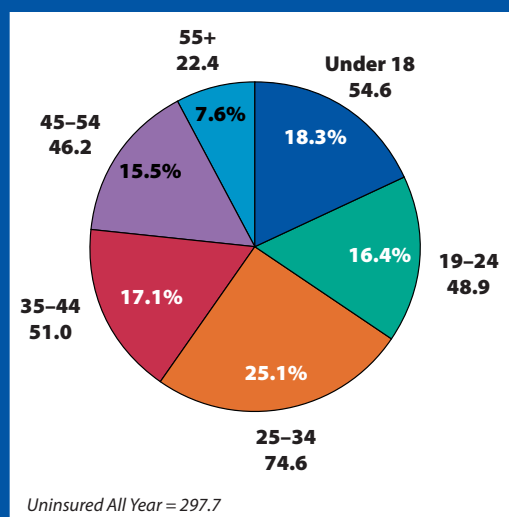
Figure 4: Uninsured Workers and Dependents in Connecticut By Employer Firm Size (in thousands)



Important Conclusions From This Data:

- 52.2% are in firms with <50 employees, confirming the need for program focus on small employers.
- A surprisingly large 24.7% are in firms of 1,000+ – mostly part-time workers – so a different solution for this group is needed.

Figure 5: Distribution of Uninsured in Connecticut By Age in 2006 (in thousands)



Important Conclusions From This Data:

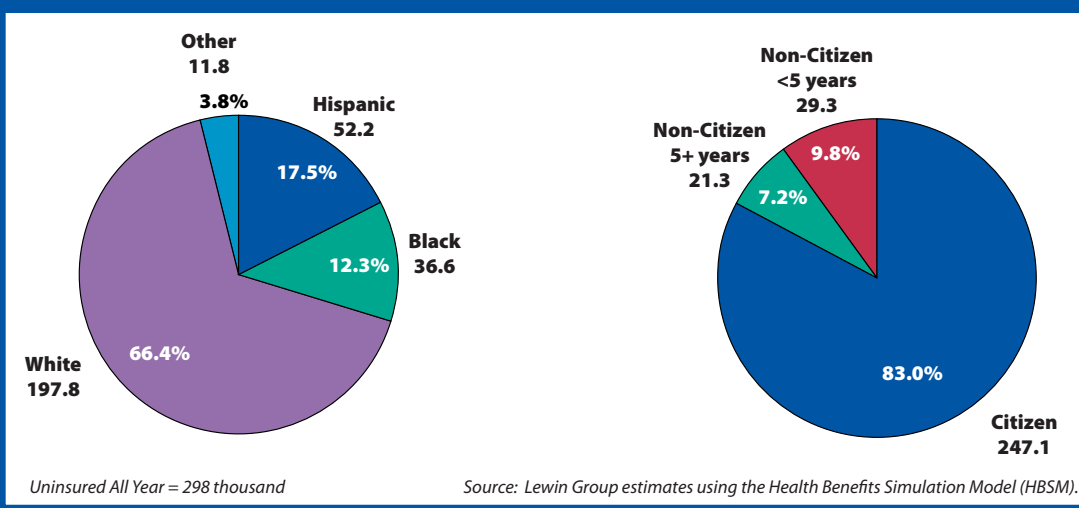
- The largest group (41.5%) of uninsured is young adults between ages 19–34.

6. Analysis by Race and Citizenship

Figure 6 below shows an analysis of the uninsured by ethnicity and citizenship in Connecticut. A material discrepancy between the Lewin/Census data and the latest OHCA report occurs in the racial breakdown of the uninsured population. The

Lewin analysis suggests that 34% of the uninsured are non-white of which 17.5% are Hispanic, while the OHCA data shows 55% are non-white and 35% Hispanic. More work is needed to understand the difference between the estimates but, whatever the reasons, more attention clearly needs to be paid to achieving coverage of minority populations, especially Hispanics.

Figure 6: Uninsured by Race/Ethnicity and Citizenship Status (in thousands)



Important Conclusions From This Data:

- We need a plan with culturally sensitive insurance initiatives to reach the Hispanic and the non-citizen populations, each of which constitutes more than 15% of the uninsured.

Summary

Taken together, this analysis calls for a targeted policy prescription that focuses on the largest opportunities for expanding insurance coverage and health care access by:

- Securing access to health care coverage for the working poor; between 100–300% of FPL, who constitute about 46% of the uninsured;
- Aggressively expanding Medicaid outreach, especially as applied to children

for whom federal matching funds are available under HUSKY;

- Helping employers, and especially those with less than 50 employees, to offer insurance at prices that they and their lower income employees can afford;
- Finding a solution for coverage for part-time and temporary employees;
- Targeting young adults with lower cost policies

4. Health Reform Goals

Health care reform cannot just be about “universal health care”, or “what can the state do to get to 100% health insurance coverage.” Rather, it has to be about what the private and public sectors, separately and together, can do to achieve necessary change in health status, health care costs and quality, and insurance coverage.

Such a health care reform effort in Connecticut should be driven by clear and aggressive goals. Without clear objectives, programs cannot be designed nor success measured. These goals must be set and accepted for the public sector by the Governor, the Legislature, and state agencies; and for the private sector by participants at every level including businesses, health care providers, insurers, and consumers.

As an overall objective, we suggest that health care reform should seek to make our health care and health insurance systems competitive advantages for our businesses and residents. In pursuit of these objectives, we propose three specific goals and emphasize that they all must be worked on concurrently and urgently.

1. Connecticut should strive to become the healthiest state in the country by 2020. Our state should reach top three status overall, and be in first place in rates of obesity and smoking, within five years.
2. High quality health care at affordable cost should become a source of economic vitality and a competitive advantage for Connecticut compared to other states, measured by:
 - (a) Below average increases in health insurance premium costs compared to

other states over rolling three-year measurement periods; and

- (b) Leadership among the states in implementing systems to aggregate and use data to measure and improve health care cost-effectiveness and quality in a meaningful way to consumers.
3. It should be unacceptable for anyone to be unable to obtain health insurance coverage in our state. We should strive to expand health insurance coverage to virtually 100% of the state’s population over time, with the specific goal of reducing the percent of uninsured by 50% in three years, and another 50% of the remainder in three more years.

We considered an alternative goal of achieving 100% coverage of children only, but rejected that for several reasons. While it has appeal, this approach is inconsistent with the basic structure of employer-based insurance which provides coverage on a family-wide basis, it distorts the risk pool within employer-provided coverage to the disadvantage of singles and couples without children, and it undervalues the importance of making sure that the wage earners in a family have effective access to health care coverage themselves in order to remain productive and able to work to feed and support their children. Further, such an approach would reach only 18% of the state’s population.

Lastly, initiatives to achieve these health insurance and health care reform goals must be sustainable financially, and should be consistent with the state’s need to manage expenditures within the Constitutional spending cap.

5. Policy Framework

From the foregoing analysis of key issues and from the proposed goals for health care reform in our state, the Council has sought to develop a “policy framework” to guide its further work. Our intent is to discuss and refine this framework with other interested groups as part of a collective effort to develop more detailed proposals.

We suggest the following principles as the basis for health care reform in Connecticut.

1. We must expand and improve Connecticut’s health care data and technology infrastructure. Policymakers, employers, consumers and providers all need better data on coverage, cost, quality, and health status to manage our complicated health care system. Priorities for the state and the private sector should include creating a shared-use health care data system, facilitating the development and implementation of “best practice” clinical guidelines by providers, and employing “pay for performance” reimbursement programs, giving consumers access to appropriate cost and quality information (“transparency”), and supporting the installation of electronic medical record systems by doctors and other providers. Any initiative to increase the use of information technology and electronic medical records must include the use of nationally recognized interoperability and privacy standards.

► **Discussion:** We need several types of improved health care management tools in the form of data and technology systems. First, we need an interoperable health data system with appropriate privacy controls to inform policy development, consumer decision-making, and performance monitoring. A central objective of that data system would be to make appropriate cost and quality information about health plans, hospitals, physicians and other providers widely available to consumers. Second, information made available to providers, health plans, and consumers should include data on both cost and quality, if possible on an episode-of-care basis, and presented in a way that is meaningful and useful to consumers. Third, we need widely accepted clinical standards and practice guidelines to assist providers and to benchmark measurements of quality. As the health care system redirects resources to prevention, wellness maintenance, and disease/condition management, new performance metrics need to be selected and tracked over time. These would include, for example, comparing data on recommended best practice vs. actual procedures performed in early detection screening such as mammograms. The percentage of women who need mammograms who get them – rather than merely able to get them – is an important piece of data in a system that values health and total cost as well as equitable access. With support from employers, health plans should adopt universal provider quality protocols and standards. See below, for example, the uniform stan-

dards for treatment of diabetes that were developed in New Mexico for use by all of that state's health plans.

New Mexico Takes On Diabetes

In 1999 the not-for-profit New Mexico Takes on Diabetes (NMTOD) was formed with grants from the American Diabetes Association and America's Health Insurance Plans (AHIP), to address the problems related to treatment and prevention of this chronic illness in the state. As a result, today providers and health plans in New Mexico use a one-page common set of standards for treatment of diabetes that that they developed based on the American Diabetes Association's work. These are updated annually and supplemented with quarterly newsletters.

The state has one of the highest diabetes rates in the country: nearly 7% of the population (120,000 people) have diabetes, and more than \$1 billion a year is spent on diabetes treatment in the state.

Today there are 26 members of NMTOD, representing a broad coalition of health plans, provider groups (physicians and hospitals), the New Mexico Department of Health, and the New Mexico Medical Review Association. Its activities are focused on provider and consumer education, prevention, early diagnosis, and appropriate treatment of people with diabetes. As its next project, this group has asked the New Mexico legislature for \$800,000 to fund the development of a diabetes system that would link all providers by computer and allow professionals to share information easily.

Fourth, we need improved information technology throughout the system – including electronic medical records (EMR) and personal health records systems – to help providers and consumers make better decisions. Employers and health plans, working together, should provide incentives to encourage network-based providers to install technology and make other needed changes.

The evidence that the use of electronic medical records improves patient care, reduces errors, and cuts down on unnecessary tests and paperwork is mounting. Other countries are far ahead of this nation in the use of such tools. A recent study found that approximately 28% of primary care physicians in the U.S. use electronic medical records, compared with 98% of those in the Netherlands, 92% in New Zealand, 89% in the United Kingdom, 79% in Australia, and 42% in Germany. Only Canada, at 23%, ranked lower than the U.S.³⁵ As this situation is remedied, it is anticipated that similar types of cost savings and increases in quality and productivity will be seen in the health care industry as have been realized in other sectors of the economy as a result of widespread implementation of computerized systems.

2. We should build upon, not replace, the current financing system. Employer-Sponsored Insurance is now and should remain the primary source of health benefits for working individuals and their families, and the primary source of initiatives on issues of wellness, cost containment and quality. That system needs to be built upon and strengthened, not weakened by governmental action. Connecticut does not need, nor can it afford, a single-payer system that would require an extraordinary redirection of public and private funding and create a new governmental bureaucracy, while at the same time casting aside the role and demonstrated capabilities of the private sector in achieving broad and significant health reform goals.

► **Discussion:** A tax-funded single payer system would produce very large dislocations in every aspect of our health care and health insurance system and would seriously challenge state finances. As we have seen in the current Medicaid program, taxpayer funded health care tends to underpay providers as rising costs bump up against funding limits set by the Constitutional spending cap. So-called single payer systems will not necessarily restrain costs without considerable rationing of care and are inconsistent with the way in which most Americans want their health care decisions made. Most so-called single payer systems are really “single decider” systems.

Further, the private sector has been the source of almost all of our nation’s advances in encouraging wellness and prevention and creating systems to better manage cost and quality. A government-run system of any kind would surely sacrifice that critical source of innovation and improvement. Since almost two-thirds of uninsured adults are working full or part time and 64% of our population has ESI, the single most important step that can be taken to increase insurance coverage is to assure that employers provide, and employees participate in, work-based coverage. It might be tempting to consider a requirement that employers provide insurance coverage – whether directly or through a “pay or play” mandate. But that would ignore both the fact that ERISA prevents such mandates and the economic realities that constrain many employers from taking on these added costs. Moreover, if ESI

is to be the bedrock of the system, it would be inadvisable to create expensive public programs – through a broad expansion of HUSKY, for example – which would compete with ESI and which might tempt employers to drop coverage.

3. Employers and the health insurance industry, working together, need to take more aggressive steps to achieve health care reform goals through creative plan design and benefit management. This principal is the inevitable corollary of the preceding point – if we want to preserve a system which is largely privately financed and administered, then the private sector has to take the lead in fixing it. In fact, employers and insurers have implemented many useful programs in the areas of wellness promotion, disease management, cost containment, quality improvement and financing, but these programs are unevenly deployed and generally uncoordinated. The private sector needs to organize itself better in Connecticut to define and implement the “best practices” that are needed in the management of employee health benefits. Such model plan designs and services should also apply to benefit plans for governmental workers and, where appropriate, to Medicaid.

► **Discussion:** Improvements in all three of our focus areas – healthy lifestyles, cost containment and quality, and expansion of affordable coverage – can be advanced through innovative employer benefit plan designs and financing. In the area of plan design, there are key elements which most

benefits experts would agree should be part of a “model plan.” The accompanying chart to the right lays out some of those elements, encompassing such things as wellness incentives, disease management, consumer information, and appropriate and selective consumer cost sharing.

The business community, perhaps acting through its various trade and business associations, may be in the best position to define such best practices, with support from health plans and consultants. Health insurers and health plans should provide appropriate incentives to agents and brokers to sell such plan designs.

The responsibility of the business community should also extend to finding solutions to fill gaps in health insurance coverage for low-wage and part-time workers, at least where the employer is already providing coverage for full-time employees. For example, some companies now scale their employee premium contributions, cost sharing, and/or out-of-pocket maximums according to wage levels – thereby assisting lower-income workers to elect coverage (see the example on page 21). More companies should do that. In the case of part-time and temporary workers, employers should be encouraged – with state assistance as necessary – to step up to providing at least a pro rata contribution to a benefit plan. So, for example, an employer might provide one-half its normal premium contribution to a 20-hour per week employee, and a mechanism might be put in place whereby such an employee could piece together funding from multiple employers in order to buy coverage.

Plan Design Enablers Of Cost Containment

There is much that employers and health plans can do in plan design and treatment of covered services that would contain costs and help consumers make more cost-effective choices. The following is a non-exhaustive list of benefit elements that the private sector, in a voluntary manner, should adopt and promote.

1. Provide consumers with financial incentives, through premium reductions or contributions to FSAs or HRAs, to undertake key wellness programs such as health risk appraisals, smoking cessation and weight management, and to use personal health records (PHRs).
2. Reduce barriers to preventive treatments. Ensure that key preventive services--such as annual exams, periodic mammography and PSA tests, and vaccinations – as well as medications for chronic disease where patient compliance is important – are exempt in whole or part from cost sharing.
3. Manage prescription drug use through the use of tiered formularies, prior authorization for selected drugs, mail order programs, generic substitution initiatives, and cost comparison information for consumers.
4. Promote better management of chronic diseases (such as diabetes, asthma, and cardiovascular disease) through patient coaching, testing, and disease management programs, and consider putting both generic and branded drug treatments for those conditions into the lowest cost formulary tiers to encourage compliance.
5. Use coinsurance and other point-of-care cost sharing to create cost consciousness on the part of the consumer, but with a cap on individual consumer out-of-pocket expense.
6. Provide participants with tools and information to become better consumers. This can include such things as nurse advice lines, patient advocates, financial modeling for health plan choice, and hospital and physician report cards.
7. Offer benefit plan choices, including account-based high deductible health plans. These plans are less costly than traditional plans and can permit consumers to retain the financial benefits of better managing their expenses.

An Example of An Employer Taking Steps to Expand Coverage

**XEROX HEALTH BENEFIT PLAN:
INCOME-BASED PLAN DESIGN FEATURES**

Stamford-based Xerox has incorporated a number of innovative and forward-looking design features in its employee health benefit plan, including some employer contributions based on employee salary levels.

**Salary-related Deductibles/
Out-Of-Pocket Maximums**

- The deductible is set at 1% of pay for an individual and 2% for family. These are both capped at \$80,000 in wages.
- Maximum out-of-pocket costs are capped at 5.5% of salary.

**Salary-related Employer FSA
Contributions**

Xerox makes contributions to flexible spending accounts for employees based on employee salary levels. These accounts, called Health Care Accounts at Xerox, are Section 125 plans, subject to the annual Internal Revenue Service use-it-or-lose-it rules. Xerox makes income-adjusted contributions to these accounts for employees based on the following salary levels:

<u>Annualized Salary</u>	<u>Xerox Contribution to Health Care Account</u>
\$30,000 or less	\$300.
\$30,000-50,000	\$200.
\$50,000-80,000	\$100.

4. We need to encourage personal responsibility in making proper use of the health care and insurance systems. Consumers at all income levels need to take responsibility for using the health care system in a cost-effective way and for maintaining their own health through more healthy lifestyles. Both the public and private sectors should explore incentives through plan design and other means to encourage healthy behavior and cost-effective decision making which can have the effect of lowering costs for all. By way of extension of this principal, the Council examined whether Connecticut should put in place a broad mandate as enacted in Massachusetts that would require individuals to have health insurance from either private or public sources. Some members thought that a limited individual mandate for people who could afford insurance, for example those with incomes above 500% of FPL, would be desirable, but there was strong disagreement and no consensus on that proposition.

► **Discussion:** There are strong arguments for and against individual mandates or coverage requirements. Many people object on philosophical grounds to forcing people to buy health insurance, since that interferes with their free use of their own resources. Further, even at higher income levels, the cost of insurance can be a burden. On the other hand, requiring coverage where it is affordable can restore a group of healthy people to the risk pool and lower the cost of coverage for others, and it can avoid the potential for cost shifting if

a non-participant has a catastrophic cost he cannot pay for.

There was no disagreement, however, on the need for a much heightened sense of personal responsibility for the proper use of health care services and insurance coverage. The Council strongly supports promoting personal responsibility by educating and empowering consumers and giving them better tools to make good decisions, while at the same time providing financial incentives to do so. This should include incentives that can be included in any type of health benefit plan design for participants to maintain healthy lifestyles. The development of plans that offer incentives for healthy lifestyles should be encouraged, and Medicaid recipients should also have incentives associated with the proper use of health care services and the maintenance of healthy lifestyles. Several states have begun such programs.

5. The state needs to facilitate the provision of more affordable policies. Insurers should be permitted to offer customized and lower cost policies in special situations so that uninsured employers and individuals can gain access to affordable coverage. This means selective relaxation of benefit mandates, flexibility in the structuring of cost sharing, and approval of appropriate “flexible benefit plans.” At the very least, such affordable policies should be allowed for small businesses that have not offered health benefits in the recent past, lower-income people in the individual market, part-time and temporary workers, and young adults. See the chart to the right on Flexible Benefit Plans.

Flexible Benefits Plans: Pathways to Health Insurance Coverage

A 2002 PricewaterhouseCoopers report found that mandates and government regulation of health plans and insurers increased very substantially between 1987 and 1996, and 15% of the overall increase in health care premium costs between 2001 and 2002 was attributable to government mandates.

Given the significant health care premium increases in recent years, 11 states have enacted legislation permitting health plans and insurers to offer flexible health benefit plans that are exempt from some or all state-mandated benefits.

Providing flexible health benefit plans tailored to the needs of specific segments of the uninsured population helps members of these target populations gain access to health care and financial protection through coverage at reduced cost. Such plans, in the interests of controlling costs, are exempted from state-mandated health benefits in whole or in part, and permit different cost-sharing features and/or coverage limits such as higher than average deductibles or dollar limits on specific services.

Post-Graduate Bridge Plans for Young Adults

An example of such a flexible benefit plan would be a plan to cover uninsured young adults who have graduated from school but are not yet employed by a company offering health benefits. All of the coverage provisions and limitations must be clearly explained to individuals in marketing and enrollment materials so that participants are fully aware of the customized plan design features.

Such a flexible plan, for example, could exclude state benefit mandates that do not address basic medical coverage needs for this population such as infertility services, mammography and prostate screening, maternity coverage, and birth-to-three coverage.

Health plans and insurers offering such plans might also be required to also offer at least one policy that would cover all state-mandated benefits.

Ideally, greater flexibility in benefit design would also be made available in the rest of the private health insurance market, since all employers and consumers are struggling with increasing cost burdens.

► **Discussion:** Well intentioned benefit mandates and coverage requirements can have the unintended effect of making health insurance unaffordable for many employers and individuals. As a first step, it is more important to get basic coverage to people than it is to insist on application of all state mandates. These policies should be seen as creating pathways to more all-inclusive coverage at a later time. Employers and individuals should be able to make these tradeoff decisions between cost and types of coverage without undue interference from regulators and legislators.

6. The state should develop a new subsidy program to lower the cost of insurance for certain groups and individuals. Even with more flexible and lower cost policies available in the market, many employers and individuals will not be able to afford them. Some state subsidies will be necessary. (It is also important for federal tax policy to be changed to provide the same deductions for individually purchased insurance as apply to employer-based coverage.) Any new state premium subsidy programs should have as a requirement the use of model benefit design provisions as described above.

► **Discussion:** There are several ways in which state subsidies in support of the expansion of private cov-

erage might be provided: tax credits (refundable or not), and premium subsidies for lower income employees and individuals with low incomes in the high risk pool. Whatever subsidy vehicles are chosen, limited state resources must be carefully targeted on uninsured people, even though that may raise equity issues for other individuals or businesses which have stretched financially to acquire coverage. These vehicles must also take advantage of research that shows likely take-up rates and price elasticity effects. The Lewin simulation models are grounded in such research and often show that hoped-for results will not necessarily be achieved.

7. The state must re-examine public policies that drive health costs higher. The state needs to seriously address several areas where Connecticut is out of line in terms of health care costs as a result of our legal, regulatory and legislative climates. These include medical malpractice, benefit mandates, hospital costs, and Certificate of Need (CON) requirements.

► **Discussion:** Our background analysis indicated several areas where our state appears to have excessive embedded costs. These need to be aggressively investigated and solutions developed if we are to bring our costs in line with those of other states. An area of particular concern is medical malpractice costs. Every effort should be made to consider the merits of new processes and structures to lower the costs of medical professional liability insurance and defensive medicine, including special health courts and/or a no-fault system.

8. The state should expand efforts to enroll eligible people in Medicaid. The current HUSKY program should undertake a major and sustained effort to enroll eligible individuals since an estimated 22% of the uninsured may be financially eligible and not enrolled. Consideration needs to be given to using some version of an “automatic enrollment” program (e.g., enrollment of households receiving food stamps unless they affirmatively decline coverage).

► **Discussion:** Until very recently, HUSKY outreach activities have been very limited because of budget constraints. A \$1 million appropriation in the last session of the Legislature is a good start and needs to be built upon. Special efforts need to be made to reach the Hispanic population.

9. The state must reform the structure and financing of Medicaid. Efforts should be made to expand Medicaid with federal funding to cover single individuals and childless couples up to 100% of FPL, replacing the state-funded SAGA program. Even if federal funding cannot be secured, SAGA needs to be expanded to cover our neediest residents – all those below 100% of FPL.

Wherever possible, Medicaid funds should be used to help eligible people buy into employer-based coverage so that they are in the mainstream health care system. Cost savings should be sought by bringing the Medicaid benefit package more in line with typical employer-based coverage.

Additionally, the growth in nursing home costs (not part of the HUSKY

program) must also be restrained so that Connecticut’s overall Medicaid program is in better balance in terms of support for children and adults as well as the elderly and disabled.

Lastly, reimbursement for managed Medicaid plans and providers should be based on reimbursement levels that would reduce and, over time, eliminate cost-shifting from public to private programs, and assure covered individuals access to care. The Council strongly believes that policymakers need to confront the fact that these programs, which serve Connecticut’s neediest population, are negatively impacting the commercial insurance marketplace due to low reimbursement levels which have the effect of shifting costs to private and commercial patients. This cost shifting creates higher premiums for private payers and employers and contributes to cost escalation which forces some employers to drop coverage. [Note that because Council members Anthem and HealthNet are participating plans in the HUSKY program, they cannot take any position regarding the need for added funding for the program and have recused themselves from voting on these sections in this report.]

► **Discussion:** Medicaid is an important and valuable program, and with some careful refinements it can make an even stronger contribution to reducing the number of uninsured people in Connecticut and to enhancing health care quality while restraining costs. The Legislature should address the need to redesign coverage under the public program to levels more in line with what the working

population receives. Health plan and provider reimbursement should be addressed so that the provision of public health insurance is not a hollow promise involving limited ability to access physicians and forcing overuse of expensive hospital emergency care.

10. We should create an authority with dedicated funding to encourage healthy lifestyles. If Connecticut is to become the healthiest state by 2020, it will have to commit funding and public and private will power to getting the job done. This job cannot be left to already overburdened state agencies. Consideration should be given to creating a Commission on Healthy Lifestyles, made up of public and private sector appointees, that would function as a quasi-public “authority” to promote programs to reduce obesity and smoking, and instill a culture of wellness and prevention in Connecticut residents. That Commission would need a dedicated, sustainable revenue source, perhaps a tax related to products associated with unhealthy lifestyles, to permit it to undertake the multi-year programs that are necessary to achieve such goals.

► **Discussion:** Achieving the effective pursuit of healthy lifestyles by the residents of Connecticut is important enough to justify specific, dedicated focus from a single-purpose authority. Governments create public-private authorities to manage critical pieces of infrastructure like airports and ports. Connecticut should take the lead by applying this degree of special focus to driving down rates of obesity and smoking and to otherwise helping

and encouraging residents in the pursuit of healthy lives. What a challenge and what a leadership opportunity for Connecticut!

6. A Program Example

While the Council is not making specific program recommendations at this time, we want our proposed policy framework to be tested against the state’s financial realities. Accordingly, the Lewin Group has priced out a specific set of program parameters to test their impact on state spending and reduction in the number of uninsured. These are not recommendations but merely a hypothetical example. We’ve assumed that:

- Health plans and the Department of Insurance, working together, will be able to fashion customized lower-cost policies for special groups that lower the cost of coverage by 15% below average commercial rates in Connecticut;
- The state will provide a 25% refundable tax credit to small employers who start to provide coverage for their workers;
- The state will provide a premium subsidy to previously uninsured individuals between 100–300% of FPL to help them buy into the lower cost private plans. The subsidy would cover the full cost of coverage for those between 100-150% of FPL, and then would be phased out above that, reducing to zero at 300% of FPL;
- People in households with incomes above 500% of FPL will be required to have coverage or pay a fine equal to the cost of insurance;

- HUSKY outreach programs will succeed in enrolling one-third of the eligible but not enrolled population;
- The SAGA program will be expanded to cover all those with < 100% of FPL, solely through added state funding (though federal matching would be sought);
- The Medicaid benefit plan will be revised to be comparable with those provided under typical private coverage, but with no change in Medicaid's nominal co-payments; and
- Medicaid payments for hospitals, doctors, and other health professionals will be increased by 10%.

Using the Lewin Health Benefits Simulation Model (HBSM), a detailed description of which is available upon request, the results of this hypothetical scenario in terms of reduction of the uninsured and cost to the state are shown below.

In addition, Lewin has calculated that these options would reduce provider uncompensated care by about \$37 million which, when added to the direct federal and state

Estimated Cost and Reduction in the Uninsured Population in Connecticut by Policy Provision			
	Reduction in Uninsured	State Cost (millions)	Federal Costs (millions)
<i>Overlapping Estimates of Program Impacts</i>			
Cover one-third of Medicaid/SCHIP not enrolled ^{a/}	22,000	\$18.6	\$21.8
Increase the income eligibility level under the State-Administered General Assistance (SAGA) program to 100 percent of the FPL for all single adults and married couples without children ^{b/}	11,220	\$29.2	--
Reduce private insurance premiums by 15% ^{c/}			
Individual coverage	10,700	--	--
Employer Coverage	16,900	--	--
25% employer tax credit for small firms that start to offer insurance ^{d/}	31,800	\$26.9	--
Premium subsidies for individuals between 100% and 300% of the FPL ^{e/}	27,750	\$72.3	--
Redesign Medicaid benefits for hospital, physician and other health professional health services ^{f/}	--	(\$65.0)	(\$65.6)
Increase Medicaid reimbursement by 10% for hospitals, physicians and other health professionals	--	\$101.2	\$103.0
Mandate for people living above 500% of the FPL to have coverage ^{g/}	49,000	(\$4.0)	--
<i>Non-Overlapping Total^{h/}</i>			
Non-Overlapping Total	157,440	\$167.4	\$59.2

a/ Assumes outreach measures succeed in enrolling one-third of the Medicaid and SCHIP eligible but not enrolled population.

b/ Program has gross income limit of \$760/month in Western Fairfield County area towns, \$660/month for individuals living in other CT towns. There is also an "applied income limit" = gross income less a disregard that varies with living situation (averages \$183 per family), varying from \$574–\$476 depending upon area of residence.

c/ Assumes steps are taken to reduce the cost of insurance by 15%. We assume a price elasticity of -0.34 for individuals and -0.65 for employers with 50 or fewer workers.

d/ Assumes a 25% refundable tax credit to small employers (i.e., 50 or fewer workers) who start to provide coverage for their workers.

e/ Assumes subsidies for private coverage are provided to individuals between 100–300% of FPL. People living between 100–150% of FPL would receive full premium subsidy. Premium subsidy would be phased-out on sliding scale with income between 150–300% of FPL. Assume the program uses 6-month waiting period for anyone with private insurance.

f/ Assumes that benefits under Medicaid are revised to be comparable with those provided under typical private employer plans. We assume no change in Medicaid nominal co-payments.

g/ Assumes that people living above 500% of the FPL are required to have coverage or pay a fine equal to the cost of insurance for a year.

h/ Numbers do not sum to total due to overlapping effects.

reimbursement increases of \$204 million, would reduce the cost shift impact and the under-payment gap by more than \$240 million. The Lewin letter summarizing this analysis is attached as Appendix 3.

In addition to these funds, we estimate the following additional needs consistent with our recommendations in the areas of cost, quality and healthy lifestyles:

- Expanded state funding for state data and quality management and technology deployment \$4 million
 - Study commissions on medical malpractice, benefit and coverage mandates, and hospital costs \$1 million
 - Commission on Healthy Lifestyles \$5 million
- TOTAL \$10 million**

In summary, this simulation suggests that under one particular set of program assumptions the state could take major steps forward in the areas of building the infrastructure for cost and quality management, promoting healthy lifestyles, reducing the number of uninsured by slightly over half, and at the same time reduce the cost shift to private payers and increase Medicaid provider reimbursement by about \$240 million--all with an increase in state funding of about \$177 million.

Conclusion

The members of the Connecticut Health Insurance Policy Council respectfully offer this report to our governmental leaders and to the public in the hope that it will help further the debate on much-needed health care reform.

Appendices

Appendix 1

SNAPSHOT>>

Connecticut

Overall Rank: 5

Change:  2

Strengths:

- High immunization coverage
- Low prevalence of smoking
- Low prevalence of obesity
- Low rate of motor vehicle deaths
- Low premature death rate

Challenges:

- High incidence of infectious disease

Significant Changes:

- In the past year, the prevalence of smoking decreased by 8%
- In the past year, the rate of motor vehicle deaths decreased by 10%
- Since 1990, the infant mortality rate decreased by 38%
- Since 1990, the rate of uninsured population increased by 77%

RANKING: Connecticut is 5th this year; it was 7th in 2005.

STRENGTHS: Strengths include high immunization coverage with 86.1 percent of children ages 19 to 35 months receiving complete immunizations, a low prevalence of smoking at 16.5 percent of the population, a low prevalence of obesity at 20.1 percent of the population, a low rate of motor vehicle deaths at 0.9 deaths per 100,000,000 miles driven and a low premature death rate with 6,043 years of potential life lost before age 75 per 100,000 population.

CHALLENGES: Challenges include a high incidence of infectious disease at 24.4 cases per 100,000 population.

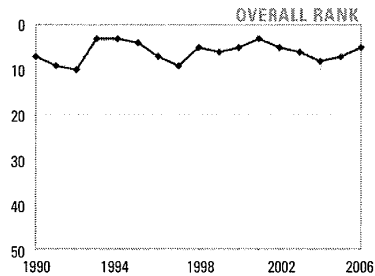
SIGNIFICANT CHANGES:

- ↓ In the past year, the prevalence of smoking decreased from 18.0 percent to 16.5 percent.
- ↓ In the past year, the rate of motor vehicle deaths declined from 1.0 to 0.9 deaths per 100,000,000 miles driven.
- ↓ Since 1990, the infant mortality rate decreased from 8.9 to 5.5 deaths per 1,000 live births.
- ↑ Since 1990, the rate of uninsured population increased from 6.4 percent to 11.3 percent.

HEALTH DISPARITIES: In Connecticut, the percentage of women who receive prenatal care varies from 78 percent among Hispanics to 92 percent among whites. Cancer is 8 percent more prevalent among whites (493.5 cases per 100,000 population) than Hispanics (457.7 cases per 100,000 population).

CLINICAL CARE: The cost of clinical care in Connecticut is high compared to other states and the quality of care is high. To view Connecticut in comparison to other states, see pages 111 to 114.

STATE HEALTH DEPARTMENT WEB SITE: www.dph.state.ct.us/



	2006		2005		1990	
	DATA	RANK	DATA	RANK	DATA	RANK
DETERMINANTS—PERSONAL BEHAVIORS						
Prevalence of Smoking (Percent of population)	16.5↓	3	18.0	5	29.6	25
Motor Vehicle Deaths (Deaths per 100,000,000 miles driven)	0.9	3	1.0	3	1.7	2
Prevalence of Obesity (Percent of population)	20.1	3	19.6	5	11.7	25
High School Graduation (Percent of incoming ninth graders)	80.9	12	79.7	11	78.2*	19
DETERMINANTS—COMMUNITY ENVIRONMENT						
Violent Crime (Offenses per 100,000 population)	275	14	286	17	419	24
Occupational Fatalities (Deaths per 100,000 workers)	3.5	6	3.5	4	8.7*	17
Infectious Disease (Cases per 100,000 population)	24.4↓	39	25.5	38	32.9	31
Children in Poverty (Percent of persons under age 18)	12.4	10	12.2	13	9.2	3
DETERMINANTS—PUBLIC & HEALTH POLICIES						
Lack of Health Insurance (Percent without health insurance)	11.3	10	11.6	12	6.4	1
Per Capita Public Health Spending (\$ per person)	\$173	18	\$173	18	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	86.1↓	4	87.8	3	—	—
DETERMINANTS—PUBLIC & HEALTH POLICIES						
Adequacy of Prenatal Care (Percent of pregnant women)	80.4↓	14	84.1	5	—	—
HEALTH OUTCOMES						
Poor Mental Health Days (Days in previous 30 days)	2.9	7	3.1	11	—	—
Poor Physical Health Days (Days in previous 30 days)	3.0	3	3.1	8	—	—
Infant Mortality (Deaths per 1,000 live births)	5.5	11	5.4	12	8.9	8
Cardiovascular Deaths (Deaths per 100,000 population)	277.6↓	9	290.0	10	374.3	15
Cancer Deaths (Deaths per 100,000 population)	191.6	10	193.4	11	203.9	32
Premature Death (Years lost per 100,000 population)	6,043↓	4	6,277	9	7,446	13
OVERALL RANK		5		7		7

↓ and ↓ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable.

Appendix 2

Connecticut Health Scorecard: How are we doing?

	United States	CT		State Ranking		Fairfield County	National Goal	CT Score*
				CT	Best			
Health Indicators								
Asthma	8.9%	8.7%	↑	25	Idaho		No goal for these indicators	
- Childhood	8.2%	9.7%	↑	47	Louisiana	7.7%		
- Adult								
Cancer incidence per 100,000	462.2	494.5	↓	36	Arizona		No goal for this indicator.	
Diabetes	7.0%	6.0%	↔	11	Colorado	5.3%	2.5%	
Hypertension	24.8%	24.2%	↑	22	Utah	23.0%	14%	
Mental Distress	10.2%	9.2%	↑	12	North Dakota		No goal for this indicator	
Obesity	23.1%	19.6%	↑	5	Colorado	17.1%	15%	
Oral Health								
- Dental visit in past 12 months	70.2%	80.2%	↓	1	CT	79.2%	No goal for this indicator.	
- Had all teeth extracted (age 65+)	21.2%	12.4%	↓	1	CT	7.3%	22%	
Smokers	20.8%	18.0%	↓	4	Utah	15.0%	12%	
Community Risk Factors								
Medical errors							The goal is to deliver safe, high quality health care.	
Medical Malpractice Claims								
- Number per 1,000 active, nonfederal physicians	18.8	16.8		27	Alabama		No goal for these indicators.	
- Average claim payments paid	\$291,236	\$486,759		49	Utah			
Health Care Access								
Uninsured (percent)	15.7%	11.6%	↑	12	Minnesota		100% insured	

Health Insurance Premium	\$3,189	40	North Dakota	No goal for these indicators.	
- Single coverage	\$8,469	46	North Dakota	No goal for these indicators.	
- Family coverage	\$3,373 \$9,047				
Health Care Workforce	281	5	District of Columbia	No goal for these indicators.	
- Physicians per 100,000 population	78	5	District of Columbia		
Health Policies					
Vaccination Rates					
- Childhood vaccination	78.0%	1	Connecticut	90%	
- Adult flu shot	67.8%	11	Colorado	90%	
- Adult pneumococcal vaccination	64.5%	11	Montana	90%	
Early Prenatal Care (1 st Trimester)	83.4%	5	New Hampshire	90%	
Per capita public health spending	\$164	18	Hawaii, Alaska	No goal for this indicator.	
Outcomes					
Heart Disease Deaths per 100,000 population	240.8	20	Minnesota	152.0	
Cancer Deaths per 100,000 population	193.5	14	Utah	158.6	
Infant Deaths per 1,000 live births	7.0	16	Massachusetts	4.5	

Notes: State rank of #1 is the best; rank of #50 is the worst. The National Goal is based upon Healthy People 2010 that is a comprehensive set of disease prevention and health promotion objectives for the nation to achieve over the first decade of the new century. There are 28 focus areas and measurable objectives. We did not include all measurable objectives.

Indicates the direction of trend Indicates a worsening trend Indicates an improving trend Indicates no change/stable

A question is assigned if data is inconclusive or is limited. A star is assigned if trend is improving or stable and state rank is 1-12. Warming lights are assigned if trend is worsening and state rank is 1-12 or state rank is 13-38 with any trend. An alarm is assigned if any trend and state rank is 39-50.

***CT scoring procedure reflects national performance stands, CT trends, and relative state ranking where data exist.**

Appendix 3



Mr. Robert Patricelli and Mr. Mickey Herbert
December 19, 2006
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December 19, 2006

Mr. Robert Patricelli and Mr. Mickey Herbert
Co-Chairmen
Connecticut Health Insurance Policy Council Inc.
22 Waterville Road
Avon, CT 06001

Dear Gentlemen;

At your request, we have estimated the impact of selected options for increasing insurance coverage in Connecticut.

We provide estimates of the impact of the following options:

- **Medicaid outreach:** Assumes that outreach measures succeed in enrolling one-third of the Medicaid and SCHIP eligible but not enrolled population. We estimate the State's share of the cost to be \$18.6 million and the Federal share to be \$21.8 million;
- **Increase SAGA eligibility:** Assumes the income eligibility level under the State-Administered General Assistance (SAGA) program is increased from the medically-needy level to 100 percent of the FPL for all single adults and married couples without children;
- **Reduce the cost of private insurance by 15 percent:** Assumes steps are taken to reduce the cost of insurance by 15 percent. We assume a price elasticity of -0.34 for individuals and -0.65 for employers with 50 or fewer workers;
- **Employer tax credit for small firms:** Assumes a 25 percent refundable tax credit to small employers (i.e., 50 or fewer workers) who start to provide coverage for their workers. We assumed a small employer price elasticity of -0.61;
- **Premium subsidies for people living between 100 and 300 percent of the FPL:** Assumes subsidies for private coverage are provided to individuals living between 100 and 300 percent of the FPL. There is a full premium subsidy for people living between 100 percent and 150 percent of the FPL. The premium subsidy would be phased-out on a sliding scale with income between 150 percent and 300 percent of the FPL. We assume the program uses a 6-month waiting period for anyone with private health insurance;
- **Redesign Medicaid benefits:** Assumes that benefits under Medicaid are revised to be comparable with those provided under typical private employer health plans. We assume no change in Medicaid nominal co-payments. We estimate a 6.5 percent reduction in spending;



Mr. Robert Patricelli and Mr. Mickey Herbert
December 19, 2006
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- **Increase Medicaid Payments for Acute Care:** Assumes that Medicaid payment rates are increased by 10 percent for health services provided by hospitals, physicians and other professionals; and
- **Individual mandate:** Assumes that people living above 500 percent of the FPL are required to have coverage or pay a fine equal to the cost of insurance for a year.

Our estimates are presented in *Figure 1* assuming that each individual option is implemented on its own. We also present non-overlapping estimates of the cost and coverage impacts of implementing these options together.

The collection of options presented in *Figure 1* would reduce provider uncompensated care by about \$37.4 million. The increase in reimbursement would reduce provider payment shortfall under Medicaid by an additional \$204.0 million. This is a total reduction in provider payment shortfalls of about \$241.4 million.

Based upon published research on the cost-shift, we estimate that about 40 percent of these reductions in payment shortfalls would be passed-back to payers in the form of lower fees from private payers, negotiated over time. The total amount of cost-shift savings would be \$96.6 million.

In *Figure 2*, we present estimates of the number of people covered under premium subsidy proposal for individuals at varying income eligibility levels.

Please call me at (703) 269-5610 if you have any questions.

Sincerely;

John Sheils
Vice President

Figure 1
Estimated Reduction in the Uninsured Population in Connecticut by Policy Provision

	Reduction in Uninsured	State Cost (millions)	Federal Costs (millions)
Overlapping Estimates of Program Impacts			
Cover one-third of Medicaid/SCHIP not enrolled ^{a/}	22,000	\$18.6	\$21.8
Increase the income eligibility level under the State-Administered General Assistance (SAGA) program to 100 percent of the FPL for all single adults and married couples without children. ^{b/}	11,220	\$29.2	--
Reduce private insurance premiums by 15 percent ^{c/}			
Individual coverage	10,700	--	--
Employer Coverage	16,900	--	--
Twenty-five percent employer tax credit for small firms that start to offer insurance ^{d/}	31,800	\$26.9	--
Premium subsidies for individuals between 100 percent and 300 percent of the FPL ^{e/}	27,750	\$72.3	--
Redesign Medicaid benefits for hospital, physician and other health professional health services ^{f/}	--	(\$65.0)	(\$65.6)
Increase Medicaid reimbursement by 10 percent for hospitals, physicians and other health professionals	--	\$101.2	\$103.0
Mandate for people living above 500 percent of the FPL to have coverage ^{g/}	49,000	(\$4.0)	--
Non-Overlapping Total ^{h/}			
Non-Overlapping Total	157,440	\$167.4	\$59.2

- a/ Assumes that outreach measures succeed in enrolling one-third of the Medicaid and SCHIP eligible but not enrolled population.
- b/ The program has a gross income limit of \$760/month in Western Fairfield County area towns, and \$660/month for individuals living in other CT towns. There is also an "applied income limit" equal to gross income less a disregard that varies with living situation (averages \$183 per family), varying from \$574 to \$476 depending upon area of residence.
- c/ Assumes steps are taken to reduce the cost of insurance by 15 percent. We assume a price elasticity of -0.34 for individuals and -0.65 for employers with 50 or fewer workers.
- d/ Assumes a 25 percent refundable tax credit to small employers (i.e., 50 or fewer workers) who start to provide coverage for their workers.
- e/ Assumes subsidies for private coverage are provided to individuals between 150 and 300 percent of the FPL. People living between 100 percent and 150 percent of the FPL would receive a full premium subsidy. The premium subsidy would be phased-out on a sliding scale with income between 150 percent and 300 percent of the FPL. We assume the program uses a 6-month waiting period for anyone with private insurance.
- f/ Assumes that benefits under Medicaid are revised to be comparable with those provided under typical private employer health plans. We assume no change in Medicaid nominal co-payments.
- g/ Assumes that people living above 500 percent of the FPL are required to have coverage or pay a fine equal to the cost of insurance for a year.



Mr. Robert Patricelli and Mr. Mickey Herbert
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h/ Numbers do not sum to total due to overlapping effects.
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 2
Reduction in Uninsured and State Cost of Covering Single Adults and Married Couples without Children for people living between 100 percent and 300 percent of the FPL ^{a/}

	Reduction in Uninsured	State Cost (millions)
100 Percent to 150 percent of the FPL	16,050	\$41.8
150 percent to 200 percent of the FPL	6,260	\$16.3
200 percent to 250 percent of the FPL	3,380	\$8.8
250 percent to 300 percent of the FPL	2,060	\$5.4
Non-Overlapping Total	27,750	\$72.3

a/ Assumes subsidies for private coverage are provided to individuals between 150 and 300 percent of the FPL. People living between 100 percent and 150 percent of the FPL would receive a full premium subsidy. The premium subsidy would be phased-out on a sliding scale with income between 150 percent and 300 percent of the FPL. We assume the program uses a 6-month waiting period for anyone with private insurance.
 Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Endnotes

Endnotes

- 1 Foundation, p. 44.
- 2 Employer-sponsored benefit plans may be self-insured (and use a third-party administrator to administer the plan for them) or insured (contract directly with an insurer or health plan to provide benefits under an insurance policy); under both arrangements the benefit plan is subject to the federal ERISA rules. However, the insured policies that employers purchase from insurers and health plans are subject to state insurance laws and mandates that are binding on the insurers, and so, indirectly become binding on the employer-sponsored benefit plan that chooses to purchase insurance. As federal law, ERISA supersedes any and all state laws that regulate employer-sponsored benefit plans (the plan structure, benefits, administration) but generally permits states to regulate insurance. States cannot treat employer-sponsored benefit plans as insurers.
- 3 National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, 2006-2007, p. 80.
- 4 HUSKY A (Medicaid) Family Income Guidelines (effective April 1, 2006-March 31, 2007) to qualify (1) for free coverage for children and pregnant women, by family size: for a family of: 2, under \$ 24,420; 3, under \$30,710; 4, under \$37,000; 5, under \$43,290; and 6, under \$49,580 ; and (2) for free coverage for parents or a relative caregiver living with a covered child by family size: for a family of: 2, under \$19,800; 3, under \$24,900; 4, under \$30,000; 5, under \$35,100; and 6, under \$40,200. (<http://www.huskyhealth.com/qualify.htm>)
- 5 HUSKY B (SCHIP) Family Income Guidelines (effective April 1, 2006-March 31, 2007) for a family of: 2, range from under \$24,420 to over \$39,600; 3, range from under \$30,710 to over \$49,800; 4, range from under \$37,000 to over \$60,000; 5, range from under \$43,290 to over \$70,200; and 6, range from under \$49,580 to over \$80,400. Premiums and copays for coverage vary based on income. (www.huskyhealth.com/qualify.htm)
- 6 The United Health Foundation, the American Public Health Association and Partnership for Prevention, *America's Health Rankings*, 2006 Edition, United Health Foundation. (www.unitedhealthfoundation.org)
- 7 "Beyond Health Promotion," *Health Affairs*, March-April, 1998.
- 8 "The Rising Prevalence of Treated Disease," *Health Affairs*, June, 2005.
- 9 Mercer Health & Benefits, LLC, *National Survey of Employer-Sponsored Health Plans*, November, 2006.
- 10 James C. Robinson, "The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage," *Health Affairs*, November-December 2006, p. 1476.
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We are indebted to Xerox Corporation for the production and printing of the document.
Report design and graphics by Lisa Panczner.