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CONNECTICUT HEALTH INSURANCE EXCHANGE BOARD MEETING

December 1, 2011

Mercer

2325 East Camelback, Suite 600, Phoenix, AZ 85016

Overview

- November 17 Board meeting covered the following:
 - General overview of all 11 tasks
 - Task 4g – Cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market
 - Task 8 – Technical requirements and development of specifications for accounting and financial system functions for the Health Insurance Exchange
 - Task 9 – Assessment of the existing Medicaid eligibility system and identification of interface issues and necessary requirements for integration with the HIE information technology (IT) infrastructure
 - Task 11 – Options for a multi-state and federal collaboration Exchange

Expectations for today's Exchange Board presentations

- Today's Board meeting will cover the following tasks:
 - Task 1 – Assess the State's uninsured and underinsured population under the various types of coverage, including government-sponsored coverage
 - Task 2 – Survey the health insurance carriers that offer coverage to Connecticut residents
 - Task 3 – Survey the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues
 - Task 10 – Review an impact study of the Medicaid program on the Exchange

Expectations for today's Exchange Board presentations (cont'd)

- Provide the Exchange Board with a foundation for the Health Insurance Exchange (HIE) planning decisions they and the State will need to consider in order for the State's Exchange to meet federal standards and be ready to offer health care coverage on January 1, 2014.
- It is our intent that this information will provide a deeper look into the issues Connecticut is facing with the establishment of the Exchange and provide the Board with an opportunity to come to the meetings with questions for the Mercer team.
- Allow for time at the end of each presentation for a question and answer period.

Future Board meetings

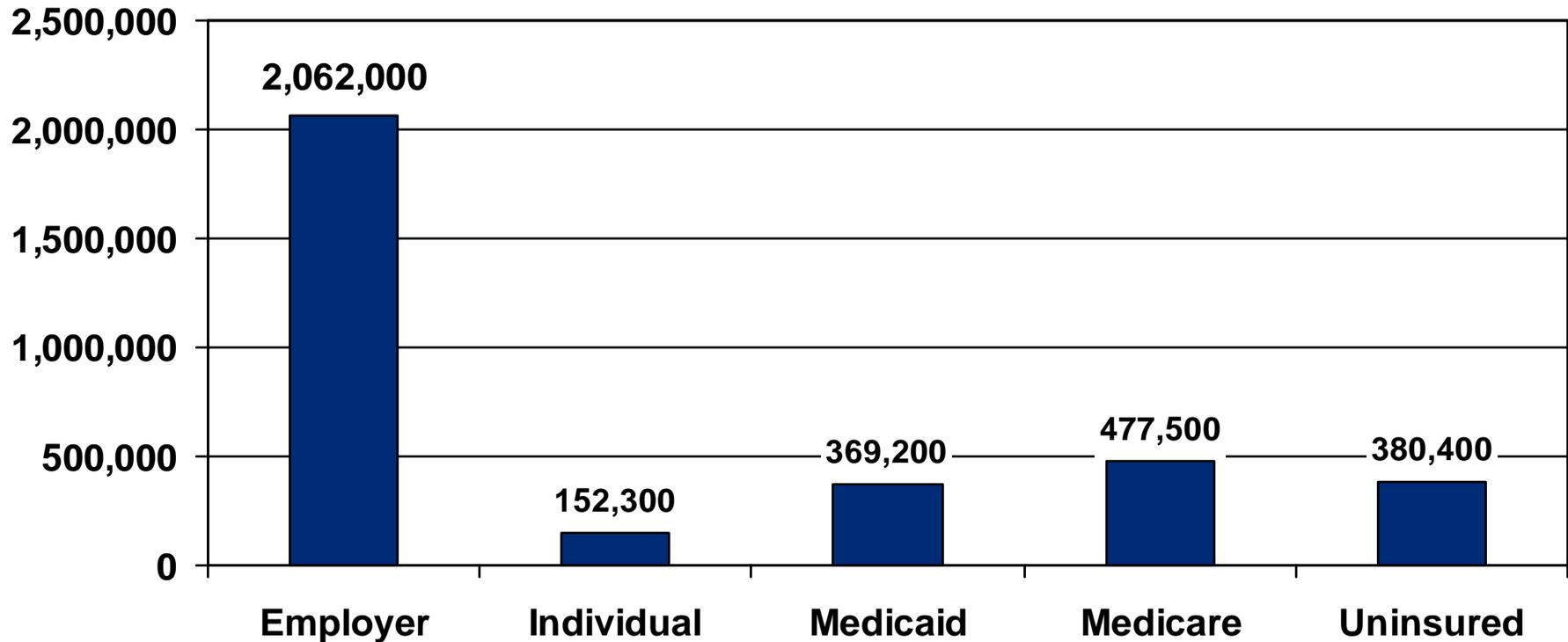
- December 15 Board meeting will cover the following tasks:
 - Task 4 – Review remaining economic and actuarial modeling and analyses that looked at trends such as the number of newly insured, the impact of certain market changes on premium levels and the implications of different policy questions such as integration of high risk pools, impact of employer-provided insurance, insurer profitability and household budgets
 - Task 5 – Discuss the effect if the large employer market (>100 employees) seeks participation in the Exchange after 2017
 - Task 6 – Impact of the HIE in regards to interaction with other health system initiatives in Connecticut
 - Task 7 – Review a financial model for the HIE (cash flow) to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges

Survey the health insurance carriers to better understand the types of plan designs being sold, the corresponding premium levels and the number of enrollees in each market segment (group and non-group)

Task 2

Connecticut marketplace

Connecticut sources of health insurance coverage



Source: Kaiser Family Foundation

Connecticut health insurer market share

	Total Membership	Fully-Insured HMO Membership	Fully-Insured, Non-HMO Membership	Total Fully-Insured Membership	Total Non Fully-Insured
Aetna	575,680	42,348	181,218	223,566	352,114
Anthem	1,350,974	224,607	312,121	536,728	814,246
CIGNA	134,817	14,845	60,432	75,277	59,540
Connecticare	219,155	154,313	22,189	176,502	42,653
Healthnet	206,558	94,390	19,256	113,646	92,912
United / Oxford	345,080	23,525	179,827	203,352	141,728
Total	2,832,264	554,028	775,043	1,329,071	1,503,193
	Total Membership	Fully-Insured HMO Membership	Fully-Insured, Non-HMO Membership	Total Fully-Insured Membership	Total Non Fully-Insured
Aetna	20%	8%	23%	17%	23%
Anthem	48%	41%	40%	40%	54%
CIGNA	5%	3%	8%	6%	4%
Connecticare	8%	28%	3%	13%	3%
Healthnet	7%	17%	2%	9%	6%
United / Oxford	12%	4%	23%	15%	9%

Source: State Insurance Department, Consumer Report Card on Health Insurance Carriers in Connecticut, 10/2010

Connecticut fully-insured health insurance marketplace

	Individual	Small Employer (1 - 50)	Large Employer (50+)	Total
Aetna Group	16,117	27,905	51,237	95,259
CIGNA Group	750	36,943	72,339	110,032
HIP Insurance Group	8,649	53,603	84,808	147,060
United Health Group	22,025	94,694	75,819	192,538
Wellpoint / Anthem	55,665	82,533	183,224	321,422
Other	5,269	2,749	7,304	15,322
Total	108,475	298,427	474,731	881,633

Source: 12/31/2010 Supplemental Health Care Exhibits filed with statutory financial statements.

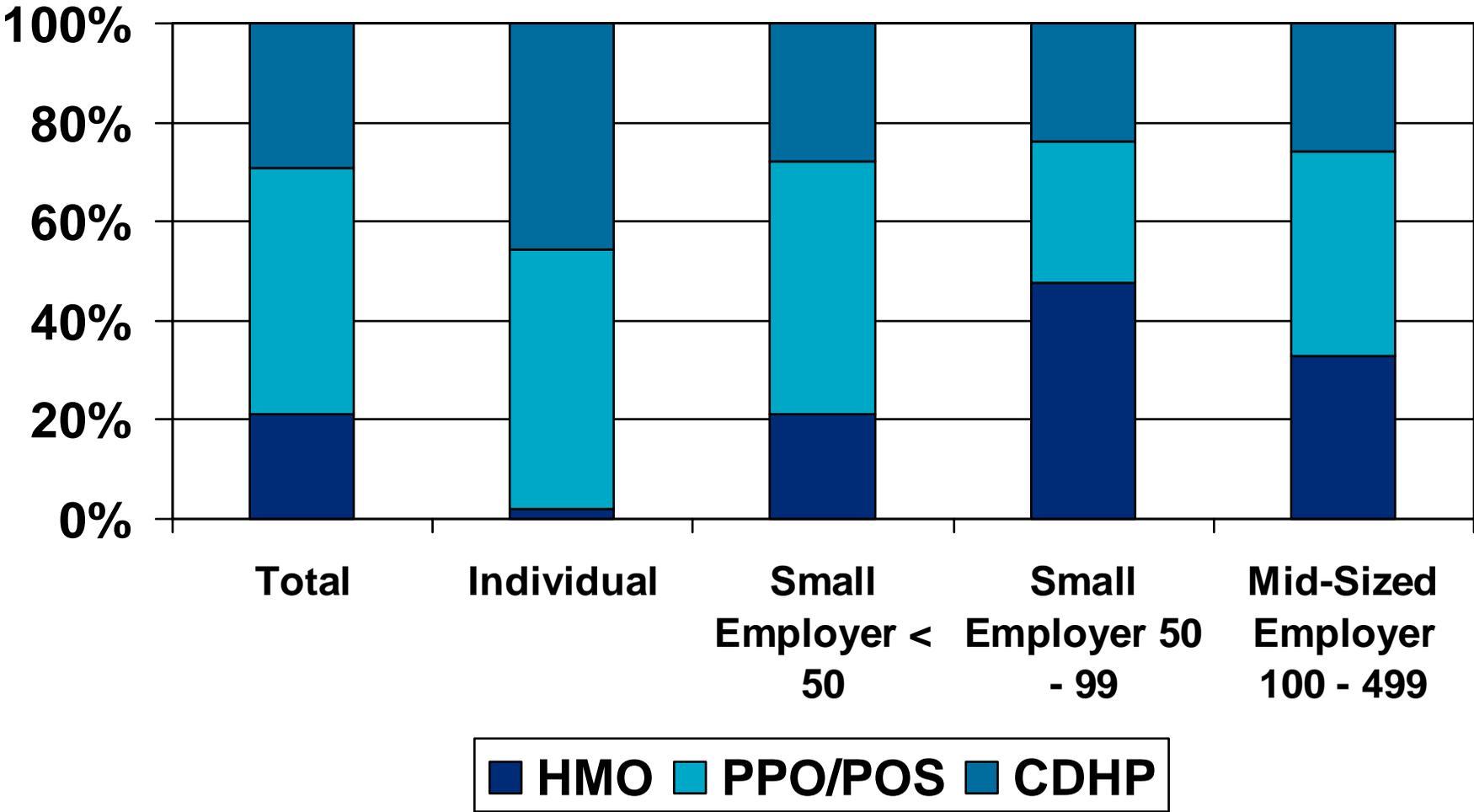


Health Insurer Survey

Task 2 – Health Insurer Survey

- Methodology
 - Met telephonically with the State to identify specific information to include in the survey
 - Determined that surveys of individual insurers was the only way to obtain the information required
 - Based upon publicly available market share data, made the decision to survey the five largest health insurers: Aetna, Anthem, CIGNA, Connecticare, United/Oxford
 - Obtained letter of support from Commissioner Leonardi
 - Released the survey to the target group
 - In response to insurer concerns about the privacy of confidential competitive information, developed a protocol with the Connecticut Association of Health Plans to permit individual insurers to respond in a manner that protects their confidential competitive information
 - Individual insurer responses have been aggregated by CAHP and shared with Mercer for analysis

Enrollment by product type and market



2014: Products available for offering in exchanges

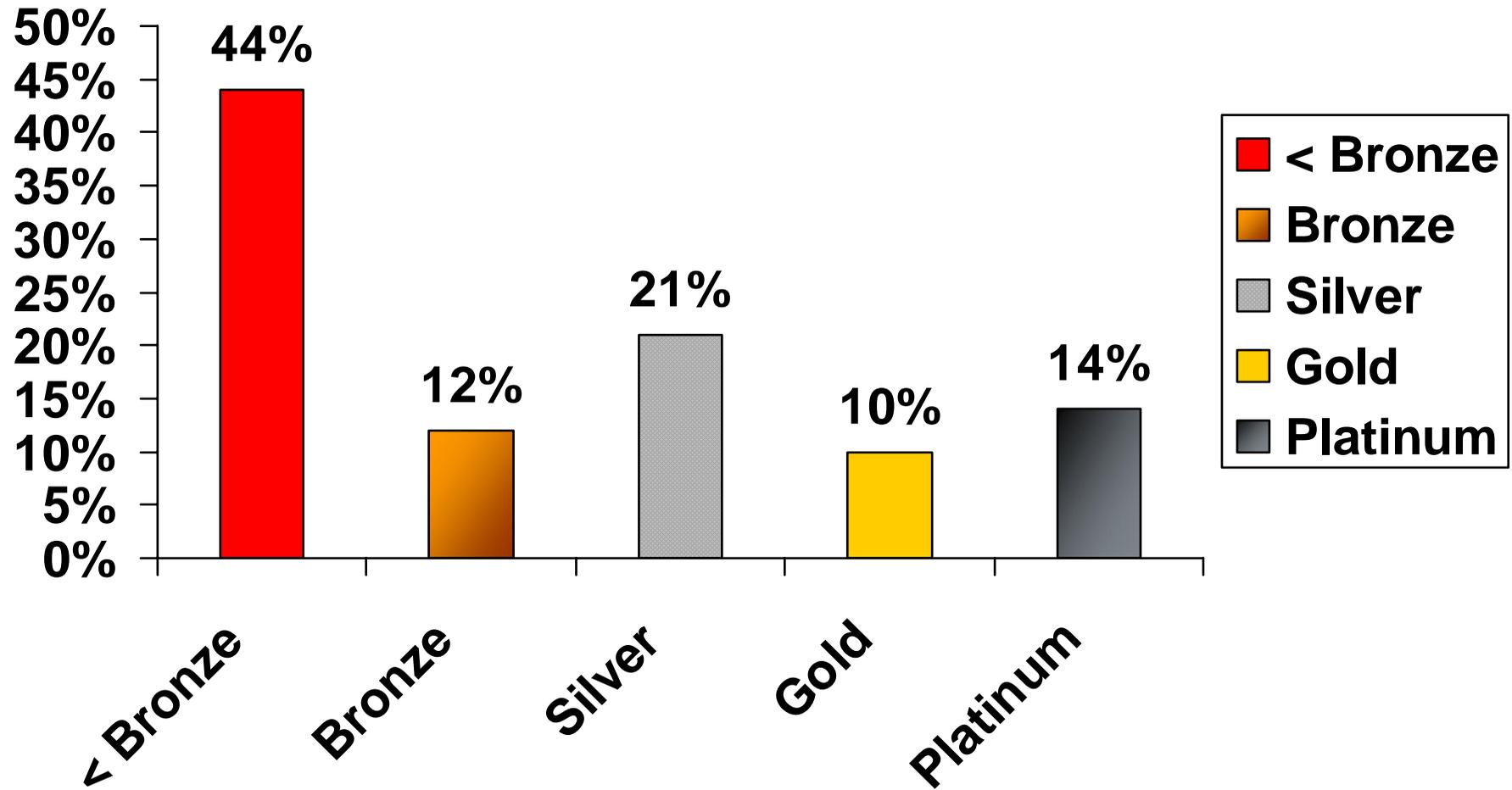
Exchange products will differ from group plans

Features	Exchanges					Group
	Bronze	Silver	Gold	Platinum	Catastrophic (age <30)	Plan design ¹
Plan value	60%	70%	80%	90%	HSA rules	≥60%
Covered services	Essential & preventive benefits	Essential benefits not required				
Essential benefits	No dollar limits	No dollar limits if covered				
2014 deductible maximums ²	HSA rules	\$2,000 (I) \$4,000 (F)				
2010 cost sharing maximums ² Will be indexed to 2014 levels	Up to \$5,950 (I) \$11,900(F)					

1. Some provisions apply differently for grandfathered and non-grandfathered plans
2. Appear to apply to employer plans and are based on current understanding, subject to change based on further guidance and regulations.

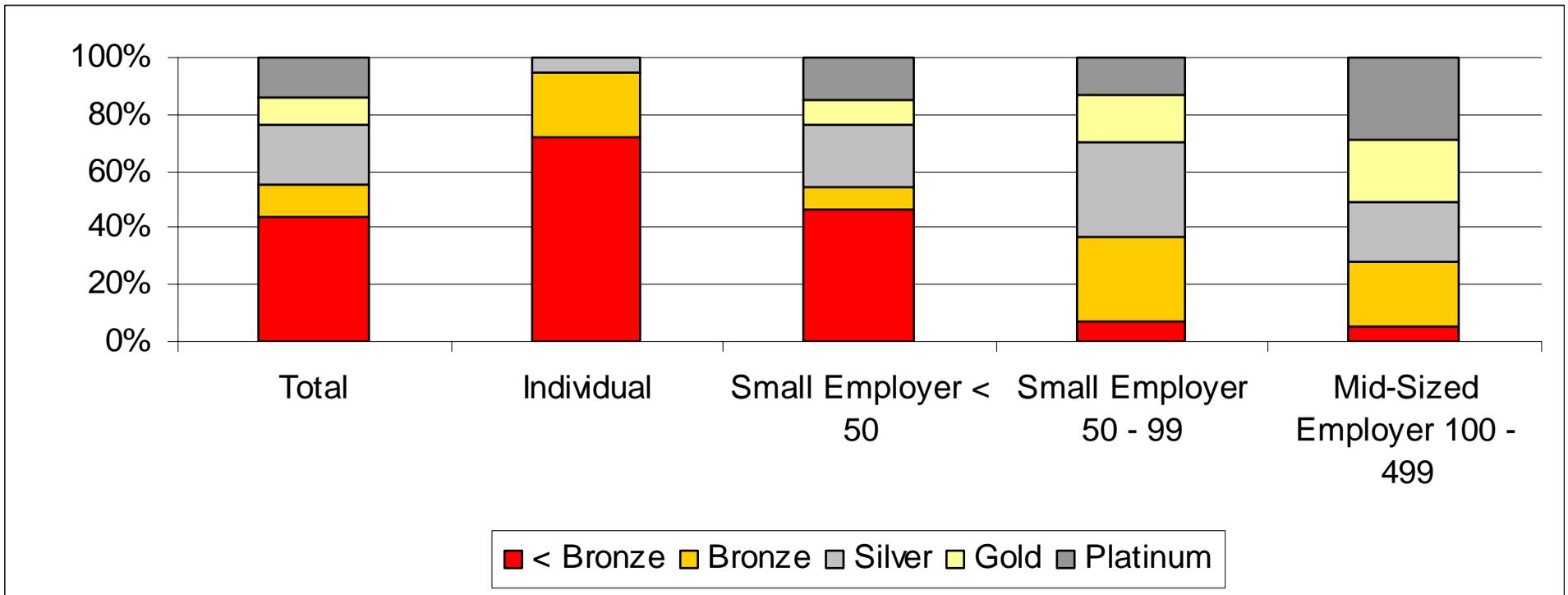
Actuarial value of products sold

All



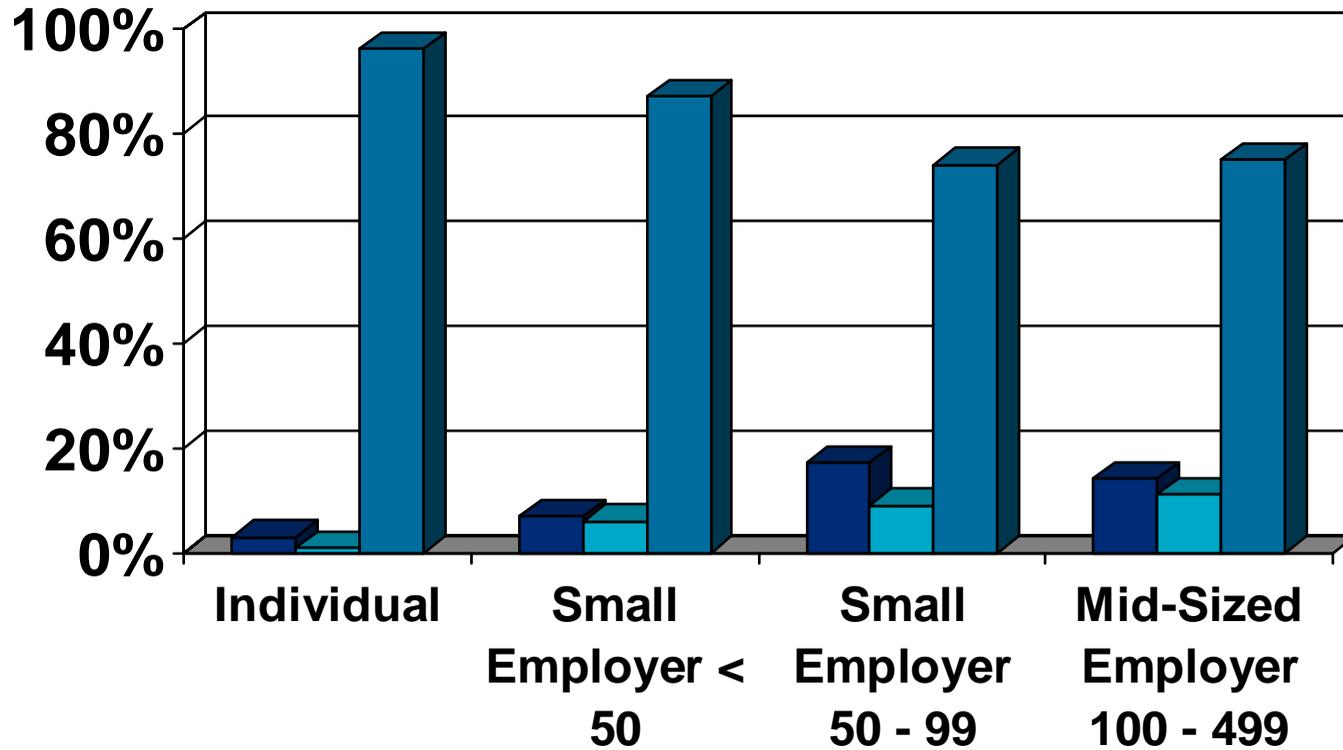
Actuarial value of plans being purchased in Connecticut today

Percentage of enrollment by plan actuarial value and employer size



Individual deductible levels

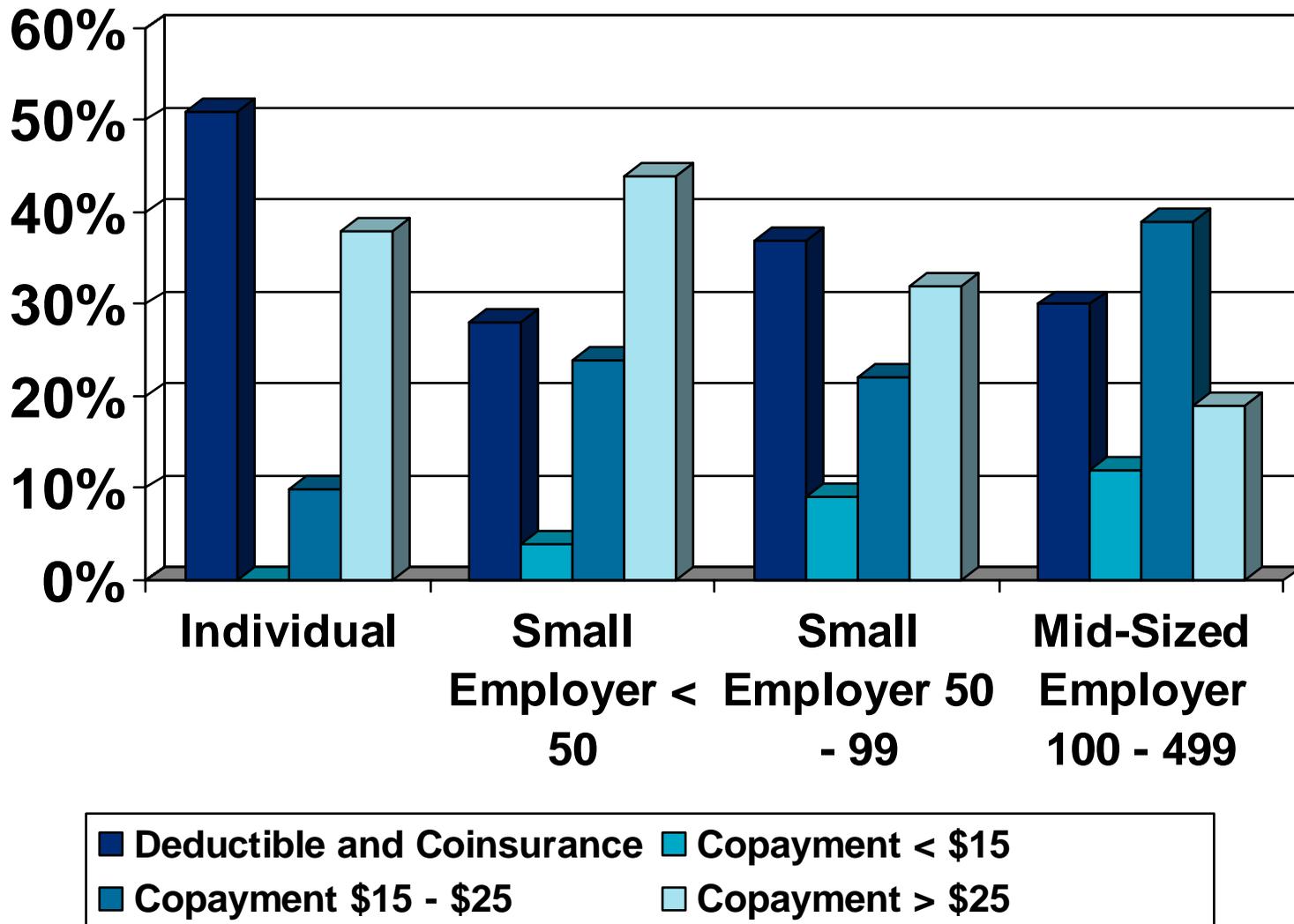
Mercer 2010 Survey: Average deductible
\$1,044 for employers with 50 – 499 employees
\$576 for employers with 500 – 5,000 employees



■ Individual < \$500 ■ Individual \$500 - \$1,000
■ Individual > \$1,000

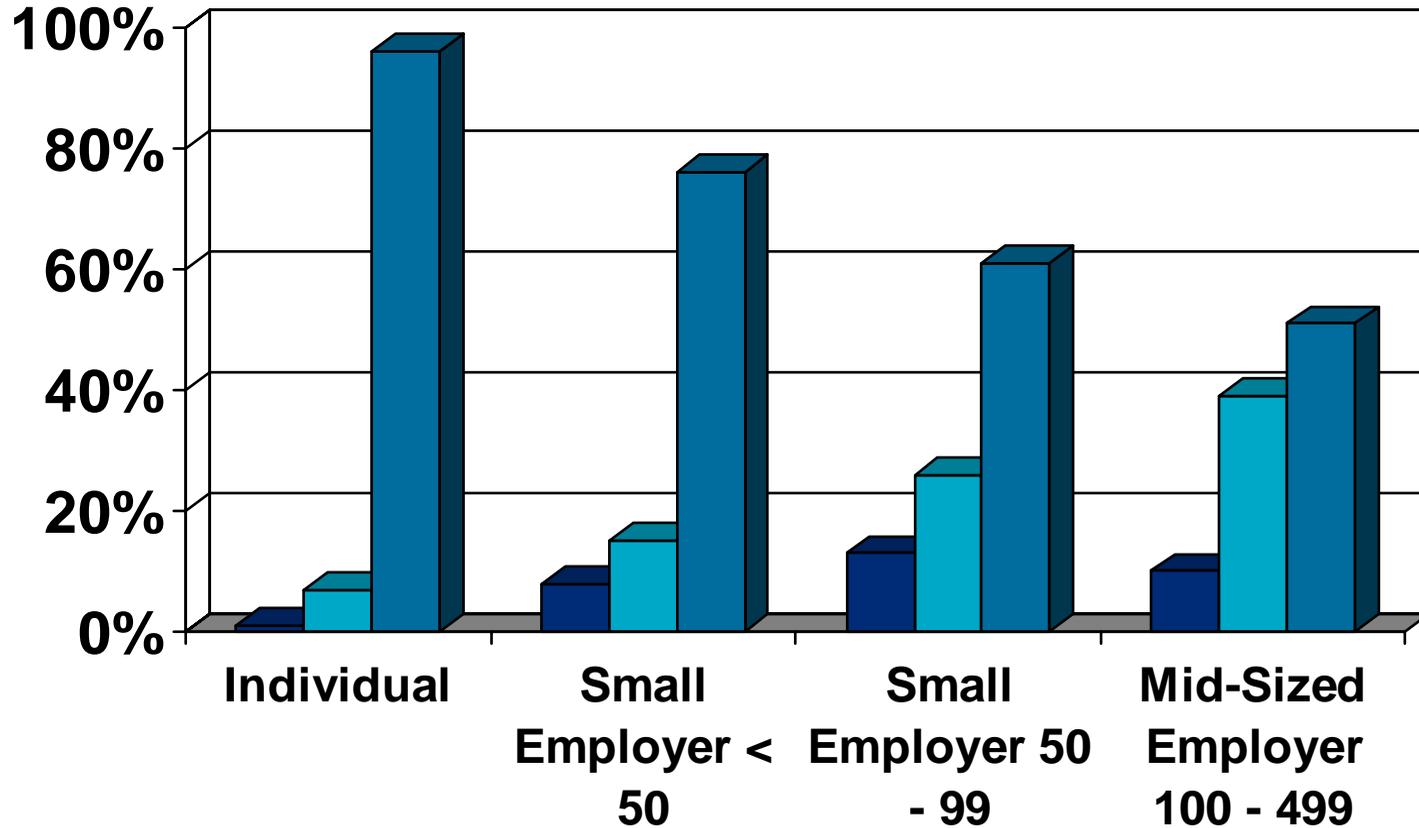
Copayment levels

Mercer 2010 Survey: Average copay
 \$19 for employers with 500 – 5,000 employees



Individual out-of-pocket levels

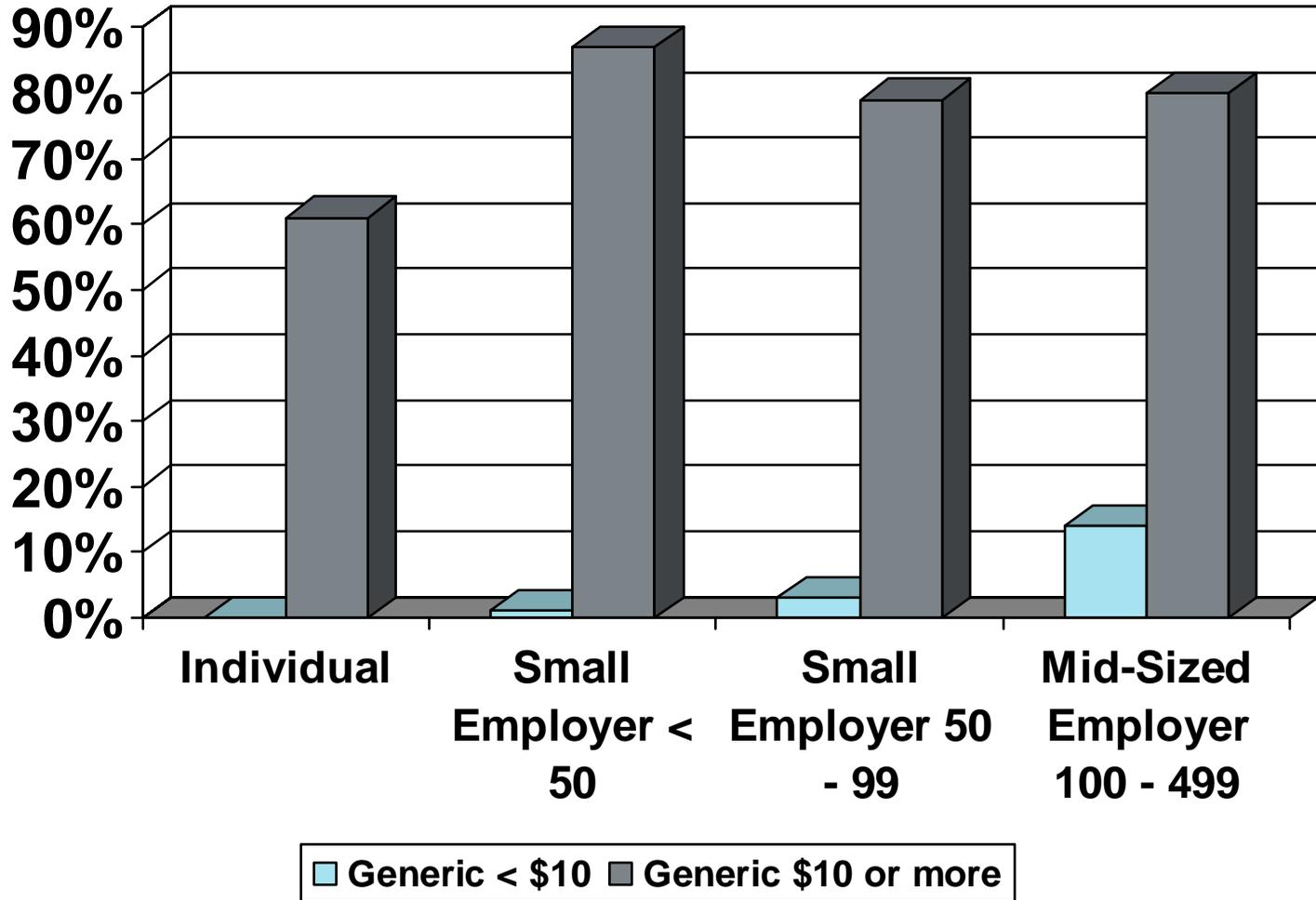
Mercer 2010 Survey: Average out-of-pocket
PPO – \$2,000



■ Individual < \$1,000 ■ Individual \$1k - \$2k ■ Individual > \$2k

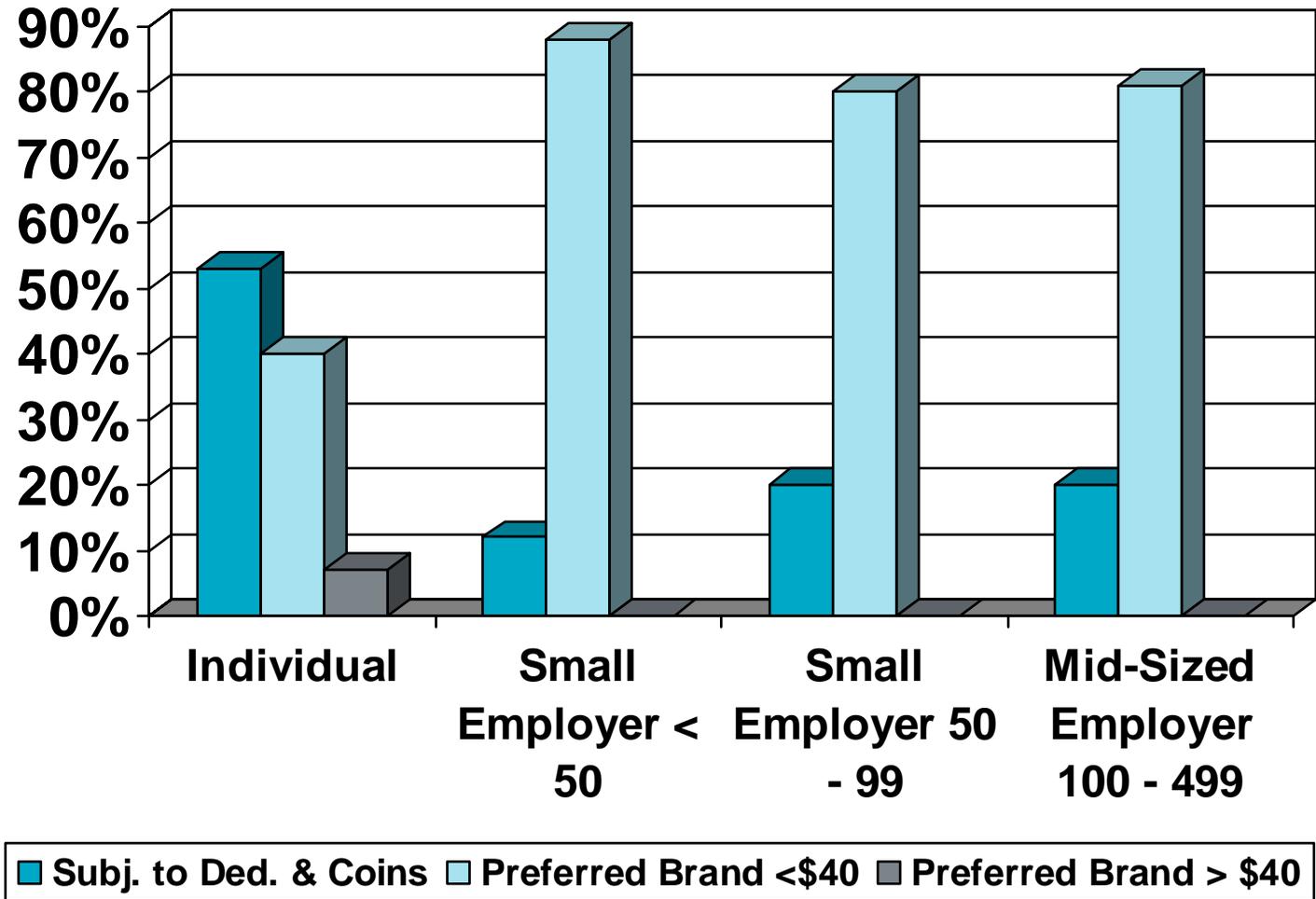
Pharmacy generic copayment costs

Mercer 2010 Survey:
Average generic copay – \$10



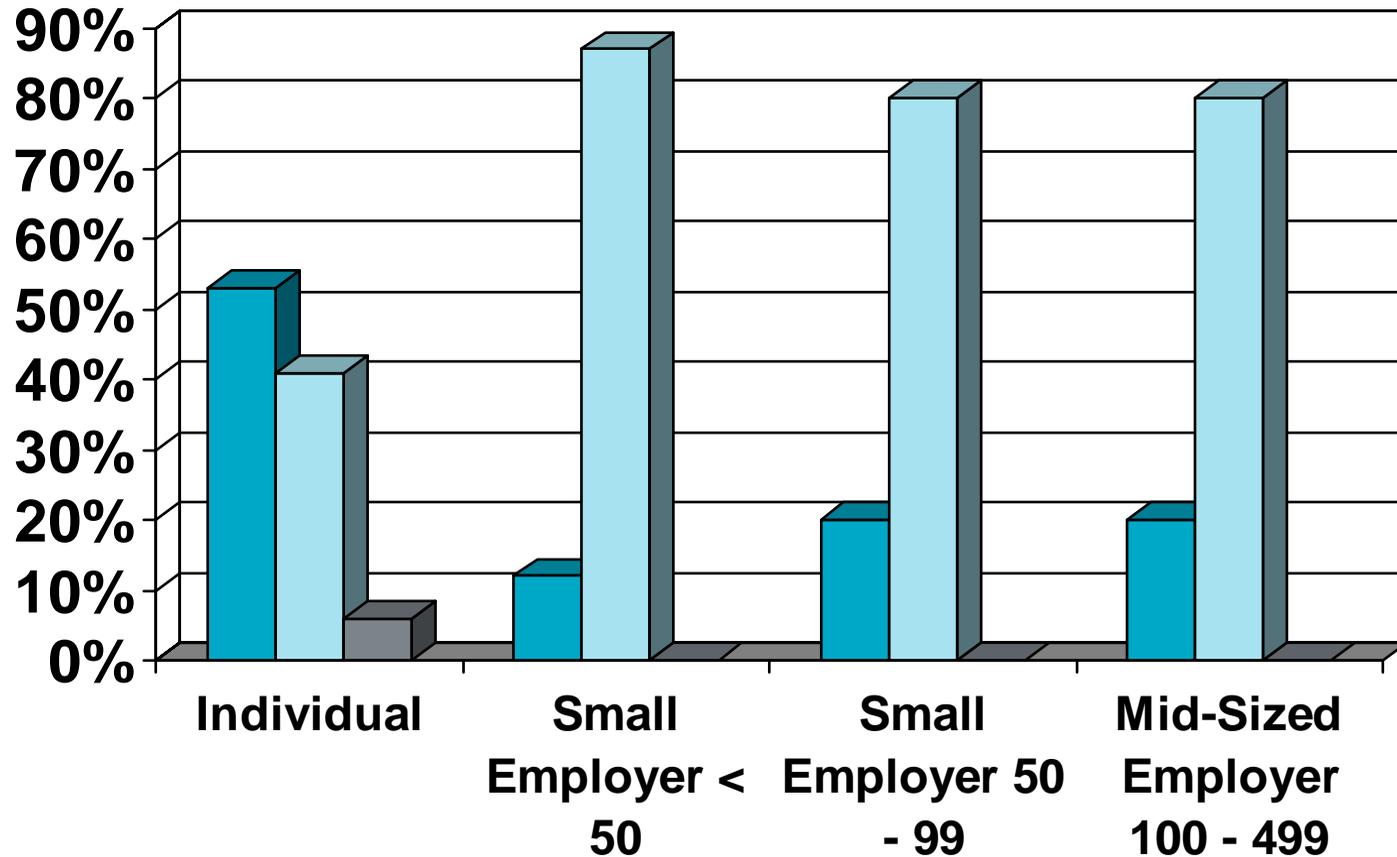
Pharmacy formulary copayment costs

Mercer 2010 Survey:
 Average formulary copay – \$28



Pharmacy non-formulary copayment costs

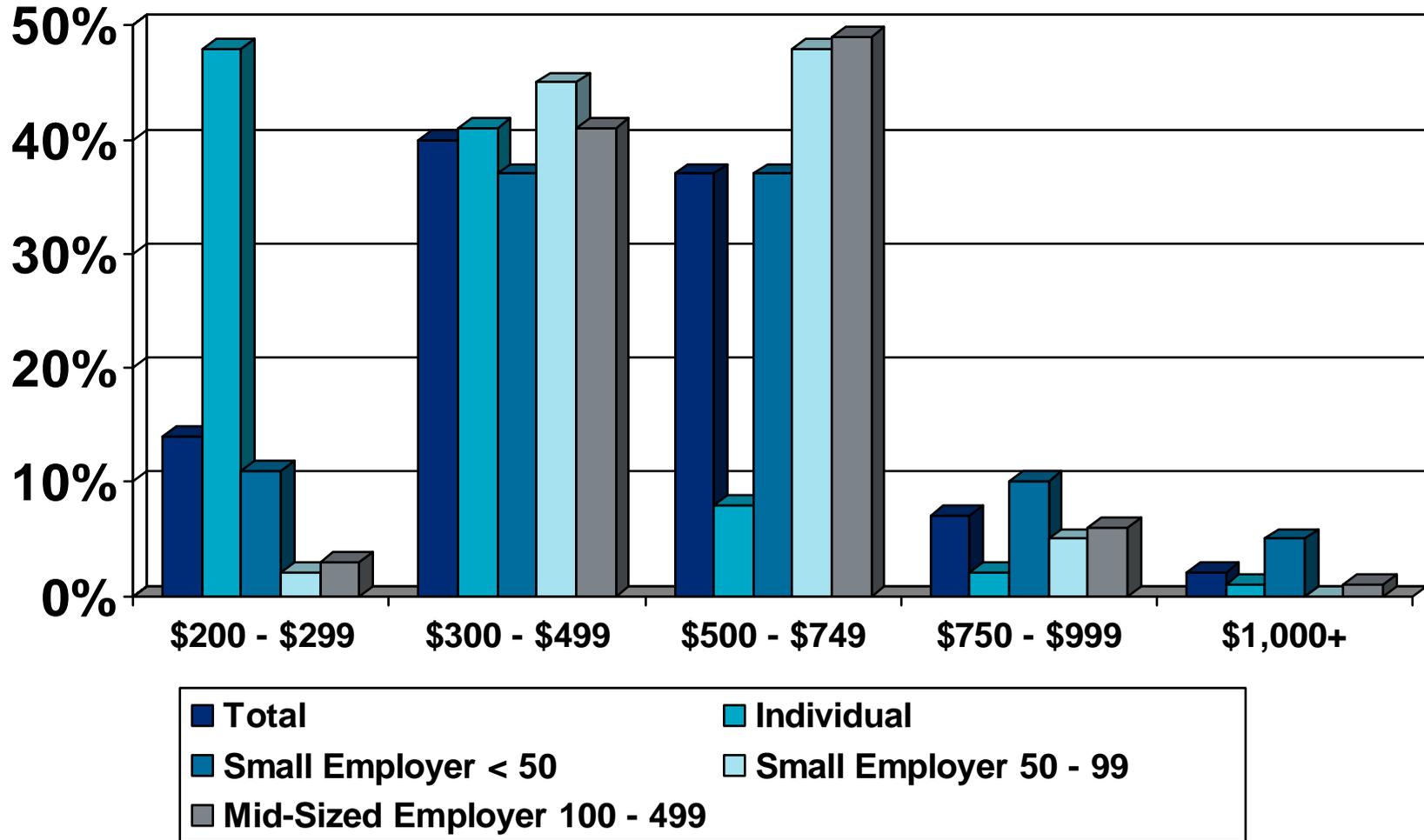
Mercer 2010 Survey:
Average non-formulary copay – \$47



■ Subj. to Ded. & Coins ■ Non-Preferred Brand <\$60 ■ Non-Preferred Brand \$60 or more

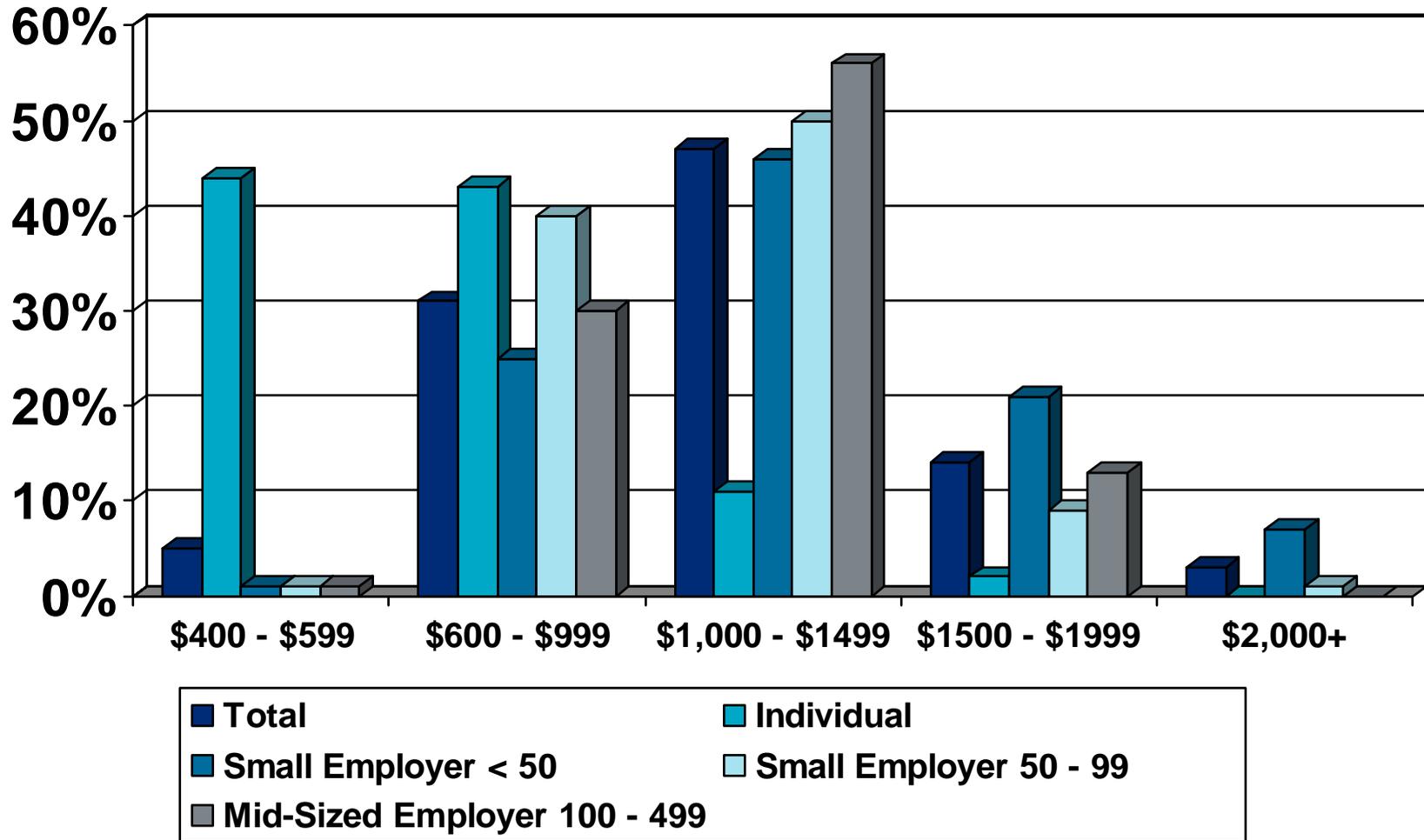
Premium costs One adult

Mercer 2010 Survey: Average national single plan cost
 PPO: \$448
 HMO: \$413
 CDHP with HSA: \$328

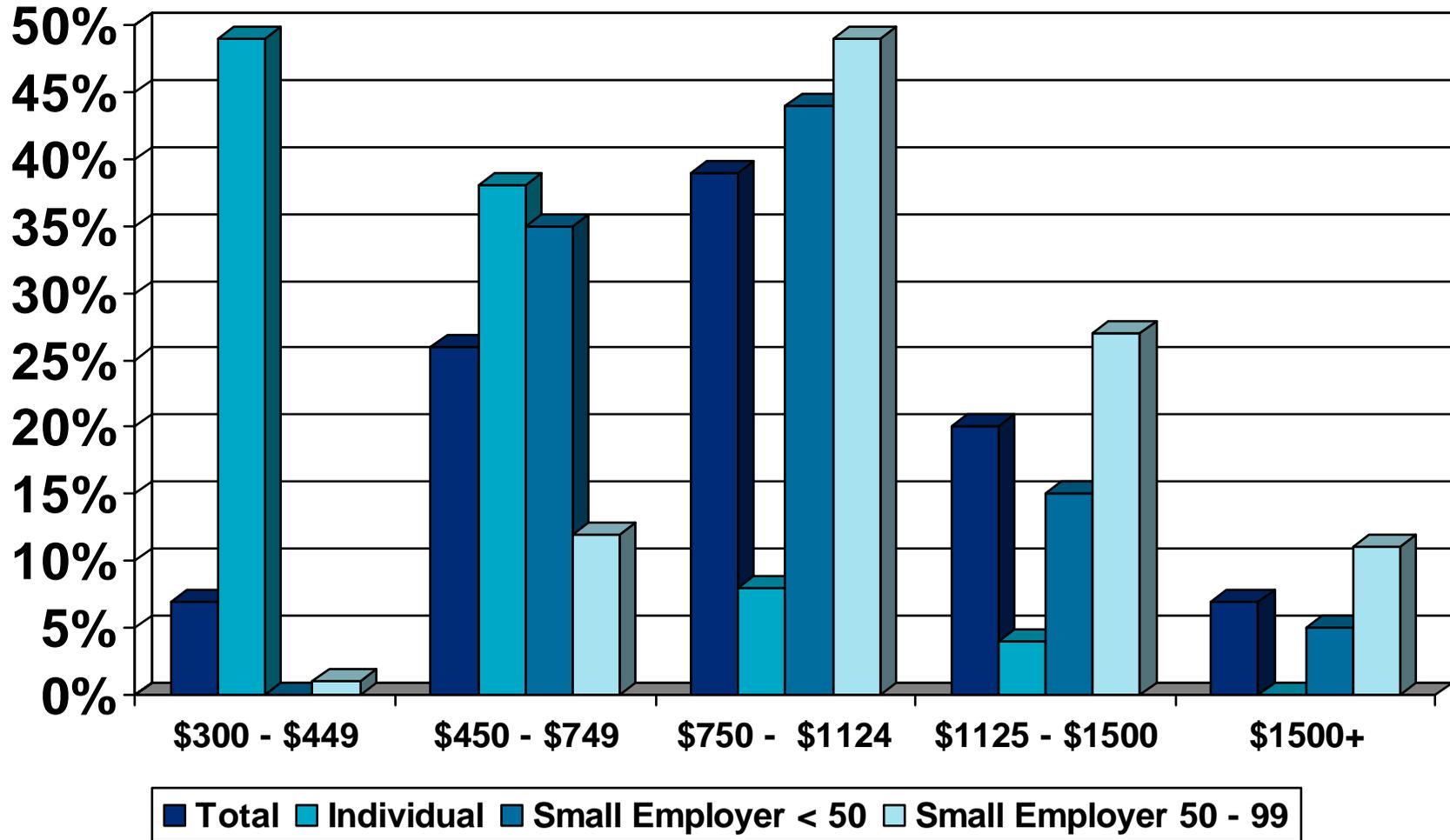


Premium costs

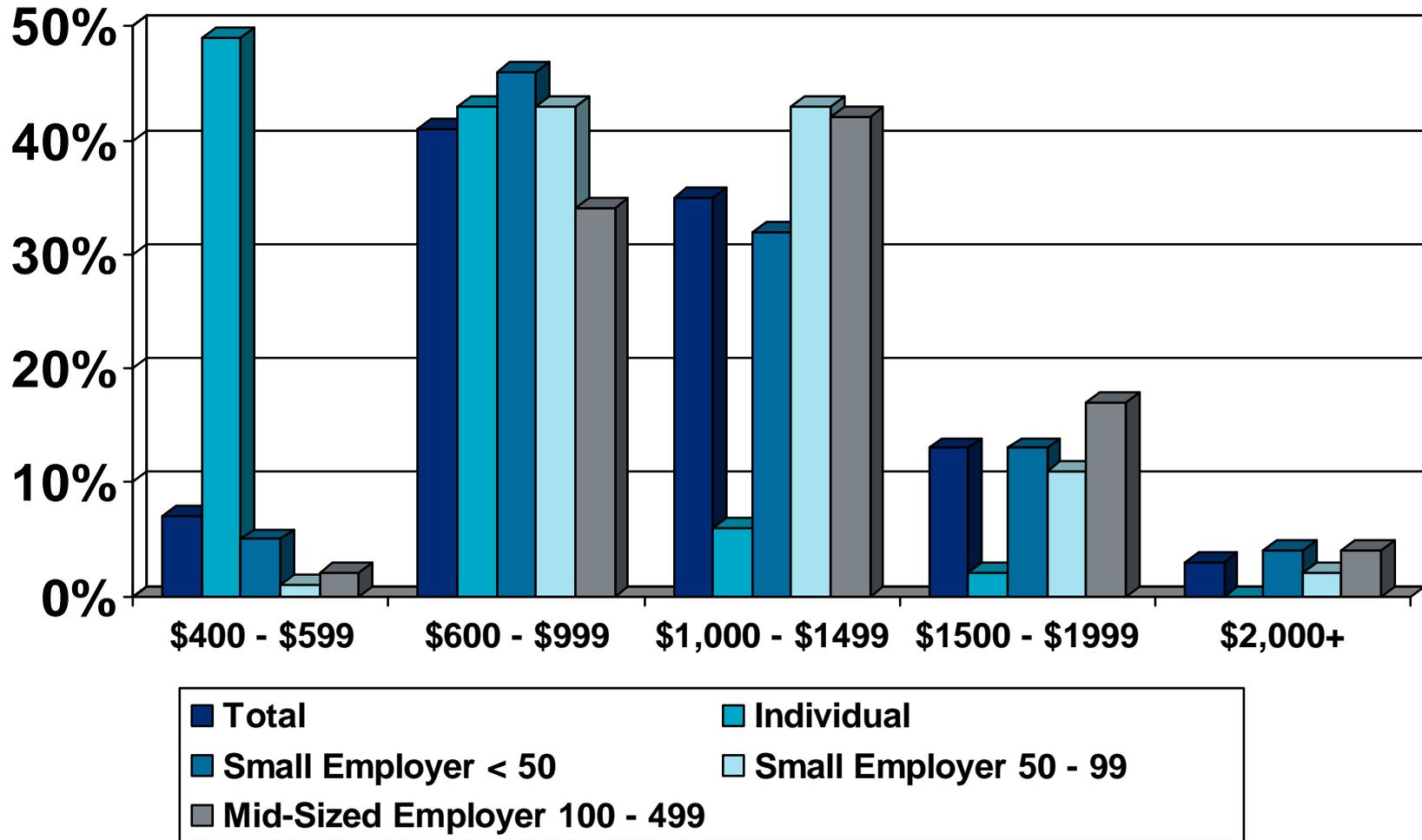
Two adults



Premium costs One adult one child



Premium costs One adult and children



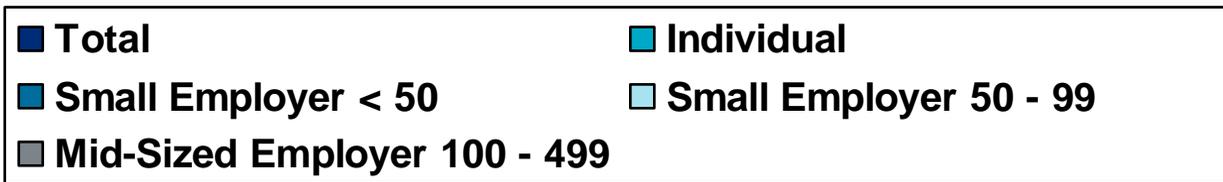
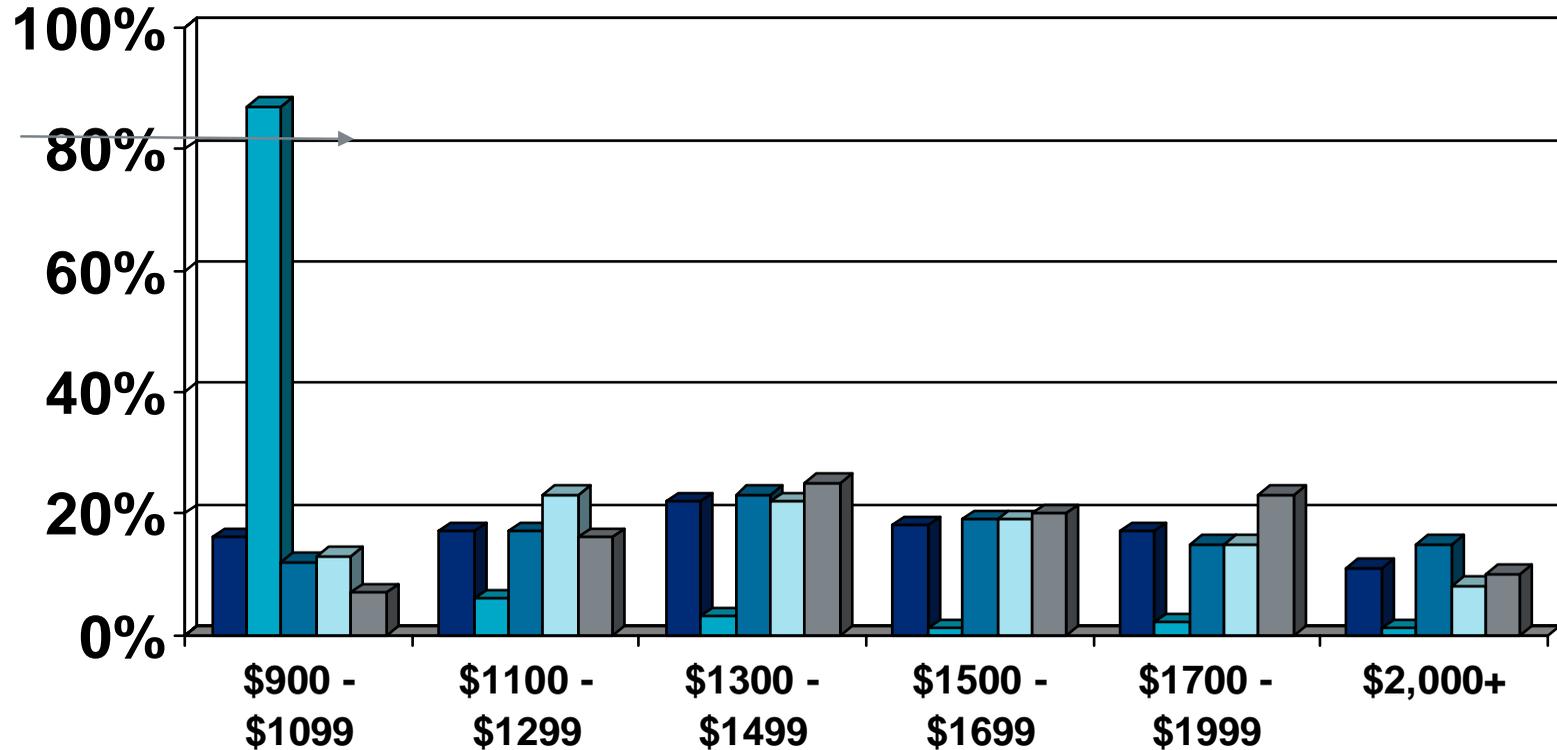
Premium costs Two adults and children

Mercer 2010 Survey: Average national family plan cost

PPO: \$1,165

HMO: \$1,193

CDHP with HSA: \$944



Task 2 – Appendix/Background

Task 2 – Health Insurer Survey

- Plan features:

Deductibles	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
Individual deductibles < \$500	3%	7%	17%	14%
Individual deductibles \$500–\$1,000	1%	6%	9%	11%
Individual deductibles >\$1,000	96%	87%	74%	75%
Total	100%	100%	100%	100%

Copayments	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
Subject to deductible and coinsurance	51%	28%	37%	30%
< \$15	0%	4%	9%	12%
\$15–\$25	10%	24%	22%	39%
> \$25	38%	44%	32%	19%
Total	100%	100%	100%	100%

Individual out-of-pocket costs	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
Individual < \$1,000	1%	8%	13%	10%
Individual \$1k–\$2k	7%	15%	26%	39%
Individual >\$2k	92%	76%	61%	51%
Total	100%	100%	100%	100%

Task 2 – Health Insurer Survey (cont'd)

- Plan features (cont'd):

Pharmacy benefits	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
Subject to deductible and coinsurance	53%	12%	20%	20%
Generic < \$10	0%	1%	3%	14%
Generic \$10 or more	61%	87%	79%	80%
Preferred brand <\$40	40%	88%	80%	81%
Preferred brand > \$40	7%	0%	0%	0%
Non-preferred brand \$<\$60	41%	87%	80%	80%
Non-preferred brand \$60 or more	6%	0%	0%	0%

Task 2 – Health Insurer Survey (cont'd)

- % Enrollment by premium costs by tier of coverage:

Single	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
\$200 - \$299	48%	11%	2%	3%
\$300 - \$499	41%	37%	45%	41%
\$500 - \$749	8%	37%	48%	49%
\$750 - \$999	2%	10%	5%	6%
\$1,000+	1%	5%	0%	1%
Total	100%	100%	100%	100%

Two adults	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
\$400 - \$599	44%	1%	1%	1%
\$600 - \$999	43%	25%	40%	30%
\$1,000 - \$1499	11%	46%	50%	56%
\$1500 - \$1999	2%	21%	9%	13%
\$2,000+	0%	7%	1%	0%
Total	100%	100%	100%	100%

One adult one child	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
\$300 - \$449	49%	0%	1%	2%
\$450 - \$749	38%	35%	12%	12%
\$750 - \$1124	8%	44%	49%	43%
\$1125 - \$1500	4%	15%	27%	34%
\$1500+	0%	5%	11%	10%
Total	100%	100%	100%	100%

Task 2 – Health Insurer Survey (cont'd)

- % Enrollment by premium costs by tier of coverage:

One adult and children	Individual	Small employee < 50	Small employer 50–99	Mid-sized employer 100–499
\$400 - \$599	49%	5%	1%	2%
\$600 - \$999	43%	46%	43%	34%
\$1,000 - \$1499	6%	32%	43%	42%
\$1500 - \$1999	2%	13%	11%	17%
\$2,000+	0%	4%	2%	4%
Total	100%	100%	100%	100%

Two adults and children	Individual	Small employee < 50	Small employer 50–99	Mid-Sized employer 100–499
\$900 - \$1099	16%	87%	12%	13%
\$1100 - \$1299	17%	6%	17%	23%
\$1300 - \$1499	22%	3%	23%	22%
\$1500 - \$1699	18%	1%	19%	19%
\$1700 - \$1999	17%	2%	15%	15%
\$2,000+	11%	1%	15%	8%
Total	100%	100%	100%	100%

Task 2 – Health Insurer Survey (cont'd)

- % Enrollment by type of plan

Type of plan	Total	Individual	Small employer < 50	Small employer 50–99	Mid-sized employer 100–499
< Bronze	44%	72%	47%	7%	5%
Bronze	12%	22%	8%	29%	21%
Silver	21%	5%	22%	34%	25%
Gold	10%	0%	9%	17%	20%
Platinum	14%	0%	15%	13%	28%
Total	100%	100%	100%	100%	100%

Type of plan	Total	Individual	Small employer < 50	Small employer 50–99	Mid-sized employer 100–499
HMO	21%	2%	21%	48%	33%
PPO/POS	49%	53%	51%	29%	41%
CDHP	29%	46%	28%	24%	26%
Total	100%	100%	100%	100%	100%

Questions and answers

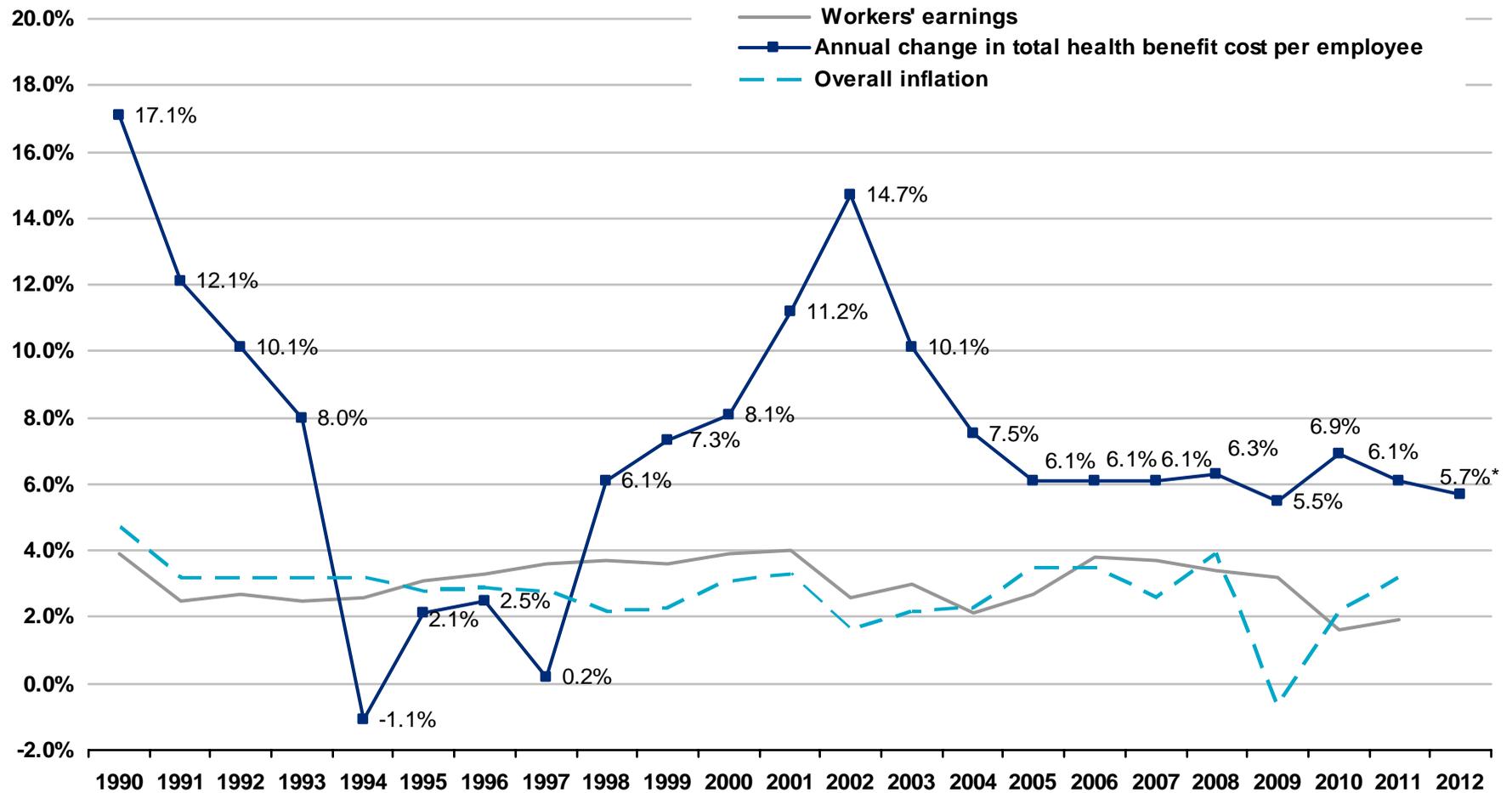
Survey the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues

Task 3

Setting the stage

FIGURE 1

Growth in total health benefit cost per employee slows to 6.1% in 2011 with a 5.7% increase expected for 2012



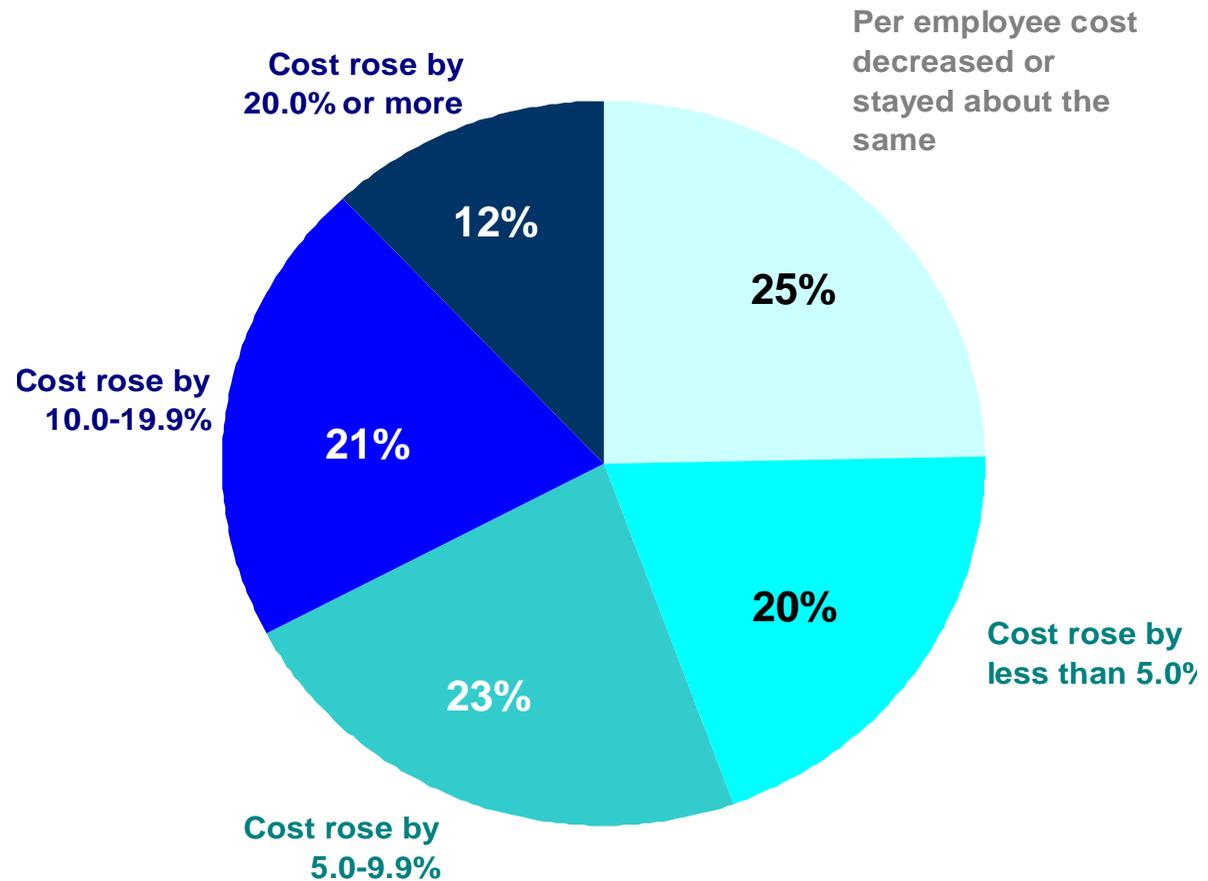
*Projected

Source: Mercer's National Survey of Employer-Sponsored Health Plans; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April) 1990-2011; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April) 1990-2011.

Behind the averages: Tough cost challenges remain

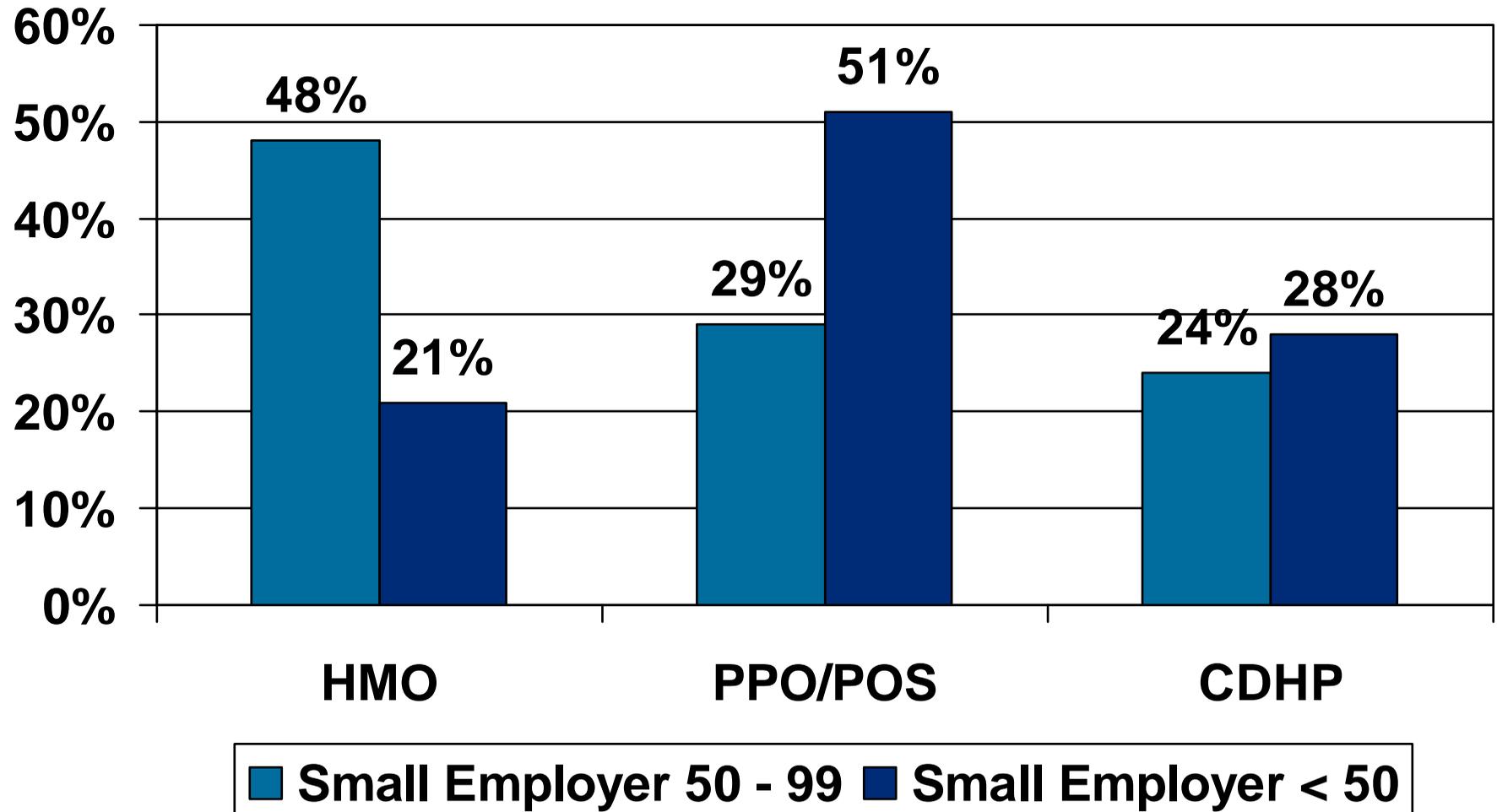
Breakdown of 2010 health plan increases

One-third of employers still saw double-digit increases after plan design changes

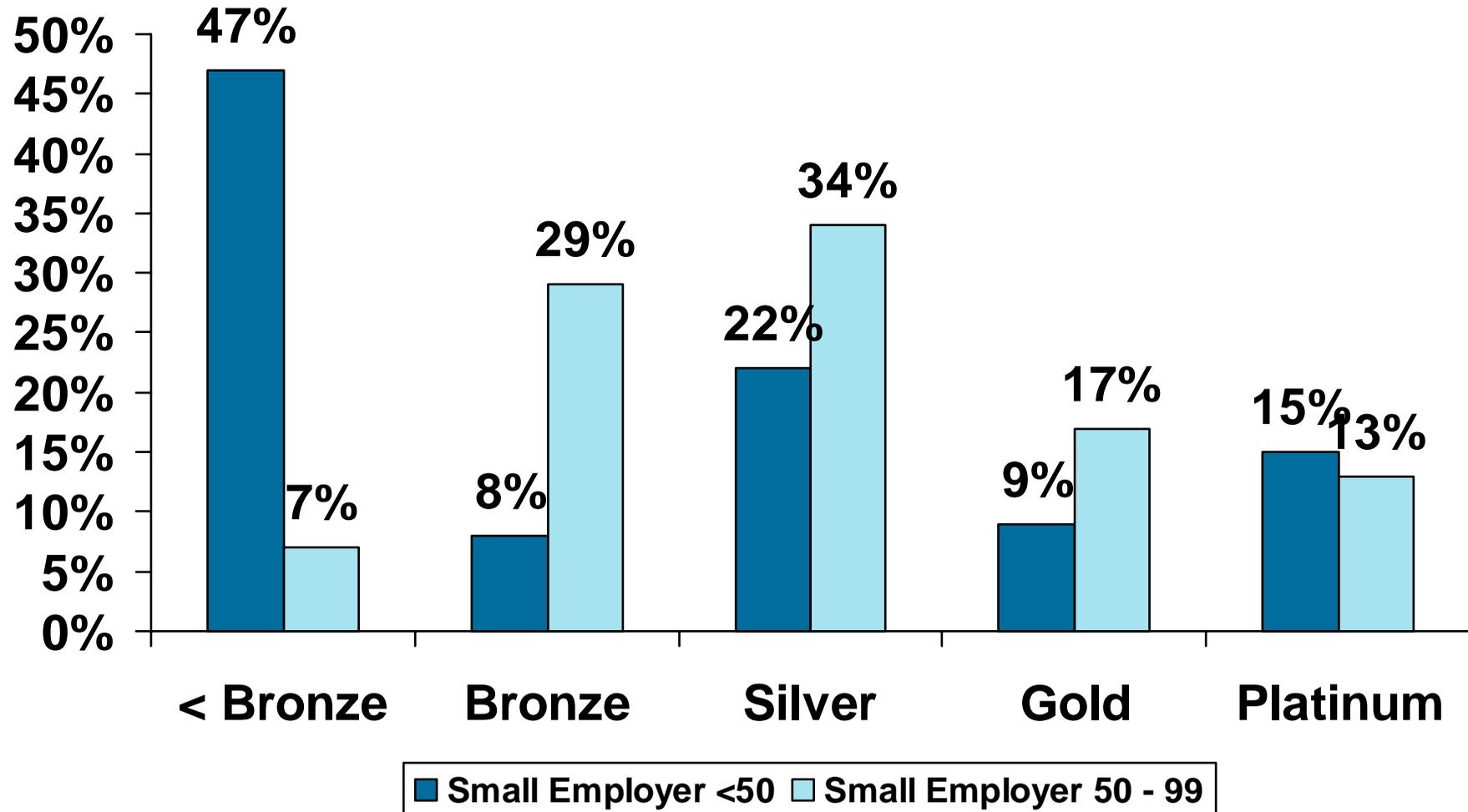


Based on all employers providing 2009 and 2010 costs under the Mercer Health Care Survey

Connecticut small employer product purchases



Actuarial value of Connecticut small employer purchases



Connecticut fully-insured health insurance marketplace

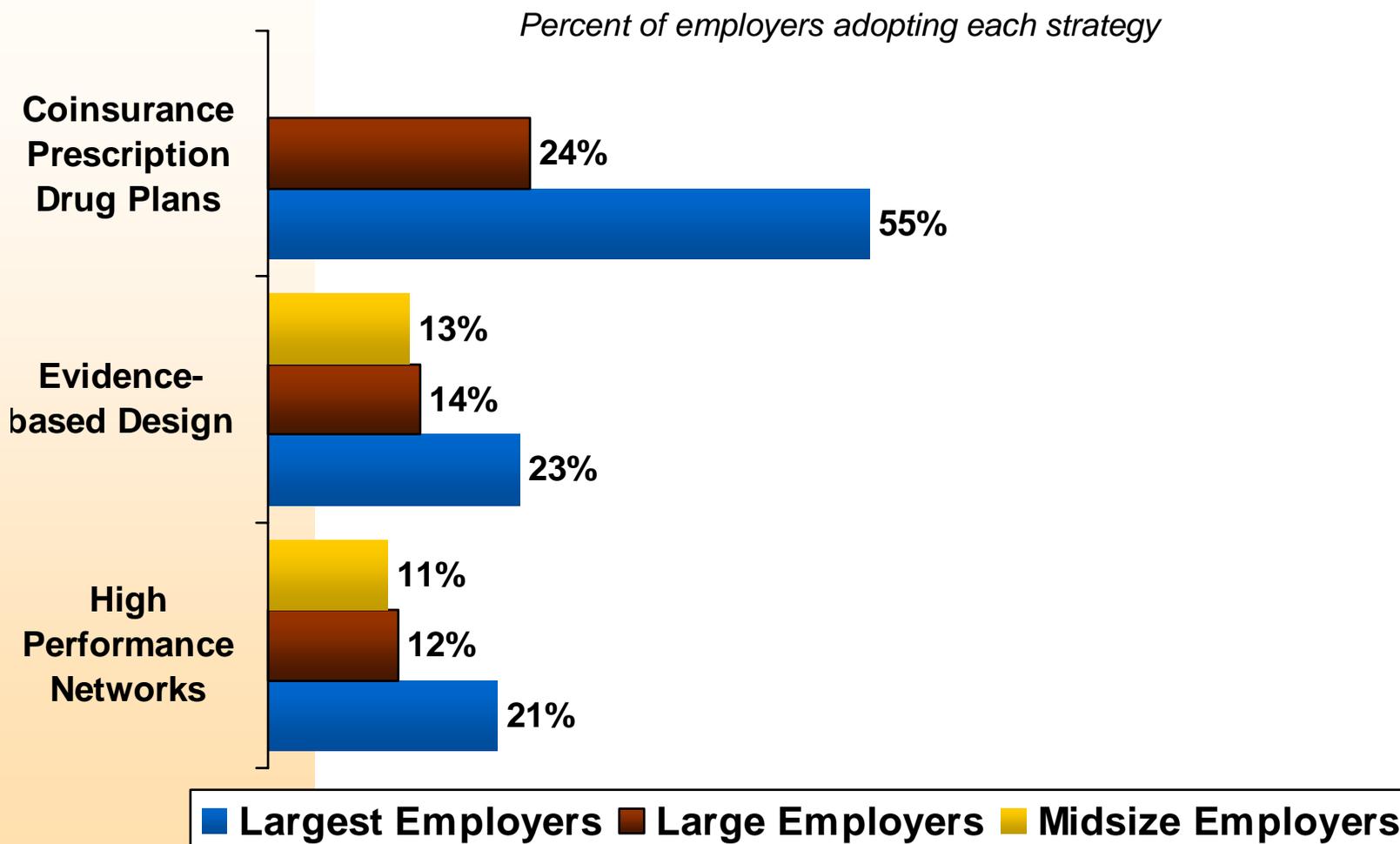
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Other	5,269	2,749	7,304	15,322
Total	108,475	298,427	474,731	881,633

Source: 12/31/2010 Supplemental Health Care Exhibits filed with statutory financial statements.

Product innovation, led by large employers

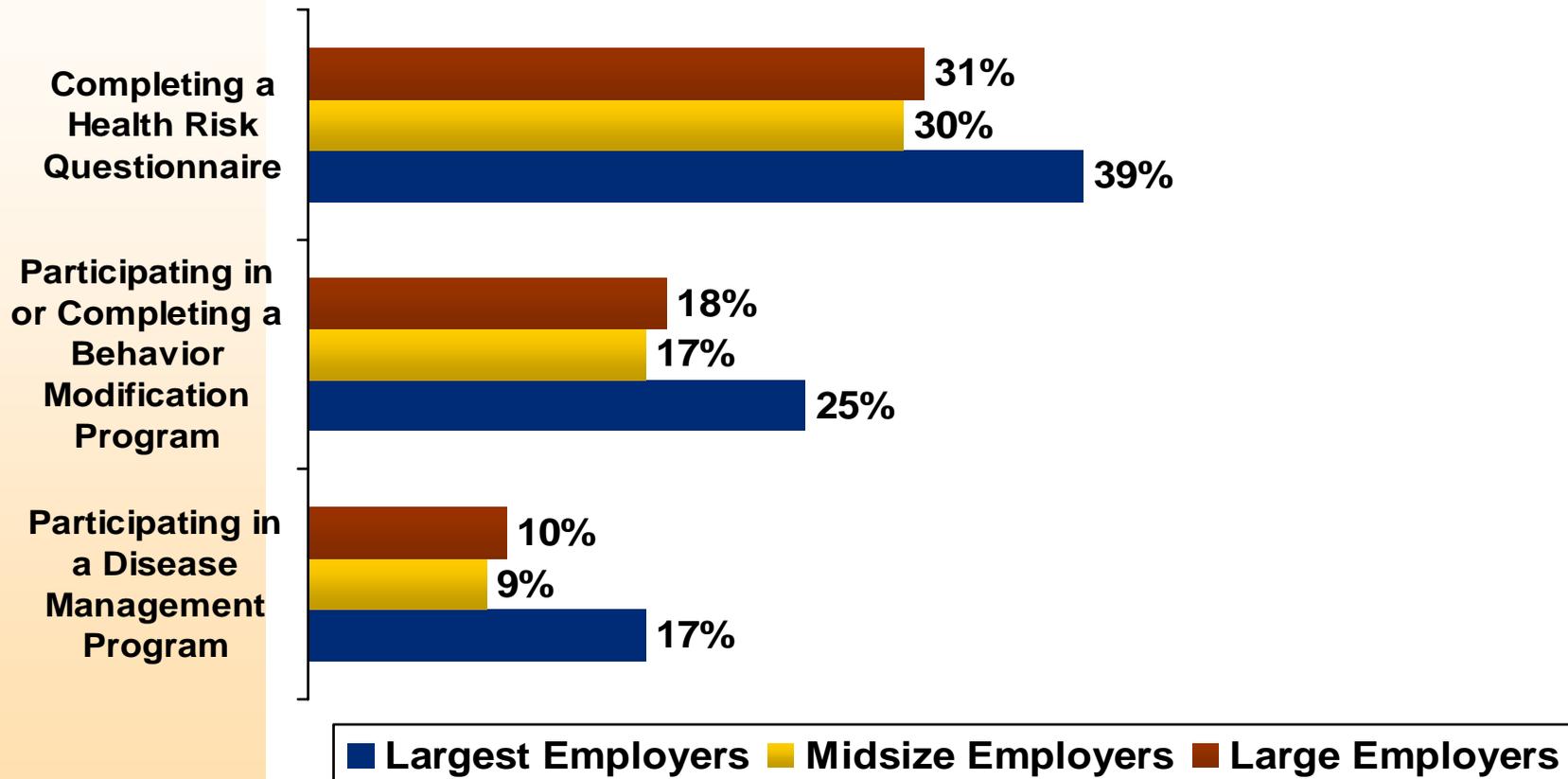
(And of interest to the uninsured)

Newer initiatives expand employers' approaches to controlling costs



Special attention being paid to incentives

Do you use an incentive to build program engagement?



Emerging cost-management strategies target quality and cost efficiency

Employers with 5,000 or more employees

■ Already use ■ Interested in using ■ Not interested in using

Surgical centers of excellence



Retail clinics for minor acute or preventive care



Telemediated care



Medical homes



Mercer analyzed 2011 survey respondents' cost based on their use of cost-management best practices

Contribution for family coverage in primary plan is at least 20% of premium

Four or more employee contribution tiers

PPO in-network deductible is \$300 or more

PPO plan has higher cost-sharing for specialists

Offer a CDHP

Make contribution to an HSA

Rx mail-order copay is at least 2.5x retail copay

Part of an Rx purchasing coalition

Spousal surcharge

Smoker surcharge

Offer optional HM services through plan or vendor

Use incentives for HM programs

Use incentives for health status targets

Offer an EAP

Voluntary benefits integrated with core benefits

High-performance networks

Data warehousing

Collective purchasing

Value-based design

On-site clinic

One or more Rx strategies (i.e. mandatory generics)

One or more specialty drug provisions (i.e., step therapy)

One or more health plan innovations:

- Surgical centers of excellence
- Retail clinics
- Telemediated care
- Medical homes

Large employers appear to be controlling cost through use of best practices

Large employers

	Total health plan cost per employee	Cost of health benefit programs as a percent of payroll
Use 6 or fewer best practices	\$10,700	16%
Use 10 or more best practices	\$10,045	14%

The uninsured want innovation too

Insights from 2011 Oliver Wyman Survey of the uninsured

- The uninsured are acutely price sensitive.
- The uninsured have different needs and preferences.
 - When offered a \$50 a month discount:
 - 52% were willing to reach a healthy body weight
 - 41% were willing to receive a majority of their medical care at a retail clinic located in a pharmacy or retail store
 - 38% of those who smoked were willing to quit
 - 48% were willing to interact with their doctor primarily online
 - When offered an opportunity to purchase a \$50 buy-up:
 - 40% wanted the ability to see doctors who provide the best quality of care and service
 - 36% wanted access to a doctor anytime, 24/7
 - 21% wanted one doctor who champions your medical care across all doctors you see

Source: Inside the Uninsured, Oliver Wyman, August 2011

Exchange experiences

It is hard to run an effective exchange

Losses shutter health group / PacAdvantage can't offer pool members enough plan choices

August 12, 2006 Victoria Colliver, Chronicle Staff Writer

Pacific Health Advantage, a statewide health-insurance purchasing pool serving 6,200 small businesses, said Friday it will shut down at the end of the year. The purchasing group, known as PacAdvantage, has 116,000 members in the state. It is dissolving because one of its insurers, Blue Shield of California, pulled out because of financial losses in the program...

Attention Business Express Shoppers

Selection is currently limited. [Click here](#) to get a message when more plans become available. Please put "notify me" in the subject line. *Thank you* for your interest and patience.



Get the Right Plan for Your Business

Contribute toward a Commonwealth Choice plan for your employees, or give them tax-free savings to buy a plan on their own.



The Health Connector offers plans from:



Now save up to 15% with Wellness Track

Eligible small businesses can save on premiums by joining our health and wellness program.

[Get Started](#)

New Federal Tax Credits

Your business may qualify for the new Small Business Health Care Tax Credit created by the national Health Care Reform law.

[Get the facts from the IRS](#)

Attention Business Express Shoppers

Selection is currently limited. [Click here](#) to get a message when more plans become available. Please put "notify me" in the subject line. *Thank you* for your interest and patience.

Tax-Free Savings

Employers of any size can offer tax-free savings through a Section 125 Plan. Employees get tax-free savings on a health plan. You save on FICA.

[Learn all about Section 125 Plans](#)

Quick Links

- ★ [Provide input for health reform implementation](#)
- ★ [Frequently asked questions](#)
- ★ [Employer obligations](#)
- ★ [All about section 125](#)

Real Customers

Massachusetts small business participation in the Exchange has been limited

- Membership:
 - Currently less than 5,000 members
- “Contributory” plan had a delayed opening in 2009 and then closed to new business in February 2010.
- Product choice was limited.
- Insurer choice was limited.
- Broker distribution limited to 19 brokers.
- Started small business exchange through an existing intermediary, “Small Business Service Bureau.”

Connecticut Business and Industry Association (CBIA) Health Connections private Exchange

- Membership:
 - Currently 75,000 members*
 - Robust “Contributory” plan that offers individual employee choice.
 - Product choice of 25 plan options.
 - Insurer choice of 2 prominent carriers.
 - Brokers key distributor.
 - Started privately in 1995.
 - Small group rates subject to the same rating rules as those outside of the Exchange. (The price for a product sold by one of the carriers inside or outside the Exchange will be exactly the same.)
- * Federal insurer filings report that there are approximately 298,000 members insured in the Connecticut small employer (1–50) market

Current Connecticut health insurance laws permit the following rate adjustments



Group Size

3 to 9

EMPLOYEES

Male

Gender

Geographic Area

Area 3

New Haven

October - December 2010

Age

Employee

Family Composition

<25 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65+

HMO \$30/\$45

CIGNA	205.00	236.70	276.02	326.97	398.47	501.62	652.99	859.27	1103.76	1455.33
ConnectiCare	244.95	274.15	314.39	349.61	462.19	559.12	723.58	953.32	1191.62	1484.52
Oxford	197.75	229.39	264.98	316.40	395.50	454.82	613.02	922.46	1212.24	1322.79

HMO \$20

CIGNA	248.45	286.88	334.53	396.27	482.94	607.94	791.41	1041.41	1337.72	1763.82
ConnectiCare	337.59	377.83	433.30	481.83	637.00	770.61	997.26	1313.89	1642.32	2046.01
Oxford	234.85	272.42	314.69	375.76	469.69	540.15	728.03	1095.53	1439.67	1570.96

POS \$30/\$45

CIGNA	209.91	242.38	282.64	334.81	408.03	513.64	668.65	879.88	1130.22	1490.23
ConnectiCare	258.56	289.39	331.89	369.05	487.90	590.23	763.84	1006.35	1257.91	1567.10
Oxford	199.77	231.74	267.70	319.64	399.55	459.48	619.30	931.92	1224.66	1336.34

POS \$20

CIGNA	273.05	315.28	367.65	435.51	530.76	668.14	869.77	1144.53	1470.18	1938.47
ConnectiCare	354.14	396.36	454.54	505.46	668.22	808.39	1046.15	1378.31	1722.84	2146.31
Oxford	242.95	281.82	325.55	388.72	485.90	558.79	753.15	1133.33	1489.35	1625.16

Illustration of how a “contributory” plan works

1. Employer Selects Health Connections
2. Employer defines their contribution
3. Employees can buy up or down, based upon their needs
4. CBIA provides employer with a single bill



3 to 9
EMPLOYEES
Male

Underwriting is complicated using this approach!

Employee

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
HMO \$30/\$45										
CIGNA	205.00	236.70	276.02	326.97	398.47	501.62	652.99	859.27	1103.76	1455.33
ConnectiCare	244.95	274.15	314.39	349.61	462.19	559.12	723.58	953.32	1191.62	1484.52
Oxford	197.75	229.39	264.98	316.40	395.50	454.82	613.02	922.46	1212.24	1322.79
HMO \$20										
CIGNA	248.45	286.88	334.53	396.27	482.94	607.94	791.41	1041.41	1337.72	1763.82
ConnectiCare	337.59	377.83	433.30	481.83	637.00	770.61	997.26	1313.89	1642.32	2046.01
Oxford	234.85	272.42	314.69	375.76	469.69	540.15	728.03	1095.53	1439.67	1570.96
POS \$30/\$45										
CIGNA	209.91	242.38	282.64	334.81	408.03	513.64	668.65	879.88	1130.22	1490.23
ConnectiCare	258.56	289.39	331.89	369.05	487.90	590.23	763.84	1006.35	1257.91	1567.10
Oxford	199.77	231.74	267.70	319.64	399.55	459.48	619.30	931.92	1224.66	1336.34
POS \$20										
CIGNA	273.05	315.28	367.65	435.51	530.76	668.14	869.77	1144.53	1470.18	1938.47
ConnectiCare	354.14	396.36	454.54	505.46	668.22	808.39	1046.15	1378.31	1722.84	2146.31
Oxford	242.95	281.82	325.55	388.72	485.90	558.79	753.15	1133.33	1489.35	1625.16

Regulation related to Exchange product and pricing

Accountable Care Act (ACA):

- ACA permits both an individual and group health insurance market to continue to exist outside of the Exchange.
- Issuers of Qualified Health Plans must agree to charge the same premium rate for a Qualified Health Plan whether it is offered through an Exchange or offered directly from the issuer or through an agent.
- Health plans must treat members in their plans as a single risk pool for members both in and out of the Exchange.

Connecticut Exchange Law:

- “All health carriers offering qualified health plans in the state shall comply with all applicable health insurance laws of the state and regulations adopted and orders issued by the commissioner.”

It is going to be very difficult for the Exchange to compete based upon price

Will current Connecticut State law and/or Insurance Department interpretation of the law allow the Exchange to offer innovative products that could reduce small employer premiums?

Sec. 38a-567. Provisions of small employer plans and arrangements.

(8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective **differences in plan design**, not including differences due to the nature of the groups assumed to select particular health benefit plans.

It would be extremely valuable to have the Exchange work collaboratively with legislators and the Insurance Department to develop innovative products to meet individual and small employer needs

Questions and answers

Assessment of the uninsured and underinsured population in Connecticut

Task 1

The bottom half of the slide features a decorative graphic composed of several overlapping, semi-transparent blue shapes. On the left, a light blue triangle points towards the right. Overlapping this is a darker blue triangle pointing towards the left. The largest shape is a bright cyan trapezoid that expands from left to right, creating a sense of depth and movement.

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut

- Summary and background
 - Task 1 goals:
 - An assessment of the State's uninsured population
 - An assessment of the State's underinsured population by various types of coverage
 - Purpose of the analysis of the uninsured:
 - Income stratification is essential – because the point is to identify individuals that may qualify for subsidized coverage through the Exchange or be part of a Medicaid expansion
 - Data will inform other team tasks:
 - Estimates for Exchange enrollment (tasks 4 and 7)
 - Estimates of impact of the ACA on Medicaid (Task 10)

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)

- Summary and background (cont'd)
 - Purpose of analyzing the underinsured:
 - To identify individuals that have high out-of-pocket costs (for premiums, deductibles and/or copayments)
 - Could result in current plans not meeting requirements for QHPs
 - Could result in current plans not meeting the ACA definition of “affordable”
 - In general, useful data is part of that being analyzed for Task 4 modeling. Team will be reviewing data to determine whether important conclusions can be drawn and to assess their relevance to the operation of the Exchange

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)

- Source information and methodology:
 - Current Population Survey (CPS) from the U.S. Census Bureau
 - As adjusted by the Urban Institute and reported by the Kaiser Family Foundation
 - Critical adjustment assigns income to “health insurance units” rather than households
 - Data for 2008 and 2009 in combination due to small sample size
 - CPS data as enhanced by the State Health Access Data Assistance Center (SHADAC) of the University of Minnesota were also used to provide additional detail on coverage sources by income
 - Carrier data relates exclusively to definition of “underinsured”

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)

Distribution of the non-elderly in Connecticut by Federal Poverty Level (FPL) and coverage

	Uninsured	Employer	Individual	Medicaid	Other Public	Total
0-138	155,700	116,300	37,900	198,900	23,900	532,800
139-200	65,400	85,700	18,300	58,000	9,700	237,000
Subtotal 0-200	221,100	202,000	56,200	256,900	33,600	769,000
200+	155,900	1,863,100	93,000	95,500	17,100	2,224,500
Total	377,000	2,065,100	149,200	352,400	50,700	2,994,300

Source: 2008–2009 CPS Data with Kaiser/Urban Health Insurance Unit Adjustment.

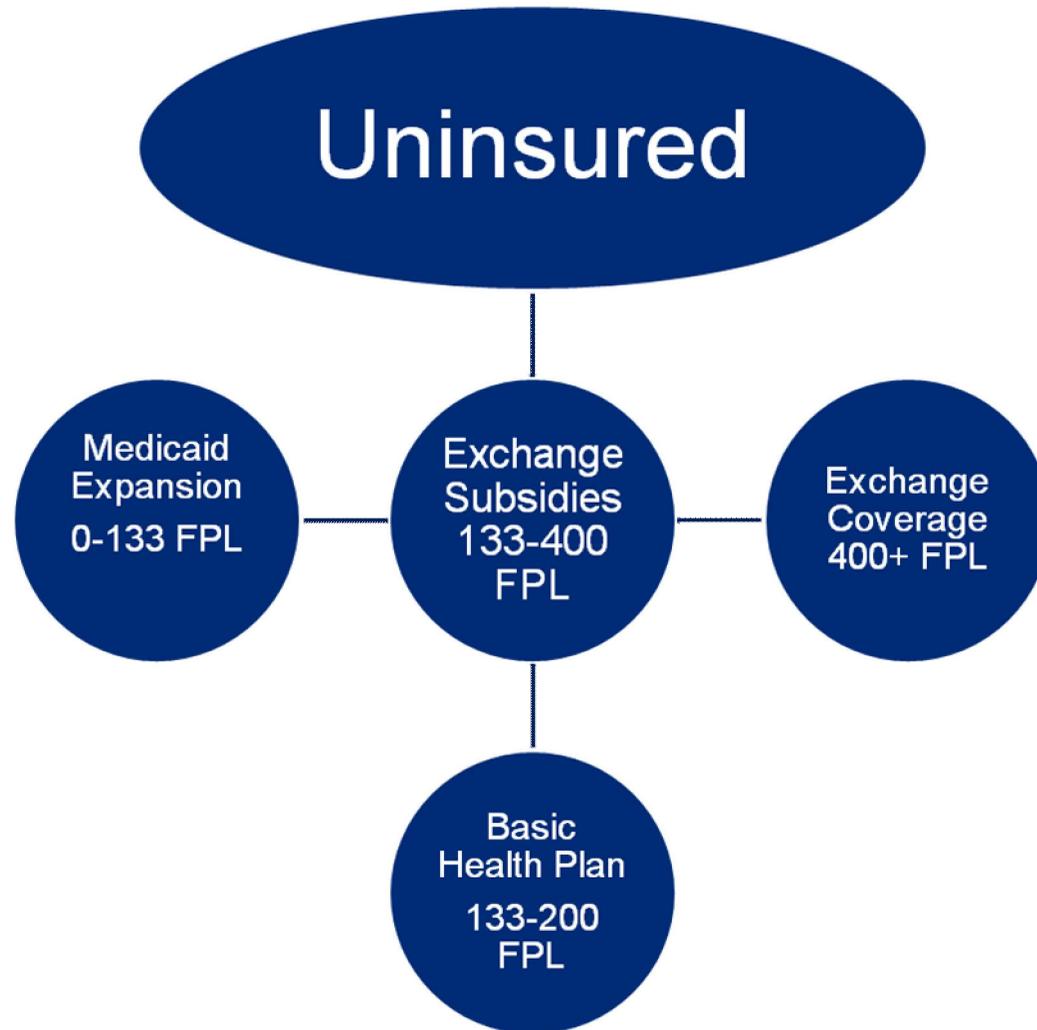
Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)

- Key findings:
 - 156,000 of the currently uninsured non-elderly in Connecticut have income below 139% of the FPL and would qualify for Medicaid under the ACA
 - 65,000 uninsured individuals are in the income range for a Basic Health Plan (BHP) (139%–200% FPL)
 - An additional 100,000 uninsured would qualify for lower levels of Exchange subsidy (incomes between 200%–400% FPL)
 - More than 116,000 individuals might be able to move from employer-based coverage to Medicaid
 - Nearly 40,000 persons with individual coverage might be able to drop those policies and enroll in Medicaid expansion
 - Note that a large portion of this population was enrolled in the State Administered General Assistance (SAGA) in 2009 and are now likely in Medicaid Low Income Adult group

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)

- Recommendations:
 - Continue to evaluate all assumptions going forward
 - Factors contributing to the need for future evaluation:
 - Assumptions are needed about “take-up rates” – the proportion of those eligible for coverage in that will actually enroll
 - Current national estimates have Medicaid take-up rate assumptions ranging from 57% to 75%
 - Take-up rates for Exchange coverage are more complex
 - The CPS data does not take account of administrative data from Medicaid and may understate Medicaid enrollment (potentially overstating either uninsurance or private coverage)
 - Medicaid analysis should always utilize State administrative data
 - Carrier data combined with Medicaid data should be used to revise the uninsured estimates

Task 1 – Assessment of the uninsured and underinsured populations in Connecticut (cont'd)



Questions and answers

Medicaid/Children's Health Insurance Program (CHIP) impact analysis and Exchange interactions

Task 10

Task 10 – Medicaid/CHIP impact analysis

- Overview:
 - Effective January 1, 2014, the ACA expands rules for Medicaid eligibility to cover nearly all individuals under the age of 65 with household incomes up to 133% of the FPL
 - In recognition of the expanded cost of covering the newly Medicaid eligible, the ACA provides enhanced federal matching dollars to states
 - The law also creates an environment where states may reduce state budget costs by transitioning current coverage groups with incomes between 134%–400% FPL to a health insurance exchange or 134%–200% for a BHP
 - *Non-Elderly Adults*: As early as January 1, 2014
 - *Children*: October 1, 2019

Task 10 – Medicaid/CHIP impact analysis (cont'd)

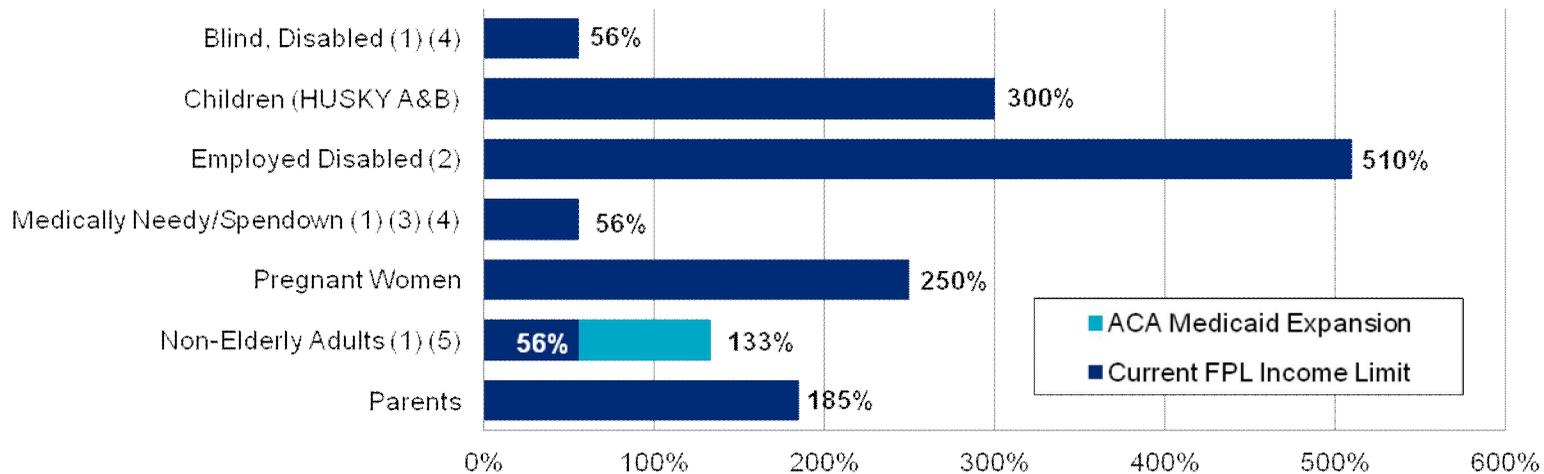
- Medicaid expansion:
 - The ACA established a new mandatory Medicaid eligibility category, effective January 1, 2014, which provides coverage to non-elderly and non-pregnant individuals with incomes up to 133% FPL who are not enrolled in Medicare and are otherwise ineligible for Medicaid
 - **Includes:** All non-elderly adults, including those without dependent children who have historically been excluded from Medicaid unless they were pregnant or disabled
 - **Excludes:** Undocumented immigrants and lawfully residing noncitizens who have been in the U.S. less than five years (no change to existing law)*

* NOTE: Connecticut provides Medicaid and CHIP coverage to pregnant women and children lawfully residing in the United States under an option authorized under the Children's Health Insurance Program Reauthorization Act.

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- The effect of the ACA is to ‘fill-in’ gaps in Medicaid coverage.

CT Medicaid/CHIP Income Eligibility by FPL for Non-Elderly/Non-Waiver Enrollees



Footnotes:

(1): 68% FPL in Region A (Southwest CT)

(2): Employed Disabled: Total income from work and other benefits must not exceed \$75,000 per year and a spouse's income is not counted in determining income eligibility. Based on 2011 FPL incomes by family size, a \$75,000 annual income equates to 510% FPL for a family of two.

(3): Medically Needy: Blind, and disabled individuals who do not meet the Medically Needy Income Limit (MNIL), but still need health care coverage may “spend down” to become eligible for Medicaid through the Medically Needy option.

(4): A number of categories of Medicaid recipients will continue to have eligibility determined based on traditional rules including asset tests, including SSI eligibles; individuals whose eligibility depends on blindness or disability; individuals aged 65 and over; individuals receiving long-term care services; and the medically needy. Adults who are blind or disabled or who are medically needy may alternatively qualify under the expansion rules if their income is at or below 133% FPL without having to establish eligibility as blind, disabled, or medically needy.

(5): Individuals with incomes not exceeding 133% FPL who are not (1) elderly; (2) pregnant; (3) entitled to or enrolled in Medicare Part A or Medicare Part B; or (4) described in an already existing group for which Medicaid coverage is mandatory, such as certain parents, children, or disabled persons receiving Supplemental Security Income (SSI) benefits.”

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Enhanced federal reimbursement:
 - For the newly Medicaid eligible, the federal government will pay 100% of health care costs between 2014 and 2016. This percentage will phase down to 90% by 2020 and thereafter
 - By contrast, Connecticut will continue to receive 50% federal financial participation for existing Medicaid-covered populations
 - The ACA increased CHIP reimbursement by an additional 23 percentage points (from 65% to 88% in CT) for federal FY16–FY19

Category	2014	2015	2016	2017	2018	2019	2020
Newly Medicaid-eligible coverage groups	100%	100%	100%	95%	94%	93%	90%
Existing Medicaid coverage groups*	50%	50%	50%	50%	50%	50%	50%
Existing CHIP coverage groups**	65%	65%	88%	88%	88%	65%	65%

* Family planning services reimbursed at 90%.

** CHIP federal reimbursement rates reported on a federal fiscal year basis (Oct–Sept).

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Medicaid and CHIP growth:
 - Connecticut’s Medicaid and CHIP programs are expected to grow as newly eligible individuals are covered, and those who are currently eligible but unenrolled enroll due to expanded outreach efforts and awareness of tax penalties for failure to secure health insurance if an affordable option exists
 - Sources of Medicaid and CHIP growth include:
 - Uninsured
 - Employer-sponsored insurance (if an employer drops coverage, “crowd out”) OR if employer-sponsored insurance does not meet ACA affordability criteria
 - Individual coverage (non-group)
 - Charter Oak Health Plan
 - Pre-existing Condition Insurance Plan (PCIP)

Medicaid: Non-elderly adults in Connecticut who meet income eligibility (Both newly eligible and currently eligible but unenrolled)

Income eligible non-elderly adults	Estimate	Data source
Uninsured	125,600	2008/09 CPS Kaiser/Urban data (Task 1)
Employer-sponsored insurance	73,700	2008/09 CPS Kaiser/Urban data (Task 1)
Individual coverage	30,300	2008/09 CPS Kaiser/Urban data (Task 1)
Charter Oak Health Plan	~1,300	Imputed from DSS enrollment file
PCIP	~40	Imputed from DSS enrollment file
TOTAL	230,900	

- Actual enrollment in Medicaid from these populations will depend on a variety of assumptions, including:
 - The proportion ineligible for Medicaid due to residency status (e.g., undocumented individuals, legal immigrants residing in the U.S. for less than 5 years)
 - Medicaid participation rates (“take-up rates”)
 - Percentage of employers who drop coverage (“crowd out”)

Medicaid and CHIP income eligible children in Connecticut (Currently eligible but unenrolled)

Income-eligible children	Estimate	Data source
HUSKY A		
Uninsured	36,200	Imputed from 2008/09 CPS Kaiser/Urban data
Employer-sponsored insurance	64,000	Imputed from 2008/09 CPS Kaiser/Urban data
Individual coverage	4,800	Imputed from 2008/09 CPS Kaiser/Urban data
HUSKY B (Bands 1 & 2)		
Uninsured	12,200	Imputed from 2008/09 CPS Kaiser/Urban data
Employer-sponsored insurance	70,000	Imputed from 2008/09 CPS Kaiser/Urban data
Individual coverage	5,200	Imputed from 2008/09 CPS Kaiser/Urban data
TOTAL	192,000	

- Like adults, new enrollment in Medicaid and CHIP from these populations will depend on assumptions about residency status, take-up rates, and crowd out.

Task 10 – Medicaid/CHIP impact analysis

- Key enrollment assumptions:
 - Citizenship and residency requirements:
 - Exact estimates of Connecticut's uninsured undocumented immigrants and legal immigrants living in the U.S. less than five years are unavailable. Possibly 10%–15% of the newly income eligible will not meet residency requirements
 - Take-up rates: Not all who are eligible will enroll
 - Existing models by the Congressional Budget Office and the Urban Institute estimate uninsured take up rates into Medicaid between 57% and 75%
 - Take-up rates may be higher due to increased enrollment and outreach efforts and individual tax penalties
 - Crowd out: Some employers may drop coverage
 - Microsimulation model estimates from RAND, the Urban Institute, The Lewin Group and the Congressional Budget Office which showed net changes to ESI under the ACA ranging from -0.3% to +8.4%
 - MIT economist Jonathan Gruber concluded that only 2% of Connecticut small business employees will shift to Medicaid under health care reform

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Key cost assumptions:
 - Annual Medicaid/CHIP medical inflation, 2011-2020: 3.5%
 - Assumes moderated Medicaid cost growth
 - Does not reflect cost growth associated with ACA-driven changes in enrollment
 - New enrollee costs
 - Estimate using CY2010 DSS cost data, trended forward
 - Cost proxies for new enrollees:
 - HUSKY A, Non-elderly Adults
 - Medicaid for Low Income Adults
 - HUSKY B, Band 1
 - HUSKY B, Band 2 (net of enrollee premium payments)

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Medicaid interactions with the Exchange
 - As soon as the Secretary of Health and Human Services certifies that Connecticut's health insurance Exchange is fully operational in 2014, Connecticut may, with CMS approval, modify Medicaid eligibility requirements and transition certain existing non-elderly adult Medicaid enrollees into an HIE plan or a state-optional BHP
 - Exchange subsidies: The law authorizes federal premium and cost-sharing subsidies to individuals who:
 - Have household income between 133% and 400% FPL
 - Are ineligible for Medicaid and CHIP
 - Have not otherwise been offered ESI that meets the ACA's affordability and comprehensiveness standards
 - Premium tax credits and cost-sharing subsidies are only available to individuals who purchase insurance through an Exchange

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Non-elderly Medicaid adults eligible for Exchange subsidies or BHP:
 - Non-elderly Medicaid adults with household incomes greater than 133% FPL could be transitioned to the Exchange or the BHP (for those below 134%–200% FPL)
 - State financial incentive: The Medicaid state share of health care costs is 50%, whereas the federal government will provide sliding scale premium and cost-sharing subsidies to Exchange enrollees without state cost
 - Coverage groups that Connecticut may wish to transition to the Exchange:

Coverage group	Income bands	Preliminary estimate
Parents (HUSKY A)	134% - 185% FPL	16,500
Pregnant women (HUSKY A)	134% - 250% FPL	1,200
Employed disabled (MED-Connect)	Above 134% FPL	1,500
Women with breast or cervical cancer	134% - 400% FPL	150
TOTAL		19,350

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Children's Medicaid and CHIP eligibility requirements:
 - The ACA included a children's eligibility maintenance of effort (MOE) requirement in which states lose access to federal financial participation if their eligibility standards, methodologies or procedures under the state's Medicaid plan (including any waivers) are more restrictive than were in effect as of the date of the law's enactment (March 23, 2010)
 - For any Medicaid-eligible child who is under age 19 (or such higher age as the state may have elected), the MOE requirement continues through September 30, 2019
 - States are also required to maintain CHIP income eligibility standards for children through September 30, 2019 as a condition of receiving Medicaid federal financial participation
 - Implication: Under current federal law, Connecticut may not transition children to the Exchange or BHP until October 1, 2019
 - In the event that federal CHIP appropriations are not made beyond FY2015, states will be required to enroll CHIP children not otherwise eligible for Medicaid into a HIE plan or BHP.

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Children eligible for Exchange subsidies or BHP in 2019:
 - Coverage groups that Connecticut may wish to transition to the Exchange in 2019:

Children's coverage groups	Income bands
HUSKY A	134% - 185% FPL
HUSKY B (Tier 1)	186% - 235% FPL
HUSKY B (Tier 2)	236% - 300% FPL
HUSKY B (Tier 3) (state-only program)	> 300% FPL
TOTAL	

- Population estimates for 2019 are under development

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Policy implications:
 - While most of the costs for newly eligible Medicaid populations will be covered by the federal government, only half of the costs of previously Medicaid-eligible but unenrolled individuals will be covered with federal dollars
 - To offset these new State costs, Connecticut may wish to transition existing non-elderly adult populations to an Exchange plan as early as 2014 and take advantage of federal premium and cost-sharing subsidies
 - Medicaid enrollees transitioned to Exchange plans will likely face higher out-of-pocket expenses than they do on Medicaid
 - Future decisions on children's health insurance programs will be influenced by federal decision-making around CHIP funding beyond federal FY2015 and to what extent MOE requirements remain unchanged before 2019

Task 10 – Medicaid/CHIP impact analysis (cont'd)

- Contents of final Task 10 report:
 - Medicaid and CHIP: Enrollment and cost projections, 2014–2020
 - Newly eligible adults
 - Previously eligible, but unenrolled adults
 - Previously eligible, but unenrolled children
 - Medicaid and CHIP enrollees eligible for Exchange subsidies or BHP, 2014–2020

Questions and answers

Next steps

- December 15 Exchange Board meeting
- Final report

