“AT UNIVERSAL HEALTH CARE FOUNDATION, WE BELIEVE SUSTINET CAN INFORM THAT DEBATE BY SERVING AS AN EXAMPLE OF A HEALTH CARE REFORM PLAN WITH A STRONG PUBLIC HEALTH INSURANCE OPTION THAT CAN BE THE ANSWER TO PROVIDING QUALITY, AFFORDABLE HEALTH CARE TO ALL.”
Universal Health Care Foundation is dedicated to achieving quality, affordable health care for all Connecticut residents. Toward that end, the Foundation over the past several years has served as a catalyst to engage a broad-based coalition of residents in a grassroots organizing campaign that successfully won passage of historic health care reform in July 2009. The legislation creates a new health plan, named SustiNet, Latin for “to sustain” from the state motto, and emphasizes the goal of developing a health care system in Connecticut that is sustainable.

The SustiNet legislation was based on the proposal detailed in this publication. The Foundation first released the SustiNet proposal in January 2009 as a policy brief, “SustiNet, Health Care We Can Count On.” This companion publication, “SustiNet by the Numbers: Projections of Cost, Coverage and Impact,” describes the policy and provides more detail about the economic modeling than was included in the earlier report.

The SustiNet policy proposal was crafted using as a guide the five Institute of Medicine (IOM) principles of what universal health coverage should be. It:

• includes everyone;
• is continuous and portable regardless of changes in employment or marital status;
• is affordable to individuals, especially those with limited income;
• is affordable and sustainable to society; and
• enhances health and well-being.

With these principles in mind, the Foundation enlisted the expertise of Stan Dorn, Senior Research Associate at the Urban Institute, to develop a proposal for transforming the health care system in Connecticut. The aim was to look at the entire system, not only addressing coverage and access, but cost and quality as well. Throughout 2008, the Foundation convened many discussions to obtain input from key groups and individuals, including small business, health care providers, labor, consumers, clergy, advocacy and philanthropic organizations.
The Foundation also sought to project the costs of the proposed changes to health care coverage and delivery. We commissioned the expertise of health economist Professor Jonathan Gruber of the Massachusetts Institute of Technology, who serves as an adviser to the Congressional Budget Office. He conducted the micro-economic simulation analysis to project cost and coverage estimates. Researchers at the Urban Institute then used Dr. Gruber’s results to project the impact of the proposal on the state’s economy as a whole.

As with any major policy proposal, the details of SustiNet changed over time in the legislative process. However, the final reform legislation passed by the Connecticut General Assembly, retained the key concepts of the original proposal. For example, the focus on delivery system change as the means to implement sustainable, cost-effective, quality, health care reform remains. The use of a public plan as a catalyst for achieving these changes also remains.

The new legislation established the SustiNet Board to proceed with implementing SustiNet. The board, appointed this summer, is responsible for making adjustments that will allow the state to benefit from federal health care reform while mitigating budgetary challenges.

As this publication goes to press, the debate over health care reform continues to rage in Washington and throughout the country. At Universal Health Care Foundation, we believe SustiNet can inform that debate by serving as an example of a health care reform plan with a strong public health insurance option that can be the answer to providing quality, affordable health care to all.
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Early in 2009, Universal Health Care Foundation of Connecticut released a proposal that seeks to slow the growth in health care costs while simultaneously expanding coverage dramatically. In modified form, the proposal was enacted into law in July 2009. This paper describes, not the final form of the bill, but the Foundation’s original policy design.

To slow cost growth, the proposal combines HUSKY and SAGA beneficiaries and state employees and retirees into a single, self-insured health plan named “SustiNet,” after the state motto. This plan implements nationally accepted best practices for improving quality while restraining spending.

SustiNet becomes an option that can be purchased by employers for their workers and by individuals who lack access to employer-sponsored insurance. People can also choose SustiNet rather than their employer-based plan if the latter coverage does not provide them with affordable access to essential health care.

While cost growth is slowed, HUSKY eligibility expands, so that, together with premium subsidies for SustiNet enrollment, all of the state’s low- and moderate-income uninsured qualify for help. Auto-enrollment mechanisms dramatically increase the proportion of eligible individuals who enroll in health coverage. Over time, provider payments for HUSKY rise to standard, commercial levels.

To help companies and individuals make good decisions about which coverage to purchase, an independent information clearinghouse gathers and reports comprehensive data showing quality of care, consumer satisfaction, health outcomes, costs, and other key facts about both SustiNet and state-licensed private insurance sold in Connecticut.

Carefully phased-in over time, these steps are accompanied by vigorous efforts to reduce the incidence of obesity and tobacco use, to increase the availability of basic preventive care in the community, and to address the state’s health care workforce shortages.
Executive Summary

Dr. Jonathan Gruber of the Massachusetts Institute of Technology, one of the country’s leading health economists, has examined the proposal’s likely effect on cost and coverage. Based on his analysis, the proposal reduces the proportion of state residents without health coverage from 12 percent (in the middle of this decade) to 2 percent by 2014 (Figure ES-1). State General Fund costs rise by $950 million as of 2014 both because many low-income uninsured receive subsidies that allow them to receive coverage and because HUSKY reimbursement rates increase substantially (Figure ES-2). However, the deceleration in health care cost increases saves the state’s private businesses and households $1.8 billion in 2014 – nearly $2 for every additional $1 spent by the General Fund – and the state receives an additional $800 million in federal matching funds.

**Figure ES-1.** Percentage of residents under age 65 who lack insurance, status quo vs. SustiNet proposal: Fiscal years 2011–FY 2016

![Graph showing the percentage of residents under age 65 who lack insurance](image)


**Figure ES-2.** Under SustiNet, projected health care cost savings for employers and households, increased General Fund costs, and increased federal matching funds: Fiscal years 2011–FY 2016 (millions)

![Graph showing health care cost savings and General Fund costs](image)

Source: Gruber Microsimulation Model.

Urban Institute researchers applied Dr. Gruber’s results to estimate the effects of the SustiNet proposal on the Connecticut economy, using the respected Regional Economic Model Incorporated (REMI). The macrosimulation showed no meaningful net impact on the state’s economy. Reduced spending on health coverage was projected to lead to a small decline in health industry employment, but the resulting increased spending on other goods and services led to an offsetting, small increase in employment in other industries (Table ES-1).
In sum, the proposal would substantially increase health insurance coverage, making health insurance affordable for the state’s low- and moderate-income residents. Although state General Fund costs would rise, far greater sums would be saved in the private sector. While net economic activity and employment would not change appreciably, the overall impact of the proposal on the state would likely be positive, given the impact on the number of uninsured and a more functional health care delivery system.

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Source: REMI Macrosimulation Model. Note: Totals may not sum because of rounding.
Early in 2009, Universal Health Care Foundation of Connecticut (Foundation) released a proposal for major health care reform in the state of Connecticut. Named “SustiNet” after the state motto, the proposal has been subjected to careful analysis by Dr. Jonathan Gruber of the Massachusetts Institute of Technology, one of the country’s most respected health economists. Dr. Gruber estimated the cost and coverage results of the proposal from 2011 through 2016, compared with projections under the status quo. These estimates were developed using Dr. Gruber’s microsimulation model, which estimates the impact of policy changes on public and private costs and the distribution of insurance coverage. The modeling approach involves the type of “microsimulation” used by the Treasury Department, the Congressional Budget Office, and other government entities. In developing his model, Dr. Gruber drew on the best evidence available in the health economics literature to model how individuals and firms will respond to the changes in the insurance environment induced by changes in government policy. In applying the model, Dr. Gruber incorporated assumptions about SustiNet’s ability to slow cost growth as well as estimates about the potential impact of auto-enrollment, based on similar strategies’ prior effectiveness.

An Urban Institute team headed by Dr. Stephen Zuckerman then took Dr. Gruber’s results and estimated the effects of the SustiNet proposal on the Connecticut economy, applying the Regional Economic Model Incorporated (REMI), a dynamic simulation model designed to assess the macroeconomic impacts of policy reforms. The REMI macroeconomic simulation model draws on econometric equations, input-output models, and computable general equilibrium models to produce state-specific economic and demographic forecasts. Economic impacts are calculated by sector, industry, and/or occupation based on an evaluation of demand for employment and capital, population and labor supply, wage rates, prices and profits, local and export market shares, and final output. REMI’s macroeconomic model is based on a database of historic and recent economic data.
This report begins by explaining the key features of the Foundation’s SustiNet proposal. It then describes the proposal’s likely results as shown by the previously described microsimulation and macrosimulation efforts.

Several preliminary comments are important at the outset. First, the proposal discussed here resembles but is not identical to the SustiNet bill passed by the Connecticut General Assembly, H.B. 6600. In one noteworthy example, the effective dates of implementation are different from those in the proposal analyzed by Dr. Gruber, Dr. Zuckerman, and colleagues.

Second, these simulation results are limited to state residents under age 65. Third, the following estimates, like all projections of future events, are imprecise. They should not be taken as infallible guides to the impact of SustiNet on costs, coverage, and the state economy from 2011 through 2016. Rather, they indicate the general magnitude of likely results.
SustiNet: Key Policy Elements

The SustiNet plan: basic structure

SustiNet is administered by the SustiNet Authority (Authority), which is a new, quasi-public agency. The Authority is governed by a Board of Directors, with guaranteed representation of key stakeholders, including health care providers, consumers, unions, employers, and state agencies.

SustiNet is a self-insured plan, which means that it does not pay premiums to insurance companies. Instead, it contracts with one or more entities to provide “Administrative Services Only (ASO).” The ASO contractor – most likely, one or more insurers – processes claims, credentials providers, and so on. It is paid a set fee per enrollee, so it does not make more money when fewer services are covered. The SustiNet plan is responsible for paying all health care claims. Such self-insured coverage is the predominant form of private insurance in Connecticut, covering 51 percent of all state residents who received coverage from their employers in 2006.

Essential to the SustiNet strategy is integrating a large number of covered lives into a single health plan. Only if delivery system reforms apply to a large percentage of patients is it feasible for physicians, nurses, hospitals, and other providers to change how they deliver care. Also essential are the management flexibility and improved information flow allowed by a self-insured structure. Because of proprietary concerns, fully insured plans typically refuse to share even such basic information as reimbursement rates paid to providers. Proactively managing health care delivery system reforms is likely to be much easier with self-insured coverage than with one or more fully insured products. As a final component of its basic structure, SustiNet can share gains with participating providers so that the same individuals and entities who make the investments necessary to slow cost growth can realize some of the resulting financial gains.
As a result of these policy design features, SustiNet will have the capacity to effectively implement health care delivery system reforms in four key areas: (1) providing members with a patient-centered medical home; (2) developing an interoperable system of electronic health records; (3) increasing incentives for providing evidence-based medicine; and (4) improving information flow in strategic ways. The ultimate goal of all these reforms is to refocus SustiNet’s health care delivery system on preserving and promoting patient health.

Patient-centered medical home
The patient-centered medical home involves three components that incorporate but go beyond standard primary care:

- **Patient self-care.** A physician, nurse, patient educator, or social worker helps the consumer understand how to maintain and improve health and functioning. With the chronically ill, this involves learning important skills to prevent acute episodes that endanger health and increase cost. With the healthy, it includes developing “wellness” plans that incorporate exercise and healthy eating, thus reducing the likelihood of obesity.

- **Care coordination.** A medical home promotes care coordination in many different ways.
  - When patients transition home from the hospital, medical professionals work with the patients to help them understand their discharge instructions. In appropriate cases, such transitions include careful monitoring of patients’ conditions, with rapid intervention as needed to prevent costly and potentially dangerous rehospitalization.
  - If a chronically ill patient is being seen by multiple providers, the medical home takes responsibility for ensuring that each provider knows what the other is doing, integrating all services into a single care plan.
  - The medical home is responsible for ensuring that consumers receive all recommended primary care and prevention services.
  - When specialty care is needed, the medical home facilitates efficient referrals. This can include a consultation between medical home and specialist during which both clinicians assess the need for specialty care and the specialist can identify tests that, before the specialty care visit, can be performed in a less costly primary care setting.

- **Round-the-clock availability,** by telephone or secure email. Such “real-time” consultation can obviate hospital or office visits. When care is needed urgently, but the patient is not experiencing a medical emergency, a rapid office visit can be scheduled, reducing the number of unnecessary visits to hospital emergency rooms.

Today, insurers typically do not reimburse these medical home services. As a result, when physicians, nurses, and others provide the kind of care they know their patients need, they often must do so as a donation to their patients’ health. With a medical
In Connecticut, implementing the medical home model requires customization. Most of the state’s physicians are in solo or very small group practices. Multispecialty, large group practices are not the norm. For good reason, many Connecticut physicians may not want to perform the full set of medical home functions in their offices.

Accordingly, each medical home provider will choose from a menu of medical home functions that go beyond “core” medical care. If a provider does not want to perform a given function, SustiNet will present options, “vetted” by SustiNet to ensure quality and efficiency, for how the function can be performed. The options may include community-based nurses, social workers, or patient educators; clinical staff based in the ASO; or SustiNet in-house clinical staff. However these functions are performed, they will be fully integrated into the medical home provider’s medical practice. The proposal suggests implementation of the medical home model for the chronically ill first, to maximize potential savings.

A broad range of providers can serve as a medical home, including both primary care clinicians and, in appropriate cases, specialists. When a patient is experiencing a temporary condition (such as pregnancy), the medical home may shift to a provider who is coordinating all care for the duration of that condition or episode.

**Interoperable electronic health records**

Several steps ensure the development and deployment of an interoperable system of electronic health records to serve SustiNet members (as well as many other Connecticut residents). Such a system ensures that, whenever a member receives care from a network provider, the provider, at the point of service, can easily access the patient’s records, use that information to furnish care appropriately and safely, and record all services the patient receives as well as any additional observations about the patient. The system will incorporate strong safeguards of privacy and data security. This system will be built, not with state taxpayer dollars, but through leveraging the state’s purchasing power and taking advantage of the state’s ability to sell tax-exempt bonds to finance capital improvements.

**Reducing the cost and disruption of implementing health information technology (HIT)**

The first step toward these goals is to make electronic medical records more affordable to physicians, nurses, hospitals, and other health care providers. The Authority will work collaboratively with the state’s providers to select a set of vendors that, together, offer a range of products that meet the needs of the state’s diverse health care professionals. The providers on whose behalf the Authority negotiates will include two groups: (1) those who agree to participate in SustiNet, serving SustiNet members, and (2) other providers who enroll in the Authority’s system for developing and deploying electronic medical records. Both groups will be
asked to pay a monthly or other periodic fee to support the purchase of necessary hardware and software as well as training and support services. This leverage will help the Authority obtain favorable prices both from vendors supplying electronic medical record (EMR) hardware and software as well as from bonded, licensed HIPAA-compliant vendors who agree to digitize participating providers’ paper records.

The initial cost of purchasing software and hardware will be financed with a bond offering through the Connecticut Health and Educational Facilities Authority (CHEFA). Participating providers will repay the bond through their monthly or periodic payments, thus overcoming the capital cost barrier to EMR acquisition. Providers’ regular payments will also cover the cost of intensive training and technical support furnished by SustiNet employees or contractors, who will locate in communities throughout the state to help minimize providers’ pain and productivity losses during the transition to a new system of electronic medical records.

As a further effort toward that end, SustiNet will negotiate for reduced-price consultant services to help physicians, nurses, clinics, and other providers restructure their practices to function more effectively and efficiently in the new health care delivery system. Such assistance will take into account not just the transition to electronic health records but also strategies for coping effectively with a small increase in the size of the average medical practice that may result from fewer uninsured, medical home implementation, and other changes to the health care delivery system.

**Increasing the usefulness of health information technology**

At a basic level, the so-called network effect will increase HIT’s value added to providers. To use a common analogy, telephones were not very useful until many people owned them. By the same token, only when all the providers who together serve a set of patients use interoperable HIT can each participating provider (and the system as a whole) realize major gains.

Further laying the groundwork to make electronic medical records useful to participating providers will be the extensive involvement of the state’s providers in selecting SustiNet HIT vendors. In addition, SustiNet will develop interfaces with pharmacies and labs so that clinicians can electronically order prescriptions and lab tests. Software will provide full functionality, including automated reminders to patients about upcoming visits and necessary tests, automated information about patient follow-through in filling prescriptions and obtaining recommended lab tests and referrals, billing (either through the EMR software or through an interface with billing software), and clinician decision support. Such decision support will warn physicians and nurses about potential drug interactions and allergies as well as recommended services not yet received by a patient.
Housing electronic health records in a secure, privacy-protected, interoperable platform

Important groundwork to establish such a platform is already being done by eHealth Connecticut. Whether through that evolving health information exchange or through another system selected by the SustiNet Board, each participating provider will be able to retrieve and add to the patient’s record to which the patient will have access.

Sensible requirements for implementing health information technology

Finally, by a date certain, providers who wish to serve SustiNet members will need to implement a system of electronic medical records that is capable of fully interfacing with SustiNet's platform for housing patients’ electronic health records. The Authority has the option to offer incentives for early adoption. Ultimately, the deadline may be delayed in selected cases to preserve access to the full range of necessary providers in particular communities.

Evidence-based medicine

Working collaboratively with physicians, nurses, hospitals, other providers, and consumers, SustiNet will select guidelines to apply in Connecticut from among the many care guidelines promulgated nationally and internationally. Such guidelines will include hospital safety standards, with a schedule for monitoring and implementation.

SustiNet will incorporate procedures to encourage the provision of care consistent with approved guidelines, when appropriate, without in any way embracing “cookbook medicine.” Critically important is preserving the ability of doctors and nurses to customize care based on the characteristics of the individual patient. Innovation and creativity are key features of high-quality medicine, and they need to be encouraged and rewarded.

To achieve this balance, electronic health records will remind physicians and nurses when they are about to depart from recommended care guidelines. Such clinicians are not required to follow the guidelines, but they will be required to make a conscious decision to provide care differently, and they will be asked to record the reasons for that decision.

Clinicians will receive periodic, confidential feedback comparing their practice patterns with others in the same specialty, both locally and statewide. Where appropriate, opportunities for continuing medical education will be noted. Providers participating in SustiNet will engage in periodic quality reviews, incorporating appropriate peer input. Such reviews will include an analysis of “near misses” and will seek to develop action plans to improve quality of care.

SustiNet will work collaboratively with consumers, physicians, nurses, and other health care providers to develop clear standards that define high-quality providers of care for consumers with particular conditions. Those standards can include but will surely not be
limited to providing care consistently with approved guidelines for a specified percentage of patients. As a result, both consumers, peers, and the public will know, for example, which physicians have been certified as high-quality providers of care to people with diabetes.

Finally, to facilitate the provision of services consistently with care guidelines, physicians, nurses, and other providers will not be liable for malpractice if injury results from following such guidelines. This “safe harbor” will not apply if a patient is negligently diagnosed or if recommended procedures are improperly performed. In the rare case of patient injury that results from following care guidelines, the patient will receive no-fault compensation for injuries, but the provider will not be liable. As a result, defensive medicine will not force physicians, nurses, and others to provide services that they believe, based on both approved clinical guidelines and their own medical judgment, are not necessary to improve patient health.

**Information reforms**

SustiNet will incorporate two information reforms. First, participating physicians and nurses will be required to file annual, publicly available disclosure forms identifying potential financial conflicts of interest that exceed a minimum dollar level, including ownership of health care facilities or stock, contracts with or honoraria received from manufacturers of prescription drugs or medical devices, and other potential conflicts. This information can be taken into account in reviewing claims for payment, deciding the terms and conditions of network participation, and identifying and analyzing emerging problems in care delivery patterns, by patients exercising informed consent, and in other ways.

Second, SustiNet will counteract untoward effects of direct marketing to physicians and nurses by manufacturers of prescription drugs and medical devices. SustiNet can provide objective information and, when appropriate, free generic drug samples when patterns emerge suggesting that industry marketing efforts directed at clinicians are increasing the cost of care without providing corresponding benefits to patient health.
**SustiNet membership categories**

SustiNet will serve five different membership categories. As is the case for many commercial insurers today, SustiNet will offer several different benefit packages, and when it operates in different markets, SustiNet will observe the distinct rules that govern each market.

1. **HUSKY beneficiaries**

   HUSKY beneficiaries, both under current law and under the expanded eligibility recommended in the proposal, will be enrolled in SustiNet. They will continue to receive the same covered services and limits on cost-sharing that apply under current law.

   Over time, the reimbursement rates paid to health care providers for their care will increase so that per member–per month costs equal average, commercial levels. This will both improve their access to care and reduce the extent to which hospitals shift uncompensated costs to the privately insured. The latter results will ultimately lower private premiums paid by employers and individuals.

2. **People not offered employer-sponsored insurance (ESI)**

   Self-employed entrepreneurs, contract workers, employees of firms that do not offer ESI, and others who lack access to ESI can enroll in SustiNet. Such individuals who are ineligible for HUSKY may receive premium subsidies, based on their income. The benefits they receive are generally typical of those offered by large employers, including annual deductibles of approximately $400 per individual ($800 per family), $15 office visit copays for nonpreventive care, prescription drug copays of $10/$25/$40 for generic/name-brand preferred/name-brand nonpreferred medicine, and so on. Dental care coverage typical of what large companies provide is included. Mental and physical health services receive parity in coverage. Preventive services are fully covered, without any cost-sharing. Although it is a self-insured plan, SustiNet will meet state benefit requirements that currently govern fully insured, private coverage.

   Both private, nongroup plans and SustiNet will be limited in the extent to which they can discriminate against people with health problems. The same rules that, in the past, have applied to small employers in Connecticut will govern the nongroup market as well. Accordingly, premiums will be adjusted based on age, industry of employment, gender, and geographic area. Individual health risks beyond these factors will not affect premiums. Further, insurers will be required to issue coverage without preexisting condition exclusions or waiting periods for people who have maintained continuous coverage for at least 12 months. If these safeguards prove insufficient, the SustiNet Authority can make necessary policy changes.

   To reduce the extent to which SustiNet becomes a “magnet” for high-risk enrollees, individual SustiNet coverage will be subject to these same new rules that apply to all private, nongroup coverage, with two exceptions. First, subsidy recipients will not have premiums adjusted based on individual factors such as age and gender. Second, while
private, nongroup coverage can exclude preexisting conditions or deny issuance of a policy to someone who has coverage gaps of at least 62 days, no such exclusions or denials will be permitted to SustiNet. Instead, SustiNet will apply the rule used by Medicare Parts B and D – namely, people who go without coverage will have premiums increased, based on the length of their coverage gaps. In that way, individuals will be discouraged from waiting until they get sick before they enroll in SustiNet.

3. People offered ESI that does not provide affordable access to essential health care

Two groups of people offered ESI can instead enroll in SustiNet. First, people with incomes low enough to qualify for HUSKY or for SustiNet premium subsidies can switch to SustiNet if the premium cost for ESI is substantially higher than the premiums they would be charged for SustiNet. Second, someone with income at any level can switch from ESI to SustiNet if either (a) they are offered ESI that has an actuarial value at least 20 percent below average ESI in the Northeast (for example, because of unusually high deductibles) or (b) the individual’s medical condition makes it highly likely that he or she will spend at least 7.5 percent of their household’s adjusted gross income (as defined under federal income tax law) on out-of-pocket health care costs. As a result, SustiNet will help not just the uninsured but also the underinsured as well as people with rare medical conditions for which ESI leaves them responsible for unusually high out-of-pocket costs.

To select SustiNet rather than ESI, individuals must apply to SustiNet and show they fit within one of these categories. When such an application is approved, the employers must pay SustiNet an “employer voucher” – that is, the amount the employer would have paid for the individual’s health coverage if the individual had accepted the offer of ESI.

Such employer vouchers seek to prevent employers from shifting costs to the public sector. However, there is a risk that, rather than preserve existing levels of employer payment for health coverage, the employer voucher requirement could increase employer costs. Two elements of the proposal seek to prevent that result. First, each employer’s total level of voucher payments is capped to ensure that the number of workers for whom the employer pays, through either buying ESI or paying employer vouchers, does not exceed the average percentage of employees who accept coverage offers from employers of the same size and industry in the Northeast. Second, the SustiNet authority operates an administrative procedure through which an employer can show that, despite such an industry-based cap, the required level of employer vouchers would cause its costs to increase.

4. State employees and retirees

State employees and retirees are enrolled in SustiNet, receiving the same covered benefits and cost-sharing protections as under current labor agreements.

5. Employers

Employers can buy SustiNet coverage for their workers. Generally, a standard benefits package is offered, although businesses can elect more generous coverage, as can individuals. When SustiNet is sold to small employers, the rules of the small-group market
apply. Premiums are only adjusted based on certain characteristics of each employer’s workforce (age, gender, industry, geographic area). When SustiNet is sold to larger employers, SustiNet also varies premiums based on the general risk level of each company’s employees, based on prior claims and the characteristics of the firm’s workforce. The intent is to simulate the cost of self-insured coverage, using the same procedure that determines premiums charged for COBRA continuation coverage when a self-insured employer terminates a covered worker. As a result, if employers with an unusually high-cost workforce enroll, premiums will increase to cover the expected costs of care. This will both prevent adverse selection and ensure that, if it takes place, costs are not shifted to other enrollees.

Health coverage for all state residents

Eligibility for subsidized coverage
To reduce the number of uninsured in Connecticut, the proposal expands HUSKY eligibility as follows:

- HUSKY A, which now covers parents and children up to 185 percent of the federal poverty level (FPL), will also cover adults in this income range who are not parents. This includes the very-low-income childless adults who, under current law, receive SAGA.
- HUSKY B, which now covers children between 185 and 300 percent of FPL, will also cover adults in this income band. However, this coverage will not be available to adults who are offered ESI, unless the employer plan fails to provide affordable access to essential health care.
- Immigration status becomes irrelevant to HUSKY eligibility.

In addition, premium subsidies for SustiNet individual enrollment are offered on a sliding scale for people with incomes between 300 and 400 percent of FPL.

Figure 1 illustrates these changes in subsidy levels.

Automatic enrollment
Rather than use an individual mandate to compel state residents to take advantage of available subsidies, the SustiNet proposal uses auto-enrollment strategies to increase participation rates. Uninsured individuals are identified at many junctures – for example, when they file state income tax forms, when uninsured children begin a school year, or when an uninsured patient seek hospital care. Based on state data about income, their eligibility for HUSKY and SustiNet is preliminarily determined, subject to the individual’s correction and appeal. Identified uninsured individuals are enrolled into health coverage unless they “opt out” and affirmatively choose to be uninsured. This involves a formal informed consent process that explains the risks of going uninsured. This process needs to be repeated annually for the individual to remain without health coverage.
Strengthening the health insurance market with new information and new coverage options for employers and individuals

To better inform consumers about their choices from among competing plans, an independent information clearinghouse gathers and reports information from those plans to improve purchasers’ ability to determine the value they receive for their premium dollars. From both SustiNet and state-licensed private insurance, reported information will include services received, plan performance on key quality indicators, outcomes for enrollees with various diagnoses (adjusted for patient risk level), consumer satisfaction measures, and other pertinent indicators. Self-insured, employer-based plans can voluntarily participate in this same data-collection and reporting process.

Additional policy elements

Other facets of the SustiNet proposal include the following:

- A “shared responsibility tax” applies to companies that do not cover their workers and that have payroll above the average amount for a 10-person employer in Connecticut (approximately $318,000 in 2008). Such a firm pays an amount equal to 3 percent of payroll above the threshold. All of the company’s employees combine to pay an amount equal to 1 percent of payroll above the threshold. This shared payment follows the basic model of current payroll taxes, for which employers and employees are both responsible.

- Comprehensive state policy initiatives seek to accomplish the following goals:
  - Reducing the incidence of obesity and tobacco use among children and adults;
  - Strengthening the state’s infrastructure for providing tests, immunizations, and other basic preventive care services in the community, in work sites, and in schools; and
  - Addressing current and looming health care workforce shortages involving physicians, nurses, and other professionals.

- The Office of the Healthcare Advocate (Office) commissions periodic studies that develop “evidence-based benefits packages.” These packages are designed, based on the medical and public health literature, to produce the greatest possible health benefits for a price typical of large employer coverage in the Northeast. The Office will develop and propose to the legislature a plan for giving employers incentives to offer such evidence-based benefits, and SustiNet standard benefits may be adjusted to take into account the results of this research.
• The SustiNet Board has the authority to make “mid-course corrections.” While the Board must provide the public and the legislature with advance notice and an opportunity to comment, the Board may implement policy changes in areas like the following, without asking the legislature to change the SustiNet law:
  • If employers begin dropping coverage and shifting costs to SustiNet, the Board may change eligibility rules for subsidies to prevent and reverse such changes.
  • If SustiNet becomes a repository for above-average risks (either in terms of individual or employer enrollment), the Board may change its policies to prevent such adverse selection.
  • If Connecticut residents enrolled in ESI do not receive affordable access to the full range of necessary care, the Board can make it easier for people offered ESI to choose SustiNet instead.
  • The Board can update the health care delivery system reforms embodied in SustiNet, including changes to provider reimbursement methods, based on evolving research.

Phasing-in policy reforms

The changes proposed here are large in scope. Under any circumstances, they would need to be phased-in carefully. The need for thoughtful staging is even more important with the prospect of major national health care reform, combined with a severe state fiscal emergency. At this juncture, the slow and careful implementation of SustiNet thus serves three goals:

• Major policy changes affecting the health care delivery system, greatly expanded subsidy eligibility and enrollment, and increased reimbursement for existing subsidy programs will be more successfully implemented if they are carefully planned and executed.

• Delaying full implementation permits the state’s elected leaders to time new General Fund obligations based on the state’s economic recovery and consequent fiscal improvement.

• A gradual phase-in puts Connecticut in a good position to take advantage of new resources and options that emerge from national health care reform efforts. Not only will Connecticut be among the “first in line” ready to implement national reforms, the Authority and the legislature can recalibrate SustiNet based on new federal developments.

Note: The phase-in described in Table 1 was developed before the state’s budget problems grew severe. If the proposal were to be revised today, with cost estimates modified accordingly, many aspects of the proposal would be further delayed.
# SustiNet: Key Policy Elements

## Table 1. Key dates for policy change, SustiNet proposal: State fiscal years 2010–2016

<table>
<thead>
<tr>
<th>Year</th>
<th>The SustiNet Plan</th>
<th>Coverage Expansion and Subsidies</th>
<th>State Employees and Retirees</th>
<th>Employers</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2010</td>
<td>Planning and infrastructure development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2011</td>
<td>Midyear: reformed delivery system begins to be phased in; initial focus is on people with chronic illness</td>
<td>Midyear: HUSKY expansion and premium subsidies begin</td>
<td>State employees and retirees enrolled in SustiNet</td>
<td></td>
</tr>
<tr>
<td>FY 2012</td>
<td></td>
<td>Auto-enrollment begins to be phased in</td>
<td></td>
<td>Small employers, municipalities, nonprofits can buy SustiNet</td>
</tr>
<tr>
<td>FY 2013</td>
<td></td>
<td></td>
<td>HUSKY reimbursement rate increases begin to be phased in</td>
<td></td>
</tr>
<tr>
<td>FY 2014</td>
<td>Phase-in complete for health care delivery system reforms</td>
<td>Phase-in of auto-enrollment is complete</td>
<td></td>
<td>Any employer can buy SustiNet</td>
</tr>
<tr>
<td>FY 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FY 2016</td>
<td></td>
<td>Phase-in of reimbursement rate increases is complete</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Except as otherwise noted, all policy changes are implemented at the beginning of the applicable fiscal year.
tables in this and the following section show the results of Dr. Gruber’s microsimulation modeling estimating the cost and coverage effects of the SustiNet proposal. These findings compare the proposal with the status quo in Connecticut in the absence of policy change. The latter, “baseline” scenario is based on Census Bureau coverage estimates for Connecticut during 2004–2006. Of course, health coverage in Connecticut has changed since then. The recession has, without a doubt, increased the number of uninsured, reduced the number of state residents with private coverage, and increased the number receiving Medicaid and HUSKY. These and other coverage changes since the middle of the decade are not reflected in this analysis. This allows the reader to isolate the impact of the policy proposal described here, distinct from other forces that changed health coverage in Connecticut.

Table 2 shows how the proposal changes coverage in Connecticut. Several conclusions stand out:

- The proportion of uninsured residents under age 65 falls from 12 to 2 percent.
- The proportion of residents with private, nongroup coverage declines from 3 to 1 percent.
- The proportion of ESI remains approximately at status quo levels for three reasons:
  - The shared responsibility tax limits the savings that employers can realize from dropping coverage.
  - Most companies that offer coverage today have at least some higher-income workers who, under the proposal, would continue to be better off if their firms bought health coverage. That is because the federal tax exclusion for ESI is available only when employers purchase coverage. Under the proposal, if employers drop coverage and provide their previous ESI payments in the form of higher take-home pay, employees whose incomes are moderate or higher will pay more in payroll and income taxes. Measured in terms of real purchasing power, the same effective health insurance...
subsidy will, as now, cost employers substantially more when it is provided through higher wages (which are taxed) than through tax-excluded payment of ESI premiums.

- Low-income workers who would be better off under SustiNet than under ESI can shift into SustiNet even if their employers continue to offer coverage. This means that firms with both high- and low-wage workers, who comprise the majority of those that offer ESI, can continue to give their higher-income workers the federal tax advantages of employer payments of health insurance premiums without preventing their low-wage employees from getting “a better deal” through SustiNet.

The employer voucher helps ensure that employers will continue to contribute to the cost of premiums of workers who switch to SustiNet.

### Table 2. Coverage estimates, state residents under age 65: Fiscal years 2011–2016

<table>
<thead>
<tr>
<th>Status Quo</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-sponsored insurance (ESI)</td>
<td>74%</td>
<td>71%</td>
<td>71%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Private nongroup coverage</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Medicaid/SCHIP/SAGA outside SustiNet</td>
<td>10%</td>
<td>18%</td>
<td>11%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Individual SustiNet enrollees</td>
<td>0%</td>
<td>5%</td>
<td>13%</td>
<td>23%</td>
<td>23%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>12%</td>
<td>5%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Notes: (1) Baseline projections assume that coverage continues as in 2004–2006. (2) Totals may not sum because of rounding.

### Effects on cost

**Cost assumptions**

The following are examples of how health care spending growth has been slowed or even reversed by coordinated delivery system reforms like those proposed for SustiNet:

- When the Geisinger Health System – an integrated health care system in Pennsylvania – implemented a patient-centered medical home model of care in the context of a preexisting system of electronic health records, hospital admissions declined by 20 percent in the first year, and net medical spending fell by 7 percent."

- With a long-standing reputation as one of the country’s worst systems of care, the Veterans Health Administration remade itself beginning in 1995. It implemented the nation’s first comprehensive system of electronic medical records, assigned every enrolled veteran to a primary care provider or team, and developed regional care networks that were held accountable for results. Over three years, the VHA increased the number of veterans served, expanded the range of services offered, and reduced total health care costs below previous levels by nearly $1 billion."

- When federally qualified health centers in South Carolina implemented a form of patient-centered medical home focused on the chronically ill, the number of outpatient visits was higher than at other practices serving similar patients, but the number and average duration of hospital visits was substantially reduced. The resulting net savings averaged more than $1,600 per patient."
• When North Carolina’s Medicaid program implemented a patient-centered medical home model that linked physicians’ offices with other community-based providers and support agencies, Mercer’s Government Human Resources Consulting Group found that reduced hospitalization and other factors created net savings of approximately $60 million in 2003 and $124 million in 2004. Unlike the previous examples, this innovation created “virtual” networks similar to those contemplated for SustiNet, linking freestanding, small physician practices with other community resources to perform the full set of medical home functions.

Critically important to SustiNet’s approach is that multiple, reinforcing reforms are implemented simultaneously, allowing a more significant impact than implementing one delivery system reform on its own. For example, simply giving each physician a computer will accomplish little. But linking that physician’s electronic medical records with a system that alerts the doctor whenever care inconsistent with approved guidelines is being requested and that tracks the physician’s care patterns for purposes of later practice pattern reports, quality certification, and peer counseling could produce more significant results.

Notwithstanding SustiNet’s implementation of multiple, reinforcing reforms, it is important to note examples of how individual delivery system changes like those proposed for SustiNet have slowed the growth of health care spending or even lowered costs below prior levels:
• When heart failure patients discharged from the hospital received home-based, follow-up care from advance practice nurses in a national trial, rehospitalization rates fell sufficiently to lower overall health care costs by one-third.
• A North Dakota program for coordinating the care of diabetic patients using a case management nurse located inside primary care practices improved clinical outcomes and lowered average costs by $530 per patient per year.

A cautionary note is important. There is a substantial literature casting doubt on whether particular delivery system reforms, in isolation, have a discernable effect on slowing cost growth. Despite this literature, the strategy SustiNet pursues is particularly promising because it has five features that, in many cases, have characterized prior systematic reform efforts that have succeeded in reducing health care costs or spending growth:
• SustiNet synergistically implements multiple, mutually reinforcing delivery system reforms.
• Provider gain-sharing allows the same entities that invest in reforms to realize financial benefits, thus aligning systemic with individual, provider incentives.
• Many enrollees are likely to remain with SustiNet for a long time, so the plan’s investments in long-term consumer wellness can yield financial gains for SustiNet. By contrast, in today’s health coverage systems with many enrollees who frequently shift from plan to plan, investments made by today’s insurer that pay off in the future will benefit a competitor rather than the current plan.
• SustiNet’s reforms are first targeted at chronically ill, high-cost populations for whom cost savings appear most feasible.
• The SustiNet Authority is empowered, without returning to the legislature, to change its delivery system configuration, including innovative reimbursement structures, based on new information both in the academic literature and in SustiNet’s actual cost performance.

One other factor is important to consider in assessing the proposal’s impact on cost growth. Including many covered lives in a single health plan provides leverage to lower prices the plan pays for health care and for administrative services. Based on both these leverage-related factors and the effect of delivery system changes, Dr. Gruber’s cost estimates incorporated assumptions shown in Figure 2 about health care spending growth inside the SustiNet plan.

**Figure 2.** Increases in per capita health care spending above 2010 levels, status quo vs. SustiNet plan: Fiscal years 2011–2016

Outside the SustiNet plan, the proposal described here is likely to slow cost growth as well, albeit by a lesser amount. Such cost savings, relative to projected levels, would result from the following factors:
• Hospitals will experience less uncompensated care because many fewer patients will be uninsured; SAGA patients will shift to HUSKY, which, even at current payment levels, provides much higher average reimbursement; and HUSKY reimbursement rates over time will increase substantially above current amounts. As a result, less uncompensated care will shift to private insurers. Ultimately, reduced cost-shifting will lower the premiums that are paid by employers and individuals receiving private coverage.
• To compete for market share, private insurers will need to implement delivery system reforms that, with SustiNet, prove effective in slowing cost growth.

Because of these factors, Dr. Gruber’s cost estimates incorporated the assumption that the proposal will modestly reduce the rate of cost growth for care furnished outside the SustiNet plan, as shown in Figure 3.
Cost estimates

Before describing Dr. Gruber’s cost estimates, a few preliminary comments are important. First, they are expressed in 2008 dollars. The “baseline” estimates – that is, the projection of what will take place if current policies remain in place – incorporate real increases in per capita health spending, but they do not reflect general inflation. Second, to indicate the general magnitude of cost consequences, the narrative discussion in this section uses the year 2014, when the SustiNet plan has been “up and running” for several years. The tables themselves present a fuller picture by setting out Dr. Gruber’s cost estimates for the entire period of FY 2011 through FY 2016.

Several cost findings stand out:

- While the shared-responsibility tax imposes $90 million in annual costs on the small number of medium-sized and large firms that do not offer coverage, the employers that do offer coverage realize much larger savings, which total $1.35 billion in FY 2014 (Table 3). As a result, employers as a whole experience significant net reductions in health care costs, amounting to $1.26 billion in 2014.

- With lower premiums and fewer out-of-pocket costs, household health care spending declines by $540 million in FY 2014 (Table 4). In addition, Dr. Gruber found that employers pass on their cost savings in the form of higher wages to employees, increasing households’ post-tax income by $930 million in 2014. As a result of these two factors, post-tax income usable for purposes other than health care increases by $1.47 billion.

Dr. Gruber’s conclusion about post-tax income has a significant caveat, however. The proposal, in its current form, projects a rise in General Fund costs, but does not specify all funding mechanisms. If those increased costs are funded through higher state-level taxes, those tax increases would partially offset the increases in household income.

- Under the proposal, Connecticut would receive substantially more federal matching dollars, with the increase reaching $800 million by FY 2014 (Table 5). This increase results from several factors: eligibility for federally matched health coverage expands, auto-enrollment increases participation rates among people who qualify for such coverage, and HUSKY reimbursement rates increase.”
• Because more people receive publicly funded coverage, and because of higher HUSKY reimbursement rates, state General Fund costs rise above projected levels by $950 million as of FY 2014 (Table 6). Approximately half of these cost increases result from higher reimbursement rates, and the other half stem from the increase in subsidized health coverage.

• As one measure of efficiency, total health care spending on each insured resident declines. The average savings per insured person equal $875 in FY 2014, representing total reductions in premiums and out-of-pocket costs, taking into account all payment sources (Table 7).

Table 3. Estimated impact of proposal on health costs for all employers, status quo vs. proposal: Fiscal years 2011–2016 (millions)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings to firms that currently offer coverage</td>
<td>$610</td>
<td>$1,040</td>
<td>$1,210</td>
<td>$1,350</td>
<td>$1,580</td>
<td>$1,800</td>
</tr>
<tr>
<td>Costs to firms that do not currently offer coverage</td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td>Net savings for all firms</td>
<td>$520</td>
<td>$960</td>
<td>$1,120</td>
<td>$1,260</td>
<td>$1,490</td>
<td>$1,700</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Notes: (1) Baseline projections assume that coverage distribution continues as in 2004–2006. (2) Cost estimates are rounded to the nearest $10 million. (3) Totals may be affected by rounding. (4) Costs are stated in 2008 dollars.

Table 4. Estimated financial impact on households under age 65, status quo vs. proposal: Fiscal years 2011–2016 (millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in post tax income</td>
<td>$380</td>
<td>$700</td>
<td>$830</td>
<td>$930</td>
<td>$1,100</td>
<td>$1,260</td>
</tr>
<tr>
<td>Reduction in health care costs</td>
<td>$420</td>
<td>$600</td>
<td>$540</td>
<td>$540</td>
<td>$810</td>
<td>$900</td>
</tr>
<tr>
<td>Total increase in post-tax income usable for purposes other than health care</td>
<td>$800</td>
<td>$1,300</td>
<td>$1,370</td>
<td>$1,470</td>
<td>$1,900</td>
<td>$2,160</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Note: (1) See notes for Table 3. (2) Federal income tax revenues are projected to increase because household income is projected to rise. To the extent that state taxes can be deducted from income as counted for federal income tax purposes, revenues will decline below stated levels.

Table 5. Estimated financial impact on the federal government, status quo vs. proposal: Fiscal years 2011–2015 (millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased federal matching funds</td>
<td>$410</td>
<td>$660</td>
<td>$640</td>
<td>$800</td>
<td>$740</td>
<td>$850</td>
</tr>
<tr>
<td>Increased federal income tax revenue</td>
<td>$120</td>
<td>$220</td>
<td>$250</td>
<td>$280</td>
<td>$330</td>
<td>$380</td>
</tr>
<tr>
<td>Net change to federal deficit</td>
<td>$290</td>
<td>$440</td>
<td>$390</td>
<td>$510</td>
<td>$400</td>
<td>$470</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Note: See notes for Table 3.
### Table 6. State General Fund costs for residents under age 65, status quo vs. proposal: Fiscal years 2011–2016 (millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Status Quo</th>
<th>Medicaid/HUSKY</th>
<th>SAGA</th>
<th>State employees and retirees</th>
<th>Proposal</th>
<th>Medicaid/HUSKY outside SustiNet</th>
<th>SAGA outside SustiNet</th>
<th>Maintenance of effort</th>
<th>Changes to state income tax revenue</th>
<th>Gains or losses from SustiNet</th>
<th>Net change in state costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$2,460</td>
<td>$1,180</td>
<td>$260</td>
<td>$1,010</td>
<td>$2,380</td>
<td>$1,470</td>
<td>$130</td>
<td>$1,140</td>
<td>$20</td>
<td>$330</td>
<td>-$70</td>
</tr>
<tr>
<td>2012</td>
<td>$2,360</td>
<td>$1,270</td>
<td>$280</td>
<td>$1,080</td>
<td>$3,050</td>
<td>$1,360</td>
<td>$130</td>
<td>$1,530</td>
<td>$40</td>
<td>-200</td>
<td>$420</td>
</tr>
<tr>
<td>2013</td>
<td>$2,810</td>
<td>$1,350</td>
<td>$300</td>
<td>$1,150</td>
<td>$3,500</td>
<td>$820</td>
<td>$0</td>
<td>$1,900</td>
<td>$50</td>
<td>-830</td>
<td>$690</td>
</tr>
<tr>
<td>2014</td>
<td>$3,010</td>
<td>$1,450</td>
<td>$320</td>
<td>$1,240</td>
<td>$3,960</td>
<td>$880</td>
<td>$0</td>
<td>$2,030</td>
<td>$50</td>
<td>-1,100</td>
<td>$950</td>
</tr>
<tr>
<td>2015</td>
<td>$3,220</td>
<td>$1,550</td>
<td>$340</td>
<td>$1,320</td>
<td>$4,160</td>
<td>$940</td>
<td>$0</td>
<td>$2,180</td>
<td>$60</td>
<td>-1,100</td>
<td>$940</td>
</tr>
<tr>
<td>2016</td>
<td>$3,440</td>
<td>$1,660</td>
<td>$370</td>
<td>$1,420</td>
<td>$4,520</td>
<td>$1,000</td>
<td>$0</td>
<td>$2,330</td>
<td>$70</td>
<td>-1,250</td>
<td>$1,070</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Note: See notes for Table 3.

### Table 7. Health care spending on people with coverage, dollars per insured resident under age 65, status quo vs. proposal: Fiscal years 2011–2016 (millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>Status Quo</th>
<th>Proposal</th>
<th>Net change</th>
<th>Dollars</th>
<th>Percentage of cost per insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>7,431</td>
<td>$6,851</td>
<td>-$580</td>
<td>-7.8%</td>
<td>-7.8%</td>
</tr>
<tr>
<td>2012</td>
<td>7,951</td>
<td>$7,221</td>
<td>-$730</td>
<td>-9.2%</td>
<td>-9.2%</td>
</tr>
<tr>
<td>2013</td>
<td>8,507</td>
<td>$7,691</td>
<td>-$817</td>
<td>-9.6%</td>
<td>-9.6%</td>
</tr>
<tr>
<td>2014</td>
<td>9,102</td>
<td>$8,227</td>
<td>-$875</td>
<td>-9.6%</td>
<td>-9.6%</td>
</tr>
<tr>
<td>2015</td>
<td>9,739</td>
<td>$8,598</td>
<td>-$1,142</td>
<td>-11.7%</td>
<td>-11.7%</td>
</tr>
<tr>
<td>2016</td>
<td>10,421</td>
<td>$9,191</td>
<td>-$1,230</td>
<td>-11.8%</td>
<td>-11.8%</td>
</tr>
</tbody>
</table>

Source: Gruber Microsimulation Model.
Notes: (1) Baseline projections assume that coverage distribution continues as in 2004–2006. (2) Totals may be affected by rounding. (3) Spending is stated in 2008 dollars.
Effects on the state economy

Based on the findings by Dr. Gruber, Urban Institute researchers found, using the REMI Macrosimulation Model, that the SustiNet proposal would have a negligible effect on the state economy as a whole. Slightly lower spending levels on health coverage would cause a small drop in health industry economic activity and employment. Slightly higher spending for all other goods and services would cause a small increase in economic activity and employment in other industries. In net, these two results would cancel out one another (Tables 8 and 9).

Table 8. Overall employment, status quo vs. proposal: Fiscal years 2011–2016 (thousands)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Status quo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health industry</td>
<td>226</td>
<td>231</td>
<td>235</td>
<td>239</td>
<td>244</td>
<td>248</td>
</tr>
<tr>
<td>All other industries</td>
<td>2,058</td>
<td>2,071</td>
<td>2,083</td>
<td>2,098</td>
<td>2,113</td>
<td>2,128</td>
</tr>
<tr>
<td>Total employment</td>
<td>2,284</td>
<td>2,301</td>
<td>2,317</td>
<td>2,337</td>
<td>2,357</td>
<td>2,377</td>
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<td>Proposal</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health industry</td>
<td>223</td>
<td>228</td>
<td>233</td>
<td>239</td>
<td>241</td>
<td>246</td>
</tr>
<tr>
<td>All other industries</td>
<td>2,060</td>
<td>2,073</td>
<td>2,084</td>
<td>2,100</td>
<td>2,115</td>
<td>2,130</td>
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<tr>
<td>Total employment</td>
<td>2,283</td>
<td>2,302</td>
<td>2,318</td>
<td>2,338</td>
<td>2,356</td>
<td>2,375</td>
</tr>
</tbody>
</table>

| Change (number of jobs) |      |      |      |      |      |      |
| Health industry | -3   | -2   | -1   | 0    | -3   | -3   |
| All other industries | 2    | 3    | 2    | 2    | 2    | 2    |
| Total employment | -1   | 1    | 1    | 2    | -1   | -1   |

| Change (percentage) |      |      |      |      |      |      |
| Health industry | -1.3% | -0.9% | -0.6% | 0.0% | -1.1% | -1.2% |
| All other industries | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% | 0.1% |
| Total employment | 0.0% | 0.0% | 0.0% | 0.1% | 0.0% | 0.0% |

Source: REMI Macrosimulation Model.
Notes: (1) Baseline projections assume that coverage distribution continues as in 2004–2006. (2) Totals may not sum because of rounding.


<table>
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<tr>
<td>Status quo</td>
<td>216</td>
<td>224</td>
<td>232</td>
<td>240</td>
<td>248</td>
<td>256</td>
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<tr>
<td>Proposal</td>
<td>216</td>
<td>224</td>
<td>232</td>
<td>240</td>
<td>248</td>
<td>256</td>
</tr>
<tr>
<td>Change (dollars)</td>
<td>$(0)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$(0)</td>
<td>$(0)</td>
</tr>
<tr>
<td>Change (percentage)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: REMI Macrosimulation Model.
Note: Baseline projections assume that coverage distribution continues as in 2004–2006.
Conclusion

In purely financial terms, the SustiNet proposal would benefit the state. Although General Fund costs would rise by $950 million as of 2014, Connecticut households and employers would see their health care costs decline by a total of $1.8 billion, and federal matching funds would increase by $800 million. Put differently, each extra dollar in General Fund spending would yield $1.89 in private-sector savings and 84 cents in additional federal dollars coming to Connecticut.

In addition to these financial gains, the SustiNet proposal would greatly expand access to care for HUSKY and SAGA beneficiaries by increasing reimbursement rates, thus improving provider participation and reducing cost-shifting to private insurance. Above all, the state’s residents would be guaranteed that, if they lose employment, suffer other financial setbacks, or lack access to employer-sponsored insurance, comprehensive health coverage will be available and affordable.
About the Author

Stan Dorn is a senior research associate at the Urban Institute. For nearly 25 years, he has worked at the state and federal level on health coverage issues. A former senior policy analyst at the Economic and Social Research Institute, managing attorney at the National Health Law Program, and Health Division director at the Children’s Defense Fund, Mr. Dorn is widely viewed as one of the nation’s leading experts on innovative strategies to expand health coverage.

About the Urban Institute’s Health Policy Center

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The Institute’s Health Policy Center (HPC) analyzes trends and underlying causes of changes in health insurance coverage, access to care, and use of health care services by the entire U.S. population. Researchers address issues that arise from the inevitable trade-offs among health care costs, access, and quality. For more information, see the HPC website, http://www.urban.org/health_policy/, or the Urban Institute’s more general website, http://www.urban.org.
About Universal Health Care Foundation of Connecticut

Universal Health Care Foundation of Connecticut is an independent, nonprofit grant-making organization dedicated to achieving a quality health care system that is affordable and available for everyone in the state. The Foundation believes that health care is a fundamental right. It views its work as part of a larger vision of social and economic justice for all.

Acknowledgments

The author thanks Universal Health Care Foundation of Connecticut for providing the funding that made this report possible. In addition, the author thanks Jonathan Gruber and William N. Barge of the Massachusetts Institute of Technology for their work on the microsimulation; Stephen Zuckerman and Karen Stockley of the Urban Institute for their work with the REMI Macrosimulation Model; Bob Berenson of the Urban Institute, for his insights about health care delivery system reforms; Arthur Tim Garson, Jr., of the University of Virginia, for numerous suggestions and comments that greatly improved the proposal described in this paper; Bogdan Tereschenko of the Urban Institute, for his tireless research that proved essential in defining many of the details of the SustiNet proposal; and for the generosity of time and insight from a broad range of Connecticut stakeholders and experts, whose comments had a profound impact on the proposal described here. Of course, the views expressed are those of the author and should not be attributed to the individuals or organizations listed above, to Universal Health Care Foundation of Connecticut, or to the Urban Institute, its sponsors, staff, or trustees.
Endnotes

i HUSKY, Healthcare for Uninsured Kids and Youth, is the portion of the Medicaid program that provides health insurance for children and their parents in Connecticut. SAGA is the state’s general assistance program for low income adults.

ii Universal Health Care Foundation of Connecticut, SustiNet Health Care We Can Count On, February 8, 2009.

iii For example, a major auto-enrollment effort was responsible for most early enrollment into subsidized health coverage offered through Commonwealth Care, the new subsidy program implemented in Massachusetts beginning in 2006; auto-enrollment has proved to have an enormous impact on enrollment into 401(k) retirement savings accounts; and auto-enrollment into Medicare Part B has historically led to 95.5 percent take-up rates. See Appendix A in Stan Dorn, Express Lane Eligibility and Beyond: How Automated Enrollment Can Help Eligible Children Receive Medicaid and CHIP, prepared by the Urban Institute for the National Academy for State Health Policy and the Robert Wood Johnson Foundation, April 2009.


v This does not include people over age 64 or who qualify for Medicaid based on severe, permanent disability. However, people with disabilities who intermittently qualify as “medically needy” through incurring periodic medical costs for noninstitutional care would typically qualify for HUSKY’s expanded income eligibility or SustiNet premium subsidies. As a result, they would receive SustiNet.

vi The amount of such increased cost must be at least 2 percent of household income.

vii For example, suppose that (a) Company X has 100 workers and (b) in companies of X’s size and industry in the Northeast the average firm has ESI offers accepted by 70 percent of its employees. Suppose further that 50 of X’s employees enroll in ESI and 30 enroll in SustiNet. X would pay employer vouchers for only 20 SustiNet enrollees, since the total number of employees for whom X is financially responsible would be capped at 70 (50 enrollees in X’s ESI and 20 recipients of employer vouchers). The other 10 SustiNet enrollees would have their premiums paid entirely by the employees themselves (based on income) and, if they qualify for assistance, by HUSKY or SustiNet premium subsidies.


xvii Sections 1931 and 1902(r)(2) of the Social Security Act permit children and the parents of minor children to be covered up to any desired income level, with federal matching funds. However, noncategorical adults are ineligible for such funds unless a state receives a waiver under Section 1115 of the Social Security Act. 11 states have received waivers to extend some coverage to noncategorical adults with incomes up to 185 percent of the federal poverty level, the level of coverage for which we assumed such adults would receive federal matching funds. Keavney Klein and Sonya Schwartz, State Efforts to Cover Low-Income Adults without Children, National Academy for State Health Policy, September 2008.
ABOUT THE FOUNDATION
Universal Health Care Foundation of Connecticut is an independent, nonpartisan activist foundation dedicated to making quality affordable health care available to everyone in the state. Its mission is to serve as a catalyst that engages people and communities in shaping a health system that provides access to quality, affordable health care and promotes health in Connecticut. To learn more about the foundation, visit www.universalhealthct.org. To learn more about SustiNet and the foundation’s statewide campaign, visit www.healthcare4every1.org.