DRAFT REPORT TO THE CONNECTICUT GENERAL ASSEMBLY
SUSTINET HEALTH PARTNERSHIP BOARD OF DIRECTORS
December 2010

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Executive Summary

Connecticut residents, businesses, and state government face deep and growing problems with health care and coverage. Costs are rising to unsustainable levels, hundreds of thousands of people lack insurance, quality is inconsistent, purchasers are unsure of the value they receive for their premium dollar, and disparities along racial and ethnic lines affect both health status and access to essential care. If policymakers do nothing and recent trends in Connecticut continue unabated, the end of this decade will see private employers spending $14.8 billion a year on insurance premiums, and nearly 390,000 people will be uninsured.

Fortunately, two developments now put Connecticut's leaders in a strong position to address these longstanding problems, despite the state's daunting budget deficit. First, the federal government passed the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA). Among its features, this legislation offers substantial new federal resources to states that aggressively tackle issues of coverage, cost, and quality. Second, the General Assembly's enactment of 2009 SustiNet legislation laid the foundation for using these new federal resources to effectively tackle the state's health care problems by applying innovative strategies that will place Connecticut in the front ranks of American states.

The 2009 SustiNet legislation embodied a distinctive vision through which uninsured, low-income residents get the help they need to afford coverage, and insurers are no longer permitted to discriminate against consumers with preexisting conditions. At the same time, a new, publicly-administered health plan—dubbed "SustiNet," from the state motto—implements the country's best thinking about how to reform health care delivery to slow cost growth while improving quality. SustiNet begins with existing state-sponsored populations, state employees and retirees as well as Medicaid and HUSKY beneficiaries. SustiNet then becomes a new health coverage option for municipalities, private employers, and families.

To flesh out this vision in detail, the 2009 law established the SustiNet Health Partnership Board of Directors (the Board), requiring the Board to make recommendations for further legislative action. After nineteen open meetings, two public briefings, a legislative briefing, and numerous meetings of advisory committees and task forces staffed by nearly two hundred volunteer citizen/experts, we are proud to present our recommendations to the Connecticut General Assembly and the Governor. Thanks to the Affordable Care Act, the Legislature's vision of SustiNet can now be implemented without increasing state spending. In fact, the combination of federal reforms and our proposal for expanding coverage, slowing cost growth, and improving quality will reduce state budget deficits, according to estimates from Dr. Jonathan Gruber of the Massachusetts Institute of Technology, one of the country's leading health economists.

We recommend a policy change with the following features:

- **The SustiNet health plan will implement delivery system and payment reforms** that move towards a more coordinated, patient-centered, evidence-based approach to health care**.**
- **The plan will be administered by a quasi-governmental agency** governed by a board of directors appointed by the Governor and the Legislature. Initially, staff and administrative support will be provided by the Office of the Comptroller.
- **SustiNet will begin by serving state employees and retirees along with Medicaid and HUSKY beneficiaries,** none of whom will see reduced benefits or increased cost-sharing as

a result of the shift to SustiNet. However, SustiNet's delivery system and payment reforms will immediately seek to achieve savings for state taxpayers while improving quality of care and health outcomes for consumers.

- **SustiNet will become a new health insurance choice for municipalities, private employers, and households.** Connecticut's cities and towns will quickly gain the ability to provide their workers with the same coverage that is currently offered to state employees. SustiNet will then gear up to offer commercial-style coverage to small employers and non-profits, if possible before 2014. Effective on January 1, 2014, when most federal reforms become operational, SustiNet will offer a range of comprehensive, commercial benefit plans to all of the state's employers and households. This coverage will be available both inside and outside Connecticut's new health insurance exchange, established under the ACA.
- **HUSKY will expand to cover all adults with incomes up to 200 percent of the Federal Poverty Level (FPL).** By drawing down the maximum possible amount of federal funding, the state can extend HUSKY's safeguards to additional vulnerable adults while reducing the amount state taxpayers must spend to cover low-income residents.

SustiNet's reforms will spark broader change throughout Connecticut. Leading by example, SustiNet's innovations will make it easier for others to follow a similar path. Our proposal harnesses the power of competition, ensuring that successful reforms implemented by SustiNet will be replicated by private insurers seeking to preserve their market share. SustiNet will work collaboratively to implement multi-payer reforms that help the state's providers give their patients high-value, quality care. And by enrolling a large number of consumers, SustiNet will gain the leverage it needs to reform health care delivery and payment.

Even if these reforms fail to slow health care cost growth, implementing national reform in the way that we propose is still projected to save Connecticut taxpayers between $226 million and $277 million a year, starting in 2014. Savings will result from substituting newly available federal dollars for current state spending on health coverage for low-income residents. And if SustiNet slows cost growth by just one percentage point per year, the state budget will improve by $355 million in 2014, with gains reaching more than $500 million a year, starting in 2019.

To support these efforts, we recommend that the Legislature work with state agency officials to find the resources needed for vigorous campaigns to reduce obesity and tobacco use, improve the state's infrastructure for furnishing preventive care and promoting healthy behaviors, eliminate health-related racial and ethnic disparities, and develop Connecticut's health care workforce. To address the access problems that result from low reimbursement rates for HUSKY providers, we recommend that the state begin with a comprehensive realignment of Medicaid and HUSKY payment, allowing targeted, budget-neutral reimbursement increases that address particularly serious access problems. After that realignment, we urge the Legislature and the Administration to implement a multi-year initiative that gradually raises HUSKY payments to at least Medicare levels.

The baton now passes to the Legislature for further progress down the path it began in 2009. We are confident that 2011 will see Connecticut enact some of America's most thoughtful and strategic health reforms, benefiting the state's taxpayers, employers, and families for years to come.

Background

2009 SustiNet legislation

The SustiNet Health Partnership Board of Directors (the Board) was established in 2009 by the Connecticut General Assembly (Public Act No. 09-148) and tasked with the responsibility of proposing to the Legislature a "SustiNet Plan … designed to (1) improve the health of state residents; (2) improve the quality of health care and access to health care; (3) provide health insurance coverage to Connecticut residents who would otherwise be uninsured; (4) increase the range of health care insurance coverage options available to residents and employers; (5) slow the growth of per capita health care spending both in the short-term and in the long-term; and (6) implement reforms to the health care delivery system that will apply to all SustiNet Plan members…" The 2009 law provided the broad outline for the SustiNet plan, but left many details open. The General Assembly charged the Board with addressing these details, including how to:

- Structure and govern the plan;
- Launch plan operations;
- Integrate SustiNet with existing state coverage programs;
- Equip SustiNet to function effectively and add value within the private insurance marketplace;
- Reduce the number of state residents without insurance coverage; and
- Integrate SustiNet with the structures to be created under federal health care reform.

The General Assembly had a clear vision that SustiNet would offer publicly-sponsored insurance coverage to many Connecticut residents and embed in that insurance coverage health care delivery system reforms that could improve health, reduce disparities, and slow health care cost growth. The goal of this new health insurance option would be to lead by example, implementing the country's best thinking about how to restructure health care delivery and financing.

The work of the SustiNet Board and its committees and task forces

Beginning its work in September 2009, the SustiNet Board is co-chaired by Nancy Wyman, State Comptroller, and Kevin Lembo, State Healthcare Advocate. The Board includes a physician, representatives of allied health professions, organized labor, small business, the faith community, and individuals with expertise in employee benefit plans, health economics, health information technology, actuarial science, and racial and ethnic disparities in health care. As directed in the 2009 legislation, the Board appointed advisory committees related to health disparities and equity, health information technology, patient-centered medical homes, preventive health care, and health care quality and providers, as well as task forces related to the state's health care work force, tobacco use and smoking cessation, and obesity. Embodying an extraordinary breadth of background and expertise, more than 160 Connecticut residents volunteered countless hours to serve on these advisory committees and task forces. Those groups developed detailed recommendations that were communicated to the SustiNet Board and to the General Assembly on July 1, 2010. Their reports were invaluable, and we are grateful for their hard work.

The Board itself has held 19 open meetings, each with advance public notice as well as agendas, background materials, minutes, and presentations posted on the internet. We also held two briefings in which we invited public testimony, and we conducted an additional briefing for state legislators. Dr. Jonathan Gruber of the Massachusetts Institute of Technology (MIT), one of the country's most respected health economists, estimated the cost and coverage effects of policy options under consideration.

Within 60 days of the federal government's enactment of the Patient Protection and Affordable Care Act (the ACA or the Affordable Care Act), we issued a report analyzing the impact of this federal legislation on SustiNet.[1] We noted the many common elements shared by SustiNet and federal reform. At the same time, we raised some important questions for further discussion.

Answering both these and other questions, this final report contains our specific recommendations to the General Assembly on some, but not all, of the issues involved in launching and operating SustiNet. We recommend further analysis to guide decisions on the remaining issues.

The board was assisted by consultants that included, in addition to Jonathan Gruber, Stan Dorn of the Urban Institute, Anya Rader Wallack of Arrowhead Health Analytics, Katharine London of the University of Massachusetts Medical School Center for Health Law and Economics, and Linda Green of Goddard Associates. Their work was funded by the

[1] *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. The report is posted on the SustiNet website, at http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/reports/sustinet_60_day_report_05272010.pdf.

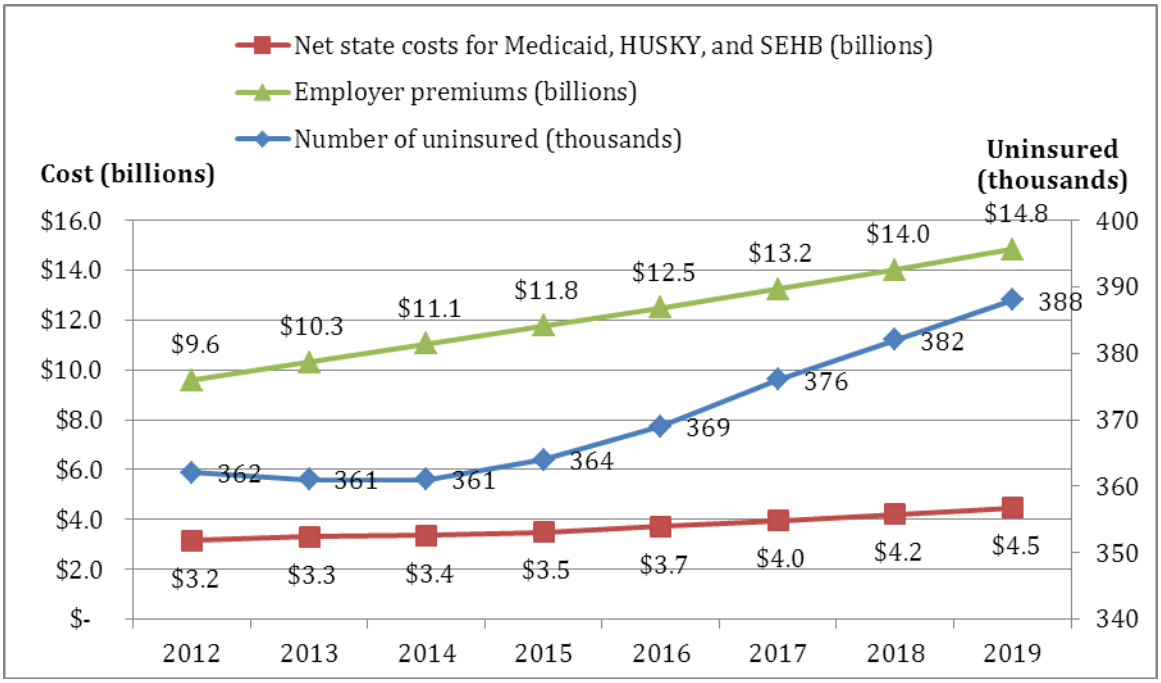
Connecticut Health Foundation, the Jesse B. Cox Charitable Lead Trust, the State Coverage Initiatives program of AcademyHealth, which is a program office of the Robert Wood Johnson Foundation, and the Universal Health Care Foundation of Connecticut. We appreciate the generous financial support of these funders.

Why action is necessary

SustiNet was conceived in the context of an ever-worsening health care cost and access crisis. Employers cannot afford double-digit health care cost increases even when economic growth is hardy, much less when it is negligible. State governments, including Connecticut's, likewise are struggling under the weight of burgeoning costs for Medicaid and coverage for state employees and retirees. At the same time, the number of uninsured residents, in Connecticut and elsewhere, has steadily increased, in good economic times and bad. If recent trends continue, by the end of this decade, among Connecticut residents under age 65:

- Nearly 390,000 people will be uninsured;
- Net state costs for Medicaid, HUSKY, and state employee/retiree insurance will climb from $3.2 billion in 2012 to $4.5 billion in 2019; and
- Premiums for private employers will increase from $9.6 billion a year in 2012 to $14.8 billion (Figure 1)—a 55 percent rise.

Figure 1. Projected number of uninsured, net state health coverage costs, and private employer premiums for Connecticut residents under age 65: 2012-2019, without reform



Source: Gruber Microsimulation Model 2010. *Notes*: State costs are limited to net General Fund outlays. They do not include federal matching funds that are subject to the state's spending cap. "SEHB" refers to state employee and retiree coverage. All costs are limited to residents under age 65. Costs are shown in 2010 dollars.

These problems are not unique to Connecticut, of course. But given the resources and talent in this state, the Board believes that Connecticut can and should be a national leader in providing consumers with high quality, affordable health coverage. To achieve this goal, state government's health care functions need to be reorganized and refocused. Our vision is that SustiNet will help lead the way, galvanizing the state's efforts to become a national frontrunner reforming health care to slow cost growth, improve quality, and make affordable, high-quality coverage available to all.

Counting both federal and state dollars, and including services provided to residents of all ages, Connecticut state government currently directs approximately $8 billion a year that is spent to cover state employees and retirees, public program beneficiaries, and the incarcerated. By improving how we manage these funds and the coverage we provide, fully implementing federal health care reform and making SustiNet broadly available, we can achieve several goals:

1. Slowing the growth of public and private health care spending in Connecticut;
2. Ensuring that all residents have access to affordable, high-quality, comprehensive coverage;

3. Implementing delivery system and payment reforms that will benefit all residents of the state;
4. Providing Connecticut's employers and families with a new health plan option—namely, an independent, transparently managed plan for Connecticut consumers, health care providers, and employers;
5. Improving access to care among low-income residents; and
6. Reducing racial and ethnic disparities related to health care access and quality.

Like nearly all states, Connecticut is suffering under tremendous fiscal stress. It is our belief that we can and should achieve SustiNet's goals without calling for substantial new infusions of General Fund dollars. This can be done by making prudent investments that reap both short- and long-term dividends, maximizing the state's utilization of available federal resources, and carefully managing the state's health care expenditures.

How this report is organized

The body of this report covers the following topics:

- Key features of federal health care reform;
- Our findings and general recommendations;
- The coverage and cost effects of our recommended policy direction, based on the research conducted by Dr. Gruber;
- Our policy recommendations in detail; and
- Our suggested timeline for implementation.

The appendix to this report includes a "cross-walk" comparing our recommendations to the relevant provisions of the 2009 SustiNet law; a brief description of the model Dr. Gruber used to project cost and coverage effects;[2] and the full recommendations of the board's advisory committees and task forces.

Federal Health Care Reform

SustiNet was envisioned prior to the passage of the ACA, but state legislators were well aware in 2009 that federal legislative efforts were under way. SustiNet's goals and structure are thus consistent with the framework established by the ACA.

The ACA allows each state to either create a state-based health insurance exchange or join a federal exchange. Beginning on January 1, 2014, the exchange will facilitate comparison-shopping for health insurance. New federal subsidies will be offered to low-income individuals who purchase insurance through the exchange. Further, Medicaid coverage of

[2] A more comprehensive description of Dr. Gruber's model is posted on the Board's website, at http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/resources/grubermodellongerdescription.pdf.

adults will expand to 138 percent of the federal poverty level (FPL).[3] During 2014-2016, the federal government will pay all the costs of covering newly eligible adults. Beginning in 2017, the federal share of their costs will begin falling, reaching 90 percent in 2020 and staying at that level thereafter.

As explained in our earlier report, the General Assembly's 2009 vision of a substantial increase in coverage, accompanied by a new, publicly administered health insurance option offered to the state's residents and employers, can now be implemented more effectively and with much more favorable fiscal effects than was anticipated in 2009. The combination of newly available federal funds and the potential impact of delivery system and payment reforms could allow substantial savings to the state General Fund, as we explain later.

Our Findings and Central Recommendations

The Board organized its effort to understand options for SustiNet design into six major subject areas: covered populations; covered benefits; delivery system and payment reform; governance and administration; expanding coverage and access to care; and public health investments. We conducted major policy meetings to examine each subject area, at which our consultants outlined policy options and applicable trade-offs.

In this section, we outline, as to each subject, the policy options we considered and our central recommendations. Our full recommendations are detailed in a later portion of the report.

Covered populations

> "SustiNet represents a unique opportunity to develop and nurture a coordinated cost effective health care delivery system for the state. …..all possible efforts should be made to assure its success and move it forward."
> *SustiNet Board Member*

We envision that the SustiNet health plan will provide a common platform for reforming health care delivery and payment. The plan will begin by covering those for whom the state is currently responsible—that is, state employees and retirees as well as Medicaid and HUSKY beneficiaries. The initial focus of our recommended proposal will thus involve slowing cost growth, rather than expanding coverage. However, as eligibility for Medicaid and HUSKY expands, so too will SustiNet enrollment.

[3] Medicaid will expand to individuals with incomes up to 133 percent FPL. However, in calculating income, 5 FPL percentage points will be subtracted from Modified Adjusted Gross Income. Accordingly, as a practical matter, Medicaid coverage will reach 138 percent FPL.

As an interim step in moving beyond state-sponsored populations, SustiNet will be offered as an option for small firms, municipalities, and non-profit corporations. Municipalities would be the first employer group outside state agencies to gain access to SustiNet, allowing cities and towns to purchase the same coverage received by state employees and retirees, benefiting from economies of scale and leverage already exerted by state government. We recognize that gearing up to offer commercial coverage in the market may not be a quick and easy task. Accordingly, we recommend that SustiNet's governing entity should move forward as feasible during the interim stage before 2014, without statutorily imposed deadlines.

By contrast, we recommend that the Legislature create a clear statutory deadline for the final stage of offering SustiNet as an option to all Connecticut employers and residents outside state government. Under our suggested approach, SustiNet will be available for any state resident or employer to purchase beginning on January 1, 2014—the date when the main provisions of the Affordable Care Act go into effect, including operation of the health insurance exchange. Under our proposal, SustiNet would be offered both inside and outside Connecticut's exchange.[4]

In serving employers and individuals outside the ambit of state government, SustiNet would offer the option of commercial-style benefits, as explained below. SustiNet would need to meet legal standards that apply to commercial coverage, including benefit requirements under state and federal law. To prevent SustiNet from becoming a magnet for high-risk enrollees, it would need to follow the same rules that apply to other plans in the applicable market, whether group or individual, including rules that govern premium variation. With public and private employers large enough to self-insure, SustiNet would need to avoid such adverse selection through steps that could include experience-rating premiums.

Of course, we understand that work will be required before offering commercial coverage. A state insurance license will be needed to offer coverage in the exchange, for example, but we are convinced that this should not be an insuperable obstacle. Publicly administered health plans at the county level in California have operated with insurance licenses for many years, even though capital requirements for licensure are much higher in that state than here. And SustiNet will need to develop a business plan, with a feasibility study, to ensure that it offers a competitive option that adds value, compared to other choices available to firms and individuals. For SustiNet to commit to this work and succeed, we believe the Legislature's needs to lay down a clear marker in statute.

[4] Perhaps the most important reason to offer SustiNet outside the exchange is that adverse selection by large employers can be prevented more effectively than inside the exchange.

Table 1. Provisions of SustiNet Law Regarding Populations in SustiNet

Population	Date of potential coverage in SustiNet	Board may or shall develop recommendations	Restrictions or other specifications
State employees, retirees and dependents	Not specified	may	Any changes in benefits subject to collective bargaining agreements
Non-state public employees	On or after July 1, 2012	may	
HUSKY Plan Part A and B	Not specified	shall	
Medicaid	Not specified	shall	
Enrollees in state-administered general assistance (SAGA) programs	Not specified	shall	
State residents not offered ESI and not eligible for Medicaid, HUSKY or SAGA	On or after July 1, 2012	shall	Premium variation limited to that allowed under small group law
Employer groups	On or after July 1, 2012, for small firms No date specified for larger firms	shall	
State residents offered ESI, whose incomes are below 400% FPL	Not specified	shall	The board may recommend mechanism for collecting payments from employers

Coordinating the design of health insurance coverage and procurement of services across these populations offers many potential advantages, including the following:

- When applied to a larger population, coordinated efforts at delivery system and payment reform can have a greater influence on provider behavior and diffusion of innovation ;
- A larger population may give the state added leverage to lower prices for goods and services; and

- The system will be simplified for both providers and consumers if reforms are consistent across multiple populations.

On the other hand, there are major differences between the potential SustiNet populations, including their covered benefits, health care needs, and applicable legal requirements. Connecticut's Medicaid and HUSKY programs cover in excess of 530,000 people, more than half of whom are children.[5] Medicaid benefits, cost-sharing, eligibility, and administration are governed by federal statutes and regulations as well as the decisions of the Centers for Medicare and Medicaid Services (CMS). Medicaid is also shaped by Connecticut statutes and judicial decisions that interpret both federal and state law.

The State Employees Health Plan (SEHP) covers about 200,000 active employees and their dependents, as well as 40,000 retirees. This coverage is governed by collective bargaining agreements between the state and public employee unions.

When SustiNet becomes an option in the group and individual markets, which currently includes approximately 2.1 million and 150,000 non-elderly residents, respectively,[6] the above constraints will not apply. SustiNet will still need to follow applicable state and federal laws, however, including state benefit requirements.

The board considered a range of options for integrating SustiNet populations. We learned about examples from other states, including Washington and Massachusetts, where joint procurement processes are in place for multiple state-covered populations.

The board also considered the advice of our Advisory Committees on the issue of integration, which included the following recommendations:

- SustiNet should use common quality measurement, payment innovations, public health initiatives, and delivery system reforms across all populations, to the greatest extent possible, to achieve maximum impact.
- SustiNet should pursue an integrated approach to reducing or eliminating health disparities across all populations.

Put simply, much of the coverage received by these different groups will continue to differ under SustiNet, including applicable legal requirements, funding sources, population characteristics, provider networks and reimbursement levels, cost-sharing, and covered benefits. At the same time, key elements of health care delivery can and, in our view, should be addressed using a

[5] In Federal Fiscal Year 2007, 530,000 Connecticut residents received Medicaid and CHIP, of whom 52.7 percent were children, according to Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on 2010 data from Medicaid Statistical Information System reports from CMS. From June 2007 through June 2009, total Medicaid and CHIP enrollment increased by more than 14 percent in Connecticut, according to data compiled in 2010 by the Health Management Associates from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured.

[6] The Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, *December 2010* (state data for 2008-2009).

common platform across all of SustiNet's membership groups. As later sections of this report will make clear, this common platform will seek to add value and slow cost growth for both publicly and privately funded health coverage alike.

BOARD RECOMMENDATION:

We recommend that the future SustiNet governing board (which will be described later) should immediately begin working with the State Comptroller and the Department of Social Services to reform health care delivery and payment for state employees and retirees as well as individuals receiving coverage under Medicaid and HUSKY.

We further recommend that the SustiNet governing Board should take all necessary actions (which may include conducting a feasibility study, developing financial projections, and obtaining a state license as an insurance carrier) to offer a SustiNet health insurance plan as an option for employers and individuals to purchase, as follows:

- Beginning as soon as possible, SustiNet should be offered to Connecticut municipalities, allowing them to purchase the same coverage that state employees and retirees receive.
- To the extent feasible before 2014, SustiNet should be offered to other employers, with a special focus on small firms and non-profit corporations.
- Beginning on January 1, 2014, SustiNet should be offered to all employers and individuals, both inside and outside the health insurance exchange.

In offering this coverage, every effort should be made to coordinate the design, delivery and administration of benefits to maximize the positive impact of SustiNet on:

- Leveraging delivery system and payment reforms;
- Slowing health care cost growth;
- Simplifying administration;
- Improving health care quality; and
- Reducing racial and ethnic disparities.

Benefits

The board examined benefits currently provided to groups intended for inclusion in SustiNet. We also examined the extent to which covered benefits and benefit design in current programs reflect the cutting-edge of value-based benefit design and prevention and thereby provide a foundation for cost containment and quality improvement. In addition, we reviewed the SustiNet law, which requires:

- SustiNet coverage of 15 service categories;[7]

[7] Section 1(2)(A) of the 2009 SustiNet law required "coverage of medical home services; inpatient and outpatient hospital care; generic and name-brand prescription drugs; laboratory and x-ray services; durable medical equipment; speech, physical and occupational therapy; home health care; vision care family planning; emergency transportation; hospice; prosthetics; podiatry; short-term rehabilitation; the

- SustiNet compliance with all applicable state coverage and utilization review mandates;
- No copayments for preventive care;
- Behavioral health parity;
- Dental coverage comparable to that offered by large employers; and
- Compliance with collective bargaining agreements for state employee and retiree coverage.

Lastly, we reviewed benefit requirements under the federal Affordable Care Act, which include:

- An "essential benefits" standard, including various specified services,[8] to be set by the U.S. Department of Health and Human Services based on "typical employer coverage;"
- A prohibition on lifetime and (beginning in 2014) annual coverage limits;
- A requirement that plans be offered in the state Exchange at 60, 70 and 80 percent of the actuarial value of the essential benefits standard;[9]
- Limits on out-of-pocket expenditures; and
- Required coverage of preventive services with no out-of-pocket cost-sharing.

We found that current covered benefits for Medicaid and state employees are comprehensive in scope. Both include services like those required under the SustiNet law and the federal ACA, and both limit or bar cost-sharing for preventive services.

We found, however, that neither the SEHP nor Medicaid covers tobacco cessation, nutritional counseling, or wellness programs, all of which were recommended by our Preventive Care Advisory Committee and the Obesity and Tobacco Cessation Task Forces.[10]

Table 2 compares benefits currently offered to potential SustiNet groups.

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identification and treatment of developmental delays from birth through age three; and wellness programs, provided convincing scientific evidence demonstrates that such programs are effective in reducing the severity or incidence of chronic disease."

[8] Service categories include ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care. ACA §1302(b)(1).

[9] This means that, for the average enrollee, health insurance will pay the listed percentage of all health care costs included within essential benefits.

[10] However, SEHP covers associated office visits, prescription drugs, lab tests, and other services.

Table 2. Covered benefits and cost-sharing for selected coverage categories

	Selected Covered Services in Sustinet Plans					
	Sustinet Act	**Husky A and Medicaid**	**Husky B**	**Charter Oak Plan**	**State Employees & Retirees (in-network care)**	**Municipal Employee HIP**
Preventive Care	✓	✓	✓	✓	✓$	✓$
Outpatient Physician Visits	✓	✓	✓$	✓$	✓$	✓$
Lab and Diagnostic X-Ray	✓	✓	✓	✓#	✓	✓$
Inpatient Hospital	✓	✓	✓	✓#	✓	✓
Emergency Department without Inpatient Admission	✓	✓	✓$	✓$	✓	✓$
Rehabilitation	✓	✓	✓	✓$	✓	✓$
Home Health	✓	✓	✓	O	✓	✓$
Prescription Drugs	✓	✓	✓$	✓$	✓$	✓$
Behavioral Health Inpatient	✓	✓	✓	✓$	✓	✓$
Behavioral Health Outpatient	✓	✓	✓	✓$	✓$	✓$
Substance Abuse Inpatient	✓	✓	✓	✓$	✓	✓$
Substance Abuse Outpatient	✓	✓	✓	✓$	✓$	✓$
Dental Services	✓	✓	✓	O	✓#	O
Eye Exams	✓	✓	✓$	O	✓$	✓$
Tobacco Cessation	✓	O	O	O	O	O
Nutritional Counseling for Obesity	✓	O	O	O	O	O
Wellness Programs	✓	O	O	O	O	O

Notes: The Sustinet Act requires copays on some services, forbids them on others, and is silent on others. The law also requires establishing an out-of-pocket maximum.

Key:

✓	Covered Service
✓$	Covered Service with a copay
✓#	Covered Service with co-insurance (and sometimes deductibles)
O	Not covered

BOARD RECOMMENDATION:

In general, we reaffirm the direction given to us in the SustiNet law: benefits under SustiNet should be comprehensive, emphasize prevention, and integrate physical and behavioral health.

In serving existing state-sponsored membership groups—namely, state employees and retirees as well as beneficiaries of Medicaid and HUSKY, including those who qualify for the expanded coverage described later in this report—SustiNet would not change covered benefits, premiums, or out-of-pocket costs. Current consumer safeguards should likewise continue to apply, including such things as Medicaid appeals and the role of the Cost Containment Committee in overseeing collectively bargained benefits for state employees and retirees.

We recommend that insurance plans for the commercial marketplace be approached quite differently. In that context, the SustiNet board should ensure that plan designs:

a. Offer a variety of benefits and out-of-pocket costs, with each package providing comprehensive, commercial-style benefits, including dental care and parity of coverage for physical and mental health conditions.

b. Include, to the maximum feasible extent consistent with commercial viability, patient-centered medical homes, integration of medical/behavioral health care, an emphasis on prevention, encouraging individual responsibility for controllable health risks, and other design features that make SustiNet stand out as a high-quality option that is attractive in the marketplace.

c. Include cost-effective preventive services that address physiological, emotional, mental, and developmental conditions for members throughout their life span from birth to the end of life. SustiNet should review and periodically revise the set of covered preventive care services based on the most current and reliable evidence available, including the success of the SustiNet Plan's prevention initiatives.

In offering commercial coverage that is financed entirely by premium payments and federal tax credits, without any state General Fund dollars, we believe the SustiNet board should have the flexibility to change benefits and cost-sharing arrangements over time, within the constraints of applicable state and federal laws, including state benefit mandates, and based on evidence about the most effective benefit designs, categories of covered services, and cost-sharing arrangements.

We further recommend that the design of SustiNet benefits:

- Encourages personal responsibility for controllable health risks, while providing the support that consumers need to exercise responsibility effectively; and
- Promotes reductions in health disparities.

Delivery system and payment reform

> "If we can make CT a healthier place we are all saving money and having a better quality of life."
> SustiNet Board Member

The SustiNet law emphasized three central components of delivery system reform:

- Patient-centered medical homes (PCMH) that combine a designated source of primary care with three additional functions: care coordination, patient education, and enhanced access to medical consultation outside the office;
- Health information technology (HIT) that supports cost and quality management; and
- Incentives for providers to practice evidence-based medicine.

The board reviewed the evidence that each of these initiatives would improve quality and control cost growth. We also reviewed the recommendations of our Patient-Centered Medical Home Advisory Committee, our Provider and Quality Advisory Committee and our Health Information Technology Advisory Committee. Lastly, we examined federal efforts to encourage and finance these reforms.

Our Advisory Committees and Task Forces supported implementation of the PCMH model through SustiNet, which builds on work already under way with HUSKY's Primary Care Case Management (PCCM) Program as well as a multi-payer pilot project led by the Comptroller. They recommended that PCMHs eventually be required to meet nationally promulgated accreditation or certification standards. However, primary care clinicians should not be required to provide all services directly in the office, according to our committees. In particular, small practices could share support services to meet PCMH standards. For example, the ACA authorizes funding for community health teams to perform functions that might not be undertaken within a one- or two-physician office. Our PCMH Advisory Committee further recommended that SustiNet create a "learning collaborative" through which practices could support each other in becoming medical homes—a strategy that also may be supported by the ACA. Federal legislation further permits states, beginning in 2011, to provide chronically ill Medicaid beneficiaries with PCMH services, with a 90 percent federal match rate applying to the first 8 calendar quarters. The ACA appropriated $25 million in state planning grants for such an initiative, available in 2011.

We also learned that efforts to develop coordinated, multi-payer reforms can be hindered by federal anti-trust law. To overcome those barriers, a regulatory program supervised by the State of Connecticut can be established to permit and encourage cooperative agreements between hospitals, health care purchasers, or other health care providers. Such a program is allowed when the benefits outweigh the disadvantages caused by potential adverse effects on competition.

We likewise found that there is a significant federal effort underway to coordinate and

finance the implementation of electronic medical records (EMRs) and interoperable electronic health records (EHRs) in medical practices. Connecticut has created Health Information Technology Exchange of Connecticut (HITECT) to oversee the state's efforts to meet federal requirements and maximize federal support. In addition, Connecticut has received a grant to support a regional extension center that will provide support and training to practices implementing EMRs. Our HIT Advisory Committee recommended that SustiNet leverage these efforts, rather than undertaking new efforts to encourage HIT diffusion. Our Committee further recommended formal representation of SustiNet on the HITECT Board. It also recommended that SustiNet influence the requirements established for EMRs in Connecticut to assure that systems employed meet basic analytic needs and capture race and ethnicity data that will allow for ongoing measurement of health disparities.

The Provider and Quality Advisory Committee supported the use of evidence-based standards of care in practices serving SustiNet members, applying in Connecticut guidelines that have already been promulgated by national and international authorities. The committee also supported payment reform that promotes provider accountability for costs, reduces unnecessary care, and provides incentives for improving quality and reducing disparities.

We found that use of each of these interventions (PCMH, HIT, evidence-based care guidelines, and payment reform) is limited in Connecticut at present, and SustiNet could play a key role in providing leadership for expanding these reform efforts. The State Employees Health Plan currently has a large-scale pilot program underway for implementation of the PCMH, as noted above. This is an example of the kind of leadership SustiNet could provide on a wider variety of delivery system and payment reforms, for a larger population.

BOARD RECOMMENDATION:

We recommend that SustiNet:

- Strongly encourage and provide incentives and technical and other assistance for SustiNet providers to implement patient-centered medical homes.
- In appropriate areas, implement alternatives to fee-for-service provider payment that encourage the provision of care that improves health. Such payment mechanisms could include- pay-for-performance, bundled payments, global payments, or other innovations that are supported by emerging research.
- Provide incentives for evidence-based care that encourage providers to follow evidence-based clinical guidelines. Such encouragement should be carefully structured to preserve clinicians' ability to provide patients with care that meets their individual needs, even when such personalized care goes outside approved clinical guidelines.
- Establish a Pay for Performance system to reward providers for improvements in health care quality and safety and reductions in racial and ethnic disparities in health access, utilization, quality of care and health outcomes.

- Encourage, support, and eventually require SustiNet providers to use interoperable, EHRs to document and manage care.
- Integrate strategies for reducing and eliminating racial and ethnic disparities into every component of the SustiNet plan.
- Take all steps necessary to collect and publish provider price information that will help consumers make informed choices.

In addition, we recommend that the Legislature establish convener authority, consistent with state and federal anti-trust law, which will allow collaboration among multiple payers and providers in developing and applying payment and delivery system innovations.

Governance and administration

> "Plan credibility and financial integrity are key issues that must be addressed as we move forward in developing the Sustinet plan."
> SustiNet Board Member

The board considered several core questions related to governance and administration of the SustiNet plan, including the following:

- How should SustiNet relate to existing state agencies?
- What governance structure is most appropriate for SustiNet?
- What powers and duties should the SustiNet governing body have?
- What administrative structures and capacities are necessary to implement SustiNet?

We considered three basic options for governance of the SustiNet plan, as follows:

1. **SustiNet as quasi-governmental health plan**. Under this option, a SustiNet governing board would oversee a quasi-governmental agency that administers the SustiNet health plan. SustiNet would contract with the Comptroller's Office and the Department of Social Services (DSS) to provide health insurance coverage to state employees and enrollees in Medicaid and HUSKY.

2. **SustiNet as overseer and health plan**. Under this option, the SustiNet governing body would, in addition to administering the SustiNet health plan, oversee the Comptroller's Office and DSS with respect to all rules, regulations and procedures related to the State Employees Health Plan, Medicaid, and HUSKY.

3. **SustiNet as superagency and health plan**. Under this option, SustiNet would be a new state agency going beyond health plan administration to oversee the State Employees Health Plan, Medicaid and HUSKY.

Each option assumes that SustiNet would develop the capacity by 2014 to offer coverage to groups and individuals both within and outside the state's Health Insurance Exchange.

The board was provided with examples of each governance model and considered the advantages and disadvantages of each. The board was particularly concerned with minimizing disruption to current coverage arrangements, maximizing coordination across programs and plans, and minimizing (in the short term, while Connecticut is faced with serious budget shortfalls) the need for new, state-funded staff and administrative infrastructure.

We also examined the administrative capacities that would be necessary in SustiNet, regardless of its governance model. These include enrollment, premium billing and collection, marketing, provider contracting, management, and payment, customer relations, data collection, and data analysis. In addition, a system for determining eligibility and calculating subsidies will be needed for SustiNet to accomplish its coverage goals. We observed that existing state agencies possess many of these capacities, which could be leveraged for SustiNet.

Lastly, the board reviewed the recommendations of our Advisory Committees and Task Forces related to governance and administration. These include the following:

- SustiNet should have strong links with all state-run health agencies, including DSS, the Department of Public Health, the Department of Mental Health and Addiction Services, and the Department of Children and Families;
- SustiNet should have a strong link to HITECT, as discussed above;
- The SustiNet board should include representation of SustiNet enrollees;
- The SustiNet board should include individuals with experience in reducing health disparities; and
- The board should establish standing advisory committees on the Patient-Centered Medical Home, obesity prevention and reduction, health care quality and payment, health care safety, preventive health care, and health disparities and equity.

BOARD RECOMMENDATION:

The Board recommends the establishment of the SustiNet Authority as a quasi-governmental agency (option #1 described above), as soon as possible. We recommend that the authority be governed by a board of directors, which could include members of the current board, and that the board should have overall responsibility for SustiNet. We further recommend including as board members both consumer representatives and individuals with specific expertise needed to oversee the operation of the SustiNet health plan. We believe that the Board will be more effective if it is as small as possible.

We recommend that staffing and other administrative support for SustiNet should be provided initially by the Office of the Comptroller and that such staff should help the SustiNet board obtain resources (including federal or philanthropic funds) to support meeting its administrative needs, in both the short and long term. We believe that a strong and adequately funded administrative infrastructure will be essential to SustiNet's success.

Table 3 summarizes our concept of how SustiNet governance and administration could evolve from 2011 through 2014.

Table 3. Possible timeline for evolution of SustiNet governance and administration, Calendar Years 2011-2014

	2011	2012	2013	2014
SustiNet Board	**Appointed by 9/1/2011. Housed within the Office of the Comptroller.**	**Transition to independence from the Comptroller's Office.**	**Independent from Comptroller no later than 1/1/2013.**	
SustiNet Authority		**Authority begins no later than 3/1/2012.**		
SustiNet staff	**Existing state agencies provide staff.**	**If sufficient resources can be identified outside the General Fund, Executive Director hired to begin work no later than 3/1/2012. Transition to independent staff.**	**Staff fully independent no later than 1/1/2013.**	
Responsibilities	**Begin advising Comptroller and DSS about delivery system and payment reforms for SEHB and Medicaid/HUSKY. ASAP, give municipalities the option to buy SustiNet. Analyze feasibility of offering SustiNet small firms and non-profit corporations.**	**Move forward, as feasible, with offering SustiNet to small firms and non-profit corporations. Begin preparing to meet 1/1/14 deadline for offering SustiNet to firms and individuals.**	**Assume direct responsibility for administering SustiNet plan no later than 1/1/2013. Contract with Comptroller and DSS to serve SEHB and Medicaid/HUSKY.**	**Beginning 1/1/2014, offer SustiNet to all employers and individuals, inside and outside the exchange.**

Coverage and access

One of SustiNet's central goals is to ensure that as many Connecticut residents as possible obtain affordable, high-quality, comprehensive health coverage. After devoting significant time to understanding the impact of federal legislation, we learned that the ACA provides significantly increased federal support for subsidized coverage along with a mandate for individuals to obtain coverage and incentives for employers to offer it; the latter incentives include tax credits for small firms that provide insurance and penalties for larger companies that do not.

However, we were troubled by the limits on ACA subsidies for adults with incomes above 138 percent FPL, who fall outside the legislation's increase in required Medicaid eligibility. Subsidies for coverage in the exchange will leave these adults facing significant costs, as illustrated by Table 4.

Table 4. Premium and out-of-pocket costs for single, uninsured adult receiving subsidies in the exchange under the ACA, at various income levels

FPL	Monthly pre-tax income	Monthly premium	Average out-of-pocket cost-sharing
150	$1,354	$54.15	6%
175	$1,579	$81.34	13%
200	$1,805	$113.72	13%
225	$2,031	$145.70	27%
250	$2,256	$181.63	27%

Source: Urban Institute, 2010. *Notes*: Dollar amounts assume 2010 FPL levels and enrollment into the second-lowest cost "silver" plan under the ACA, which is the plan to which ACA subsidies are pegged. Out-of-pocket cost-sharing represents the average percentage of covered health care services paid by the consumer, taking into account deductibles, copayments, and co-insurance. These costs would apply under the ACA anywhere in the country, so they are not limited to Connecticut.

Considerable evidence suggests that cost-sharing imposed on low-income households can deter enrollment into coverage and prevent utilization of essential services, with potentially significant adverse effects on patient health.[11] We were thus concerned about the impact of cost-sharing on two groups: 16,000 HUSKY parents with incomes between 138 and 185 percent FPL, who today receive comprehensive benefits and are not charged premiums or copayments; and 41,000 other low-income adults with incomes between 138

[11] See, e.g., Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations*, Kaiser Commission on Medicaid and the Uninsured, March 2003; Bill J. Wright, Matthew J. Carlson, Heidi Allen, Alyssa L. Holmgren and D. Leif Rustvold, "Raising Premiums And Other Costs For Oregon Health Plan Enrollees Drove Many To Drop Out," *Health Affairs*, December 2010; 29(12): 2311-2316; Dana P. Goldman; Geoffrey F. Joyce; Yuhui Zheng, "Prescription Drug Cost Sharing: Associations With Medication and Medical Utilization and Spending and Health," *Journal of the American Medical Association*, July 4, 2007; 298(1):61-69; Becky A. Briesacher, Jerry H. Gurwitz, and Stephen B. Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," *Journal of General Internal Medicine*, June 2007; 22(6): 864–871; Samantha Artiga and Molly O'Malley, *Increasing Premiums and Cost-Sharing in Medicaid and SCHIP: Recent State Experiences*, Kaiser Commission on Medicaid and the Uninsured, May 2005. Of course, this research was done before enactment of an individual mandate, which, all else equal, will increase enrollment.

and 200 FPL, many of whom will be unable to afford what they will be charged in the exchange.[12]

To prevent today's HUSKY parents from encountering new barriers to accessing care as well as to improve coverage and access for other low-income adults, we believe that, beginning on January 1, 2014, Connecticut should implement the Basic Health Program (BH) option provided under federal law. With BH, Medicaid-ineligible adults with incomes at or below 200 percent of FPL are covered through state contracts with health plans or providers. Such adults either (a) have incomes too high to qualify for federally-matched Medicaid or (b) are lawfully resident immigrants whose immigration status makes them ineligible for federally-matched Medicaid (most often because their status was granted within the last 5 years). To fund the state's BH contracts, the federal government provides 95 percent of what it would have spent on subsidies if BH members had received coverage through the exchange. State contracts must have "attributes of managed care," which can involve primary care case management systems, such as patient-centered medical homes, rather than risk-bearing, fully capitated, private insurance. Federal BH dollars must be placed in a trust fund and spent only to benefit BH members. Covered benefits and cost-sharing protections may not fall below federally-specified minimums. However, states may provide more comprehensive benefits with lower cost-sharing (such as the benefits and cost-sharing protections that states provide through federally-reimbursed Medicaid).

To be clear, we would not recommend implementing the Basic Health option if the state provided no more than the minimum level of coverage required by federal law. Rather, the purpose of our proposed BH implementation is two-fold: to preserve, for populations covered by current law, HUSKY's existing affordability and comprehensiveness of coverage, so that, from the member's perspective, benefits would be exactly what Medicaid now provides; and to extend that same level of assistance to other low-income, uninsured adults.

One disadvantage of providing HUSKY rather than subsidies in the exchange is that provider payment rates are now much lower in HUSKY than in the kind of commercial coverage likely to be offered in the exchange. While we believe that, for this particular population, access to care is typically impaired more by cost-sharing than by HUSKY's provider participation limits, the BH option allows a modest improvement of provider payment rates at no cost to the General Fund. According to Dr. Gruber's modeling, federal BH payments will exceed HUSKY costs for low-income adults by at least 7 to 13 percent. Accordingly, as the state uses BH to extend HUSKY, in its current configuration of covered benefits, cost-sharing rules, and consumer safeguards, to adults with incomes up to 200 percent FPL, the excess of federal BH payments over baseline HUSKY costs should be used to raise reimbursement rates for adults with incomes above 138 percent FPL.

Not only would this approach make coverage and care more affordable for low-income adults, it would also save money for the state General Fund. By moving HUSKY parents above 138 percent FPL from Medicaid, for which the state pays 50 percent of all costs, into

[12] These population estimates were developed by the Gruber Microsimulation Model.

BH, where the federal government will pay all costs, taxpayers will save approximately $50 million a year, according to Dr. Gruber's modeling.

Under the approach we recommend, a single, integrated HUSKY program will provide subsidized coverage to all otherwise uninsured adults with incomes up to 200 percent FPL and children up to 300 percent FPL. Not only will this make coverage more affordable, our recommended strategy will also improve continuity of care. Income levels fluctuate greatly for many low-income households. Under the recommended policy, income changes that move families above or below 138 percent of FPL will not force a change between HUSKY and the very different systems of coverage and care that will be available in the exchange. Rather, coverage and care will be continuous, so long as household income does not exceed 200 percent of FPL.

We also considered two other policy options that, unlike BH, would increase state General Fund costs. First, HUSKY eligibility could expand before enhanced federal funding is available in 2014. If HUSKY covered all adults up to 185 percent FPL, rather than just parents, approximately 60,000 uninsured residents would gain coverage, according to Dr. Gruber's estimates. However, because federal matching funds would cover only 50 percent of Medic aid costs before 2014, the resulting net expense to the state General Fund would be approximately $100 million to $150 million a year.

Second, as noted above, HUSKY reimbursement, as a general matter, now falls far below private levels. As a result, many providers are unwilling to see HUSKY patients. Access to care could improve considerably if HUSKY reimbursement rates increased.

To address this longstanding problem, we considered a policy option that would have increased HUSKY reimbursement rates to the point that *per capita* costs would equal those paid by large employers—in effect, increasing HUSKY payment to private levels. According to Dr. Gruber's estimates, this would raise net General Fund costs by approximately $180 million to $190 million a year.

Recognizing the state's fiscal situation, we urge the Legislature and Executive branch officials to work together to find the necessary resources to raise HUSKY eligibility before 2014, to the highest possible income level, and to embark on a multi-year effort to increase HUSKY reimbursement rates.

The latter effort aims at a general increase of HUSKY payments to at least Medicare levels, rather than private levels. With some populations and services, a benchmark other than Medicare should be used. For example, Medicare payments for pregnant women and children are problematic, and an appropriate level of payment will be needed to secure provider participation comparable to Medicare's.,

We recommend beginning with a comprehensive analysis of HUSKY and Medicaid payments. With some services, current payment levels are sufficient or even excessive. For fiscal year 2012, any increases in HUSKY payment should be part of a budget-neutral overall adjustment to Medicaid and HUSKY reimbursement, given the state's current

budget challenges. In subsequent years, it is essential for payment levels to gradually rise to Medicare levels.

One final issue involves maximizing the number of eligible uninsured who sign up for coverage. According to Dr. Gruber's estimates, nearly half (47 percent) of Connecticut residents who would remain without coverage under our recommendations will qualify for subsidies, either through HUSKY or the exchange. We accordingly recommend that the Legislature authorize state agencies along with SustiNet to take vigorous steps needed to identify, enroll, and retain the uninsured who qualify for Medicaid, HUSKY, or subsidies in the exchange.

BOARD RECOMMENDATION:

As part of SustiNet, we recommend that, beginning on January 1, 2014, HUSKY eligibility for adults should increase to 200 percent of FPL, continuing the same benefits, cost-sharing limits, and consumer protections that apply under current law. Federal funding for this coverage should be maximized by implementing the Basic Health Program (BH) option for individuals who are ineligible for federally-matched Medicaid. To the extent federal BH dollars exceed baseline HUSKY costs, reimbursement rates should increase for the BH-eligible population.

We further recommend that the state begin down a path of increasing HUSKY provider payments to at least Medicare levels (with exceptions for discrete populations, like children, and services, like prenatal care, where a different benchmark than Medicare is needed). The first step down this path would occur in fiscal year 2013, as part of a budget-neutral reform of provider payments. In subsequent years, further payment increases would require a net increase in state General Fund spending. We believe that such increased reimbursement is essential for HUSKY to provide adequate access to essential care, particularly with the increased population the program will serve in the future.

We thus urge the General Assembly and state agencies to work together to find the resources necessary both for this increase in HUSKY reimbursement and, before 2014, to expand HUSKY eligibility for childless adults to the highest possible income level—if possible, to the same 185 percent FPL threshold that now applies to parents.

Finally, we recommend that SustiNet, the Department of Social Services, other state agencies, and Connecticut's health insurance exchange should work together to maximize identification of the uninsured, determine their eligibility for assistance, and enroll them into coverage.

Prevention and public health investments

The SustiNet law placed a strong emphasis on health insurance coverage for preventive care and increased investments in public health improvement in Connecticut. The SustiNet board considered several issues related to preventive care and public health investments. These included:

- The extent to which current coverage for potential SustiNet populations includes appropriate preventive care;
- The extent to which coverage offered in the future to privately-insured groups and individuals should include preventive care;
- The appropriate role of the SustiNet plan in promoting public health; and
- The highest priorities for state investments in public health outside the scope of SustiNet, with coordination between the Department of Public Health and the SustiNet plan, to maximize opportunities for success.

We also considered the recommendations of our Preventive Health Care Advisory Committee. That committee broadly defined its charge to improve health for SustiNet members, addressing the needs of the whole person, including physical health, mental health, addictive behaviors, and oral health. The Committee recommended that SustiNet cover a comprehensive package of preventive services, without requiring cost sharing. These services included:

- A basic set of preventive services (including items receiving an "A" or "B" rating on the US Preventive Services Task Force list) addressing physiological, emotional, mental, and developmental conditions for members from birth to the end of life;
- All Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children;[13]
- Regularly scheduled screenings and other preventive services, such as mammograms, immunizations, assessments of behavioral health needs, and other evidence-based care;
- Dental services;
- An annual Individual Preventive Care Plan;
- Chronic care planning and support, including promoting healthy nutrition, sleep, exercise, and tobacco and substance abuse cessation; and
- Counseling and education about sexually-transmitted disease, infectious disease control, domestic violence, and environmental toxins.

The Obesity Task force and the Tobacco Use and Cessation Task Force also offered guidance about preventive benefits and public health investments. On benefits, they recommended coverage for nutrition counseling and smoking cessation treatment.

Those task forces also recommended statewide efforts to:

- Enhance surveillance related to key health indicators;
- Provide more tobacco cessation services;
- Include in K-12 education tobacco, drug and alcohol use prevention, as well as nutrition, stress management, and exercise; and

[13] Under current federal law, these services are provided to all Medicaid children, without cost-sharing.

- Improve the nutrition environment in schools and reduce unhealthy marketing to children.

In addition, the PCMH Advisory Committee recognized that public education would be necessary to maximize the use of preventive services through the medical home model.

BOARD RECOMMENDATION:

The board recommends that SustiNet continue to emphasize preventive health and public health promotion by:

- Incorporating the best available knowledge on the return on investment from preventive care in benefit designs for both populations currently covered by the state and populations that might purchase the SustiNet plan as a competitive option in the Connecticut marketplace;
- Appropriately investing in the health of its covered population through education and support services that might fall outside the traditional scope of delivery of health care services but could have a clear impact on the population's health.

In addition, the board recommends that the General Assembly, in collaboration with state agencies, the SustiNet Board, and other appropriate stakeholders, identify necessary resources and enact legislation to invest in statewide primary prevention efforts that promote healthy nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances. The board also supports investments in:

- Improving community infrastructure to support healthy lifestyles and furnish preventive care;
- Including public health workforce capacity in state health care workforce assessment and strategic planning;
- Reducing racial and ethnic disparities in access to resources that improve health while increasing support for healthy living by families from multiple, diverse cultures; and
- Facilitating the receipt of funds for health care workforce training and development, including efforts to promote cultural and linguistic competence in serving the state's diverse residents.

Coverage and Cost Estimates

Coverage

Based on Dr. Gruber's projections, our proposal, along with national legislation, would substantially increase insurance coverage in Connecticut. Taking 2017 as a representative year,

the number of uninsured would fall by at least 55 percent, compared to levels in the absence of reform.[14] More than 200,000 otherwise uninsured residents would gain coverage.

The availability of subsidies would cause a minority of firms with 100 or fewer employees to stop offering insurance. This would reduce by 9 to 10 percent the number of people covered by such employers. More than 70 percent of affected workers would shift to subsidized coverage in the exchange or other individual insurance, and the overall proportion of small firm employees without coverage would decline from 45 percent to between 26 and 27 percent.

The overall impact on Connecticut coverage would include a sizable reduction in the proportion of residents without insurance, a significant increase in the percentage of Connecticut citizens receiving subsidized insurance, and a small drop in employer-sponsored insurance (ESI) (Figure 2).

[14] Dr. Gruber's projections suggest that, under a pessimistic scenario in which SustiNet does not slow cost growth, the number of uninsured will fall by 38 percent in 2014, 48 percent in 2015, 53 percent in 2016, and 55 percent in 2017 and later years. If SustiNet slows cost growth by 1 percentage point per year, that will increase the number of insured, because slightly fewer small firms will drop coverage. Under the latter, more optimistic scenario, the number of uninsured will fall by 56 percent in 2017 and later years—slightly more than the level stated in the text.

Figure 2. Coverage of residents under age 65, with and without reform: 2017

Source: Gruber Microsimulation Model. *Notes*: "ESI" means employer-sponsored insurance. Public coverage includes Medicaid and HUSKY. With reform, "individual" coverage includes both subsidized and unsubsidized coverage in the exchange as well as nongroup insurance outside the exchange. This figure assumes that SustiNet's delivery system and payment reforms have no effect slowing cost growth.

Cost

Our discussion of cost requires several preliminary comments:

- Like the rest of Dr. Gruber's estimates, the analysis is limited to effects involving residents under age 65.
- Costs are stated in 2010 dollars.
- The combined policies under discussion do not include either (a) an expansion of HUSKY eligibility before 2014 or (b) an increase in overall HUSKY reimbursement rates to at least Medicare levels. As explained earlier, these two initiatives will require the Legislature, SustiNet, and the Administration to collaborate in finding new resources to fund the resulting costs. The costs of these proposals, to the extent they are known,[15] are set forth in the earlier discussion, rather than here.

[15] The proposed increase in HUSKY payments cannot currently be modeled, because it involves a thorough analysis of and revision of HUSKY reimbursement practices. The precise details of changed reimbursement will not be known until after that analysis is done. After that point, modeling cost effects should be much more feasible.

- State costs itemized below represent net charges to the State General Fund. They do not include matching federal dollars, even if those funds are subject to the state's spending cap.

An important question involves the extent to which SustiNet slows cost growth. To address this question, Dr. Gruber produced two estimates, reflecting two different scenarios: a pessimistic scenario, in which SustiNet has no effect on cost growth; and an optimistic scenario, in which SustiNet slows cost growth by 1 percentage point per year. In neither case did Dr. Gruber assume any "spillover" effects, through which a reduction in uninsurance (and a consequent decrease in shifting uncompensated care costs to private insurance) or a spread of SustiNet reforms to other health plans would slow cost growth outside the four corners of the SustiNet plan.

Beginning in 2014, the proposal we recommend, combined with national reform, would improve the state's fiscal situation, in several ways:

- Implementing the Medicaid expansion required by the ACA will greatly increase federal funding for the population formerly covered by State Administered General Assistance (SAGA). By converting SAGA into a new category of Medicaid eligibility (Medicaid for Low-Income Adults, or LIA), Governor Rell reduced the proportion of costs paid by Connecticut from 90 percent to 54 percent. [16] Beginning in 2014, the state share will fall to 9 percent, yielding significant savings.
- By implementing the Basic Health Program option, the state shifts the cost of covering 16,000 HUSKY parents from Medicaid, for which the federal government pays 50 percent of all costs, into BH, where the federal government pays all costs.
- The above-described small decline in ESI will result in a modest increase in wages, based on research showing that employers increase pay, to some degree, when they achieve health care cost savings. A slight wage increase will, in turn, raise state income tax revenues.
- If SustiNet slows health care cost growth, state Medicaid and HUSKY spending will decline, compared to projected spending without reform. The state will likewise achieve savings in providing employees and retirees with health coverage.

On the other hand, reform will increase state costs in several areas:

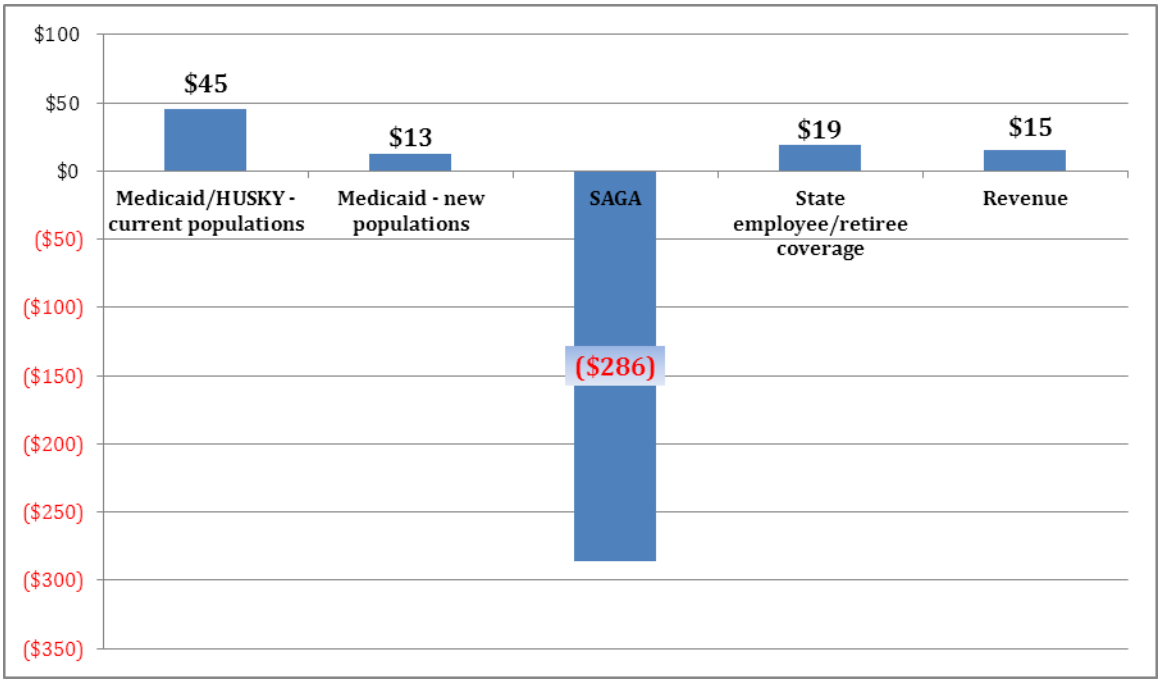
- Enrollment is likely to increase in existing categories of Medicaid and HUSKY eligibility, for which the state pays 50 percent of all costs.
- For newly eligible Medicaid adults with incomes at or below 138 percent of FPL, the federal government stops paying for all costs after 2016. While the state's share is small, gradually rising to 10 percent in 2020 and remaining at that level thereafter, there will be some state costs for these adults beginning in 2017.
- Enrollment into state employee coverage is likely to increase modestly because of the individual mandate.

Altogether, state budget gains will outweigh new costs by a substantial margin. Figure 3 illustrates the magnitude of the above factors under the pessimistic scenario, through which

[16] In estimating savings, Dr. Gruber compared the policy that will exist when federal and state reforms are fully implemented, beginning in 2014, with the policy that preceded this step by Governor Rell.

SustiNet has no effect in moderating health care cost growth. Under this assumption, total state budget deficits would fall by $224 million in 2017, compared to levels in the absence of reform.

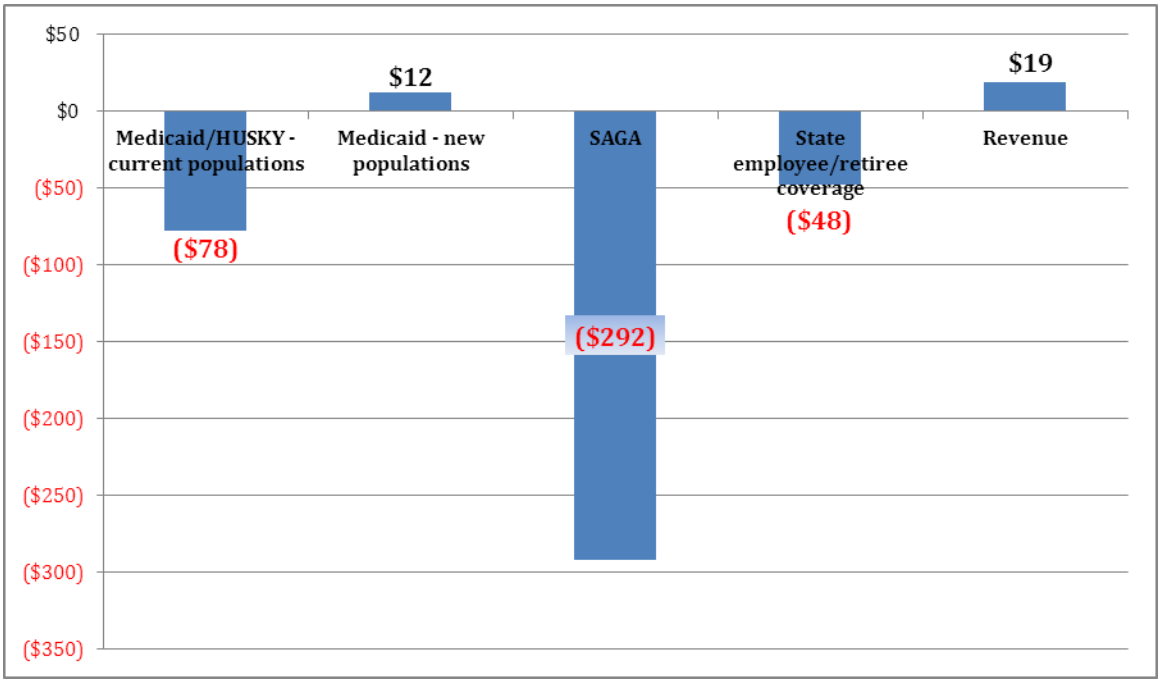
Figure 3. Effects on state spending and revenue for residents under age 65, pessimistic scenario: 2017 (millions)



Source: Gruber Microsimulation Model. *Notes*: Savings from shifting HUSKY parents into BH are included in the cost estimates for existing Medicaid/HUSKY populations. Savings for the conversion of SAGA to Medicaid for low-income adults are shown against a baseline in which SAGA was not converted into Medicaid. Cost estimates do not include any savings on state health care costs for state-funded immigrants with incomes at or below 138 percent of FPL, who will be shifted into federally-funded BH under our proposal.

Figure 4 shows the state fiscal effects in 2017 if SustiNet succeeds in slowing cost growth by 1 percentage point per year. Under this more optimistic scenario, the state budget will improve by $425 million.

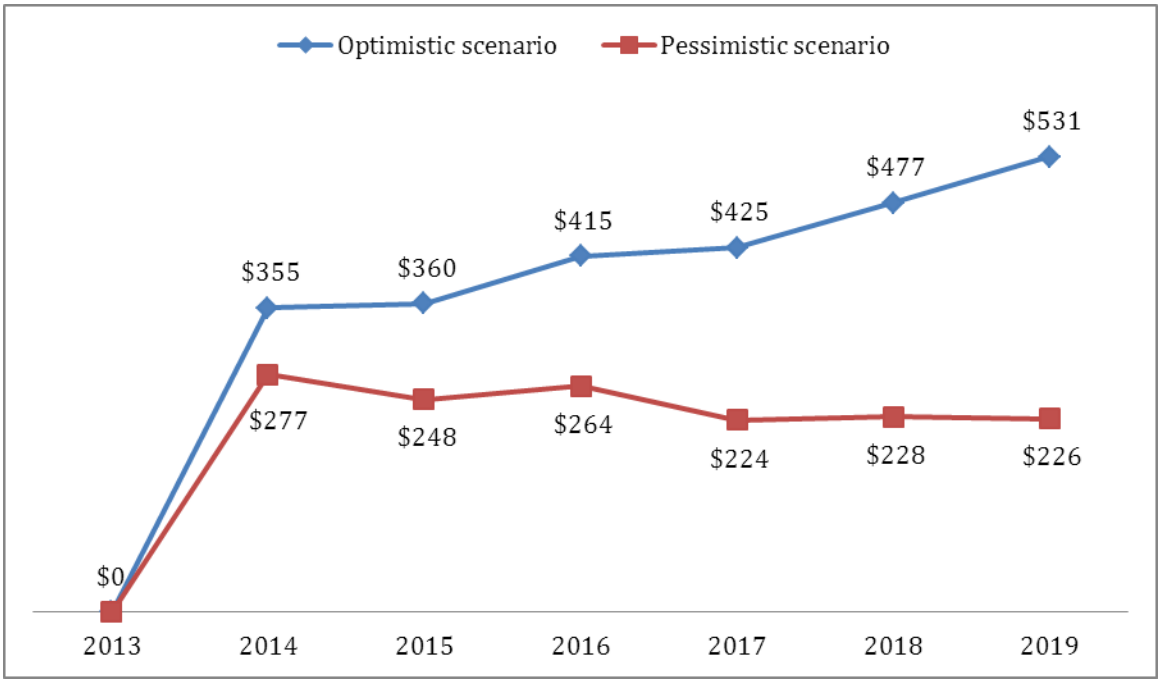
Figure 4. Effects on state spending and revenue for residents under age 65, optimistic scenario: 2017 (millions)



Source: Gruber Microsimulation Model. *Note:* This figure assumes that, in SustiNet, delivery system and payment reforms slow cost growth by 1 percentage point per year. See also notes to Figure 3.

The state's net budget gains over time are displayed in Figure 5. Under the pessimistic scenario, savings gradually decline as the federal government reduces its share of Medicaid costs for newly eligible adults. Under the optimistic scenario, the impact of SustiNet on health care spending outweighs this modest decline in federal support, so net state budget gains increase.

Figure 5. Net state budget savings for residents under age 65, optimistic and pessimistic scenarios: 2014-2019 (millions)

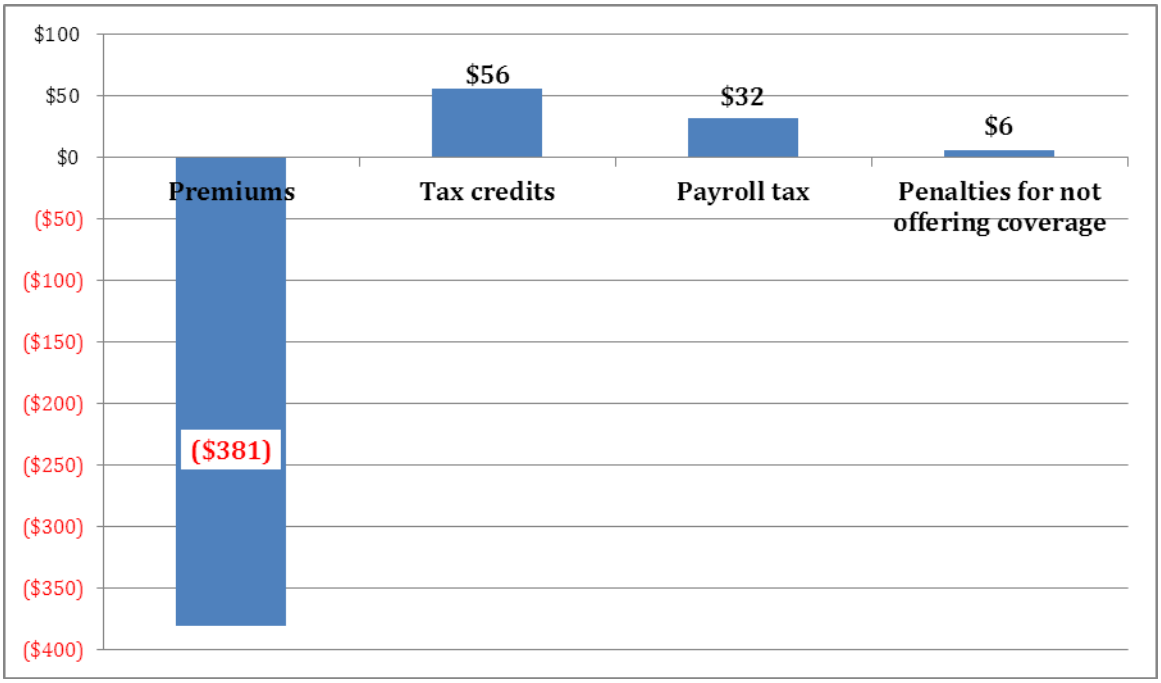


Source: Gruber Microsimulation Model. *Notes*: State budget effects include both outlays and revenues. See also notes to Figure 3.

Our proposal will also have implications for private sector costs. As noted earlier, small firm coverage will decline by 9 to 10 percent in 2017. As a result, small firms will save approximately $380 to $400 million in premiums. Ironically, these companies will save slightly less if SustiNet is more effective in slowing cost growth, because fewer small firms will drop coverage.

Although premium savings will be the most significant cost effect for small employers, some firms with fewer than 50 workers will also receive tax credits created by the ACA. A few companies with between 50 and 100 employees will pay penalties because they fail to offer ESI. In addition, any firms that drop coverage and increase wages will see their payroll taxes rise. The net effect of all these factors is that companies with 100 or fewer workers will realize gains of $399 to $415 million in 2017. Figure 6, below, shows how all these factors are projected to play out under the scenario in which small employers' costs are a little higher because SustiNet slows cost growth to the point that slightly more firms offer coverage.

Figure 6. Effects on health insurance costs and taxes for firms with 100 or fewer workers, scenario in which SustiNet slows cost growth and more such firms offer coverage: 2017 (millions)

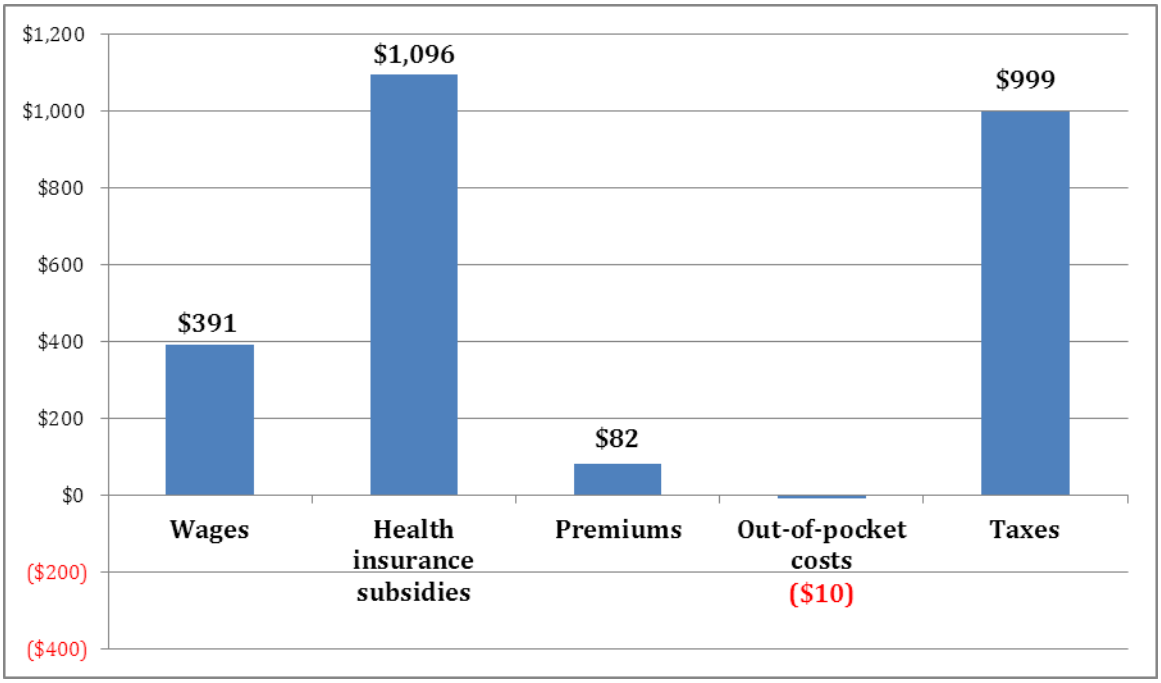


Source: Gruber Microsimulation Model. *Notes*: This figure assumes that SustiNet is effective in slowing cost growth. Under a scenario in which SustiNet has no effect slowing cost growth, premium savings will equal $403 million, tax credit amounts will total $52 million, payroll taxes will increase by $34 rather than $32 million, and penalties for not offering coverage will remain at $6 million.

Among larger firms, the effects of reform are estimated to be negligible. In 2017, total costs for companies with more than 100 employers are projected to decline by roughly $50 to $70 million, or less than one-half of 1 percent.

Similarly, total household post-tax purchasing power will be essentially unchanged under the combination of federal reform and our proposal, rising between $416 and $420 million, or less than one-half of 1 percent. Wages will increase modestly, because some firms will stop offering coverage, as explained above. Connecticut residents will receive more public-sector assistance in purchasing health coverage because of expanded Medicaid and HUSKY as well as newly created subsidies in the exchange. On the other hand, taxes will rise, mainly because the ACA increases Medicare payroll taxes for families earning more than $250,000 a year. Premium payments will increase because more people enroll in coverage, but out-of-pocket costs will decline slightly. Figure 7 shows how these effects balance out, under the pessimistic scenario in which SustiNet fails to slow cost growth.

Figure 7. Effects on household purchasing power for residents under age 65, scenario in which SustiNet fails to slow cost growth: 2017 (millions)



Source: Gruber Microsimulation Model. *Notes*: This figure assumes that SustiNet does not slow cost growth. Under a different scenario in which SustiNet slows cost growth by 1 percentage point per year, wages will increase by $452 million, health insurance subsidies will grow by $1.055 billion, premium payments will rise by $72 million, out-of-pocket costs will fall by $13 million, and taxes will increase by $1.028 billion.

More broadly, SustiNet aims to spark broader reform of health care delivery and payment in Connecticut, using several strategies. First, SustiNet will lead by example, rather than compulsion. It will demonstrate the impact of nimbly implementing cutting-edge reforms that seek to improve quality while slowing cost growth. If SustiNet proves effective, it will be easier for others to move in similar directions.

Second, SustiNet will galvanize broader change by harnessing the power of competition. If SustiNet's initiatives slow cost growth while maintaining or improving quality and value, then private insurers will need to implement similar reforms to preserve market share.

Third, SustiNet's continuity of coverage will strengthen the business case for savings. Today, both commercial insurers and Medicaid expect that a substantial fraction of their members will soon be gone, which reduces incentives to invest in long-term wellness. In the commercial world, an employer may change carriers, or a worker receiving ESI may move to a new job that offers different insurance. In Medicaid, small changes in income and failure to complete necessary paperwork cause caseload "churning," with members leaving the program. Under our proposal, by contrast, regardless of changes of income (and in some cases, even if workers move from job to job), SustiNet's members will stay with the plan, thus increasing the return on investment from efforts that improve the receipt of preventive care, reduce obesity and tobacco use, or successfully intervene in the early development of other ongoing health problems.

Fourth, SustiNet will work with other payers to implement coordinated efforts to help providers make necessary changes to health care delivery. Already, the Comptroller's office is leading such a multi-payer initiative to pilot-test patient-centered medical homes, as noted above.

Fifth and, in some ways, most important, as SustiNet enrollment increases, SustiNet's leverage to bring about delivery system and payment reform will likewise increase. The number of commercial enrollees who will join SustiNet depends, in part, on whether SustiNet achieves cost savings. But Dr. Gruber found that, under both pessimistic and optimistic scenarios, SustiNet is likely to gain a significant share of the state's small group and individual markets, along with a modest share of the large group market (Table 5).

Table 5. Estimated SustiNet enrollment, outside state-sponsored groups: 2017

	Small firm enrollment		Large firm enrollment		Individual enrollment	
	Covered lives	Share of small firm coverage	Covered lives	Share of large firm coverage	Covered lives	Share of individual market
Pessimistic scenario	136,000	24%	126,000	8%	32,000	14%
Optimistic scenario	164,000	29%	165,000	10%	33,000	15%

Source: Gruber Microsimulation Model.

Detailed Recommendations to the General Assembly

Our detailed recommendations address six core areas related to implementing SustiNet:

1. Governance and location within state government;
2. Policy-making duties and responsibilities of the Authority Board;
3. Administrative duties and responsibilities of the Authority Board;
4. Reforming health care delivery and payment;
5. Expanding coverage and access to care; and
6. State public health investments.

As detailed above, during our sixteen months of deliberations we reviewed many of the challenges that make it difficult to simply "flip the switch" and begin SustiNet operations. These challenges include different benefits, reimbursement levels, and provider networks across state-funded groups; constraints of collective bargaining agreements and Medicaid law; and the need to obtain a state license to offer SustiNet in Connecticut's health insurance exchange. In addition, challenges such as the lack of an adequate primary care workforce and low Medicaid payment levels must be overcome if SustiNet is to be fully successful. We have attempted, in crafting the following recommendations, to address these issues and build a strong foundation for future

success. We believe strongly that the potential benefits of the SustiNet plan warrant addressing the operational, technical, and fiscal challenges inherent in start-up.

Governance and location within state government

1. A quasi-governmental agency (the SustiNet Authority) should be established, no later than September 1, 2011, to oversee and operate the SustiNet plan. The Authority generally should be modeled after Connecticut Health and Educational Facilities Authority, and should be bound by the highest legal standards of ethics, transparency, and accountability. The Authority should be structured to reflect governance principles embodying the country's best thinking about effective and accountable administration (such as those recommended by the Pew Center for the States), including providing the public with regular performance information.
2. The Authority should be established as soon as possible and in no event later than March 1, 2012.
3. The Authority should be governed by a reconstituted board of directors (the Authority Board). The Authority Board should be responsible for setting overall policy for the SustiNet health plan.
4. The Authority Board, which could include members of the current Board, should be appointed by a combination of elected officials in the Executive and Legislative branches of Connecticut state government and specified stakeholder groups. Board members should be required to have specified areas of expertise. The Board should have authority to increase its membership to bring in additional expertise. At the same time, the Board should be as small as possible, to facilitate effective decision-making.
5. The Authority Board should establish a Consumer Advisory Committee with broad consumer representation. The Consumer Advisory Committee should elect a representative to sit as a voting member on the governing Board and to report the full breadth of advice from the Committee to the Board.
6. Until the SustiNet Authority obtains funding and staffing, the Office of the Comptroller should provide administrative support to the Authority Board and help the board maximize its access to resources outside the General Fund, including federal funds and philanthropic grants. This interim arrangement should terminate as soon as possible and in no event later than January 1, 2013.

Policy-making duties and responsibilities of the Authority Board

1. The Authority Board should be responsible for overseeing the SustiNet plan. This role includes setting binding policy for delivery system and payment reform affecting coverage received by SustiNet members, except where such policy conflicts with state or federal law or with collective bargaining agreements. The Board should work with the Legislature and with other state agencies to identify funding sources to cover any necessary initial investments.
2. The Authority Board should be authorized to convene committees and advisory groups as it deems necessary to address such issues as implementation of the patient-centered medical

home, health care quality, health care safety, provider payment, prevention, health disparities and equity, and health information and technology.

3. In addition to its policy-making authority described above, the Authority Board should be authorized to advise the State Comptroller and the Department of Social Services on other matters related to health insurance coverage for state employees and retirees and individuals receiving coverage under Medicaid and HUSKY. The Board should likewise be authorized to make recommendations to the General Assembly or state agencies about changes in state law, policy, or procedure that would slow health care cost growth, improve health care quality, increase access to health care, improve population health, or reduce racial and ethnic disparities.
4. The Authority Board should take all necessary actions (which may include conducting feasibility studies, developing financial projections, and obtaining a state insurance license) to offer a SustiNet health insurance plan as an option for employers and individuals to purchase, as follows:
    a. Beginning as soon as possible in calendar year 2011, SustiNet should be an option for purchase by municipalities, using the same benefits and out-of-pocket costs that apply to state employees and retirees. If requested by a particular municipality and approved by the Authority Board, SustiNet may provide commercial benefits like those described below.
    b. To the extent feasible, taking into account other duties of the Authority, SustiNet should be available before 2014 to small firms and non-profit corporations, offering commercial benefits, as described below.
    c. Beginning on January 1, 2014, SustiNet should be offered to all Connecticut employers and individuals, both inside and outside the exchange.
5. In structuring insurance plans for the commercial marketplace, the Authority Board should ensure that plan designs:
    a. Offer a variety of benefits and out-of-pocket costs, with each package providing comprehensive, commercial-style benefits, including dental care and parity of coverage for physical and mental health conditions.
    b. Include, to the maximum feasible extent consistent with commercial viability, patient-centered medical homes, integration of medical/behavioral health care, an emphasis on prevention, encouraging individual responsibility for controllable health risks, and other design features that make SustiNet stand out as a high-quality option that is attractive in the marketplace.
    c. Include cost-effective preventive services that address physiological, emotional, mental, and developmental conditions for members throughout their life span from birth to the end of life. The SustiNet Authority should review and periodically revise the set of covered preventive care services based on the most current and reliable evidence available, including the success of the SustiNet Plan’s prevention initiatives.
6. SustiNet should work with the Comptroller, DSS, and other appropriate government agencies and non-governmental organizations to encourage inclusion of cost-effective smoking cessation services within covered benefits.

7. When sold in the individual or group market, SustiNet should be subject to the same rules that apply in that market, including rules for permitted premium variation. The Authority may use channels of distribution and sale that apply to other plans in those markets, including the use of brokers and agents.
8. The Authority should prevent harmful adverse selection when commercial enrollees choose SustiNet. This may include experience-rating premiums when SustiNet is sold outside the exchange to firms large enough to self-insure.
9. To cover unexpected differences between plan expenditures and premiums, the Authority should maintain prudent reserves and should be authorized to take other appropriate steps, such as purchasing stop-loss coverage or reinsurance.
10. The Authority should implement multi-year action plans to achieve measurable objectives in such areas as the effective prevention and management of chronic illness, reducing racial and ethnic disparities involving health care and health outcomes, and reducing the number of state residents without insurance. The Authority should monitor the accomplishment of such objectives and modify action plans as necessary.
11. The Authority should be authorized to conduct public education and outreach campaigns to inform state residents about the SustiNet Plan and to encourage enrollment. The public education and outreach campaigns could utilize community-based organizations and target populations that are underserved by the health care delivery system. The Authority Board should monitor the effectiveness of such campaigns and modify strategies as necessary.
12. The Authority should, within available appropriations, develop and implement systematic policies and practices to identify, qualify for subsidies, enroll, and retain in coverage otherwise uninsured individuals. Such policies and practices may include collaboration with the Department of Revenue Services, the Labor Department, and other local, state, and federal agencies, as well as health care providers, including hospitals and community health centers, and other nongovernmental organizations, as appropriate.

Administrative duties and responsibilities of the Authority

The Authority, with approval from the Authority Board, should be authorized and empowered to:

1. Recruit and hire an Executive Director, who will implement the administrative operations of the SustiNet Authority. The Executive Director should have the authority to hire staff and enter into contracts, consistent with the Board's overall direction and budget.
2. Adopt guidelines, policies and regulations necessary to carry out its duties.
3. Contract with one or more insurers or other entities for administrative purposes, such as claims processing, credentialing of providers, and establishing provider networks, provided that any such administrative contract should pay per enrollee or on another basis that does not provide an incentive to delay or deny coverage of necessary services.
4. Contract with the Comptroller and the Department of Social Services to provide health insurance coverage for the following populations:
    a. State employees and retirees; and

b. Individuals who receive Medicaid, HUSKY (including with the eligibility expansions described below) and (if approved by the Authority Board) other state-arranged or state-funded health coverage.

Enrolling these populations in SustiNet should not be construed as authorization to modify premiums, covered benefits, out-of-pocket cost-sharing, or access to out-of-state providers for these membership categories.

5. Solicit bids from individual providers and provider organizations and arrange with insurers and others for access to existing or new provider networks and take such other steps as are needed to provide all SustiNet Plan members with access to timely, high-quality care throughout the state and medically necessary care outside the state's borders.
6. Commission surveys of consumers, employers and providers on issues related to health care and health care coverage.
7. Negotiate on behalf of providers participating in the SustiNet Plan to obtain discounted prices for vaccines and other goods and services.
8. Make and enter into all contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers under its enabling legislation, including contracts and agreements for professional services, including but not limited to financial consultants, actuaries, bond counsel, underwriters, technical specialists, attorneys, accountants, medical professionals, consultants, bio-ethicists, and such other independent professionals or employees as the Authority shall deem necessary.
9. Enter into interagency agreements for performance of the Authority's duties where such duties can be implemented at lower cost or more cost-effectively by contracting with a state agency.
10. Establish policies and procedures:
    a. Governing the use of new and existing channels of sale to employers, including public and private purchasing pools, agents and brokers;
    b. Allowing the offering to employers of multi-year contracts with predictable premiums; and
    c. Ensuring that employers can easily and conveniently purchase SustiNet Plan coverage for their workers and dependents. Policies and procedures in this area may include, but are not limited to, participation requirements, timing of enrollment, open enrollment, enrollment length and other subject matters as deemed appropriate by the Authority Board.
11. Apply for and receive grant funding from private and public sources to support functions consistent with its mission.
12. Make optimum use of opportunities created by the federal government for securing new and increased federal funding.

Reforming health care delivery and payment

The Authority should be authorized to:

1. Implement changes in health care delivery and payment for the populations covered in the SustiNet plan, within the constraints of collective bargaining agreements and federal law (including Medicaid). Such changes may include provider contracting requirements and, to the extent consistent with the above constraints as well as other state statutes, benefit design modifications that do not increase net state-funded costs. In making such changes, the board should prioritize strategies that offer the greatest potential for slowing cost growth.
2. Integrate strategies for reducing and eliminating racial and ethnic disparities into every component of the SustiNet plan, including outreach, enrollment, benefit design, provider networks, financial incentives, quality measurement, provider credentialing, enrollee communications, and appeals.
3. Establish payment methods for licensed health care providers that reflect evolving research and experience both within the state and elsewhere, promote access to care and patient health, prevent unnecessary spending, and ensure, to the maximum extent feasible, sufficient compensation to cover the reasonable cost of an efficient provider to provide necessary care.
4. Strongly encourage and provide incentives and technical and other assistance for SustiNet providers to implement patient-centered medical homes. The Authority should establish a timeline for ensuring that all SustiNet members can receive care from a patient-centered medical home.
5. In appropriate cases, implement alternatives to fee-for-service provider payment that encourage the provision of care that improves health. Such alternatives may include pay-for-performance, bundled payments, or global payments. To the extent warranted by available evidence, the board should establish goals for increasing the percentage of SustiNet expenditures made under alternative payment methodologies over time. Based on experience in Connecticut and elsewhere, the Board should evaluate the effect of alternative payment methodologies on quality and cost growth.
6. Provide incentives for evidence-based care that encourage providers to follow evidence-based clinical guidelines. Any system that rewards providers for meeting evidence-based guidelines should also provide a mechanism for providers to document reasons for deviating from guidelines because of, for example, an individual patient's clinical condition.
7. Establish a Pay for Performance system to reward providers for improvements in health care quality and safety and reductions in racial and ethnic disparities in health access, utilization, quality of care, and health outcomes. Such Pay for Performance systems could reward providers for (a) making improvement as well as for meeting benchmarks; (b) having an effective plan in place for preventing illness and improving health status; and (c) caring for patients with the most complex and least well-controlled conditions.
8. Encourage, support, and eventually require SustiNet providers to use interoperable, electronic health records to document and manage care. The Authority Board should work with other organizations within the state to maximize the usefulness and minimize the cost to providers of this transformation, leveraging the combined purchasing power of the state's health care providers to obtain reduced-cost goods and services, and taking advantage of available federal resources.

9. Include in all SustiNet plan data intake systems and data storage systems member race, ethnicity, and language in addition to age, gender, and other demographic data to create the capacity to track disparities in health outcomes and health care services. Data systems should enable coding of multiple races and ethnicities for a single individual.
10. Report provider performance in health care quality, efficiency, safety, and racial and ethnic disparities in health access, utilization, quality of care and health outcomes by geographic area and by provider or organization, where feasible, with outcomes risk-adjusted based on patient characteristics, to the maximum extent possible. The SustiNet Authority would:
    a. provide information to each provider organization comparing its performance to benchmarks and to other providers;
    b. provide guidance to providers on specific actions that they can take to improve their performance; and
    c. give providers an opportunity to review their own data, suggest revisions, and take corrective action before results are made public.
11. As soon as possible, create and maintain a data warehouse tracking health care utilization by SustiNet members and other state-sponsored populations. Whether through this data warehouse or otherwise, SustiNet should capture information necessary to publish provider price comparisons that will help consumers make informed choices.
12. Work with other health plans and organizations inside Connecticut to facilitate multi-payer initiatives to reform health care delivery and payment.
13. Modify the above-described delivery and payment reforms as warranted by evolving evidence.

To maximize the effectiveness of the above-described reforms, the General Assembly should make the following statutory changes:

1. Where necessary, modify scope of practice laws involving such provider groups as physician assistants and advance practice nurses to help these providers function effectively as part of a patient-centered medical home.
2. Modify medical malpractice liability laws to (a) provide a “safe harbor” that precludes liability for patient injury that results from clinicians appropriately following approved clinical guidelines; and (b) ensure that patients, in such circumstances, receive compensation for the harm they suffer.
3. Authorize SustiNet or another state agency, with appropriate convener authority, to provide direction, supervision, and control over approved cooperative agreements and to provide health care providers, health provider networks, and purchasers who participate in discussions or negotiations authorized by this program with immunity from civil liability and criminal prosecution under federal and state antitrust laws. The purpose of such actions is to facilitate the exchange of information among hospitals, other health care providers, and other appropriate entities to encourage the development of cooperative agreements, delivery arrangements, and relationships intended to promote more cost-effective health care delivery.

4. To the extent that delivery system and payment reforms implemented by the SustiNet plan achieve cost savings, the SustiNet Authority should be permitted to retain most of the savings to invest in further improvements in services provided to SustiNet members.

Expanding Medicaid coverage and access to care

As of January 1, 2014, HUSKY should expand to cover uninsured adults with incomes at or below 200 percent FPL. Such expansion would receive federal financial support as follows:

1. Federal Medicaid matching funds should be claimed up to 138 percent FPL;[17] and
2. Federal funding under the Basic Health Program should be claimed for individuals up to 200 percent of FPL for whom federal Medicaid funds are unavailable. Any excess in federal Basic Health funding over HUSKY costs should be paid out in the form of increased reimbursement rates to HUSKY providers serving HUSKY members with incomes above 138 percent FPL. For all HUSKY adults, benefits, cost-sharing arrangements, and other consumer protections (such as appeals) should what current law provides to HUSKY parents.

The General Assembly, in collaboration with the Department of Social Services, other state agencies as appropriate, and the Authority Board, should take the following steps, and identify revenue sources or cost savings that are sufficient to pay for them:

1. Expand HUSKY eligibility to include childless adults up to 185 percent FPL from July 1, 2012 through December 31, 2013.
2. Gradually increase HUSKY and Medicaid provider payment to at least Medicare levels for clinical services for which current rates are inadequate, beginning on July 1, 2012. Such plan should include payment increases to another appropriate benchmark for services as to which Medicare fee schedules are insufficient, such as for services to pregnant women and children. Such rate increases should be part of a broader reform to Medicaid reimbursement methodologies. Accordingly, any such increases in FY 2013 should be cost-neutral. In subsequent years, payment should gradually increase to the levels described above.

State public health investments

The General Assembly, in collaboration with state agencies, the Authority Board, and other appropriate stakeholders, should identify necessary resources and enact legislation to accomplish the following goals:

1. Invest in primary prevention efforts to promote healthy nutrition, sleep, physical exercise, and the prevention and cessation of the use of tobacco and other addictive substances.
2. Improve community infrastructure to support healthy lifestyles and furnish preventive care. Such investments could include, for example, creating safe spaces for low-income children to play. They should also include efforts to increase the availability of tests, immunizations, and other preventive services at work, at school, and in the community.

[17] Nominally, Medicaid will expand to individuals with Modified Adjusted Gross Incomes (MAGI) up to 133 percent FPL. However, in determining income, 5 FPL percentage points are subtracted from MAGI. Accordingly, the effective eligibility threshold is 138 percent FPL.

3. Implement and sustain a statewide, telephone quit-line for smoking cessation that provides both counseling and nicotine reduction products.
4. Increase the number and types of Tobacco Use Cessation (TUC) services available in diverse settings and develop and provide educational opportunities for training traditional and non-traditional TUC service providers.
5. Require age-appropriate life skill education in grades K-12 in Connecticut that address anti-tobacco education, drug and alcohol use prevention, nutrition, stress management, and exercise.
6. Update, adopt, implement, fund, and sustain the *Connecticut Tobacco Use Prevention and Control Plan*.
7. Implement statewide surveillance of key health indicators, using standard national surveys.
8. Improve the nutrition environment in schools and day care facilities, including providing breakfast in school and providing healthy school lunches.
9. Reduce unhealthy food marketing to children, including making schools “ad-free” zones.
10. Provide or otherwise facilitate the receipt of funds to expand the state’s public health workforce.
11. Include public health workforce capacity in state health care workforce assessment and strategic planning.
12. Reduce racial and ethnic disparities in access to resources that improve health while increasing support for healthy living by families from multiple, diverse cultures.
13. Provide or otherwise facilitate the receipt of funds for health care workforce training and development, including efforts to promote cultural and linguistic competence in serving the state’s diverse residents.

Timeline for Implementing SustiNet and Affordable Care Act [Note: this table is new]

	2011	2012	2013	2014
SustiNet Board and Authority	• Appointed by 9/1/2011. • Housed within the Office of the Comptroller.	• Authority operational no later than 3/1/2012	• Independent from Comptroller no later than 1/1/2013.	
SustiNet Staff	• Existing state agencies provide staff.	• Executive Director begins work no later than 3/1/2012, if resources identified outside General Fund.	• Staff fully independent no later than 1/1/2013.	
SustiNet Coverage	• Includes current Medicaid and HUSKY enrollees, and state employees and retirees • As soon as feasible, municipalities can buy SustiNet	• As soon as feasible, offer SustiNet to small businesses and non-profits • Expand HUSKY to childless adults up to 185% FPL, if funding identified	• As soon as feasible, offer SustiNet to small businesses and non-profits • Expand HUSKY to childless adults up to 185% FPL, if funding identified	• Offer SustiNet to all individuals and employers through the Exchange and other channels, 1/1/2014 • Expand HUSKY to adults up to 200% FPL, using Medicaid and Basic Health to maximize federal funds. Excess federal funds increase payment rates
Delivery System and Payment Reform	• Begin advising Comptroller and DSS on delivery system and payment reforms for SEHB and Medicaid/ HUSKY. . • Review Medicaid payment methods and rates; implement budget-neutral re-alignment of rates	• Begin multi-year initiative to increase Medicaid rates, 7/1/12, with goal of reaching Medicare levels over time	• Assume direct responsibility for administering SustiNet plan and implementing delivery system and payment reforms, no later than 1/1/2013. • Contract with Comptroller and DSS to serve SEHB and Medicaid/HUSKY.	
Federal Reform: Coverage & Funding	• States may provide Medicaid to childless adults (standard federal matching rate), beginning 2010 • Federal planning grants and enhanced federal matching rates for medical home services in Medicaid, 1/1/2011 • Tax credits to purchase coverage for some small businesses, beginning 2010		• Medicaid payment rates for certain primary care services increased to Medicare levels, with full federal funding (2013 and 2014)	• Medicaid coverage for adults to 138% FPL, with enhanced federal match for the newly eligible • Basic Health Program option available up to 200% FPL • Federal premium and cost sharing subsidies available to individuals in the Exchange up to 400% FPL • Individual mandate • Penalties for large employers failing to offer coverage • Small business tax credits limited to firms buying in the exchange
Federal Reform: Insurance Market	• Minimum medical loss ratio • Insurance market reforms prohibit rescissions, lifetime caps, pre-existing condition exclusions for children, beginning 2010			• States must establish an Exchange or federal government will • Insurance market reforms establish community rating, eliminate pre-existing condition exclusions, limit waiting periods to 90 days, etc.

Conclusion

The state of Connecticut faces daunting budget challenges. Those challenges make it more important than ever to address serious problems involving limited access to health coverage and care for thousands of state residents; misdirected incentives that interfere with the provision of high-quality, efficient care by doctors, nurses, hospitals, and clinics; and health care cost increases that are unsustainable for public and private sectors alike. Our goal has been to develop recommendations for both the Connecticut General Assembly and any future governing entity for SustiNet that, while cognizant of today's budget challenges, will help Connecticut assume a leadership role in addressing these pressing problems, which are national in scope. We urge Connecticut's policymakers to move towards a more rational and fair system of health care delivery and coverage, making wise choices in 2011 that yield major gains for the state's taxpayers, employers, and families for years to come.

APPENDIX

This appendix includes the following materials:

- A "cross-walk" that compares the 2009 SustiNet law to our recommendations;
- A brief explanation of Dr. Gruber's methodology for developing cost and coverage estimates, using the Gruber Microsimulation Model; and
- Full reports of our Advisory Committees and Task Forces.

[to be added]