

# SustiNet: The original policy proposal

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# Topics to discuss

- Context
- Proposal in a nutshell
- More detailed proposal outline

*Note: at the end, appendixes explore:*

- 1) More specifics on intrinsic funding mechanisms;*
- 2) Assumptions behind estimates that SustiNet will slow the growth in health care costs; and*
- 3) More cost and coverage estimates for SustiNet.*

# Context

- Proposal developed over two years
- Discussions with multiple stakeholders—e.g.:
  - ❖ Small business
  - ❖ Physicians
  - ❖ Labor
  - ❖ Consumers
  - ❖ Disease groups
  - ❖ Clergy
  - ❖ Hospitals
- Goals
  - ❖ Cover all residents
  - ❖ Reform health care delivery system to slow cost growth while improving quality

# Theory of change - How to galvanize a more rational delivery system?

- Option 1: Have public sector take over health care. **Not this proposal.**
- Option 2: Use the public sector to facilitate change, without mandating private behavior
  - ❖ Critical mass that makes it feasible for providers to change how they do business
  - ❖ Build provider trust and cooperation by transparent health plan management + a seat at the table for providers
  - ❖ Promote competition and accountability by a pluralistic system of competing health plans + new data requirements

# The proposal in a nutshell

- 1. A new, publicly administered, self-insured plan (SustiNet) covers HUSKY beneficiaries, state employees and retirees, and the uninsured. The plan implements best practices for slowing the growth in health spending while improving quality of care.**
  - ❖ Medicaid/HUSKY reimbursement rises to commercial levels
- 2. Extra choices and better information for the private sector**
  - ❖ SustiNet is a new option for employers and individuals
  - ❖ An independent information clearinghouse provides comparative data about plan cost, quality, and outcomes
- 3. More than a health plan: public health investments slow cost growth and improve health for all residents, including both publicly and privately insured.**
  - ❖ Obesity prevention, tobacco, health care workforce, preventive care

# Proposal outline

- A. SustiNet administration
- B. SustiNet delivery system reform: “Focus on health”
  - 1. Health care delivery system
  - 2. Public health investments
- C. Coverage for everyone
  - 1. SustiNet membership groups
  - 2. Subsidies
- D. Strengthening private choices
  - 1. Employer options
  - 2. Enrollment and marketing
  - 3. Information clearinghouse
  - 4. Transparency and information reforms
- E. Financing

# A. SustiNet administration

# Administrative body

- New, quasi-public authority, using agreements with state agencies
  - ❖ Why? Questions about existing state agencies in CT
  - ❖ Models
    - CHEFA – audit and ethics standards
    - Other states (MRMIB in CA, Connector in MA)
- Governance
  - ❖ Board with stakeholder representation
    - Including physicians, to engender trust and cooperation in making delivery system reforms
- Protecting state employees and retirees
  - ❖ Essential to critical mass needed for delivery system reform
  - ❖ Approach
    - Authorize cost-containment committee to have final jurisdiction over issues that uniquely affect state employees and retirees
    - Explicitly recognize supremacy of collective bargaining
    - Avoid any cost increases or any reductions in covered benefits, provider networks, or access to care

# Plan structure

- Self-insured plan – why?
  - ❖ Transparency
  - ❖ Management capacity
- ASO contractor
  - ❖ Any number possible: 0, 1, >1
- Gain-sharing authorized from plan to provider

# Mid-course corrections possible

- With public notice, but without legislative change, SustiNet Board can:
  - ❖ Change rules if the proposal is unsuccessful in its attempts to prevent the following from becoming serious problems:
    - Adverse selection
    - Crowd-out
    - Inadequate ESI
  - ❖ Modify delivery system to incorporate new research findings
- Annual reports recommend legislative changes to CGA

B. Delivery system reform within the new, SustiNet health plan: “Focus on health”

# Health care delivery system goals

- Change the goal to improving health
  - ❖ Prevention and management of chronic illness
  - ❖ Promote wellness
  - ❖ End racial and ethnic disparities in health care and health outcomes
- How are these goals achieved in SustiNet?
  - ❖ Patient-centered medical home
  - ❖ Health information technology
  - ❖ Evidence-based medicine
  - ❖ Public health investments
  - ❖ Transparency and information reforms
  - ❖ Other methods

# Patient-centered medical home

- Functions
  - ❖ Patient education to better manage their own conditions
  - ❖ Care coordination
  - ❖ 24/7 availability
- Structure in a state with many small practices
  - ❖ Each practice chooses its functions from a menu
  - ❖ Partners vetted by Sustinet perform the remaining functions
    - Community-based nurses, patient educators, social workers
    - Insurers
    - Sustinet staff

# Health information technology

- Make HIT affordable to providers
  - ❖ CHEFA bonding to cover capital costs
  - ❖ Subscriptions, from Sustinet providers and others, covering
    - Hardware and software, including updates, replacements, and digitizing paper files
    - Support for installation, operation, maintenance, customization
  - ❖ Leverage to get good prices on all the above
- Make HIT useful to providers
  - ❖ Platform for integrating data from multiple providers into a single record for each patient (HIE)
  - ❖ Incorporate interface with labs, pharmacies
  - ❖ Financial gain-sharing
- To participate in Sustinet, physicians, hospitals, etc., must implement HIT by a date certain (e.g., 2015)
  - ❖ Need not use state-contracting HIT vendors, but must be interoperable

# Evidence-based medicine, without cookbooks

- Physicians, nurses, other clinicians work with Board to choose from among national/international guidelines
- Encouraged to implement guidelines when reasonable, without lapsing into “cookbook medicine”
  - ❖ Reminders embedded in Electronic Health Records
  - ❖ “Safe harbor” from malpractice liability
  - ❖ Confidential practice profiles, comparisons to peers
- Certify high-quality providers for particular conditions, based on transparent criteria
- Periodic quality reviews

# Public health investments

- Obesity
- Tobacco
- Provider workforce
- Immunizations, screenings at work, school, community

# Other

- Medical home will require new payment modality
  - ❖ Risk-adjusted monthly fee for basic case management
  - ❖ May need supplemental payment for outliers, given
    - Uncertainties surrounding new payment methods
    - Random fluctuations that affect small medical practices
- More broadly, Sustinet can implement new methods of provider reimbursement
  - ❖ Permitted, but not required
  - ❖ Critically important to involve physicians in developing new payment methods

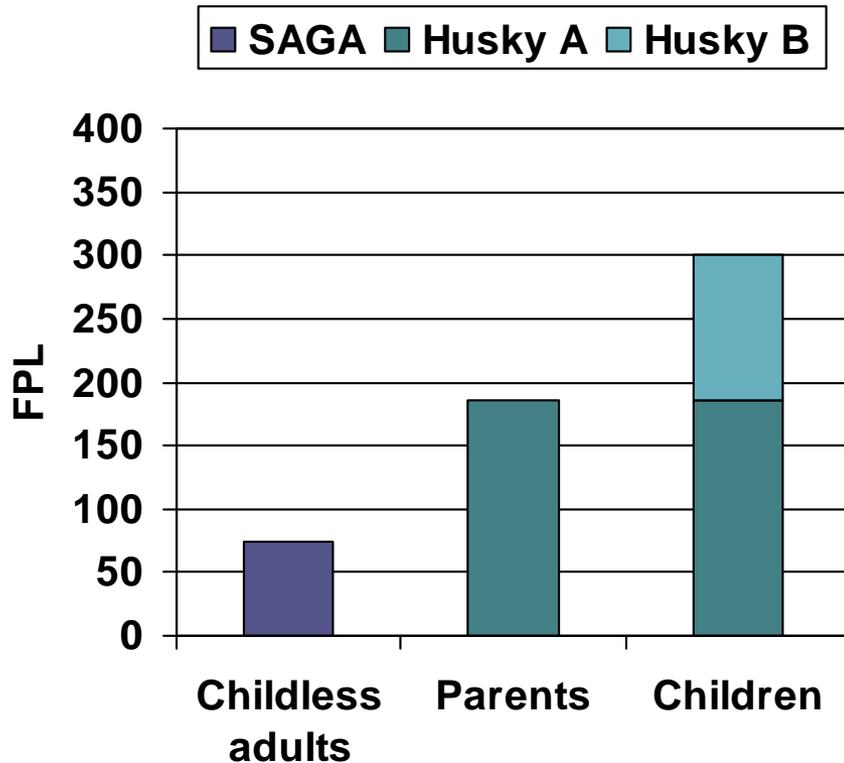
# C. Coverage for everyone

# SustiNet membership groups

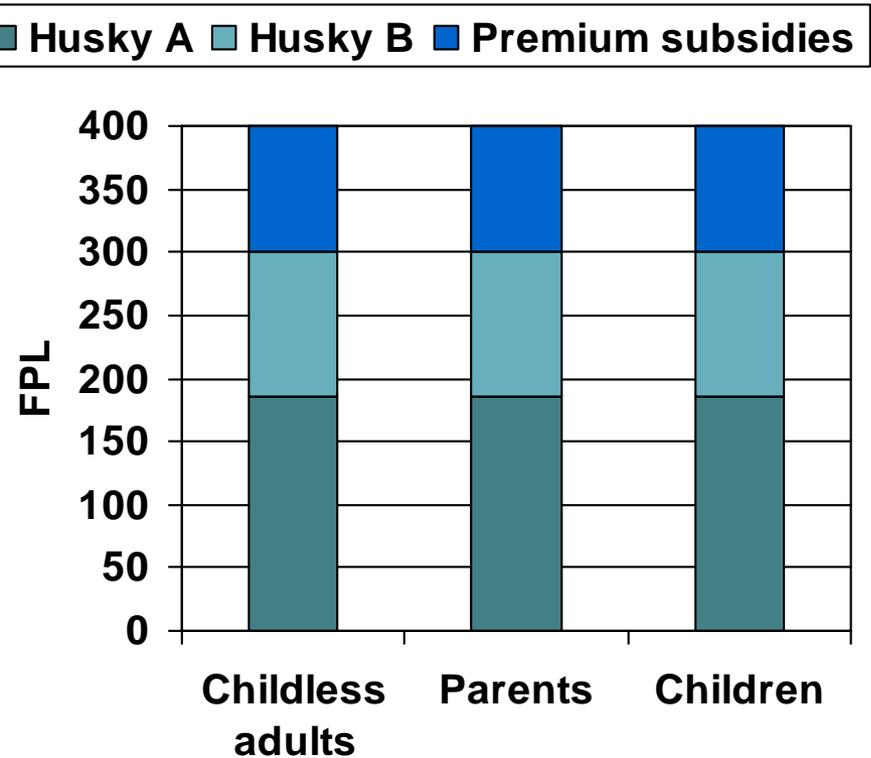
- 1. Consumers not offered employer-sponsored insurance (ESI)**
  - ❖ Premiums charged on sliding scale, based on income, subsidized up to 400% FPL
  - ❖ **“Standard Plan”** with benefits typical of large group plans
- 2. Low-income and high-cost consumers offered ESI that is unaffordable or has inadequate benefits**
  - ❖ **“Standard Plan”**
  - ❖ Current employer dollars move to Sustinet via “voucher payments,” capped at current take-up rates
- 3. Medicaid/HUSKY families**
  - ❖ *No change to Medicaid/HUSKY benefits, cost-sharing*
  - ❖ Increased reimbursement rates reaching, by 2016, average for large-group coverage in CT
  - ❖ HUSKY A includes childless adults up to 185% FPL (no SAGA)
  - ❖ HUSKY B includes adults between 185% and 300% FPL
- 4. State employees/retirees**
  - ❖ *No change to covered benefits, cost-sharing*

# Health coverage subsidies: up to 400% FPL

## Current law



## SustiNet



# D. Strengthening private choices

# New options for individuals and firms

- Employers can purchase Sustinet – **standard plan**
  - ❖ Start with small firms, municipalities, non-profits
  - ❖ Eventually, any employer can purchase
  - ❖ Multiple options can be offered
    - Benefits, cost-sharing
    - Network flexibility
  - ❖ Avoid adverse selection – same rating rules as with other ESI
- Individuals not offered ESI can choose between Sustinet **Standard** and non-group coverage
  - ❖ Non-group market reform – apply small-group rules to:
    - Risk rating
    - Preexisting condition exclusions
  - ❖ Avoid adverse selection by:
    - Same rating rules for unsubsidized Sustinet as for private plans
    - Incentives for early enrollment – premiums increase if enrollment is deferred (Medicare B/D model)

# Enrollment and Marketing

- Auto-enrollment following identification as uninsured
  - ❖ Start school;
  - ❖ File state income tax forms;
  - ❖ Seek health care; etc.
- Individual can “opt out” and remain uninsured
  - ❖ Annual informed consent process
- SustiNet can be marketed through existing channels, including brokers and agents

# Health plan information

- Independent information clearinghouse
  - ❖ Independent of Sustinet
  - ❖ Gathers and reports comprehensive data from state-licensed private plans and Sustinet
  - ❖ Self-insured plans have the option to participate
  - ❖ More informed choices by employers and individuals = better health plan incentives
- Evidence-based benefit packages
  - ❖ Office of Health Care Advocate recommends incentives for adoption

# Other information reforms

- Annual disclosure forms in which SustiNet providers list potential financial conflicts of interest
- Academic counter-detailing from SustiNet consultants provides objective perspectives on drugs and devices being marketed by private companies
  - ❖ SustiNet authorized to provide free samples of generic drugs

# E. Financing

# Intrinsic funding – not enough

- Federal matching funds
- Individual premium payments
- Employer “voucher” payments for workers who shift from ESI to SustiNet
  - ❖ Capped based on average for firm of applicable industry and size
- Shared responsibility payments from medium-sized and larger firms not offering coverage
  - ❖ 4% of payroll above average for 10-person firm (\$318,000 in 2008 dollars)
  - ❖ Employer pays 3%, workers pay 1%

# Upshot for General Fund

- Under current federal matching rules, \$950 million in increased General Fund costs
  - ❖ Approximately half for increased reimbursement rates
  - ❖ Approximately half for more people receiving coverage through:
    - Increased HUSKY eligibility
    - New premium subsidies
    - Increased enrollment by people eligible under current law
- If federal reforms increase federal matching percentages, state costs will decline

# Estimated public sector costs for residents under age 65, FY 2014 (assuming current federal law)

	Federal funding	State general fund spending
Status quo	\$1.46 billion	\$3.01 billion
Proposal	\$2.26 billion	\$3.96 billion
<i>Increase</i>	<i>\$800 million</i>	<i>\$950 million</i>

# Estimated private sector savings for residents under age 65, FY 2014

	Employer spending on health care	Household spending on health care	Total
Status quo	\$11.40 billion	\$7.26 billion	\$18.66 billion
Proposal	\$10.14 billion	\$6.72 billion	\$16.86 billion
<i>Savings</i>	<i>\$1.26 billion</i>	<i>\$540 million</i>	<i>\$1.8 billion</i>

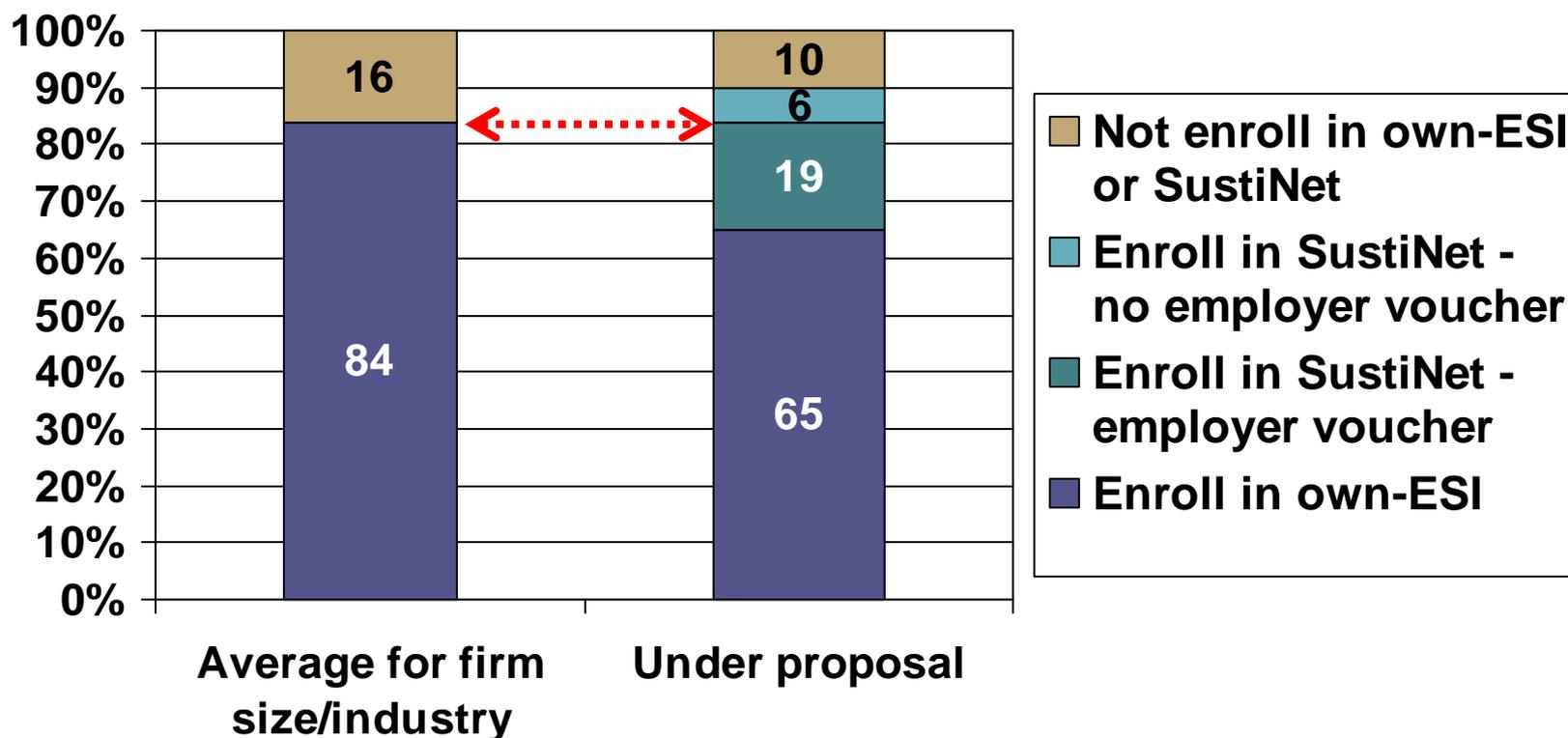
# What does CT get for its \$950 million?

- Reaches universal coverage while delivery system reforms slow cost growth and improve quality
- Current coverage not displaced – but a new option becomes available
- Private savings of \$1.8 billion
  - ❖ Employers and households realize financial gains inside SustiNet because of:
    - Delivery system reforms
    - Lower administrative costs
    - Leverage from large number of covered lives
  - ❖ Lower premiums outside SustiNet, because:
    - Less cost-shifting
    - Private insurers adopt SustiNet's successful innovations
  - ❖ Public health investments slow cost growth both inside and outside SustiNet
- HUSKY payment increases improve access to care
- Public health investments lower costs for all residents

# Appendix I: More specifics on intrinsic funding mechanisms

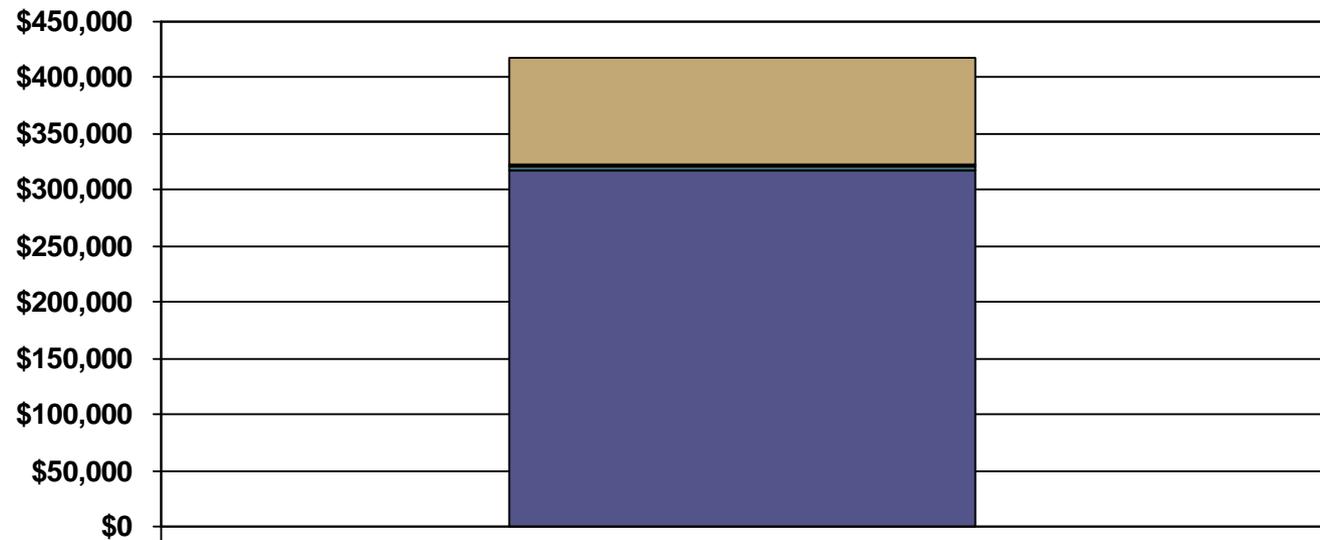
- Employer vouchers; and
- Shared responsibility

# Employer voucher example: Manufacturer with 150 employees



Source: MEPS/IC for manufacturers with 100-999 employees, 2006.

# Shared responsibility example: Firm with 2008 payroll of \$418,000, doesn't offer coverage



■ Remaining payroll	\$96,000
■ Payment from all employees	\$1,000
■ Employer payment	\$3,000
■ No payment required	\$318,000

# Appendix II: assumptions about the proposal's capacity to slow cost growth

- Inside the Sustinet plan; and
- Outside the Sustinet plan

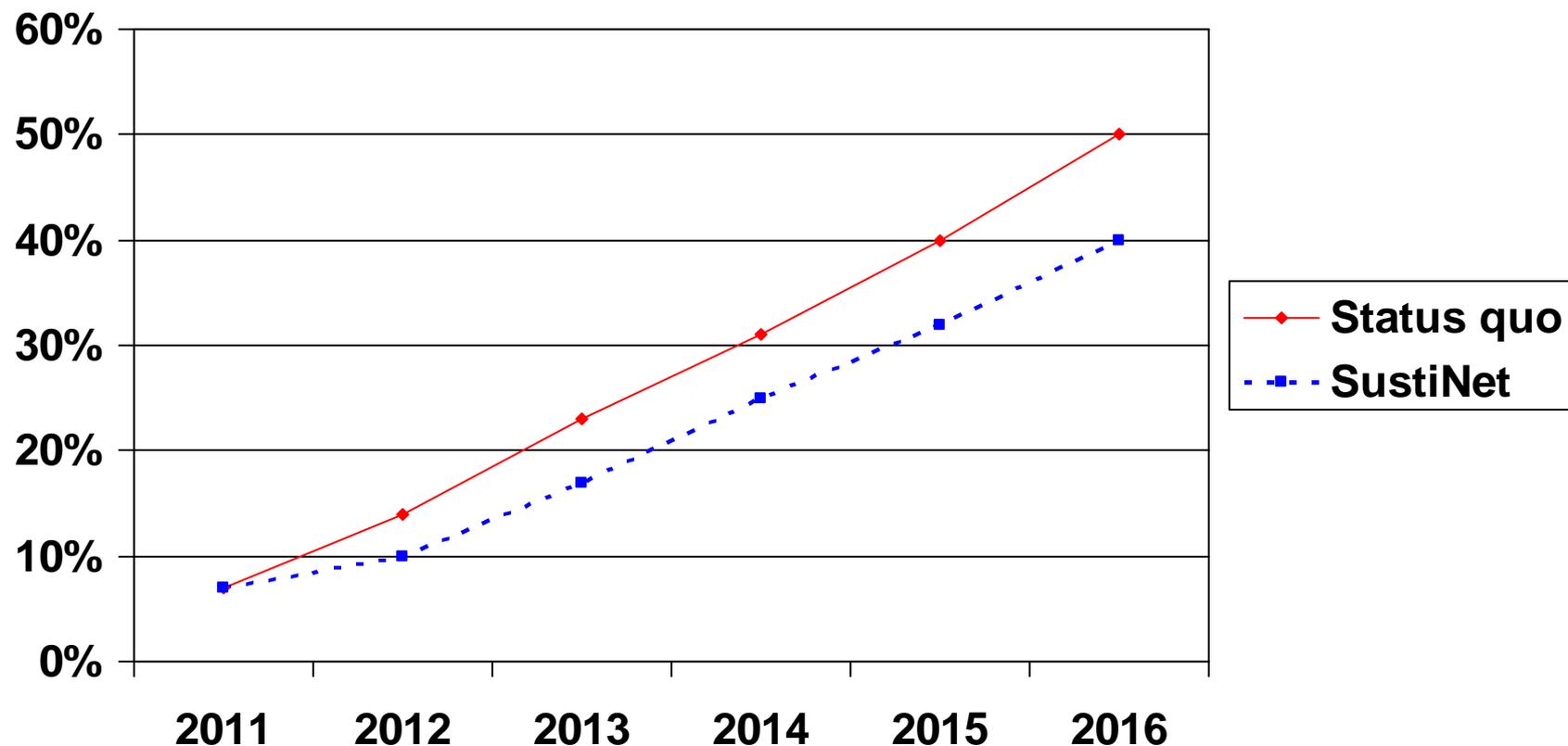
# Examples of where delivery system reform has yielded savings

- Geisinger Health System: implemented a patient-centered medical home, with HIT. Year 1, hospital admissions fell 20%, net spending fell 7%.
- VHA: HIT, medical home model, proactive management. Over 3 years, increased census, improved quality, lowered health spending by nearly \$1 billion.
- SC: FQHCs implemented medical home model. Increased outpatient visits, lowered inpatient utilization. Net savings exceeded \$1,000 per capita.
- NC: Medicaid program implemented medical home. Saved \$60 million in 2003 and \$124 million in 2004.

# Counterexamples abound. Why will SustiNet succeed?

- One reform alone may accomplish little (e.g., a computer on the doctor's desk). SustiNet implements delivery system reforms synergistically.
- Initial focus on the chronically ill.
- Gain-sharing with providers aligns individual and systemic incentives.
- Little churning means SustiNet realizes the financial gains of long-term investments in health.
- Delivery system reforms can be changed, in response to new information, without seeking statutory amendment. For example, new payment methods can be adopted if they prove successful elsewhere. PLUS
- Leverage on prices, from large number of covered lives

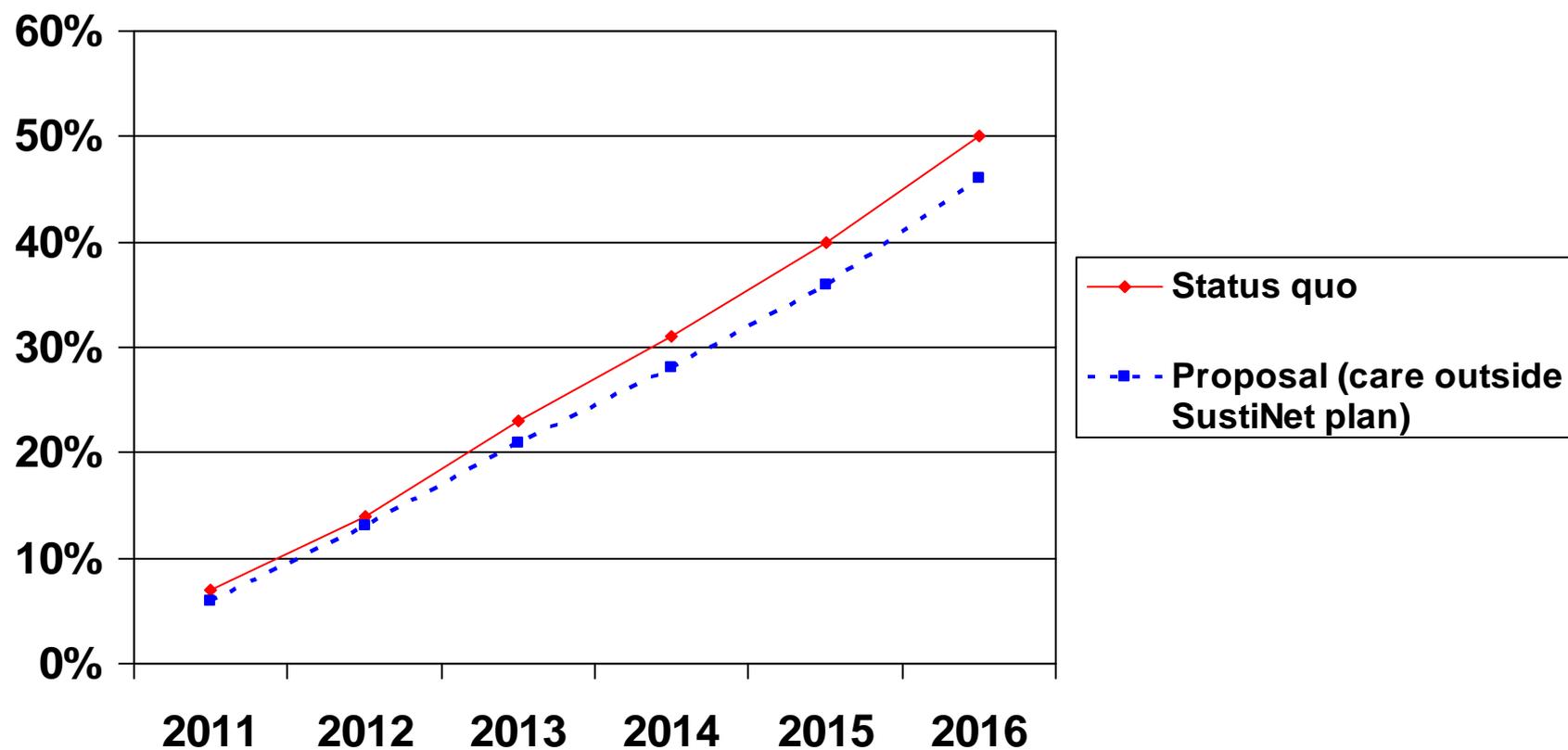
# Increases in per capita health care spending above 2010 levels, status quo vs. SustiNet plan: FY 2011-FY 2016



# How the proposal slows cost growth outside the Sustinet plan

- Less cost-shifting
- If Sustinet delivery system reforms slow cost growth, other insurers will try to do the same to retain market share
- Sustinet's delivery system reforms allow self-insured employers and others to make similar changes
- Initiatives to reduce smoking and obesity slow cost growth for all payor categories

Increases in per capita health care spending above 2010 levels, status quo vs. care outside the Sustinet plan under the proposal: FY 2011-FY 2016

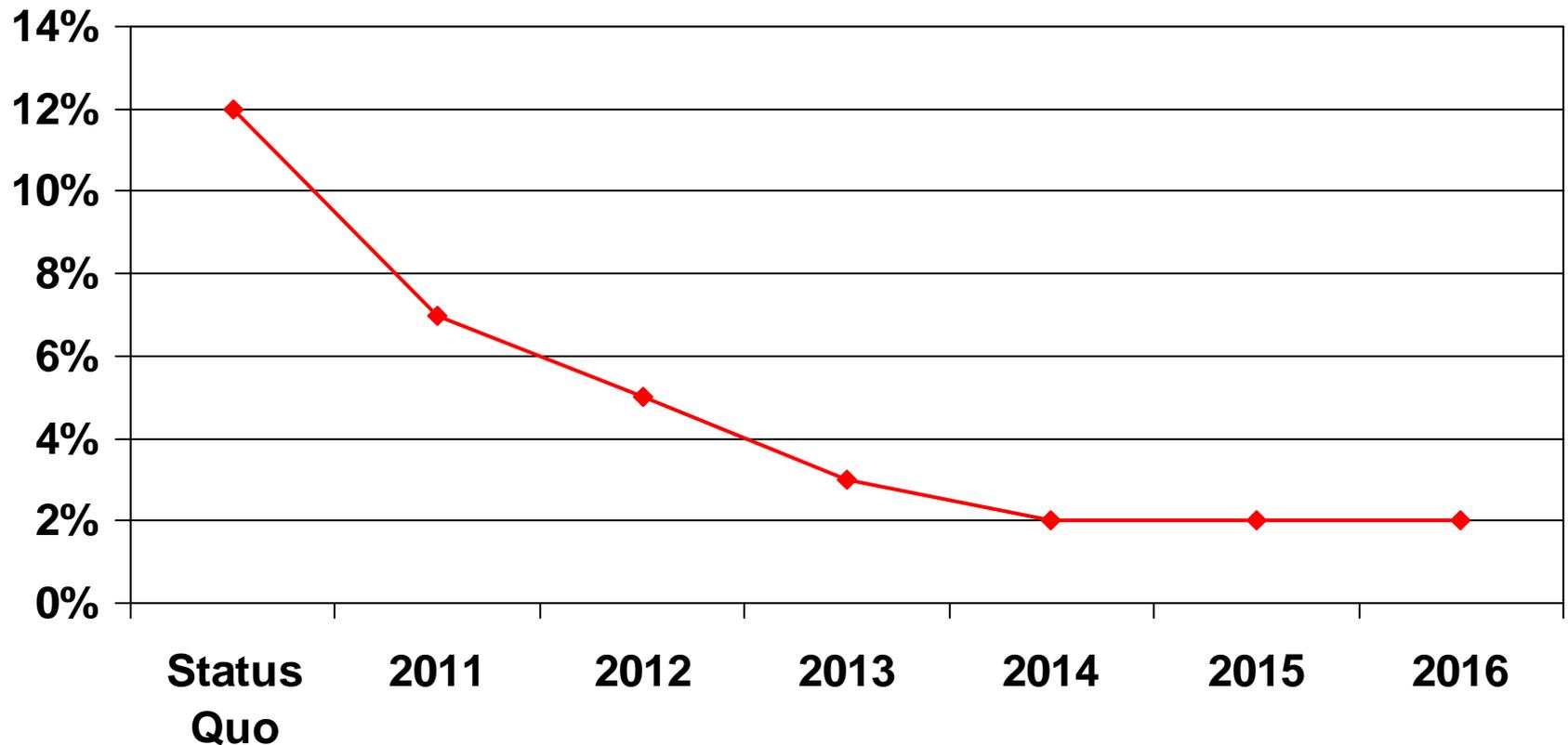


# Appendix III: cost and coverage estimates

Source: Dr. Jonathan Gruber, MIT

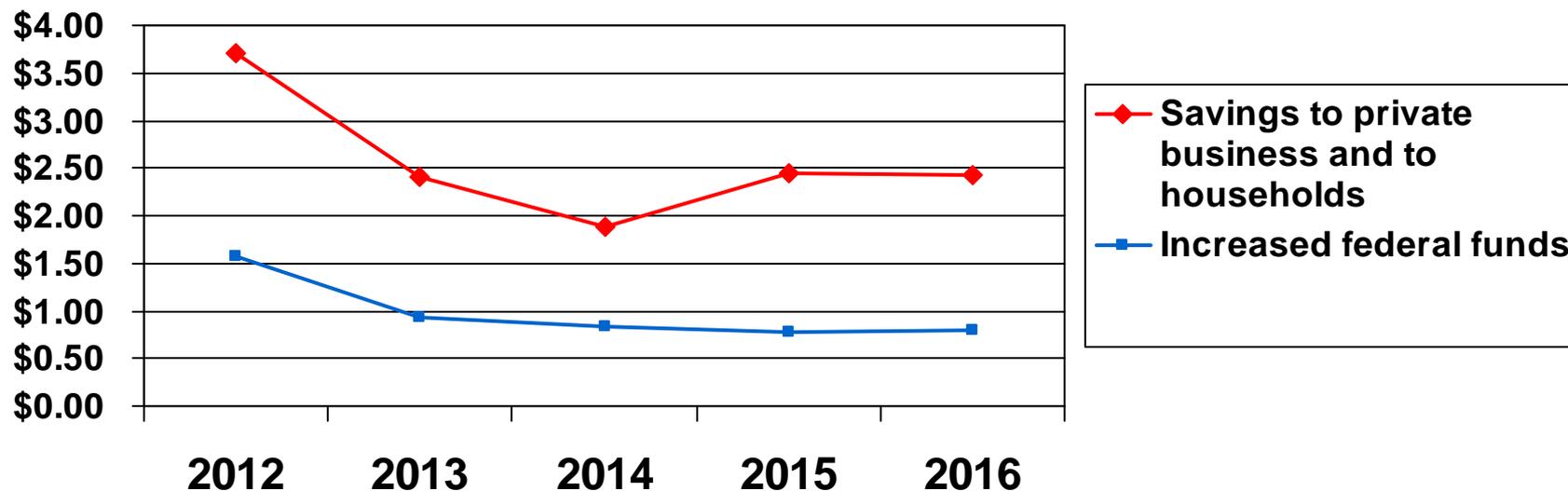
Notes: (1) Costs are stated in 2008 dollars. (2) Estimates assume that, without policy change, CT would have the same coverage as in 2004-2006. That allows the effects of policy change to be seen more clearly. (3) Based on original timeline with start-up in 2011. 2014 chosen for illustrative purposes, representing plan “in full swing.”

# Percentage of residents under age 65 who lack insurance, status quo vs. Sustinet proposal: FY 2011 – FY 2016

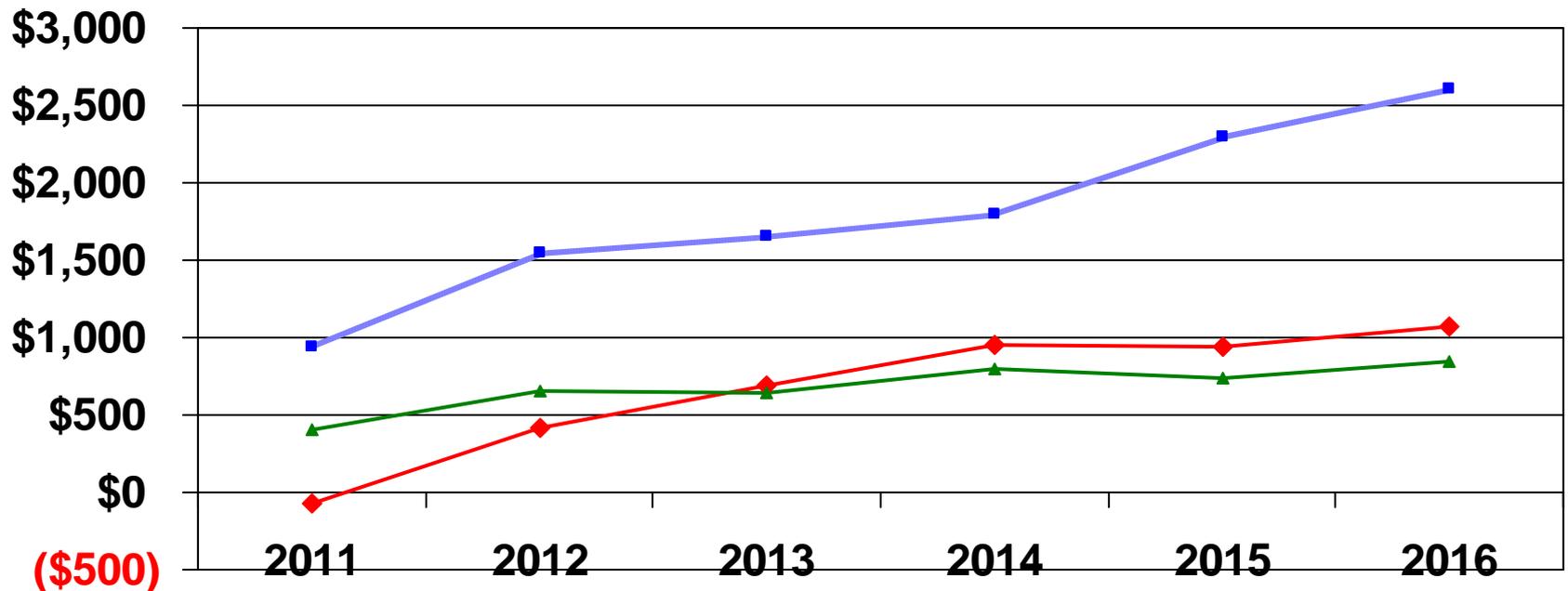


# Financial overview

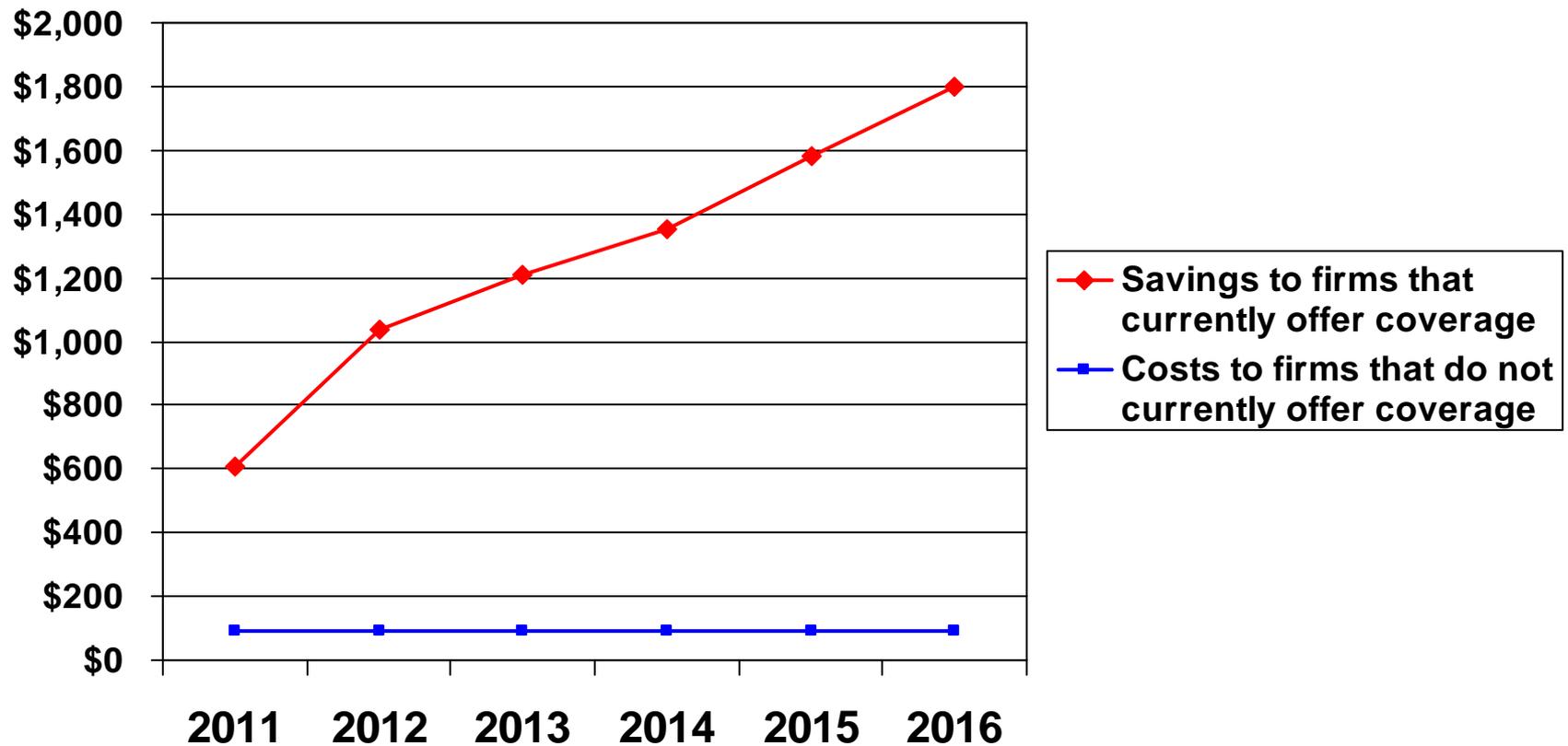
**For each dollar of increased General Fund spending, private-sector savings and increased receipt of federal funds: FY 2012-2016**



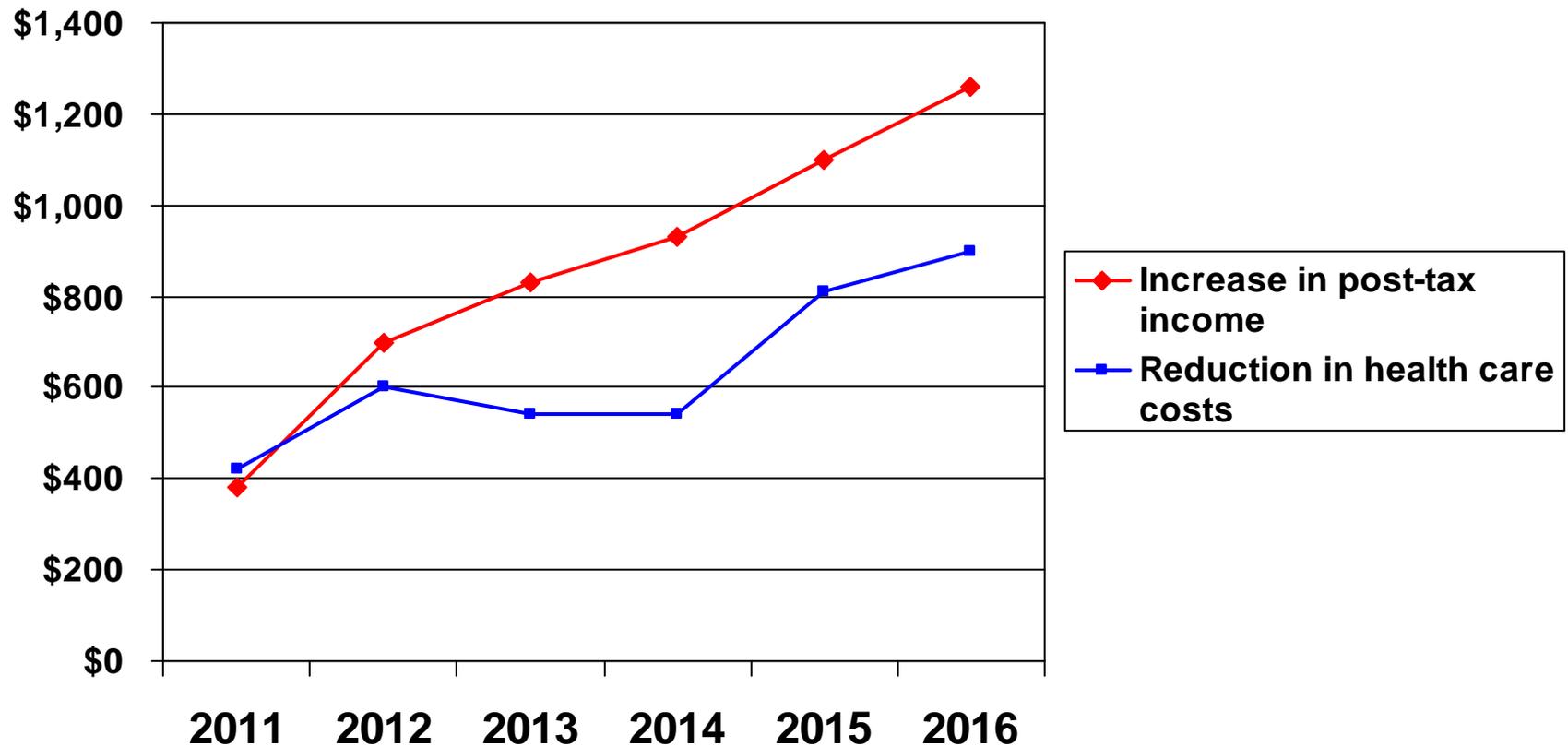
Under Sustinet, projected health care savings for employers and households, increased General Fund costs, and increased federal matching funds: FY 2011 – FY 2016 (millions)



# Estimated impact of proposal on health costs for employers, compared to projections under the status quo: Fiscal Years 2011-2016 (millions)



# Estimated financial impact of proposal on households under age 65, compared to projections for status quo: Fiscal Years 2011-2016 (millions)



# Macroeconomic projection

	2011	2012	2013	2014	2015	2016
<b>Status quo</b>						
Health industry	226	231	235	239	244	248
All other industries	2,058	2,071	2,083	2,098	2,113	2,128
<b>Total employment</b>	<b>2,284</b>	<b>2,301</b>	<b>2,317</b>	<b>2,337</b>	<b>2,357</b>	<b>2,377</b>
<b>Proposal</b>						
Health industry	223	228	233	239	241	246
All other industries	2,060	2,073	2,084	2,100	2,115	2,130
<b>Total employment</b>	<b>2,283</b>	<b>2,302</b>	<b>2,318</b>	<b>2,338</b>	<b>2,356</b>	<b>2,375</b>
<b>Change (number of jobs)</b>						
Health industry	-3	-2	-1	0	-3	-3
All other industries	2	3	2	2	2	2
<b>Total employment</b>	<b>-1</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>-1</b>	<b>-1</b>

Source: REMI macrosimulation model for CT.

# Estimated cost and coverage effects for residents under age 65, FY 2014

	Uninsured	Total health spending	Average spending on each insured person
Status quo	12%	\$23.13 billion	\$9,102
Proposal	2%	\$23.07 billion	\$8,227