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An Assessment of the SustiNet Health Partnership Report to the Connecticut General Assembly

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Introduction

With the enactment of the Patient Protection and Affordable Care Act (PPACA), states are evaluating their options for implementing Health Care Reform. Prior to PPACA, Connecticut had already started on a path to reform health care financing, design, administration and delivery for various groups for which the state currently manages and/or finances health care. In January 2011 the Board of Directors of the Sustinet Health Partnership issued their report (Sustinet Report) to the Connecticut General Assembly.

Hay Group was retained by America's Health Insurance Plans (AHIP) to review the Sustinet Report and provide an assessment on the report with a focus on the recommendations and their implications on health care reform.

In order to objectively evaluate the Sustinet program it is important to understand its major components and to evaluate the benefits of the Sustinet program itself. It is also important to understand how Sustinet will relate to other changes the State has made or will be required to make, independently of the Sustinet program, as a result of federal health care reform.

What is Sustinet?

In January 2009, a proposal for a statewide health care plan for Connecticut termed “SustiNet” was unveiled. The proposal set out to provide residents with their choice of health coverage and care regardless of their employment status, age, or pre-existing conditions.

Later that year, the Connecticut Legislature enacted the “SustiNet law” which included the creation of a new health plan, named “SustiNet.” The Sustinet plan envisioned making coverage available as a starting point to a range of coverage groups:

- State employees and their dependents;
- State retirees and their dependents;
- Medicaid/State Administered General Assistance (SAGA) enrollees; and
- Healthcare for Uninsured Kids and Youth (HUSKY) enrollees.

In addition, under the 2009 law, the Sustinet plan was also to be offered to the state’s small firms, non-profit corporations, and municipalities beginning on July 1, 2012.

The legislation that established the Sustinet Health Partnership included specific task forces or studies covering:

- childhood and adult obesity;
- preventive health care (nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances);
- tobacco use by children and adults; and
- the state's health care workforce addressing shortage of necessary medical personnel, including physicians, nurses and allied health professionals.

The task forces were to report back no later than January of 2011.

During the time this effort was underway, Congress enacted the Patient Protection and Affordable Care Act (PPACA). Recognizing this, at the time the Connecticut Legislature passed the Sustinet law, it authorized the Sustinet Board, within 60 days of enactment of PPACA, to report on how the Legislature could modify Sustinet to take account of the new federal law’s provisions.

The Sustinet Board responded in a report dated, May 30 2010 (the “2010 Report”), with recommendations that appear to be based on three core building blocks:¹

1. Taking advantage of increasing federal funding for Medicaid expansion and participation in the “Basic Health Program” option outlined under PPACA;
2. Expanding the availability of Sustinet by 2014 to all individuals and employers, in addition to State municipalities - making the Sustinet Health Plan available both inside and outside Connecticut’s Exchange; and,
3. Leveraging the size of the covered population to slow cost growth and applying the best available practices to reform of the health care delivery and provider payment systems.

This assessment examines these three elements as outlined in the 2010 Report and in the January 2011 Report to the Connecticut General Assembly.

¹ See May 2010 Report and Testimony of Stan Dorn, concerning HB 6305 Before the Insurance and Real Estate Committee, Public Health Committee, and Human Services Committee of the Connecticut General Assembly (February 14, 2011).

Key Findings

This report examines these elements from an analytical perspective, bridging actuarial, budgetary, and regulatory considerations, in order to offer insight into the potential implications of the program for the State of Connecticut and its residents.

Key findings of our assessment include:

1. ***SustiNet shows an increase in state spending, not a reduction, once the conversion of SAGA to Medicaid (which has already occurred and is unrelated to Sustinet) is accounted for.*** Using a baseline cost that reflects that the SAGA conversion to Medicaid has already occurred, and excluding what appears to be an anticipated \$15 million increase in tax revenues attributable to a drop in employer-sponsored coverage, the cost estimates in the Sustinet report indicate that the program will result in a net cost increase of \$77 million in 2017. Even including the \$15 million in projected additional revenues due to the reduction in employer-sponsored coverage, there is a \$62 million net cost increase to the state in 2017 rather than a savings of \$224 million.
2. ***Implementation of Sustinet carries “insurance risk” and liability implications for the state.*** The State would, through the Sustinet program, take responsibility for paying the benefit costs for all Sustinet enrollees – and the associated risk if premiums are lower than the actual claim costs. This is a significant issue given that with the size of the proposed Sustinet population even a very small underestimate in required premiums could result in significant liability for the state. The Sustinet report notes that the State currently oversees approximately \$8 billion in spending through health programs for the populations that would be combined into the Sustinet program. A one percent error in setting premiums for a program of this size could result in a loss of \$80 million.
3. ***Establishment of a Basic Health Program (BHP) is not dependent upon implementation of Sustinet.*** Capturing additional federal funding through expanding Medicaid and implementation of a Basic Health Program (BHP) is not dependent upon implementation of the Sustinet program. In fact, the particular goal of capturing additional federal funding through the creation of a Basic Health Program may be made more difficult by implementation of Sustinet to the extent that the BHP option would be made available through an exchange or those receiving coverage under the BHP are combined as part of Sustinet with other populations, as this would appear to be inconsistent with federal requirements. In addition, in lieu of pursuing a BHP the state might wish to consider further analyzing the option of facilitating those who would be eligible for the BHP to obtain federally subsidized coverage on the exchange.

4. ***Combining diverse enrollment populations as proposed under Sustinet raises significant actuarial and policy challenges as well as potential unintended consequences.*** Combining all of the Sustinet enrollee populations into a single, uniform pool involves a number of serious actuarial and policy challenges. It appears that the report contemplates implementing the Sustinet program as a single risk pool, using a consolidated provider network with a single set of provider payment rates, and a common set of benefit options. Because the different populations have different demographics, pooling them will likely increase premiums for some populations, while reducing premiums for others, creating implicit subsidies between the populations. Creating a common set of benefits would either require certain populations, such as State Employees, to receive reduced benefits or, it would lead to the creation of a benefit plan that is likely to be very expensive relative to other coverage options expected to be available on an exchange. Similarly, equalizing payment rates to hospitals, physicians, and other providers would require either increasing payment rates for the providers currently serving some populations (such as Medicaid-eligible individuals) or reducing them for providers currently serving others (such as State employees).

In addition, it appears that the current State Employee Health Plan (SEHP) design has an actuarial value that is significantly in excess of the 90% platinum level established in the federal reform law, which might, in turn, frustrate the offering of the current SEHP package on an exchange.

5. ***Diminishing returns to size.*** There are natural limits to the savings that can be achieved through size alone. Once an insurance pool reaches a critical size, the marginal benefit from additional growth becomes quite small. The SEHP, for instance, covers over 200,000 employees, retirees and dependents. Medicaid and HUSKY enrollment exceeds 500,000. Programs with this level of enrollment in a single state have the critical mass necessary to bargain effectively with providers and to establish efficient administrative systems. It is not clear that the additional enrollment achieved by combining the Medicaid/HUSKY populations with SEHP would result in materially better results from provider negotiations, or materially improved administrative efficiencies. In addition, the complexities of serving such disparate populations would likely complicate both network negotiations and the administrative process.
6. ***While combining populations carries unintended consequences, unbundling raises questions over stated goals.*** While combining populations raises the challenges and potential unintended consequences highlighted above, on the other hand, if the Sustinet enrollee pool were unbundled it would undermine the stated goals (whether realizable or not)

of using the combined enrollment to drive provider negotiations and using consolidated administration to reduce overhead costs and improve the management of health delivery.

7. ***Exchange requirements would apply to Sustinet and highlight the insurance carrier risks the state would be taking on under the program.*** There are specific federal requirements for health plans to participate in the new Exchanges. While the Sustinet report does state that the program would obtain a state insurance license in order to enable the program to offer coverage through the Connecticut exchange, our review suggests that the federal requirements could represent a significant barrier to Sustinet's participation in the exchange.
8. ***The goal of seeking to accelerate payment and delivery system reform efforts is laudable, but few specifics are provided.*** The goal of seeking to align incentives and leverage the size of the covered population envisioned under Sustinet to encourage reform of the health care delivery and provider payment system is laudable. The Sustinet report includes "optimistic" projections based on the assumption that Sustinet is successful in reducing the growth in health care spending by one percentage point each year beginning in 2012. Too few specifics are provided for us to be able to evaluate the ability of Sustinet to achieve this goal. We would note, however, that a variety of delivery system and payment reform initiatives are proceeding already in both the private and public sectors. It is unclear what the Sustinet program would add to these efforts.

A more detailed discussion of these key findings is provided in the body of our report.

Increased federal funding & “Basic Health Program” option

The Sustinet Board report presents several recommendations that are intended to drive improvements in the general health and wellbeing of the Connecticut residents as well as the wellbeing of the state’s finances. The report includes projected net state budget savings ranging from \$277-\$355 million in 2014 to \$226-\$531 million for 2019, the latest year of the forecast. These ranges represent two different cost projections; the second or “optimistic” assumes that Sustinet is successful in slowing the growth in health care costs by one percentage point annually (“bending the cost curve”) beginning in 2012.

Increased Federal Dollars Related to Conversion of SAGA to Medicaid

The report shows savings to the State but provides few details on where or how these savings are achieved. While not stated directly in the report, it appears that most of the projected savings can be attributed to policy decisions that have already been enacted. As shown in the table below, using figures from the Sustinet report, the bulk of the savings are attributable to the (SAGA) program’s conversion to Medicaid which was accomplished in 2010.² In this regard, the Sustinet report states the \$286 million in savings for 2017 shown for SAGA are “shown against a baseline in which SAGA was not converted into Medicaid coverage of low-income adults.”³ The report also appears to project a \$15 million dollar increase in state tax revenues attributable to a drop in employer-sponsored insurance (ESI).⁴ Accounting for the SAGA conversion to Medicaid, and excluding the revenues attributable to reductions in ESI, Figure 3 would appear to suggest a \$77 million increased cost for the Sustinet program. Even including the \$15 million in projected additional revenues due to the reduction in ESI, there is a \$62 million net cost increase to the state instead of a \$244 million savings.

² See *Implementing Sustinet Following Federal Enactment of the Patient Protection and Affordable Care Act of 2010: A Preliminary Report to the Connecticut General Assembly* (May 27, 2010) at p. 9. The report states that “the state is already implementing this option by shifting into Medicaid recipients of State-Administered General Assistance (SAGA), a program that previously furnished health coverage to childless adults with very low incomes and limited assets. Moving these adults from the previous, fully state-funded system into a program with joint federal-state funding achieves savings for the state General Fund.”

³ Note to Figure 3 on page 26.

⁴ Sustinet 2011 report at page 25 and Figure 3 on page 26.

Table 1	
Projected Impact on State Budget of the Sustinet Program	
Increased Costs	
Medicaid / HUSKY – current population	\$45 million
Medicaid – new population	\$13 million
State employee / retiree coverage	\$19 million
Total Net Increase in Costs to the State	\$77 Million⁵
Increased Tax Revenues/Federal Funding	
Increase in State Tax Revenue Due to Loss of ESI	\$15 million
SAGA Conversion to Medicaid (<i>already included in budget baseline</i>)	\$286 million
Total Increase in Revenues/Federal Funding	\$301 million
Net Impact Projected By Sustinet Report	\$224 million
Source: Net estimated impact of \$224 million taken from page 25 of the Sustinet report. Projections for specific programs taken from Figure 3 on page 26 of the Sustinet Report.	

The State of Connecticut spent \$182 million on SAGA in FY 2009-10, estimated \$307 million for FY 2010-11, and has no expected cost for SAGA in FY 2011-12 due to coverage under Medicaid.

Basic Health Program Option Under Federal Law

Both the 2010 and 2011 Reports spend considerable time advancing the recommendation that the state pursue the creation of a “Basic Health Program” (BHP) as provided for under the federal health care reform law. The recommendation relates to a potential increase in federal dollars tied to creation of a BHP for certain HUSKY enrollees for which the State currently derives a 50% Medicaid match. According to the Sustinet report, “[b]y implementing the Basic Health Program option, the state will shift the cost of covering 16,000 HUSKY parents from Medicaid, for which the federal government pays 50 percent of all expenses into BHP, where the federal government pays all costs.”⁶

⁵ If the \$15 million dollar increase in state tax revenues attributable to small employers discontinuing ESI is netted out against the costs, the net budgetary impact would be an increase in costs for the state of \$62 million.

⁶ Sustinet 2011 report at 25.

There are a number of observations that flow from the proposal to pursue a BHP option.

First, pursuit of a BHP option does not appear dependent upon Sustinet. In fact, while we are not regulatory experts, we note that Sustinet could have the effect of frustrating the state's ability to meet the requirements for participation in the BHP if the proposal is to offer the BHP on an exchange as part of Sustinet or to combine those receiving coverage under the BHP with other Sustinet populations, as this would seem inconsistent with federal requirements. In this regard, as the Sustinet Report explains, the BHP option is provided for under the federal reform law. The provision allows states, subject to numerous certifications, to establish a "basic health program" under which subsidized coverage is offered to individuals not eligible for Medicaid, but whose household income is between 133% and 200% of the Federal Poverty Level (FPL), *"in lieu of offering such individuals coverage through an Exchange."* The program must be competitively bid with contracts offered to one or more "Standard Health Plans" "under which the only individuals eligible to enroll are eligible individuals." If the U.S. Secretary of Health and Human Services finds that a state meets the requirements of the program, the federal government pays into a trust (that can only be used to reduce premiums and cost sharing of those eligible) 95% of the premium tax credits and cost-sharing reductions that would have been provided for the fiscal year if those individuals were allowed to enroll in qualified health plans through an exchange.

Thus, if it were the case that the BHP option, as part of Sustinet, were to be offered on the exchange, or if those participating in the BHP option were to be included as part of the broader Sustinet population, there would seem to be a conflict with the BHP provisions stating that BHP eligible individuals may not use an exchange and that the Standard Health Plans required under the BHP option may only enroll those eligible for this program.

Second, apart from Sustinet, in order to better understand the pros and cons and potential cost implications of seeking to pursue the BHP it may be helpful to distill what appear to be the relevant options. Several points are worth noting here:

- The Sustinet Report proposes an expansion of the state-sponsored population covered under the existing HUSKY population. In this regard, the Report recommends beginning January 1, 2014 an expansion of HUSKY eligibility for adults with incomes between 138% and 200% of FPL. According to the report this encompasses approximately an additional 41,000 low-income adults.⁷ (See 2011 Report p. 19).

⁷ This represents an expansion of current law which allows parents or relative caretakers of HUSKY children with family incomes up to 185% of FPL to participate in the HUSKY A program.

- The Report envisions that both this expanded population and the existing 16,000 low-income HUSKY parents covered today would participate in the BHP program.
- As an alternative, the Report seems to acknowledge that in lieu of pursuing the BHP or maintaining or expanding HUSKY for low-income adults, the state could facilitate these individuals receiving coverage through an exchange, with all such enrollees receiving both premium and cost sharing assistance as provided for in the federal law.⁸ Under this option, the state would have no potential continuing financial obligations or liabilities with respect to this coverage – as opposed to under the BHP program where the state would seem ultimately to be liable for any difference between payments made to Standard Health Plans and the value of subsidies paid by the federal government.
- In support of the recommended approach of pursuing the BHP, the Report suggests that enrolling HUSKY parents through the exchange could lead to these individuals paying more for their coverage than is currently required under the HUSKY A program (with more restrictive eligibility).
- The Report suggests that federal BHP payments will exceed HUSKY costs for low-income adults, although details of the analysis are not provided.⁹ Similarly, the May 2010 Report seems to have made an effort in this regard, but that report appeared to rely on a comparison of a federal Congressional Budget Office (CBO) estimate of average subsidy amounts in 2016 against to an estimate of average annual per capita costs for non-disabled adults under 65 in Connecticut’s Medicaid program for FY 2006 (with no apparent trend adjustment for the 2006 costs to reflect continued expected underlying growth in costs as standard procedures for estimation would suggest).¹⁰
- In estimating the costs associated with its recommendations, the Report states that its discussion of costs do not include either (a) an expansion of the HUSKY eligibility prior to 2014 or (b) an increase in HUSKY payment rates to at least Medicare levels. (See page 24). The Report indicates that these recommendations would require “the Legislature, SustiNet, and the Administration” to collaborate in finding new resources to fund the

⁸ Premium credits under the federal law are offered on a sliding scale basis, regardless of whether someone files taxes. A family of four with income between 133% and 200% of FPL would contribute between 3% and 6.3% of their income on premiums. Those with incomes below 250% of FPL would also receive cost sharing assistance, effectively raising the actuarial value of the coverage they receive.

⁹ Report at p. 20.

¹⁰ May 2010 Report at p. 12 & Footnote #7. In addition, Connecticut appears currently to have the highest average annual growth rate in Medicaid spending in the country. See Kaiser Family Foundation. Average Annual Growth in Medicaid Spending, FY1990 to FY2009. Washington D.C.: Author. (2010).

resulting costs, and the accompanying footnote provides that “the proposed increase in HUSKY payments cannot be modeled because it requires a thorough analysis and revision of HUSKY and Medicaid payment.”¹¹ At the same time, however, the Report suggests in other places that since it expects BHP payments to exceed HUSKY costs for low-income adults (an assumption that might benefit from further analysis as described below) this excess should be used to raise payment rates for adults with incomes above 138 percent FPL.¹²

- Thus, in the end, while the Report seems to suggest that current payment levels under HUSKY are too low to provide adequate access to essential care, particularly with the expanded population, and recommends the state begin down a path of raising rates, it provides no estimate of the cost implications of these recommendations.

In summary, putting these pieces together our takeaway with respect to the issue of BHP is as follows:

- The BHP is not dependent upon Sustinet, and in fact Sustinet may frustrate establishment of the BHP.
- The cost implications of different options with respect to the state’s low-income adult population are complex. In this regard, it is laudable that the state is seeking to ensure that coverage remains affordable for this population, but the cost implications to the state of pursuing this option seem uncertain. This is because the state in pursuing the BHP would seem to retain liability for the coverage costs of the existing and expanded HUSKY low-income adult population (as offset by federal assistance), and the stated need to ultimately increase reimbursement rates would seem to have the effect of increasing program costs and the state’s ultimate liability under the program.

Given that the state would be assuming the risk and liability associated with this population (and expanding it beyond those that are currently eligible for HUSKY), it would be useful in understanding the implications of the BHP proposal if the savings and associated assumptions could be shown in detail compared to other alternatives, such as allowing individuals with incomes of 133 to 200 percent of FPL to enter the Exchange and receive the federal subsidies directly.

¹¹ Report at p. 24.

¹² Report at p. 20.

Assuming Health Care Cost Growth Reduced By 1 Percentage Point

Finally, there is little discussion of how the proposed changes would reduce health care cost growth by one percentage point annually beginning in 2012 – the “optimistic” scenario assumed in the Report. This implies a continued (as opposed to one time change) reduction in trend by a full percentage point that begins starting in 2012. For the reasons described below it is equally likely that Sustinet would increase costs, and certainly liability to the State.

Expanding the availability of Sustinet by 2014

The second element in the Sustinet program involves expanding Sustinet to all individuals and employers. The proposal is to expand the pool to State municipalities and make the Sustinet Health Plan available both inside and outside Connecticut's Exchange. The Sustinet program envisions pooling the groups currently supported and managed by the State to create a large pool capable of assuming these additional risks.

The Exchange and Actuarial Value

Based on our estimates, it appears unlikely that the current State Employee Health Plan design could be offered on an exchange due to its actuarial value as explained below.

To facilitate comparison shopping for health plans and ensuring plans use the appropriate portion of premium dollars for health care delivery, the PPACA established a set of four benefit tiers ("Bronze," "Silver," "Gold" and "Platinum") to be used in health insurance exchanges beginning in 2014. These tiers are intended to make choosing a health plan easier while providing for a reasonable range of benefit options. They are defined in terms of "actuarial value," and establish specific levels of coverage while allowing for meaningful variation in cost sharing and provider network options within a given benefit tier.

Table 2 shows the current plan designs of the Connecticut health plan options available to State employees and retirees. Comparing the plan design features we see that the State as an employer pays a larger share (and therefore employees pay a smaller share) than under any of the PPACA tiers. We also included the Federal Employees Health Benefit BCBS Standard Option plan. The BCBS Standard Option plan, which has the largest enrollment of all the plans in FEHB, has an actuarial value slightly less than Platinum, and therefore serves as a useful benchmark for comparing typical plan designs.

Table 2

	Connecticut State Health Plans			FEHB	PPACA Benefit Tiers			
	POE, POE-G and Out-of-Area In Network	POS In Network	POS Out-of-Network	BCBS Standard Option Plan	Platinum	Gold	Silver	Bronze
Deductible	None	None	\$300	\$300	\$300	\$800	\$1,900	\$3,000
Out-of-Pocket Limit	None	None	\$2,000	\$5,000	\$3,000	\$5,000	\$6,000	\$8,000
Coinsurance	0%	0%	20%	15%	10%	20%	35%	40%
Office Copayment	\$10	\$15	\$50	\$20	\$20	\$35	\$50	\$90
Hospitalization per admission copay	None	None	None	\$200	\$200	\$300	\$600	\$1,000
Hosp. coverage after copay	100%	100%	80%	100%	90%	80%	65%	60%
Rx - Generic copay	\$5	\$5	\$5	20%	\$15	\$20	\$20	\$30
Rx - Brand Preferred copay	\$10	\$10	\$10	30%	\$25	\$40	\$50	\$70
Rx - Brand Non-Preferred copay	\$25	\$25	\$25	30%	\$40	\$50	\$60	\$100

Source: Healthcare Options Planner 2010-2011 for CT health plans. Hay Group analysis of prevailing benefit designs and actuarial values using the 2010 Hay Benefits prevalence Report and the Health Care Benefit Value Comparison (HCBVC) Actuarial Model.

Using Hay Group’s Health Care Benefit Value Comparison (HCBVC) actuarial model, we quantified the relative values for the Connecticut State Employee Health plans as well as the FEHB Blue Cross Blue Shield Standard Option plan and the illustrative “Platinum,” “Gold,” “Silver,” and “Bronze” plans shown above.

Table 3 shows (in descending value) the relative benefit values for the plans. We determined the relative benefit values (BVC values) using the HCBVC model. The HCBVC model enables us to compare the relative value of the benefits packages by controlling for extrinsic differences in plans, such as demographics and funding methods that distort the direct comparisons of premiums. In other words, the model evaluates the *relative* cost of each benefit package, assuming the same group of enrollees and funding method for each. The BVC values shown in Table 3 represent relative plan values, which include the value of benefits provided and the savings produced by using a negotiated provider network. Consequently, the BVC value of a PPO or POS plan will be lower than a fee-for-service (FFS) plan with exactly the same benefits. Thus, because of network discounts, moving from a FFS plan to a PPO plan will often result in both lower costs and reduced patient cost sharing. Because the purpose of this analysis was to

focus on the design of the benefits provided, we used the same network discount assumptions for all plans in order to ensure that we were measuring differences in design, rather than differences in network efficiency.

Table 3 shows the Point-of-Enrollment (POE) and POE-Gatekeeper (POE-G) plans have very high actuarial values and are about 19 percent richer than the FEHB Standard Option plan. The Point-of-Service (POS) Plan also has a very high actuarial value of 97% and is about 15 percent richer than the FEHB Standard Option plan.

Table 3		
Actuarial Value of Health Plans		
Plan	Actuarial Value	BVC Value Relative to FEHB BCBS Standard Option Plan
POE, POE-G	98%	119%
POS	97%	115%
FEHB	89%	100%
Platinum	90%	102%
Gold	80%	86%
Silver	70%	72%
Bronze	60%	59%

Source: Hay Group analysis using the HCBVC model.

Based on this actuarial analysis, it appears unlikely that the current State Employee Health plan design could be offered on the Exchange as the actuarial value exceeds 90 percent. If such a plan cannot be offered on the Exchange the benefits would need to be adjusted to become “Exchange eligible.” The change in benefit levels would impact current state employees who would see their benefit levels drop to the Platinum level.

Furthermore, even in the event that the plan design is permitted (e.g., with a federal waiver), municipalities faced with tight budgets may not be able to afford the “above Platinum” plan level of coverage as the cost would be over 15% more expensive than the most popular FEHB plan.

Challenges Relating to Pooling Multiple Populations

SustiNet envisions coverage of a wide range of groups. One would expect such disparate groups to have different cost levels as a result of differences in demographics, population health, provider payment rates and benefit levels. In addition, the level of federal funding available for each group also varies significantly.

From an actuarial perspective, the fact that the pool of covered “state subsidized” groups is quite varied is significant. It helps highlight the differing risk profiles, benefit levels, and provider payment levels associated with these populations. Because of these differences, the blended claims cost for this pool would likely result in a higher cost than a typical individual seeking coverage through an Exchange.

Because the plan has such a high actuarial value (whether at 97-98% if allowed or at the 90% Platinum level), it is unlikely to be attractive to many small employers. From a selection standpoint it is reasonable to assume that mainly those with extreme health care needs would seem to be attracted to such a plan.

As noted, if the pooled experience is used as a base, and is adjusted for benefit level, it is likely that the premiums will be high relative to the Exchange market, due to the risk profile, age, and utilization rates associated with the pooled groups and their coverage. The base claims experience will need to be adjusted to price individual and small group policies on the Exchange taking into account:

- Relative demographics of the different target enrollee populations;
- Impact of the PPACA’s age rating rate bands that will significantly “compress” premium rate variation and can be expected to raise premiums (before the application of any subsidies) for younger individuals on the ability of the program to accommodate the demographic range of the target enrollee populations;
- The effect of tobacco use on program costs, and the ability within the PPACA to reflect that effect in SustiNet premiums;
- The effect of generous benefit levels, and low enrollee cost sharing requirement, on the ability of the program to control costs; and
- Differences in provider payment rates.

Under these conditions Sustinet would take on the “pricing” or “insurance” risk. If the premiums for covered members do not cover the claims incurred then the state would be taking on potentially unknown additional liability related to subsidizing the coverage. To give a sense of the potential magnitude, if the State were to combine all of the approximately \$8 billion in health benefits it currently supervises in the Sustinet, a one percent underestimate in the claims and premiums required to cover these claims could yield a loss of \$80 million. Similarly, as noted based on the benefit levels and average risk profile for the Sustinet population, we would expect premiums to be high relative to other coverage. To the extent premiums did not take full actuarial account of these factors, the state would effectively be further subsidizing the cost of coverage with a potentially unknown and unlimited fiscal impact.

This is particularly significant because of the uncertainties inherent in combining such a disparate set of potential enrollees, and the lack of meaningful experience on which to base costs for populations not currently managed or financed through the state. The fundamental market reforms implemented in the individual and small group markets in 2014 make this an especially challenging time for pricing a new health plan for those markets. We simply do not know what the enrollee mix, and resulting health care costs, will be in those markets.

From a governance standpoint, combining all of the enrollees into a single insurance pool has the potential to reduce the transparency of the budgeting process. The funding for all of the various groups would be commingled, with the potential for material cross-subsidization between enrollee groups.

As described above, we have assumed that the Sustinet program would be implemented as a single risk pool, using a consolidated provider network with a single set of provider payment rates, and a common set of benefit options. While the alternative of using separate risk pools, provider networks and benefit packages for each target enrollee population would have the advantage of reducing the pricing risk, it would also undermine the goals of using the combined enrollment to drive provider negotiations and using consolidated administration to reduce overhead costs and improve the management of health delivery.

For example, if a network tailored to the needs of the HUSKY population with Medicaid payment levels is used, along with a separate network tailored to the needs of State employees and payment levels consistent with the state employee plan, it will fundamentally affect the negotiating process. While some providers may participate in both plans, the providers will be faced with two separate participation decisions based on two sets of potential patients and two different reimbursement levels. Some providers may agree to participate in one network, but not another. For those providers with few if any HUSKY enrollees, the decision to participate in the network serving State employees will not be fundamentally changed, and the presence of a

separate network serving HUSKY enrollees will have no more significance to the negotiations than it does today.

Administratively, the enrollment, provider management and claim adjudication processes will have to reflect both networks and provider fees. Each “unbundling” decision will have similar consequences. If a dedicated set of benefit packages are developed for each subpopulation, then the enrollment process must track which set of benefits is available to each enrollee, premium and contribution rates must be developed for each plan of benefits, providers must be educated as to what benefits are available to each enrollee population, and the claim adjudication system must be able to support each available plan. Table 5 in the Sustinet report shows a range of expected enrollment outside of state sponsored groups as of 2017 based on the “Silver” plan under PPACA. As shown in the actuarial analysis in this report, the State employee plan is above Platinum, which may frustrate its being offered on an exchange without a reduction in benefit levels. In addition, to the extent Sustinet were treated as a Qualified Health Plan (QHP), it would need to provide benefit plan offerings equal to the silver and gold actuarial value levels in order to offer a platinum level offering.

Operationally, Sustinet would need to address whether the rates for each tier or level of benefits would be set based on the experience of that tier’s enrollees, or if experience would be blended. The pool of state sponsored groups is quite diverse and their experience may not be aligned well with the individuals who would seek coverage on the Exchange.

Public Policy and Regulatory Considerations

As noted, the report raises a number of regulatory questions such as whether a BHP approved population can be pooled with other populations and offered on an Exchange. As discussed, this would seem to go against the intent of PPACA given that the BHP is supposed to operate in lieu of offering individuals enrolled under the BHP subsidized coverage through an Exchange. In addition, this coverage is supposed to be offered through “Standard Health Plans,” and it does not appear that those receiving coverage under a Standard Health Plan can be pooled or combined with other populations.

The Report also seems to suggest that Sustinet would operate as a self-insured program. However, it is not clear if the offering of self-insured plans on the Exchange is even contemplated in the statute, which raises the issue of whether the Sustinet program could be eligible for the Exchange.

As the February 14, 2011 testimony of Connecticut Office of Policy and Management Secretary Benjamin Barnes suggests, it would appear that in order for Sustinet to be offered on an

exchange it would have to take the form of a QHP and would be subject to all requirements applicable to other QHPs, including the requirement of obtaining licensure from the state.¹³ From an actuarial and solvency perspective, if capital sufficient to meet risk-based capital and solvency requirements was not raised to support Sustinet on a non-recourse basis, the State would seem ultimately to be liable for losses and insurance risk for the entire covered population. In addition, as a QHP Sustinet would be subject to the various market reform provisions effecting other health plans, including the requirement that it treat as a “single risk pool” all enrollees it provides coverage to on an individual basis and all coverage provided to those through small businesses. This would again raise potential pooling issues for the program – and could raise questions about how to categorize the program’s diverse enrollment.

¹³ See Testimony of Secretary Benjamin Barnes on House Bill 6305 Before the Human Services, Insurance and Real Estate, and Public Health Committees (February 14, 2011).

Leveraging the size of the covered population

The SustiNet proposals are intended to achieve some laudable goals on delivery system reforms and payment reforms, as well as using health information technology to support cost and quality management. These state-based efforts are intended to be independent of federal health care reforms and would embrace a patient-centered, evidence-based approach to health care. These efforts present the promise of applying coordinated reforms to influence provider behavior. Operationally, the proposals appear to seek the development of a unified program that pools together different programs and enrollment populations and aims to operate both inside and outside the Exchange.

Based on the goals enunciated in the SustiNet report, and the description of the program, it appears the intent is to pool all of these populations into a single program that will support consolidated administration and provider negotiations. While the report is not entirely clear on the details, it appears that the reforms contemplate a single insurance pool with a consolidated provider network and uniform set of benefits. As indicated above, if this is not the case, it will affect the level of savings that may be achieved.

There are natural limits to the savings that can be achieved through size alone. Once an insurance pool reaches a critical size, the marginal benefit from additional growth becomes quite small. The State Employees Health Plan (SEHP), for instance, covers over 200,000 employees, retirees and dependents. Medicaid and HUSKY enrollment exceeds 500,000. Programs with this level of enrollment in a single state have the critical mass necessary to bargain effectively with providers and to establish efficient administrative systems. It is not clear that the additional enrollment achieved by combining the Medicaid/HUSKY populations with SEHP would result in materially better results from provider negotiations, or materially improved administrative efficiencies. In addition, the complexities of serving such disparate populations would likely complicate both network negotiations and the administrative process.

Several aspects of the SustiNet proposal deserve additional analysis. These include the form of the provider networks and the level of provider payments and the details of the program implementation.

Provider Payment Considerations

- A long-standing concern regarding public programs has been that their primary tool for managing cost is to set or fix provider payment rates, possibly at unsustainable levels or at rates that materially impact the availability of health professionals. As noted above, in estimating the costs associated with its recommendations, the Report states that its

discussion of costs does not include an increase in HUSKY payment rates to at least Medicare levels. (See page 24). Thus, in the end, while the Report seems to suggest in other places that current payment levels under HUSKY are too low to provide adequate access to essential care, particularly with the expanded population, and recommends the state begin down a path of raising rates, it provides no estimate of the cost implications of these recommendations. Consequently, to the extent payment levels to providers under Sustinet were to be increased it is difficult to estimate the effects.

- The other possibility to consider is that to the extent the issues discussed above, including the discussion about actuarial value levels and higher than average risk profile, led to the need to reduce provider payment levels in order to hold down costs, concerns about patient access to care – particularly primary care would increase – as would concerns about cost shifting to private coverage. To the extent this resulted in the expanded use of administratively set rates – which by definition are not defined by the market – it could result in unintended consequences, including a reduction in access and the shifting of costs to private coverage.¹⁴
- It is also not clear that simply reimbursing less for particular services translates into overall lower cost of those services, especially when other factors are considered such as the potential loss of care management strategies that are recognized to improve quality and reduce unnecessary re-admissions, and considering that government-run programs have traditionally had difficulty preventing and detecting fraud.¹⁵

Administrative Considerations

- Efficient and effective administration is important for any health benefit program. Large programs have the advantage of being able to spread their fixed costs over a larger enrollment base. They often also have the ability to automate and streamline certain functions. However, the marginal savings from additional enrollment declines with increasing size.

¹⁴ For a discussion of the effects of public sector reduced provider reimbursement rates and the associated cost shift to private sector payers see: Ginsburg, Paul. *Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power*. Washington D.C.: Center for Studying Health System Change. (November 2010); Bamezai, Anil and Jack Zwanziger. *Evidence of Cost Shifting in California Hospitals*. Washington D.C.: Health Affairs. 25, no.1 (2006):197-203; Frakt, Austin. *How Much do Hospitals Cost Shift? A Review of the Evidence*. Washington D.C.: Health Care Financing and Economics. (December 2010).

¹⁵ United States Government Accountability Office. *Medicare Program Remains at High Risk Because of Continuing Management Challenges*. Washington D.C.: Author. (March 2011).

- It does not appear that the Sustinet program eliminates any administrative functions. In fact, by placing different populations with very different needs under the same administrative umbrella, the administration may be made more complex. For example, as described, the Sustinet enrollment system will have to support the enrollment rules for Medicaid, the State Employee program, and the new Exchange. Each will be subject to its own rules and reporting requirements.

Glossary

BHP – Basic Health Program.

ESI – Employer-Sponsored Insurance.

FEHB – Federal Employees Health Benefit program. The health benefit program offered to employees and retirees of the federal government and the United States Postal Service.

FPL – Federal Poverty Level.

HCBVC – An actuarial model that determines the relative value of benefit packages.

HUSKY A – Children under age 19 with family income at or below 185% of the federal poverty level and families receiving TFA are eligible for Medicaid under the HUSKY A program. Parents or relative caregivers of HUSKY children are eligible with family income at or below 185% of the federal poverty level. There is no asset limit under HUSKY A for most families.

HUSKY B – Children in families with household incomes above 185% of the federal poverty level are eligible to receive health insurance from a number of health maintenance organization plans. Certain cost sharing provisions apply on a sliding scale depending on family income level. Based on federal Title XXI rules for the Children’s Health Insurance Program, the state receives 65% reimbursement on these expenditures.

POE – Point of Enrollment Plan option available to State employees and retirees

POE-G – Point-of-Enrollment – Gatekeeper Plan option available to State employees and retirees

POS – Point of Service Plan option available to State employees and retirees

PPACA – abbreviation for the Patient Protection and Affordable Care Act. Sometimes known as the ACA (Affordable Care Act)

SEHP – State Employees Health Plan. Collectively bargained health benefit program covering active state employees, retirees and their dependents.

State Administered General Assistance (SAGA). Prior to April 1, 2010, medical assistance under SAGA was provided to individuals who were ineligible for HUSKY and Medicaid. These individuals are now served under the Medicaid for Low Income Adults coverage group, taking advantage of a provision of the Affordable Care Act that allows states to expand Medicaid coverage and receive federal reimbursement for a greater portion of program expenditures.

SustiNet – a proposal for a statewide health care plan for Connecticut that would provide residents with their choice of health coverage and care regardless of their employment status, age, or pre-existing conditions.