Implementing SustiNet Following Federal Enactment of the Patient Protection and Affordable Care Act of 2010:

A Preliminary Report to the Connecticut General Assembly

May 30, 2010

The SustiNet Partnership Board of Directors
Nancy Wyman, State Comptroller, Co-Chair
Kevin Lembo, State Healthcare Advocate, Co-Chair
Hartford, CT

Table of contents

Executive Summary

In 2009, the Connecticut Legislature enacted the "SustiNet law," embarking on a path towards health reform that would guarantee coverage to all state residents while slowing the unsustainable growth in health care costs that threatens public and private sectors alike. This report explores how the state's reform strategy could be adjusted to reflect the federal government's passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law 111-152.

The 2009 state law created a new health plan, named "SustiNet." The plan's original members will include state employees and retirees as well as Medicaid and HUSKY beneficiaries. The plan will provide health coverage through a delivery system that implements reforms intended to slow cost growth while improving quality and access to care. Such reforms include the use of health information technology to avoid unsafe and unnecessary services, a patient-centered medical home that provides care coordination and patient education, and incentives for high-quality, evidence-based care. Among the law's central goals are better management and prevention of chronic disease, which generates most health care spending; improved access to medically necessary health care; and the elimination or reduction of racial and ethnic health disparities in health care access and health status.

Under the 2009 law, the SustiNet plan will be offered to the state's small firms, non-profit corporations, and municipalities beginning on July 1, 2012. To cover the uninsured through SustiNet, additional low-income adults will qualify for HUSKY up to the income levels that now apply to children, and sliding-scale premium subsidies may be offered to other residents unable to afford coverage. Both the SustiNet plan and other state-licensed insurers will be forbidden from discriminating against consumers on the basis of health status.

SustiNet's approach to reform shares many common elements with PPACA. Accordingly, the federal law will require only minor mid-course adjustments to the SustiNet law, rather than a radical change in direction. Such adjustments include three core elements:

1. **Immediate implementation of SustiNet delivery system reforms**. With existing state-sponsored populations, Connecticut should take full advantage of new federal resources that can help implement SustiNet's delivery system reforms, thereby slowing cost growth while improving quality and laying the groundwork for other consumers to join the plan.
2. **SustiNet as an option for employers and individuals**. PPACA does not affect the Connecticut General Assembly's decision that, beginning in July 2012, SustiNet should be offered to small firms, municipalities, and non-profits. After PPACA's main provisions go into effect in 2014, these employers could continue to purchase SustiNet, and individuals without access to employer-based insurance could also enroll. To accomplish this goal, SustiNet would be offered as one of many options in the health insurance exchange created by the federal law.
3. **Implementing the Basic Health Program option**. PPACA permits states to cover adults with incomes between 133 and 200 percent of FPL by converting such adults' federal subsidies into state contracts with health plans, beginning in 2014. This would let Connecticut enroll these low-income adults in SustiNet, providing benefits and cost-sharing

protections like those HUSKY now offers to low-income parents. As a result, current HUSKY parents would be spared major increases in health care costs; the state General Fund would realize savings, since the federal government would pay 100 percent of health care costs incurred by adults for whom the state now receives only 50 percent federal matching funds; continuity of care would increase, since income fluctuations would be less likely to force changes in low-income families' health coverage; and adding more patients to SustiNet would make it easier for health care providers to change how they deliver services.

Even with these core elements resolved, many remaining questions need to be answered about how, in the wake of federal reform, SustiNet can continue to pursue the strategies and goals embodied in Connecticut's 2009 law. The SustiNet Partnership Board of Directors will address these and other questions relevant to the Board's mission of presenting to the Connecticut General Assembly, before the start of its 2011 regular session, detailed recommendations about the further implementation of SustiNet, consistent with both federal law and the 2009 decisions made by the Connecticut Legislature.

Introduction

This report explores the intersection between two laws, one state and one federal:

- In June 2009, the Connecticut General Assembly enacted "SustiNet" legislation embodying a state-based strategy for providing all residents with health coverage while reforming health care delivery to slow cost growth and improve quality of care. Among other provisions, this legislation established the SustiNet Partnership Board of Directors (SustiNet Board) and commissioned the Board to propose, in time for the Connecticut Legislature's 2011 session, a detailed legislative approach to full SustiNet implementation.
- Two months ago, President Obama signed into law national health reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA), Public law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Public Law 111-152..

These two enactments take similar approaches to resolving vexing problems of unsustainable health care costs, inconsistent health care quality, and a large and growing number of working families without health insurance. Furthermore, the passage of SustiNet legislation in 2009 greatly strengthened Connecticut's ability to claim its share of federal funds newly available under national health reform. And the enactment of federal legislation means that SustiNet's goals for coverage expansion can be pursued at substantially reduced cost to the state General Fund.

When the Connecticut Legislature passed the SustiNet law in 2009, it understood that federal legislation was under active consideration. Accordingly, the Legislature authorized the SustiNet Board, within 60 days of the enactment of national reform, to report how the Legislature could modify SustiNet to take into account the new federal law. This paper carries out that charge.

To be clear, this report has two important limitations. First, we are not proposing a comprehensive approach to implementing national health reform in Connecticut. Rather, our much more limited goal is analyzing how Connecticut could implement the SustiNet law in view of changes made by federal legislation. Second, we are not revisiting the goals and strategies enacted by the Connecticut General Assembly as part of the SustiNet law. Instead, we focus on how those goals and strategies can continue to be implemented most effectively in the changed environment that follows the enactment of PPACA and HCERA.

We begin by explaining key features of the 2009 Connecticut law and the basic architecture of federal legislation. We then propose a specific approach to implementing SustiNet, given the new resources and context established by national health care reform. Finally, we raise some important questions that will need to be answered in fleshing out a detailed plan for SustiNet implementation as part of the Board's final report to the Legislature before 2011.

State legislative context

In its 2009 regular session, the Connecticut General Assembly adopted Public Act No. 09-148, "An Act Concerning the Establishment of the SustiNet Plan." Among other things, the law established the SustiNet Board and required it, by January 1, 2011, to present legislative recommendations that would fully implement the SustiNet health reform proposal. In addition, Section 3(b)(16) of the law authorized the Board:

> "In the event of the enactment of federal health care reform, to submit preliminary recommendations for the implementation of the SustiNet Plan to the General Assembly not later than sixty days after the date of enactment of such federal health care reform."

This report provides such preliminary recommendations, in response to the enactment of federal health reform on March 23, 2010 and March 30, 2010, when President Barack Obama signed into law PPACA and HCERA, respectively.

The 2009 SustiNet law embodies the following key features:

The SustiNet health plan. The 2009 law calls for the development of a new, publicly administered health plan that will incorporate the country's best thinking about how to slow cost growth while improving quality and safety. The SustiNet plan's delivery system thus includes several dimensions:

- **Health information technology (HIT)**. Without calling on state General Fund dollars, the combination of the state's bonding authority and negotiating leverage on behalf of the state's providers will give physicians, hospitals, and others affordable access to software, hardware, technical support, training, installation, and digitization of paper records. Benefiting will be all providers who participate in SustiNet as well as others who choose to join this HIT effort. SustiNet will provide automated interfaces with labs and pharmacies to maximize the usefulness of HIT to participating providers. A health information exchange or other mechanism will give participating providers "point of service" access to SustiNet members' electronic health records, with decision support that improves quality, safety, and efficiency of care. Electronic health records will also help SustiNet's governing agency track the accomplishment of measurable goals for improving members' health care and health status, including efforts to end or lessen racial and ethnic disparities.
    - ***Note***: since the passage of the SustiNet law, the federal government has been implementing important HIT reforms contained in the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. 111-5. ARRA implementation has caused major changes in Connecticut, which will be taken into account in the Board's final report to the Legislature before 2011. Such final report will explain how the objectives and methods used in the 2009 SustiNet law can best be updated to reflect these new developments in Connecticut HIT.
- **Patient-centered medical homes (PCMH)**. To implement the PCMH model, SustiNet will cover care coordination, patient education, management of transitions (e.g., from hospital to home), and 24/7 availability of appropriate consultation and rapid scheduling of office visits.
- **Incentives for evidence-based medicine.** Working collaboratively with the state's physicians, nurses, consumers, and other stakeholders, SustiNet will prioritize for implementation guidelines chosen from among nationally and internationally recognized standards for the care of particular conditions. While keeping a focus on the needs of each unique patient, allowing for creativity and innovation by the state's skilled clinicians and community-based practices, and assuring the delivery of medically necessary services, SustiNet policies will encourage the appropriate provision of care consistent with approved guidelines, including through decision prompts from electronic medical records whenever services are rendered outside the guidelines. Other measures will encourage safe, high-quality care. Such measures include public recognition of providers meeting agreed-upon

standards for quality of care in treating particular conditions; anonymous feedback to clinicians about their practice patterns (based on electronic health records); and regular, confidential peer review.

- **Further reforms**. As knowledge evolves about effective methods of health care reform, SustiNet can modify its approach to the system through which its members receive care.

SustiNet membership. To provide the critical mass needed to make health care delivery changes economically feasible for physicians and other providers, SustiNet will cover state employees and retirees as well as Medicaid and HUSKY beneficiaries. By July 1, 2012, the plan will also be offered to small firms, municipalities, non-profits, and individuals without access to employer-sponsored coverage (ESI). Workers offered ESI that is unaffordable or insufficiently comprehensive may decline such offers and enroll in SustiNet, taking with them the premium payments their employers would otherwise have made on their behalf. Eventually, large firms can also buy SustiNet for their employees. To compete effectively for the business of employers and unsubsidized individuals, SustiNet can offer multiple benefits packages that are less costly than the coverage provided to state employees. However, all such packages must be comprehensive and meet minimum benefit requirements (including those that apply to all state-licensed insurance).

Broadening delivery system reform beyond SustiNet. If SustiNet's reforms prove successful in slowing cost growth while maintaining or improving quality, private plans may adopt such reforms to preserve their market share. In addition, by implementing reforms that affect a significant percentage of state residents, SustiNet will make it easier for other providers and insurers, including self-insured employers, to take similar steps.

Reforming the health insurance marketplace. To provide better information about health insurance value when employers and individuals choose a health plan, the 2009 law creates an information clearinghouse that will gather and report data about the performance of both SustiNet and private plans licensed in Connecticut. The 2009 law also envisions market reforms that prohibit insurers from discriminating based on health status or condition.

Expanding coverage and access to care. The law provides for a substantial reduction in the number of uninsured residents through an expansion of HUSKY, the potential creation of sliding-scale premium subsidies for uninsured residents with incomes too high for HUSKY but too low to afford coverage, and mechanisms that identify uninsured consumers and automatically determine their eligibility for assistance and enroll them into coverage unless they affirmatively opt out. The SustiNet law also authorizes provider payment rates that cover the cost of care, which would increase reimbursement rates for Medicaid and HUSKY.

Broader initiatives. The law establishes task forces to develop comprehensive plans to slow cost growth by reducing obesity and tobacco use across the state. A third task force develops comprehensive plans to address potential health care workforce shortages.

Additional details of the SustiNet law are analyzed below.

National reforms: A broad overview

Federal health reform legislation, including both PPACA and HCERA, covers many issues. It is beyond the scope of this report to provide a full summary.[1] But key elements include the following basic architectural features, which go into effect by January 1, 2014:

- Health insurance exchanges in each state offer competing health plans to small firms and to individuals who either lack access to ESI or for whom ESI is unaffordable or insufficiently comprehensive. In addition to state-specific plans, the federal Office of Personnel Management (OPM)—the agency that provides health coverage and other benefits to federal workers—contracts with several national health plans (one of which must be non-profit) to serve consumers in all states' exchanges. At state option, exchanges can be operated by a state agency, a state-created non-profit corporation, or the federal government.
- Medicaid expands to cover all adults with incomes at or below 133 percent of the federal poverty level (FPL).[2] Newly eligible adults qualify for full federal funding from 2014 through 2016. After that, the percentage of health care costs paid by the federal government gradually declines to 90 percent in 2020 and later years.
- Fully refundable tax credits that can be advanced directly to insurers when premiums are due provide sliding-scale premium subsidies to households with incomes between 133 and 400 percent of FPL. Additional subsidies reduce out-of-pocket costs for households with incomes up to 250 percent of FPL.
- For adults with incomes between 133 and 200 percent of FPL, states have a "Basic Health Program" option to convert federal tax-credit and cost-sharing subsidies into contracts with health plans to cover low-income adults. When a state implements this option, the federal government funds these contracts by providing 95 percent of what it would have spent on such adults' tax credits and subsidies if the state had not chosen this option.
- As a general rule, individuals must obtain health insurance or pay a tax penalty. A firm with more than 50 full-time employees must likewise pay penalties if it fails to offer ESI and one or more of its workers use tax credits to enroll in the exchange.
- Health insurance markets are reformed in many ways. Although some of these reforms go into effect earlier, all of the following are in place by 2014:
    - Insurers are forbidden from discriminating against consumers based on gender or health status (including preexisting conditions).
    - Insurers are required to cover federally-specified minimum benefits, including preventive care services (which must be exempt from cost-sharing). Certain annual and lifetime limits on coverage are outlawed.
    - Insurers must provide substantial information about quality, consumer satisfaction, how premiums are used, enrollment, disenrollment, claims, etc.
    - The percentage of premium used to pay for health care must meet or exceed certain thresholds, which vary based on the applicable market.

Before 2014, other measures apply. For example, the following provisions first go into effect this year:

- States may expand Medicaid to cover childless adults, whose coverage was previously forbidden in the absence of federal waivers. Standard Medicaid matching percentages apply before 2014.
    - Note: the state is already implementing this option by shifting into Medicaid recipients of State-Administered General Assistance (SAGA), a program that has

previously provided health coverage to childless adults with very low incomes and limited assets. Moving these adults from a fully state-funded system into a program with joint federal-state funding achieves savings for the state General Fund.

- Small firms with 35 or few workers may qualify for tax credits helping them purchase coverage.
- Grants and other new federal initiatives encourage a broad range of care innovations, including patient-centered medical homes, reimbursement reforms to incentivize safe, effective, high-quality care, accountable care organizations, better integration of care for individuals who receive both Medicaid and Medicare, etc.
- $5 billion in federally-funded reinsurance is available to subsidize the cost of early retirees whose former employers implement reforms that slow cost growth for the chronically ill.
- Community health centers receive an $11 billion increase in funding.
- Insurers may not discriminate against children based on preexisting conditions. (As noted above, this prohibition extends to adults beginning in 2014.)
- Until 2014, $5 billion is available for high-risk pools that cover uninsured individuals with preexisting conditions.
- Private insurers must offer dependent coverage through age 26.
- Independent state offices of health insurance consumer assistance, like Connecticut's Office of the Healthcare Advocate, receive grants to provide individuals with consumer assistance and to document systemic insurance issues.

For calendar years 2013 and 2014, Medicaid reimbursement rates for primary care rise to Medicare levels, and the federal government pays all the resulting costs.

SustiNet in the wake of federal reform: A strategy for continued forward movement

With national health reform in place, the approach enacted by the Legislature in 2009,can continue moving towards full implementation through a policy that includes three components.

1. Immediate implementation of SustiNet delivery system reforms

For existing state-covered populations—that is, state employees and retirees and beneficiaries of Medicaid and HUSKY—we recommend that the state take full advantage of new federal resources and options that can help implement the delivery system reforms included in the 2009 SustiNet law. Without waiting for 2014, these steps would seek to slow cost growth while maintaining or improving quality. As new populations join SustiNet, they would be included in these reforms.

Following are some federal provisions that could help the SustiNet plan reform the health care delivery system that serves its members:

- Section 1102 of PPACA provides $5 billion in reinsurance for early retiree coverage offered by employers (including state governments) that implement measures to address the cost of

chronic illness. This provides financial support for measures being undertaken by the Comptroller consistent with SustiNet implementation, such as incorporating the patient-centered medical home into coverage for state retirees and employees.

- Sections 2601 and 2602 of PPACA give states new options for combining Medicare and Medicaid funds into integrated delivery systems serving low-income seniors and people with disabilities who qualify both for Medicare and Medicaid. This offers the possibility of improving care and limiting cost growth for some of Medicaid's most costly and frail beneficiaries by providing more coordinated and accountable service as part of SustiNet.
- Under Section 2703, the federal government will provide 90 percent matching funds for Medicaid's implementation of patient-centered medical homes for beneficiaries with significant chronic illness. Such enhanced match is limited to the first two years these benefits are offered. $25 million in planning grants are appropriated for 2011, the same year that enhanced federal funds for medical home services are first available. These resources could be used to help implement this care model for chronically ill Medicaid beneficiaries included within SustiNet.
- Section 3021 establishes the Center for Medicare and Medicaid Innovation within HHS. The bill appropriates $10 billion for this new Center to test and implement promising models for reforming care delivery. Connecticut could seek support from this new Center for SustiNet's innovative strategy, which can be characterized as involving three elements:
    - synergistically integrating multiple reforms in care delivery, such as HIT, medical homes, and incentives for evidence-based, high-quality care;
    - creating a new health plan that will apply these integrated reforms to the many residents who are currently served by state programs; and
    - using this new plan to facilitate broader implementation of reforms statewide, including by spearheading multi-payor delivery system initiatives and by making the plan available to other employers and individuals within the state.
- Section 3502 funds community-based health teams to support patient-centered medical homes. Such teams provide a range of services, including patient education and care coordination, that a small physician office may or may not want to undertake, This new program could prove critically important to effective implementation of the medical home model in Connecticut, where medical practice is dominated by one- and two-physician offices.
- Section 4108 appropriates $100 million, beginning in 2011, for projects that help Medicaid beneficiaries lower their weight, stop smoking, improve their cholesterol levels, or prevent or better manage diabetes.
- Section 4201 authorizes funding, from fiscal years 2010 through 2014, for Community Transformation Grants. If funding is appropriated, these grants will support community-wide strategies to promote healthier behaviors, reduce the incidence and severity of chronic illness, and reduce racial and ethnic disparities.
- Section 5405 authorizes $120 million a year for 2011 and 2012 to establish state and regional primary care hubs and extension centers to spread improved models of primary care, including the patient-centered medical home.[3] SustiNet could seek to establish itself as such

a hub, facilitating the development of improved care models for both SustiNet enrollees and other state residents.

PPACA also includes initiatives related to workforce development and obesity and tobacco use. These initiatives could play a role in the comprehensive plans being prepared by the above-described task forces established under the 2009 SustiNet law.

2. SustiNet as an option for employers and individuals, both before and after 2014

The 2009 law did not limit SustiNet to state-sponsored populations. Instead, the law made SustiNet an option for purchase by other Connecticut residents and employers.

Of course, nothing in PPACA prevents the state from implementing the the 2009 law's provision that, effective July 1, 2012, SustiNet must be offered for purchase by small firms, non-profits, and municipalities.[4] In the wake of PPACA, SustiNet could continue to be offered to Connecticut's small firms and individuals in 2014 and later years via the exchange. This will require SustiNet to become a state-licensed insurance product. It will also require SustiNet to offer plans in the exchange that involve substantial out-of-pocket cost-sharing.[5]

A policy approach to ban SustiNet from the exchange would disregard the judgment reached by the Connecticut General Assembly about the value added by SustiNet as an option for purchase by the state's firms, municipalities, non-profits, and individuals. PPACA does not change the facts pertinent to that judgment in any meaningful way. The federal legislation assures that the exchange will include at least one plan offered by a nationwide, non-profit insurer, but such a plan is not required to incorporate any of the delivery system reforms envisioned by the 2009 SustiNet law. These reforms are the heart of the 2009 legislation's strategy for slowing health care cost growth in Connecticut.

3. Implementing the Basic Health Program option, in 2014 and later years

Beginning in 2014, we recommend that Connecticut implement the Basic Health Program (BHP) option, as described above. Almost certainly, per capita federal payments through BHP will equal or exceed the average cost of HUSKY coverage for adults.[6] As a result, BHP implementation would provide full federal financing for SustiNet coverage of adults between 133 and 200 percent of FPL, furnishing these adults with benefits and cost-sharing protections modeled after existing HUSKY coverage of low-income parents.

Implementing the BHP option will yield several advantages. First, it will prevent HUSKY parents with incomes between 133 and 185 percent FPL from experiencing the substantial increase in premiums and out-of-pocket costs that would otherwise result if they were shifted to the exchange and received subsidies that were limited to federal tax credits and assistance with out-of-pocket costs. To illustrate the magnitude of that increase, a parent with income at 151 percent of FPL, or $2,304 a month for a family of three in 2009, today receives HUSKY coverage without a premium, deductibles, or copayments beyond nominal levels. If such a parent was shifted to the exchange and received only tax credits and other subsidies under PPACA, he or she would pay a premium of 4 percent of income, or $92 a month, and would have copayments and deductibles that consume 13 percent of average health care costs.

Second, the BHP option would let Connecticut terminate its share of Medicaid payments for parents with incomes above 133 of FPL who qualify for HUSKY under current law. This would realize net savings to the General Fund. Without the BHP option, Connecticut policymakers would need to choose between terminating HUSKY above 133 percent of FPL, thus shifting parents from HUSKY into the federal subsidies that make coverage much less affordable; or retaining HUSKY and continuing to pay 50 percent of health care costs that could instead be paid entirely by the federal government. Put simply, the BHP option will let Connecticut stop paying for adults above 133 percent of FPL without reducing affordable access to care by HUSKY parents.[7]

Third, the BHP option would use the same health plan—SustiNet—to cover households throughout a broader income range, increasing continuity of coverage and care. If a family's income moves above or below 133 percent of FPL but remains under 200 percent of FPL, the family will stay in the same health plan and continue to use the same provider network. By contrast, if adults above 133 percent of FPL went into the exchange, coverage and care could be disrupted when income fluctuations force a shift between HUSKY and the exchange.

Finally, by increasing the number of covered lives within SustiNet, the BHP option would increase the critical mass of consumers who receive coverage through a system that is focused on delivery system reforms. Only if a large number of patients participate in such a system can Connecticut's doctors, nurses, hospitals, and other providers reasonably consider making major changes in how they deliver care.

Remaining questions

Even with these three components identified as core elements of the state's approach to implementing SustiNet in the wake of federal reforms, many remaining questions need to be answered. The Board's final report to the Connecticut General Assembly, due before January 1, 2011, will propose an approach to these and other outstanding questions, which ultimately will need to be resolved by the Legislature.

Some of these questions involve policies that first become effective before 2014. For example:

- **Before 2014, should Connecticut expand HUSKY to cover more low-income uninsured?** The 2009 SustiNet law envisions such an expansion, although the time frame is unspecified. Under PPACA, less federal funding is available before than after 2014. Accordingly, coverage expansion will be more costly to the state if it begins before 2014. As Connecticut's budget situation continues to evolve, state policymakers will need to weigh the health and other benefits of early coverage expansion against the resulting costs to the state General Fund. A related issue involves streamlined enrollment mechanisms to increase participation by eligible households, which could begin either before or after January 1, 2014. For more analysis of these issues, see Appendix 1 to this report.
- **Before 2014, should Connecticut reform its individual insurance market to forbid discrimination against adults on the basis of health status?** (As noted above, PPACA already forbids such discrimination against children, effective this year.) To pursue this goal, reforms must be carefully constructed. Otherwise, disproportionately high-cost individuals could enroll in individual coverage, potentially increasing premiums to unaffordable levels for many current beneficiaries. For more analysis, see Appendix 2 to this report.

One issue arises both before and after 2014:

- **Should the Legislature adjust particular details of the SustiNet proposal to conform to directions taken by federal policy?** Depending on the issue, policymakers may conclude that Connecticut should not devote time and effort revisiting questions that have already been decided at the national level. For example, PPACA directs Medicare to develop outcome-based quality measures that adjust for patient risk. The SustiNet plan could use similar measures, rather than develop a distinct methodology to establish risk-based quality metrics. For additional examples, see Appendix 3 to this report.

Other questions will affect implementation in 2014 and beyond. For example:

- **How can independence of SustiNet and the exchange be ensured?** The same agency of state government cannot credibly run the exchange while sponsoring one of the plans that competes in the exchange. To avoid such a conflict, Connecticut could let the federal government run the exchange for Connecticut residents. Alternatively, SustiNet could be administered by an independent authority or quasi-governmental agency outside the structure of current state government.[8]
- **How (if at all) should state licensure laws be modified for SustiNet?** As noted above, SustiNet must be a state-licensed insurance product to be offered in the Exchange. State policymakers will thus need to analyze the specific requirements that apply to licensure under current state law and decide whether any of those requirements must be modified in its application to SustiNet.
- **Should Connecticut supplement federal subsidies for state residents with incomes between 200 and 400% FPL?** Such supplements could lower premium costs and out-of-pocket expenses for low- and moderate-income families for whom federal subsidies are insufficient to make coverage affordable. Limiting supplements to enrollees in SustiNet and other health plans implementing delivery system reforms would also have the advantage of encouraging membership in such plans, thus promoting the spread of reforms. Of course, since supplements will require spending General Fund dollars, policymakers will need to weigh these advantages against the resulting cost to the state.

Conclusion

In passing the 2009 SustiNet law, Connecticut's legislators endorsed many of the key policy choices that were later incorporated into federal health reform. Adjusting SustiNet to fit the new federal legislation will thus require minor, rather than major changes.

In fact, national health reform makes it substantially easier for Connecticut to pursue SustiNet's basic approach. Many new resources are now available to cover the state's low-income uninsured and to support the SustiNet plan's reconstruction of health care delivery to focus on patient health, thereby slowing cost growth while improving quality and consumer satisfaction.

Important questions remain for the SustiNet Board to resolve before presenting the Connecticut General Assembly with detailed legislative recommendations for further action. Not subject to question, however, is one key conclusion: federal reform provides a solid foundation for Connecticut's continued pursuit of the basic strategies embodied in the 2009 SustiNet law.

Appendix 1. Options for expanding HUSKY before 2014

Under PPACA, federal matching funds are now available to cover all categories of uninsured residents who meet citizenship and immigration status requirements, up to any income level chosen by Connecticut. This represents a major step forward in the availability of federal assistance. Before PPACA, waivers were required to obtain federal matching funds for adults who were neither elderly, disabled, pregnant, nor caring for a dependent child. Waivers were not accompanied by increased federal funding, so states were required to achieve savings in other parts of their Medicaid programs before they could cover childless adults. Such steps are no longer needed. As noted in the text, this has allowed Connecticut to shift SAGA adults into Medicaid.

An even larger step forward will be taken nationally in 2014, when the federal government will pay 100 percent of the costs of so-called "newly eligible" adults – that is, adults with incomes at or below 133 percent of FPL who would not have qualified for Medicaid under state law before the enactment of PPACA.

State policymakers could simply wait for this greater availability of federal funds before expanding HUSKY or creating other subsidy mechanisms to help low-income, uninsured residents afford coverage. Alternatively, the state could increase eligibility for subsidized coverage before 2014, recognizing that standard federal Medicaid matching rates will apply. For example, in 2012 or 2013, Connecticut could go beyond the incorporation of SAGA into Medicaid by taking the following steps:

- Extending Medicaid or HUSKY eligibility for childless adults above SAGA thresholds to 100, 133, or 185 percent of FPL. The latter is the maximum income level for HUSKY parents under current law.
- Increasing HUSKY eligibility for all adults to 200 or 300 percent of FPL. The latter is already HUSKY's income-eligibility threshold for children.
- Providing sliding-scale premium subsidies up to 300 percent of FPL or 400 percent of FPL. If subsidies reach these income levels, other measures may be needed to prevent a significant erosion of ESI. For example, subsidy eligibility could be denied to workers with affordable access to ESI; large employers that fail to cover their workers could pay a penalty; and individuals could be mandated to have coverage, which would increase the labor market advantages employers receive from offering health insurance.

State policymakers interested in pursuing these options will need to weigh the cost of each coverage expansion against the resulting gains. The feasibility of pre-2014 increases in HUSKY eligibility may be affected substantially by the speed with which the Connecticut state budget recovers from recent deficits.

Similar trade-offs apply to the establishment of expedited enrollment mechanisms before 2014, such as those discussed in the 2009 SustiNet law. For such mechanisms to work effectively beginning in 2014, they would benefit from several years of prior implementation, to assure smooth operation. Statewide early implementation would raise costs to the General Fund, of course. If state policymakers wish to avoid such costs, they could consider pilot-testing

innovative methods for streamlined enrollment before 2014, laying the groundwork for effective statewide implementation after federal funding becomes much more generous in 2014.

Appendix 2. Options for barring insurers, before 2014, from discriminating against consumers with health problems

Nothing prevents Connecticut lawmakers from reforming the state's individual market to forbid insurers from denying or limiting coverage or raising premiums based on an individual consumer's health status. However, such a policy change, by itself, could cause a significant premium increase in the individual market. That is because consumers would no longer pay a penalty for delaying coverage until they know they need health care. The average risk level of recipients of individual coverage would increase, which in turn would raise premiums.

To avoid such a result, PPACA accompanies its insurance market reforms with an individual mandate to purchase coverage and subsidies that seek to make coverage affordable. Connecticut could do likewise before 2014. However, this would be costly to the state General Fund, as explained in Appendix 1.

In short, spending the resources required for a major expansion of HUSKY and other subsidies is an essential precondition of reforming the entire individual market without causing a potentially significant premium increase. That said, a policy approach is theoretically available that, in the absence of major subsidy expansion, could extend individual market reforms to some state residents—namely, those who can already afford coverage without subsidy. For this group, an individual mandate could apply, allowing the application of individual market reforms that forbid insurers from discriminating on the basis of health status. In effect, an individual mandate would be the "quid pro quo" for the protection provided by insurance reforms. Such a step could benefit many of the more than 40,000 Connecticut residents who are uninsured today despite incomes above 400 percent of the federal poverty level.[9]

Appendix 3. How the details of the SustiNet law could be adjusted to conform to the directions taken by PPACA

The following table shows some of the policies in the 2009 SustiNet law that are also addressed, in some fashion, by PPACA. The column on the right asks how SustiNet could be modified to align with the new federal policy direction. While this table illustrates many of the relevant issues facing Connecticut policymakers, it is not an exhaustive catalog of policy issues that involve the intersection of SustiNet and PPACA. To be clear, these issues involve topics where federal law leaves room for states (or health plans, like SustiNet) to either follow a federal model or pursue other directions.

Table A-1. SustiNet policy details that could be adjusted to fit federal law

General issue area	SustiNet policy	Federal policy	Questions about modifying SustiNet in view of federal policy
Health care delivery	SustiNet defines the preventive care services that are exempt from cost-sharing.	Federal law defines the preventive care services that are exempt from cost-sharing	Should SustiNet cover, free of cost-sharing, other preventive services outside the federal definition?
	High-quality providers are publicly recognized.	Federal authorities develop outcome-based quality measures that adjust for patient risk and practice size.	Should SustiNet follow the federal methodology for case mix adjustment? Should SustiNet apply any quality measures other than those recognized by federal agencies?
	Participating providers must report their financial interests involving drug companies, device manufacturers, etc.	Manufacturers must report payments to physicians and other clinicians.	Should SustiNet supplement federal requirements to require specific reports from participating providers? Are there major gaps in the federal law that such reports would fill?
	SustiNet has the flexibility to make additional reforms to health care delivery, including provider payment methodologies, based on emerging evidence.	Many provisions support innovative reimbursement methods (e.g., bundled payments for inpatient care episodes, accountable care organizations, differential reimbursement based on performance, etc.).	Should SustiNet implement similar reimbursement reforms, taking advantage of available federal models and resources?

General issue area	SustiNet policy	Federal policy	Questions about modifying SustiNet in view of federal policy
Health care delivery (cont.)		PPACA authorizes grants that support innovative state policies aimed at medical malpractice.	Should Connecticut use such grants to implement a limited "safe harbor" that precludes malpractice liability for SustiNet-participating providers when patient injury results from following a clinical guideline approved for SustiNet implementation?
		PPACA recognizes models that go beyond the approaches contained in the 2009 SustiNet law (e.g., pharmacist-managed coordination of prescription drugs, intensive support for patient involvement in clinical decision-making, interventions to prevent costly re-hospitalization soon after hospital discharge, community-based wellness demonstrations, community health worker programs).	Should SustiNet implement some or all of these models, in addition to the delivery system reforms in the 2009 state law?
		PPACA authorizes the use of differential cost-sharing that saves Medicare patients money when they use high-quality, efficient health care providers.	Should SustiNet be authorized to use differential cost-sharing to encourage members to use high-quality, efficient providers?
Insurance markets	The Office of Healthcare Advocate develops and updates evidence-based benefit packages, recommending incentives for adoption by employers.	Federal authorities define minimum essential benefits, based on evidence.	Should Connecticut officials develop evidence-based benefit packages, in addition to the federal definition of minimum essential benefits?

General issue area	SustiNet policy	Federal policy	Questions about modifying SustiNet in view of federal policy
Insurance markets (cont.)	Through an independent information clearinghouse, SustiNet and private insurers provide public with information about spending, quality, outcomes, etc.	Federal law (a) requires insurers to provide information about spending, quality, etc., and (b) establishes systems for presenting that information to the general public in understandable and usable form.	Should Connecticut supplement federal requirements with additional requirements for reporting by insurers (including SustiNet) that serve Connecticut residents? Should Connecticut operate a separate information clearinghouse or rely on the information dissemination framework created by PPACA?
	Individuals offered ESI may choose SustiNet instead, but only if ESI is unaffordable or insufficiently comprehensive. When workers choose SustiNet, they bring with them the money their employer would have spent on their premiums.	Individuals offered ESI may use the exchange instead, but only if ESI is unaffordable or insufficiently comprehensive. In some cases, when workers use the exchange, they bring with them the money their employer would have spent on their premiums ("free choice vouchers").	Should SustiNet be available to workers offered ESI who cannot access the exchange, under federal law? Should Connecticut increase workers' access to free choice vouchers when they use the exchange rather than accept ESI offers?
Public coverage programs	Board authorized to pay reimbursement sufficient to cover the reasonable cost of care.	For 2013 and 2014, Medicaid reimbursement for primary care providers increases to Medicare levels. Federal government pays 100% of costs.	Should Connecticut raise Medicaid and HUSKY reimbursement for other providers? For years following 2014? To private levels, which exceed Medicare levels?

Endnotes

[1] Good summaries are available elsewhere, including the Kaiser Family Foundation's health reform web page, http://healthreform.kff.org/.
[2] In 2009, the federal poverty level was $10,830 a year for a single individual, $14,570 for a 2-person household, $18,310 for a 3-person family, etc.
[3] It remains to be seen whether this authorized funding will in fact be appropriated.
[4] As under the 2009 law, the same rules and channels of sale that apply to other small group plans would also apply to SustiNet. Two issues not resolved by the 2009 SustiNet law are outside the scope of this report because they are not affected by the enactment of national reform: namely, the interaction between the SustiNet Plan and the Municipal Employees Health Insurance Plan (MEHIP), and access by private employers to a new initiative being undertaken by the Comptroller to lower the cost of prescription drugs by purchasing on behalf of multiple public programs and agencies.
[5] Under PPACA, each plan offered in the exchange must be available at both "silver" and "gold" levels of actuarial value. These actuarial value standards respectively require consumers to pay, on average, 30 percent and 20 percent of health care costs. PPACA also permits SustiNet to offer plans with lower consumer cost-sharing levels.
[6] As of 2015, the Congressional Budget Office (CBO) estimates that the average subsidy in the exchange will equal $5,200. CBO, *Preliminary Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872*, March 18, 2010. For the lowest-income adults in the exchange, subsidies will be higher. By contrast, average annual per capita costs for non-disabled adults under age 65 in Connecticut's Medicaid program were $2,591 in FY 2006. Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, "Medicaid Payments per Enrollee, FY2006," *statehealthfacts.org*, 2009.
[7] On the other hand, if they were shifted into the exchange, HUSKY parents would be enrolled in private plans that pay higher provider reimbursement rates than HUSKY and thus may offer greater choice of provider. In our judgment, that factor is outweighed for these low-income families by the impact of greatly increased cost-sharing impairing access to care and utilization of essential services.
[8] Another approach would organize SustiNet as a member-owned cooperative, using resources (including a loan of initial capital that would need to be repaid in 5 years) that PPACA offers to help establish such plans. It is not clear that this option is available to SustiNet, however. PPACA forbids the use of this funding for entities that offered insurance before July 16, 2009 or for plans that are sponsored by state or local government.
[9] Gruber Microsimulation Model, analyzing CPS-ASEC data for 2007-2008.