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HEALTH INSURANCE EXCHANGE PLANNING REPORT

THE STATE OF CONNECTICUT

JANUARY 19, 2012

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Introduction

In April, 2011, the State of Connecticut Office of Policy and Management (State) hired Mercer to provide projections and guidance related to the planning, research and data analytics that will help to establish the policy direction and implementation strategy for the State's Health Insurance Exchange (Exchange) as outlined under The Patient Protection and Affordable Care Act (PPACA). The scope of the report is defined in bid number OPM PDPD_InsuranceExchangePlanning_020111 issued by the State and the scope of work was further clarified through discussions with State staff. Work on the project officially began on June 24, 2011.

About This Report

In June 2011, Mercer began working on eleven task areas that will provide the State with a solid baseline foundation for thoughtful decision making around its Exchange. In order to cover each task area in a comprehensive manner, Mercer collaborated within the Mercer family of companies to include Mercer Government Human Services Consulting, Mercer Health & Benefits, and Oliver Wyman. This collaboration also included an outside consultant, Health Management Associates, Inc (HMA).

The report that follows provides details around the research and analysis performed by Mercer and its contributing partners. This report is broken down into "chapters" that follow the numbering system identified in the RFP, each correlating to eleven task areas as follows:

TASK 1: Assess the State's uninsured and underinsured population under the various types of coverage, including government-sponsored coverage.

TASK 2: Survey the health insurance carriers that offer coverage to Connecticut residents to better understand the types of plan designs being sold, the corresponding premium levels and the number of enrollees in each market segment (group and non-group). This information will help to calibrate the micro-simulation model to be specific to the current market environment in Connecticut.

TASK 3: Survey the small employer market (<50 and 50–100 employees) to identify current and anticipated future benefit design needs and other issues. This information will be included in the modeling of the Connecticut market place and utilized to project the possible impact that certain policy decisions may or may not have for the small employer. These decisions include tax credit and hiring decision impacts, and whether employers will offer coverage and whether they will purchase it in or out of the Exchange.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

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TASK 4: Conduct economic and actuarial modeling and analyses to project trends such as the number of newly insured, the impact of certain market changes on premium levels and the implications of different policy questions including:

- Task 4a: The pros and cons for Connecticut to maintain a separate high risk pool or integrate it in the non-group market
- Task 4b: The pros and cons of expanding the definition of small group in Connecticut to include employer groups with 51 to 100 employees prior to 2017
- Task 4c: The impact of an Exchange on employer provided insurance and specifically the impact of employer penalties and tax credits by different scenarios
- Task 4d: The implications for pricing in the small group and non-group markets and the implications of merging the markets
- Task 4e: The impact of the individual mandate to purchase health insurance, its influence on the market and the assumptions made in that regard with respect to the modeling
- Task 4f: The impact to the markets and the HIE if the Basic Health Program (BHP) option is considered
- Task 4g: The potential cost to the State related to the Connecticut health benefit mandates that are assumed to be in excess of the federal essential health benefits package
- Task 4h: The impact of the HIE on insurer profitability and potential market exit
- Task 4i: The impact of the Exchange on household budgets

TASK 5: Analyze the impact of the large group market participation in the Exchange after 2017.

TASK 6: Analyze the impact of the HIE in regards to interaction with other health system initiatives in Connecticut such as Health Connections and Charter Oak.

TASK 7: Develop a financial model for the HIE (cash flow) to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges.

TASK 8: Assess the technical requirements and development of specifications for accounting and financial system functions for the HIE.

TASK 9: Assess the existing Medicaid eligibility system and identify interface issues and necessary requirements for integration with the Exchange information technology (IT) infrastructure.

TASK 10: Provide an impact study of the Medicaid program on the HIE.

TASK 11: Options for a multi-state and federal HIE collaboration

Mercer and our partners presented the team's findings from each task to the Exchange Board (Board) during three Board meetings in 2011 – November 17, December 1 and December 15.

The information was then presented to the State in a draft report for each task in December. Valuable feedback was provided by the State through a serious of written comments and conference calls. This feedback is incorporated into the final report.

The final report is comprised of a section on the executive summaries for each task followed by a report on each of the 11 task areas. Mercer encourages the reader to read the report in its entirety as many of the sections intersect with each other to some degree.

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Health Care Reform Disclosures

It was Mercer's goal is to provide objective, unbiased information for use in decision making by the Board as it relates to their Exchange planning activities. Where appropriate, Mercer provided recommendations and possible implications (pros/cons) for certain decisions understanding that each decision is fluid and one decision may alter or change the decision for another issue. Many of these decisions are complex and should be viewed in light of the entire Exchange and the welfare and benefit for all Connecticut citizens, not simply made in isolation for each task.

There remains significant uncertainty surrounding the projections and estimates made in this report due to constraints such as imperfect data, changing and or future legislation and assumption of behavior at the individual and group levels. Mercer recommends the Exchange Board understand these constraints and continue to refine the analysis during Connecticut's future planning. Mercer also encourages the State to continue to solicit input from all stakeholders in the Exchange planning.

Mercer has prepared these projections exclusively for the State, to estimate the range of the impact of federal Health Care Reform as it pertains to a state Exchange. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

For our analysis, we relied on data and information provided by several carriers operating in Connecticut and other sources of data as described in this report. We have relied on these data without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data, and it should also be noted that our review of data may not always reveal imperfections. We have assumed that the data provided is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

In addition, the projections we show in this report are dependent upon a number of assumptions regarding the future economic environment, medical trend rates, carrier behavior, the behavior of individuals and employers in light of incentives and penalties, and a number of other factors. These assumptions are disclosed in our report and have been reviewed by the Board and its consultants. While this analysis complies with applicable Actuarial Standards of Practice and Statements of Principles, users of this analysis should recognize that our projections involve estimates of future events, and are subject to economic, statistical and other unforeseen variations from projected values. To the extent that future conditions are at variance with the assumptions we have made in developing these projections, actual results will vary from our projections, and the variance may be substantial.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the Patient Protection and Affordable Care Act (PPACA) and Health Care Education and Reconciliation Act (HCERA) have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding PPACA and HCERA. Such decisions should be made only after careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly the State understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise. The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

The financial projections contained in this report must be interpreted as estimates and are based upon the information and data available at a point in time. All estimates are subject to unforeseen and random events and, therefore, any projection must be interpreted as having a likely range of variability from the estimates provided.

Copies of electronic signatures for the Actuaries involved in the actuarial modeling conducted as part of Task 4 of this report can be found in attached file labeled: *Health Care Reform Disclosures.pdf.*

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Executive Summaries

Following are the executive summaries for each of the eleven tasks areas reviewed under the Connecticut Health Insurance Exchange planning project

TASK 1 – Assessment of the Uninsured in Connecticut

Executive Summary

As Connecticut (State) prepares for implementation of a Health Insurance Exchange (Exchange) and the expansion of Medicaid under the Patient Protection and Affordable Care Act (PPACA), the State needs information about the number and characteristics of State residents that are currently uninsured or underinsured to better understand the potential impact on the Exchange and other programs within the State. The analysis contained in this report provides Connecticut with these numbers and characteristics of non-elderly individuals by federal poverty level (FPL) and coverage source in order to help Connecticut make informed decisions regarding the uninsured and underinsured individuals that might enroll in the Exchange and other programs.

Among the key data that will inform Connecticut's planning for the Exchange and expansion of Medicaid is information on the uninsured in Connecticut by the following groups:

1. People who are eligible for Medicaid today plus those who will be eligible under the expansion of Medicaid per the PPACA (individuals with income at or below 138%[1] of the FPL that do not meet current Connecticut Medicaid eligibility criteria).

2. People who would be eligible for either a Basic Health Program (BHP) or would be eligible for subsidized coverage through the Exchange (adults that are citizens or legal immigrants with incomes from 139% to 200% of FPL and legal immigrants with fewer than five years US residency with incomes below 139% of FPL).

3. Additional individuals that would be eligible for subsidized coverage through the Exchange (with incomes from 201% to 400% of FPL).

4. Higher-income individuals not eligible for subsidies that might, nevertheless, choose to purchase coverage through the Exchange.

Table ES-1 reflects a distribution of the uninsured[2] in Connecticut based on work of the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured to refine the income distribution from the Census Bureau's Current Population Survey (CPS). Due to the limited size of the CPS sample, a distribution of coverage by more detailed income strata is only possible for employer-based coverage, Medicaid and the uninsured. (See tables in Appendix 1A.) For other tasks it was necessary to extrapolate this data to the specific income categories applicable for the Exchange.

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[1] While the PPACA defines Medicaid expansion as coverage for all low-income non-elderly with incomes at or below 133% of the FPL, the expected implementation of the new Modified Adjusted Gross Income (MAGI) will include a "disregard" which increases the gross income limit to 138% of FPL.

[2] Uninsured individuals are defined as those that do not have health care coverage through either private or public programs, including employer-sponsored insurance, individual insurance policies, Medicaid, Medicare, TriCare (for uniformed service members, retirees and their families) and other comprehensive public coverage programs.

Table ES–1

Distribution of the Non-elderly in Connecticut by FPL and Coverage Source, 2008–2009 CPS Data With Kaiser/Urban Health Insurance Unit Adjustment

	Uninsured	Employer	Individual	Medicaid	Other Public	Total Population
Up to 138% FPL	155,700	116,300	37,900	198,900	23,900	532,800
Between 139% and 200% FPL	65,400	85,700	18,300	58,000	9,700	237,000
Total up to 200% FPL	*221,100*	*202,000*	*56,200*	*256,900*	*33,600*	*769,800*
Above 200% FPL	155,900	1,863,100	93,000	95,500	17,100	2,224,500
Total	377,000	2,065,100	149,200	352,400	50,700	2,994,300

Key Findings

Data on the uninsured indicate the following possibilities:

- About 156,000 of the currently uninsured would qualify for Medicaid. Most likely, these are primarily “childless adults”. Additionally, an estimated 3,500 of the uninsured individuals between 139% and 200% of FPL are low-income children that would qualify for HUSKY B with Children’s Health Insurance Program (CHIP) funding today. (Data not shown in Table ES-1.)

- More than 116,000 individuals might be able to move from employer-based coverage to Medicaid.

- Nearly 40,000 persons with individual coverage might be able to drop those policies and enroll in Medicaid expansion. (However, it is likely that a large portion of this population was enrolled in the State Administered General Assistance (SAGA) medical assistance program in 2009.)

- About 237,000 individuals are in the income range for a BHP. Of that total, only 65,400 are uninsured.

Use of the data in Table ES-1 must be tempered with the observation that the CPS routinely results in an understated Medicaid enrollment. National analysis of the “Medicaid undercount” indicates that many individuals enrolled in Medicaid report their status as either privately insured or uninsured.[3] The “other public” category, which would include disability-based Medicare and SAGA in 2008–2009, also appears to be undercounted. It is likely that the number of individuals that are uninsured and the number of individuals that are privately insured are both overstated. These data indicate the universe of individuals that might be eligible to participate in Medicaid, in a BHP or in the Exchange.

[3] Analysis of CPS and Medicaid enrollment data for 2000 through 2005 is available at: http://www.shadac.org/publications/snacc-phase-v-report

Future reports on this project will assess the number of individuals that are likely to actually enroll in these programs.

Recommendations

- These population estimates should be updated using 2010 CPS data once CPS data with the Urban Institute health insurance unit (HIU) adjustment is available on the Kaiser Family Foundation's website at www.statehealthfacts.org.

- All estimates should be updated annually during the Exchange planning and implementation process in order to capture changes in the baseline data.

Connecticut also requested information about the "underinsured". Task 2 of the planning project provides information about insurance coverage in Connecticut that may result in underinsurance due to high deductibles, annual benefit limits or any other features that would result in an individual who has insurance not being able to receive necessary health care. One possible measure of underinsurance is the actuarial value of a health insurance policy – or the proportion of health care costs that, on average, are covered by the premium (rather than by out-of-pocket costs, such as deductibles and copayments, or costs that exceed benefit limits). Task 2 found that premiums covered less than 60% of the expected cost of health care for 47% of health insurance purchased directly by individuals and 45% of health insurance purchased through employers with fewer than 50 employees.[4] (See Task 2 detailed report.)

[4] It should be noted that while the Health Management Associates (HMA)/Mercer team was able to assess the proportion of contracts for which premiums covered less than 60% of the expected cost of health care, there was no review of the extent to which the benefits were less than or perhaps exceeded the "essential benefits" requirements of the Affordable Care Act. (At the time of this analysis, the "essential benefits" had not yet been defined.) As Connecticut prepares for implementation of an Exchange, further work is required to better understand the level of coverage purchased in Connecticut's individual and small group markets.

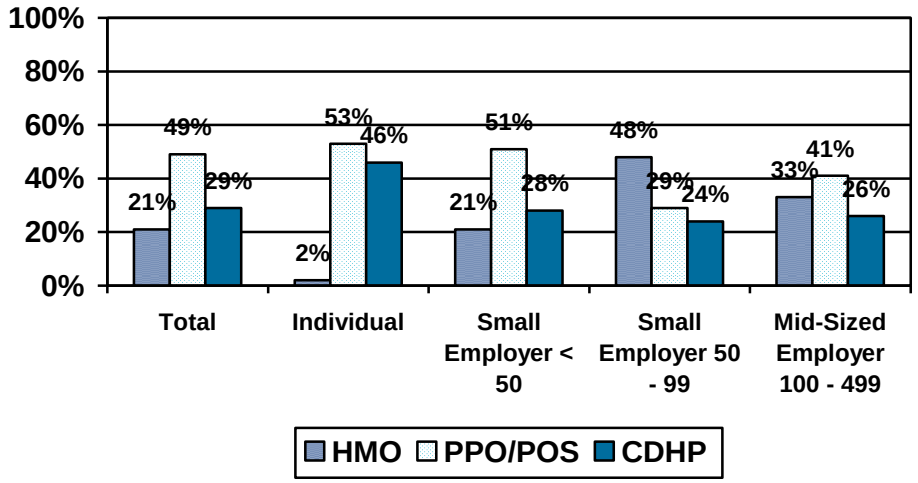
TASK 2 – Survey of Connecticut Health Insurers

Executive Summary

As the Board begins to consider the potential range of products that are offered through the Exchange, it is important that it be grounded in the types of products that individuals and small employers are purchasing today. There has been limited Connecticut-specific data available on the types of plans that individuals and small employers have been purchasing. To fill this gap, Mercer conducted a survey of Connecticut's major health insurers. Survey findings are summarized here:

- It appears that the majority of policies bought by individuals and small employers are at or below the Bronze level established as the minimum coverage level available on the Exchange.
- Small employers have relatively high rates of consumer-driven health plan (CDHP) adoption. The extent to which employers are funding CDHP health savings accounts is unknown.
- Connecticut premiums are slightly higher than national averages, consistent with survey data that finds that health care costs in the Northeast are the highest in the country.[1]
- Individuals and small employers appear to be purchasing plans with higher out-of-pocket features (deductibles, out-of-pocket maximums) in order to control their premiums.

Connecticut, Enrollment by Product Type and Market[2]



[1] Mercer 2010 National Survey of Employer-Sponsored Health Plans

[2] Mercer/Oliver Wyman 2011 survey of Connecticut major health insurers

Nationally, enrollment in CDHPs has been rising as enrollment in traditional health maintenance organization (HMO) plan designs has fallen. This pattern is true in Connecticut as well, with CDHP enrollment in the individual market at 46% and 28% in the small employer market.

Plan Design

The Patient Protection and Affordable Care Act (PPACA) establishes tiers of health insurance coverage that will be offered in the Exchanges – they'll be standardized so that insurers are covering the same package of essential benefits without dollar limits in each of the five types of plans: Bronze, Silver, Gold, Platinum and the catastrophic plan, which will generally be available only to people under age 30 or who have a financial hardship exemption from the individual coverage mandate.

The levels of coverage are defined by their actuarial value. Actuarial value represents the percentage of medical expenses that an insurer is expected to cover for a "standard" population.

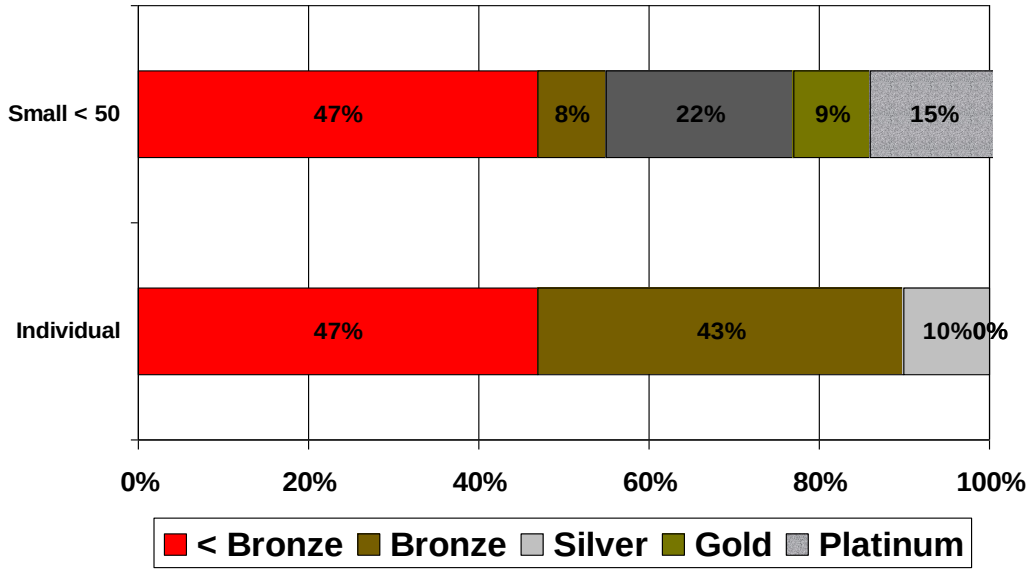
Illustration of Exchange Plan Offerings

Features	Exchanges					Group
	Bronze	**Silver**	**Gold**	**Platinum**	**Catastrophic (age <30)**	**Plan design[1]**
Plan value	**60%**	**70%**	**80%**	**90%**	HSA rules	≥60%
Covered services	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential benefits not required
Essential benefits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limit if covered
2014 deductible maximums[2]	HSA rules	HSA rules	HSA rules	HSA rules	HSA rules	$2,000 (I) $4,000 (F)

Figure notes:
1. Some provisions apply differently for grandfathered and non-grandfathered plans.
2. Appear to apply to employer plans and are based on current understanding, subject to change based on further guidance and regulations. Individuals who have a financial hardship exemption from the individual coverage mandate may also select the Catastrophic plan

Most Connecticut individuals and small businesses are purchasing medical plans that have actuarial levels that are at the Bronze level and below.

Connecticut Insurer Survey – Actuarial Value of Plans Sold Today, Based Upon Membership by Market Segment[3]



Actuarial value and price are closely related to one another. All other things being equal (group demographics, network discounts, administrative costs, etc.), premium will be lower if the insurer has less responsibility for paying for covered services.

A note of caution as we look at the relatively high percentage of Connecticut individuals and small employers offering plans at Bronze or less actuarial values: insurers do not report the value of employer self-insured contributions to CDHP savings accounts. The actuarial value of CDHPs will be understated for those plans where employers are making a contribution, and Connecticut has meaningful enrollment in CDHPs.

Premiums

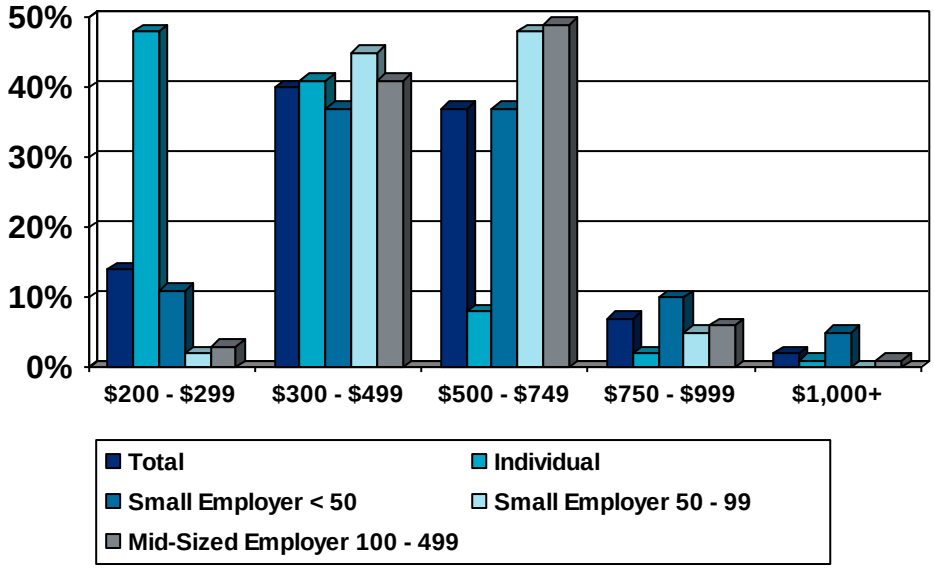
In 2010, the national average "single" (one adult) plan cost for a preferred provider organization (PPO) was $448 per month and $413 for an HMO[4]. For the 2010 tax year, the IRS reported that the average annual premium for the Connecticut small group market was $5,419 ($452 per

[3] Mercer/Oliver Wyman 2011 survey of Connecticut major health insurers. Four of the five surveyed insurers provided their calculated actuarial values for the small employer < 50 market. Actuarial value for the individual market was derived from rating data provided by insurers.

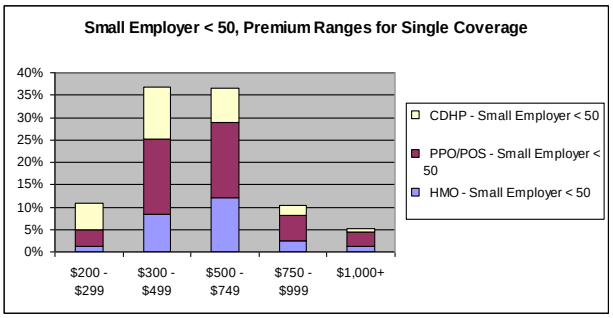
[4] Mercer 2010 National Survey of Employer-Sponsored Health Plans.

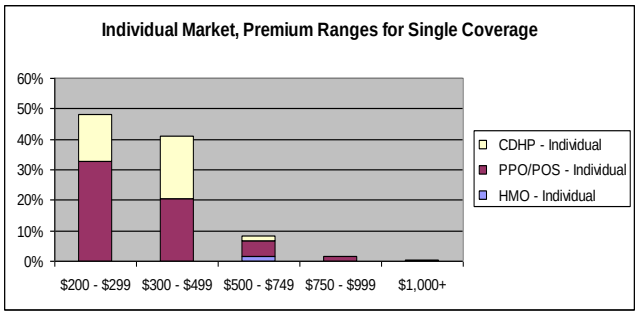
month) for single coverage and $13,484 ($1,124 per month) for family coverage.[5] The Connecticut insurer survey found that the majority of policies for single coverage ranged in price from $300 to $749.

Connecticut – Monthly Premium for "Individual" or "Employee Only" Coverage



As the Board considers the products it offers on the Exchange, it will be important to offer products that recognize the lower premium levels that individuals and small employers have been purchasing. Of particular interest to individuals and small employers will be products that appear to only be available through CDHP and PPO/point-of-service (POS) plan designs.





[5] IRS Code, Part 1, Section 45R, available at www.irs.gov/pub/irs-drop/rr-10-13.pdf

TASK 3 – Small Employer Market Assessment

Executive Summary

The purpose of this report is to provide the Board with insight into the current and future needs of the small employer market. This insight will allow the Board to position its products and services to meet the needs of the small employer market.

Connecticut Small Employer Market

1. The ability of the Board to influence the affordability of health insurance premiums requires an understanding of the underlying cost pressure on premiums. Before plan design changes, employer health care costs have been rising an average of 9% for the last five years[1].

   A. These increases have been driven by:

      i. Citizens that are increasingly unhealthy primarily as a result of excess weight

      ii. A healthcare system that is not as efficient or effective as it should be

      iii. Patients being treated by providers whose quality varies greatly

      iv. A system of paying providers that is ineffective, with compensation paid for simply providing more services, often without regard to outcome

      v. A primary care system that is undervalued and has not received the financial support that it should have. The consequence is the unsatisfying eight-minute visit with the primary care doctor that many of us experience

2. Connecticut's existing small employer market is very competitive, with four insurers actively competing for market share.

3. Small employers are very price sensitive. This is apparent in the relatively low actuarial value of the plans that small employers are purchasing in Connecticut. While small employers want to provide more comprehensive benefits, they have had no choice but to reduce the value of benefits offered to obtain the premium that they can afford.

4. Federal and State insurance regulations are going to make it difficult for the Exchange to have a meaningful impact upon premiums. These rules are intended to prevent adverse selection in the marketplace.

[1] Mercer 2010 National Survey of Employer Health Plans. Connecticut specific cost-change data is not available; however, Mercer believes that the experience of Connecticut employers is similar to the national data.

5. It is unlikely that many small employers in Connecticut will be attracted to the Exchange:

    A. Connecticut already has a successful private Exchange, the Connecticut Business and Industry Association's (CBIA's) Health Connections

    B. Plans offered inside the Exchange can be offered outside of the Exchange and, if they are, they must have the same price

6. The small employer market needs more product innovation and the Board/Exchange can positively influence premiums by leading the introduction of new innovative products. Innovative products are being offered in other parts of the country and not in Connecticut because of State insurance laws and regulatory review.

7. Lessons learned from other Exchange experiences include:

    A. The Exchange must understand and quickly react to the small employer marketplace

    B. Exchanges do not work without the support and participation of health insurers

    C. Successful exchanges have treated brokers and other established distribution channels as partners

    D. The Board must understand and effectively manage Adverse Selection

8. There are elements of the small employer market that are not purchasing health insurance, despite tax credits. The biggest segment of this market is employers with less than 10 employees in certain industries: construction, financial services and real estate, retail trade and professional services.

Recommendations

The following are recommendations for the State to consider as they continue to assess the small employer market:

- The key to providing affordable products that meet the needs of small business is the development of products that consider and attempt to improve the underlying drivers of health care cost. Given its mission of reducing the number of uninsured and making coverage more affordable, the board is in a unique position to influence state law and regulation so that more innovative and affordable coverage becomes available. New products should consider:

    – The innovative approaches that large employers have taken

    – The price sensitivity of these populations

  - The willingness of these participants to try new approaches if it saves them money

- A critical policy decision for the Board will be how it interacts with the CBIA exchange. With 75,000+ members, CBIA plays a key role in today's small employer market. Duplicating what CBIA has done would be difficult, expensive, and disruptive.

TASK 4 – Overview of Tasks 4a to 4i

Following are executive summaries for each of the sub-task areas analyzed as part of Connecticut's request for an economic and actuarial modeling and analyses to project trends within the Health Insurance Exchange (Exchange).

Connecticut asked Mercer and its team to address the following scenarios:

- Task 4a: To integrate high risk pools in the non-group market or maintain high risk pools separately
- Task 4b: Advantages and disadvantages of expanding the definition of small group from 50 to 100 employees prior to 2016
- Task 4c: Impact of an Exchange on employer-provided insurance and, specifically, the impact of employer penalties and tax credits by the different scenarios
- Task 4d: Implications of merging the markets for pricing in the small group and the non-group markets
- Task 4e: Impact of the individual mandate to purchase health insurance and its influence on the markets and the assumptions made with respect to the models
- Task 4f: Feasibility of a basic health program (BHP)
- Task 4g: The cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market
- Task 4h: Impact of the Exchange on insurer profitability and potential market exit
- Task 4i: Impact of the Exchange on household budgets

The Oliver Wyman HRM Model was used to address several questions related to the design and operation of the individual and Small Business Health Options Program (SHOP) Exchanges. As further described in the report, the model is based upon the assumption that consumers will select the option that maximizes the utility for the health insurance unit (HIU). Employers' decisions to offer or continue offering coverage is based on a demand elasticity curve. Significant rate shock for some small groups and individuals in the State will result in dropped coverage or movement among coverage levels in the new market, as healthier consumers react to premium increases associated with the new rating rules. Other consumers who are currently not covered may be attracted to the marketplace as premiums become more affordable for them, or as financial penalties associated with the individual mandate reduces the utility associated with remaining uninsured. Finally, other consumers, many of whom will be newly eligible for Medicaid, will leave the insurance market to participate in that program.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

TASK 4a – To Integrate High Risk Pools in the Non-group Market or Maintain High Risk Pools Separately

Executive Summary

The State of Connecticut's (State's) Health Reinsurance Association (HRA), the State's high risk pool, is among the oldest high risk pools in the country. The HRA is funded through a combination of premiums, assessments and federal grants. By statute, premiums under the HRA are set to be equal to no less than "125% nor more than 150% of the average group rate charged for that classification or group with similar characteristics under a policy covering 10 lives."[1] In 2010, premiums were set at the top end of this range.[2] Assessments are made against HRA member companies (commercial carriers and stop-loss carriers). In 2010, the assessment totaled $11 million. The HRA also includes an option for low-income insureds, the Special Health Care Plan, which pays providers 75% of Medicare reimbursement to keep premiums affordable. At the end of 2010, the HRA had 1,870 active covered lives.

Premiums under the HRA in 2010 were $21.7 million, and claims were $31.2 million.[3] The loss ratio (claims divided by premium) under the HRA is 1.439. If premiums were adjusted to 100% of the standard rate and claims were adjusted to commercial levels to remove the low provider reimbursement under the Special Health Care Plan, the loss ratio would increase to 2.588.

In 2010, total premiums in the individual market were $362.5 million, and incurred claims were $251.3 million.[4] The resulting loss ratio was 0.693.

To model the effects of rolling the HRA membership into the individual market, we started with the experience in the individual market and adjusted this experience under two assumptions. First, we recognized the expected growth in the number of insureds in the individual market in 2014. Second, we reflected the expected increase in morbidity in the individual market that we describe in Task 4d; this increase in morbidity arises as a result of the availability of premium and cost sharing subsidies and the mandate, and the influx of the previously uninsured. The expected increase in morbidity in the individual market would increase the loss ratio to 0.776.

We then included the experience of the HRA, with that HRA experience adjusted to commercial premiums and reimbursement. The result is an increase in the loss ratio by 2.6 percentage points to 0.802.

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[1] Connecticut General Statute Chapter 700c, 38a-556c.

[2] Private communications with Pool Administrators, Inc., the organization administering the HRA.

[3] Health Reinsurance Association (Connecticut) Statutory-Basis Financial Statements as of and for the Years ended December 31, 2010 and 2009.

[4] Oliver Wyman summaries of the 2010 statutory Supplemental Health Care Exhibits.

It is likely that the HRA enrollees will migrate to the individual market in 2014. Premiums will be lower in the individual market than in the HRA, and these enrollees will have guaranteed access to coverage. In addition, they may be eligible for premium and cost sharing subsidies based on income.

The HRA enrolled population is very small relative to the expected individual market in 2014, and it would likely contribute less than 2% of premium. So, while claims are considerably higher than premium, adding these enrollees to the individual market would increase the loss ratio by 2.6 percentage points.

The State does have the option of continuing the HRA assessment. However, it may be difficult to have the assessments follow the HRA members given privacy concerns and the fact that an individual who met the eligibility criteria for the HRA at one point in time may not be eligible for the HRA at some future date. In addition, the payout of the assessments would have to be coordinated with the risk adjustment and reinsurance programs that will be operational in 2014. Finally, the State would have to devise an alternative means of calculating the assessment in 2014 and beyond. If the State were to continue the assessment at 2010 levels, increased for premium trend, and if the assessment were used to support the individual market, premiums would be roughly 1% lower.

TASK 4b – Advantages and Disadvantages of Expanding the Definition of Small Group from 50 to 100 Employees Prior to 2016

Executive Summary

Connecticut defines small groups as those with 1 to 50 employees.[1] The Patient Protection and Affordable Care Act (PPACA) defines small employers as those with up to 100 employees but gives states the option to define small employers as those with up to 50 employees, until January 1, 2016.[2] Premium rates in the small group market are calculated on the basis of modified community rating, and they can only vary based on a given group's demographic makeup. Allowable factors include such things as age, gender and family size. [3] In contrast to the small group market, premiums in the mid-group market (i.e., groups with 51 to 100 employees) are based, in part, on the employer's experience (i.e., the health risk of the group's members).

The PPACA will introduce additional incentives for groups to self-insure their health benefits, beyond those which currently exist. The PPACA includes an annual tax on health insurance providers that begins in 2014 at $8 billion and increases thereafter.[4] These fees are estimated to increase premiums by roughly 2%.[5] More significantly, a move to modified community rating for mid-sized groups would likely push some of the healthiest mid-sized groups to self-insure to avoid subsidizing the claims of less healthy groups.

In addition, we note that self-insuring in Connecticut is allowed at relatively low attachment points, meaning that groups that choose to self-insure their medical programs do not necessarily need to assume significant risk.[6] Further, under the proposed federal regulations, the Small Business Health Options Program (SHOP) Exchange must "permit a qualified employer to purchase coverage for its small group at any point during the year."[7]

Our modeling results show that opening the SHOP Exchange up to mid-sized groups before it is required in 2016, could increase enrollment in the SHOP by 6,000 lives or 15%.

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[1] Connecticut Statutes, Chapter 700c, Sec. 38a-564.

[2] PPACA Sec. 1304(b)(2).

[3] Connecticut Statutes, Chapter 700c, Sec. 38a-567.

[4] PPACA Sec. 9010.

[5] Carlson, Chris, "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans," October 31, 2011. http://www.ahipcoverage.com/2011/11/02/new-technical-analysis-of-impact-of-premium-tax/.

[6] Connecticut Insurance Department Bulletin Number PC-11 & HC44 requires that the employer's retention must be "at least $6,500 per individual or family."

[7] 45 CFP §155.725.

The advantages of opening the SHOP to mid-sized employers before 2016 would include the following: a moderate increase in the number of enrollees in the SHOP Exchange over which to spread fixed costs, potential access to lower cost insurance for mid-sized groups with high morbidity and potentially greater interest in participating in the SHOP.

However, opening the SHOP Exchange to mid-sized employers prior to 2016 would require the State to accept the PPACA's definition of small employer for the operation of its insurance markets outside of the SHOP Exchange. This would subject all mid-sized employers to the PPACA's modified community rating laws in 2014, which would, in turn, introduce significant premium rate disruption relative to the current market. Keep in mind, small group law currently requires premiums based on modified community rating; premiums in the mid-sized employer market are based, at least in part, on a group's own experience.

There would also be the potential for deterioration in the morbidity of the SHOP Exchange pool as mid-sized employers with relatively healthy work forces could self-insure until their experience deteriorated and it became financially advantageous to enroll in the SHOP Exchange.

TASK 4c – Impact of an Exchange on Employer-provided Insurance and, Specifically, the Impact of Employer Penalties and Tax Credits by the Different Scenarios

Executive Summary

Although employer-provided insurance is, in aggregate, expected to substantially maintain its share of the overall market, some segments of the market will likely have changes occur beginning in 2014 when the Exchange becomes operational. Low wage workers, whether employed by small employers or large employers, who currently have employer-provided insurance, may be moved to Medicaid or subsidized Exchange coverage. Small employers face no penalties for not providing coverage (and some may receive incentives for providing coverage). Larger employers who have significant numbers of low wage workers may find it cost effective to drop employee coverage, thereby sending their employees to the Exchange for coverage, The employer penalties (and incentives for some small employers) in the Patient Protection and Affordable Care Act (PPACA) are insufficient to deter employers from driving such a change. They are also insufficient to encourage employers to begin providing coverage for those that do not already do so.

Another expected change is for those employers that provide medical coverage for their early retirees, those retirees and spouses of retirees are not yet eligible for Medicare. The availability of guaranteed issue coverage in the Exchange may provide these employers a means of removing these persons from employer-sponsored insurance. Employers may provide funding for the Exchange coverage at a defined dollar amount. The premiums for individual coverage in the Exchange are subject to the three to one limit for age as a rating parameter, although actual age-based costs are in the range of five or six to one. The early retirees are generally in the 55 to 64 age group, which has higher costs than younger persons, so the premiums for early retirees will be subsidized through higher rates charged for younger persons covered in the Exchange. Employer-sponsored medical coverage for early retirees (as well as retirees eligible for Medicare) care has been declining over recent years; public sector employers and larger private sector employers more commonly offer the coverage than smaller private sector employers. PPACA has provided financial assistance for employers that continue to pay for retiree medical coverage for early retirees through the Early Retiree Reinsurance Program (ERRP) for high cost early retirees, but that program's $5 billion is almost fully paid out, with $4.5 billion having been paid as of December 2, 2011. The expiration of the ERRP will be a contributing reason for employers to consider eliminating medical coverage for their early retirees once Exchange coverage is available. The availability of retiree medical coverage has been declining as employers have seen accounting rules require the recognition of retiree medical costs over the employees' working lifetime instead of on a pay-as-you-go basis and seen those pay-as-you-go costs rise. The table below shows information from the 2010 Mercer employer survey on the prevalence of retiree medical coverage among employers with 500 or more employees. (The prevalence of retiree medical coverage among smaller employers is much lower than among employers with 500+ employees.)

	Public Sector Employers with 500+ Employees		**Non-public Sector Employers with 500+ Employees**	
Mercer's 2010 Employer Survey	Number of survey responses	Portion of employers providing pre-Medicare retiree medical coverage	Number of survey responses	Portion of employers providing pre-Medicare retiree medical coverage
Entire United States	222	73%	1,545	27%
Northeastern US	23	70%	324	30%
Connecticut	Insufficient data		21	29%

TASK 4d – Implications of Merging the Markets for Pricing in the Small Group and the Non-group Markets

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) gives states the option to merge their small group and individual markets.[1] A state may make this election at any point in time.

In Connecticut, individual and small group markets function differently, in that coverage in the small group market is provided on a guarantee issues basis, and premiums in the small group market are based on a modified community rating technique – a group's claims experience or morbidity cannot be taken into account in the rating process.[2] In the individual market, carriers are allowed to reflect an individual's expected claims in determining premiums, or the carrier may choose not to issue coverage to an applicant based on the applicant's health status.

In 2014, with the influx of the previously uninsured, subsidy-eligible population, we estimate that morbidity in the individual market will increase by 12% over the current individual market. In our modeling, the morbidity in the small group market in 2010 is 5% higher than the current individual market and does not change significantly between 2010 and 2014.

Further, our modeling shows that the individual market will grow significantly as a result of the availability of premium and cost sharing subsidies, and it will grow as a result of the individual mandate. Our modeling also shows that the small employer market shrinks as small employers first buy down benefits in response to premiums increasing faster than wages and then lapse coverage when they can no longer provide Bronze level coverage.

Across both markets, the relative morbidity is 1.09. If the markets were merged, they would both be priced to a relative morbidity of 1.09. This would represent a 2% decrease for those in the individual market and a 4% increase for those insured in the small group market.

A merged market would have the following characteristics:

- It would result in a larger pool of insureds which could provide more rate stability and less need for risk adjustment
- It could simplify the administrative functions that carriers would need to perform, for example, only needing to maintain one product portfolio[3]

[1] PPACA Sec. 1311

[2] Connecticut Statutes, Chapter 700c, Sec. 38a-564

[3] Carriers will likely need to maintain separate product portfolios for competitive purposes if the markets are separate.

- It would allow employees losing group coverage to maintain their policies, provided their employer had offered coverage through the Exchange or otherwise offered coverage that was available through the Exchange

- It may encourage greater carrier participation, as carriers who would have otherwise only participated in the Small Business Health Options Program (SHOP) or the individual Exchange would be forced to participate in both markets, though we note that Connecticut could require that any carrier participating in one Exchange participate in the other without merging the markets

- It may result in enrollment shifts as small employers would see higher premiums and individuals would see lower premiums

- It would likely result in small employers subsidizing the individual market

- It may encourage small employers to drop coverage, as their employees would be obtaining the same coverage from the same source and at the same premium rates as those with individual coverage

- It may be more difficult to meet the needs of the respective markets, and the operation of the Exchange could be complicated; for example, if the markets were merged, it would require the single Exchange entity to enforce two open enrollment periods, an annual open enrollment period for individuals and a rolling open enrollment for small groups

Separate markets would have the following characteristics:

- Potential for less rate stability and greater need for risk adjustment due to the smaller risk pools

- There could be different premium rates for an individual who is eligible to purchase coverage in both markets

- There would likely be more benefit options and a wider range of benefit variations
- Premiums for each market would be more reflective of the underlying risks being covered

- There would be no cross-subsidization between the markets

TASK 4e – Impact of the Individual Mandate to Purchase Health Insurance and Its Influence on the Markets and the Assumptions Made with Respect to the Models

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) imposes an individual mandate to encourage healthy populations to stay in the market and balance the risk pool. Beginning in 2014, all non-incarcerated US citizens must maintain minimum essential coverage.[1] Individuals not maintaining coverage will be subject to the following penalties, as outlined in the PPACA:

Year	Flat Annual Penalty	Percent of Income Penalty
2014	$ 95	1.0%
2015	$325	2.0%
2016	$695	2.5%

The penalty is the larger of the flat annual penalty or the percent of income penalty shown in the table above.

The penalty will not apply in certain circumstances. First, there is an affordability exemption. Those individuals whose household income is less than the filing threshold for federal income taxes[2] will not be subject to the penalty, and those individuals whose required contribution for self-only coverage exceeds 8% of household modified adjusted gross income will also not be subject to the penalty. In addition, certain other individuals are exempt from the penalty, including those qualifying with religious exemptions, incarcerated individuals and individuals not lawfully present in the United States.[3]

We modeled the penalty's effect on an individual's purchasing decision using a utility function. For each individual in our model, we tested the various options available to that individual (e.g., purchase an individual policy, take the coverage offered by the employer, if available, or go uninsured). For each option, we calculated an expected utility and assumed the individual will select the option that yields the highest utility. We modeled the effect of the penalty by including the cost of the penalty in the utility function if an individual chooses to forego insurance.

[1] PPACA Sec. 1501

[2] The 2010 filing threshold was $9,500 for those filing as single and $19,000 for those married filing jointly. Source: http://www.irs.gov/publications/p17/ch01.html#en_US_2011_publink1000170392

[3] Chaikind, H. and Peterson, C., Individual Mandate and Related Information Requirements under PPACA, Congressional Research Services, August 16, 2010.

In addition to testing the effects of the penalty, we tested the effects of the mandate. As we discuss in the report, in calibrating our migration model in 2010, we assumed that individuals without current health insurance do not seek medical services at the same level as those with insurance. The Congressional Budget Office (CBO) estimates that the uninsured currently use about 60% as much medical care as insured individuals, after taking into consideration differences in age and morbidity.[4] We used this same assumption in our modeling. In 2014 and beyond, we used 100% of expected claims as the cost of being uninsured in the utility function. We did this to reflect the effects of the mandate and the idea that there will be an expectation in 2014 that individuals will maintain health insurance and that there will be additional "disutility" in 2014 associated with being uninsured compared to the current environment. We note that this assumption produces roughly 150,000 uninsured in Connecticut in 2014 or a 4% uninsured rate. We note that the uninsured rate in Massachusetts is 1.9% in 2010 but that Massachusetts' reforms included more generous subsidies and stronger individual and employer penalties.[5]

Under the assumptions we have employed, removing the penalty would increase the number of uninsured in Connecticut by roughly 5,000 lives, and removing the mandate would increase the uninsured rate by roughly 90,000, increasing the uninsured rate to roughly 6%.

[4] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf

[5] Health Reform Facts and Figures: Winter 2011/2012. Available at:
https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf

TASK 4f – Feasibility of a Basic Health Program

Executive Summary

The State of Connecticut (State) contracted with Mercer Government Human Services Consulting (Mercer) to assess the financial feasibility of the Basic Health Program (BHP) option, as defined in the Patient Protection and Affordable Care Act (PPACA). The feasibility determination is based on whether the BHP option could be implemented in Connecticut at existing Medicaid payment rates at little to no cost to the State (i.e., entirely funded by federal subsidies).

The task of assessing the feasibility of the BHP option in the State of Connecticut is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Health Insurance Exchange (Exchange) in Connecticut and the subsets likely to enroll in the BHP and the Exchange
- Estimate the Silver Level benefits and premiums likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the State BHP based on the estimated second-lowest cost Silver Level plan offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population at estimated Medicaid provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums, and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

The results of the analysis outlined above indicate that the State of Connecticut may be able to implement the BHP option at no cost to the State general fund. Mercer estimates the weighted average 2014 federal BHP monthly subsidy to be $435 per member per month (PMPM). Using our conservative assumptions with respect to health status and costs, Mercer estimates the weighted average monthly BHP premium cost to cover this population to be $355 PMPM with very low premiums and cost-sharing levels, using the same set of benefits offered in the Exchange. Based on these estimates, there is a projected excess of BHP subsidies over BHP costs of $80 PMPM, or approximately 22% of the BHP premium.

These estimates are speculative at this early stage with so many provisions of the PPACA undefined and specifics of the BHP undetermined. However, the gap between the estimated premium subsidy and projected health care cost to cover the BHP population, driven largely by the estimated differential in Medicaid (HUSKY) versus commercial provider reimbursement rates, provides a level of confidence in the observed results. If the State increases its HUSKY provider reimbursement rates from the levels included in this analysis, Mercer recommends

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

assessing the impact of the changes in provider reimbursement as it could alter the final conclusions and recommendations made in this report. The excess of the federal subsidies over the resulting costs of a BHP could be used in multiple ways. The funds could be used to increase provider reimbursement rates to potentially attract more providers to the Medicaid network, reduce member premiums and cost sharing, expand benefits, and extend outreach to enroll a greater share of this low-income population.

The results identified in this report are similar to the January 2011 Sustinet Health Partnership Board of Directors Report to the Connecticut General Assembly, the June 2011 Community Service Society (CSS) report on the feasibility of a BHP in New York, which projects a 10% excess of federal subsidies over estimated BHP costs, and the September 2011 Urban Institute 50 state analysis report on the BHP.

A significant caveat to the BHP modeling, calculations and conclusions contained in this report is the key unknown of the variation of the Silver Level premiums offered in the Exchange. These calculations and conclusions are based on the $450 PMPM weighted average estimate of Silver Level premiums from our micro-simulation modeling. Implicit in the use of this $450 PMPM premium estimate is that this will represent the second lowest Silver Level plan offered in the Exchange, or that the Silver Level premiums offered in the Exchange will be tightly clustered around this value.

However, should there be a wide variation in Silver Level premiums offered in the Exchange – e.g., if they range from a low of $350 to a high of $550 PMPM – the BHP subsidies will be based on a much lower weighted average premium of perhaps $360 PMPM. This would result in an almost 25% reduction in the weighted average BHP subsidy from $435 to $330 PMPM. If this were to occur, a BHP probably could not be implemented without additional State funding.

Caveats to these preliminary conclusions are discussed in detail in the “Analysis and findings,” section 4 of this report.

In addition to the question of financial feasibility of a BHP option, we also note some of the potential impacts adopting a BHP could have on the Exchange.

Medicaid and BHP Provider Availability and Access

The PPACA effectively expands Medicaid to 138% FPL, which is estimated to increase Medicaid/CHIP enrollment by almost 100,000 in 2014 as estimated in Task 10. This enrollment expansion could place additional strain on the Connecticut Medicaid provider networks, increase cost-shifting to commercial carriers, and reduce the access and availability to providers for Medicaid patients. Implementing a BHP would increase the Medicaid patient base by another 51,000, further exacerbating this impact in 2014. A thorough analysis of the Connecticut Medicaid provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population as required by the PPACA, as well as the additional impact of potentially adding the BHP population to this patient base.

Impact on Exchange Risk

The level of premiums and cost sharing in a BHP and in an Exchange (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. Specifically, higher premium and cost-sharing levels increase the level of adverse risk selection among the enrolled population – i.e., higher monthly premiums encourage healthier individuals to opt-out of the Exchange to avoid purchasing benefits they are not likely to use. With the assumption that a BHP would only be implemented with reduced premiums and cost sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP at lower member premium levels, than the risk of the same population subgroup that would likely enroll under an Exchange, at higher member premium levels.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange. However, one could argue that with less disposable income at the lower income (FPL) levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP.

Impact on Exchange Self-Sustainability

All Exchanges must be self-sustaining by January 1, 2015. Therefore, it is reasonable to be concerned about removing some Exchange-eligible members from the pool from which the Exchange may be funded. Our estimate of those in the 138%–200% FPL bands eligible for the BHP is approximately 74,000.

We assume that 51,000, or 70%, would enroll in a BHP, enticed by the additional incentives of reduced premiums and cost sharing. However, without these additional incentives in the Exchange, we assume that only 37,000 or 50% of those in the low income band would enroll in the Exchange, comprising about 15% of the total Exchange enrollment. Implementing a BHP would remove these 37,000 from the Exchange, and would increase the Exchange premium assessment from 2.8% to 3.0% of premium based on the Task 7 Exchange sensitivity analysis.

Additional Risks of Variation in Federal BHP Subsidies

Two additional identifiable categories of BHP risks that cannot be quantified at this stage deal with retrospective adjustments to the federal subsidies provided to fund the BHP. Section 1331(d)(3)(A)(ii) of the PPACA specifies that the Secretary of HHS will make retrospective adjustments to the amounts of federal BHP premium and cost sharing subsidies to the states to account for the actual income and health status of each individual enrollee.

The retrospective income adjustment presumably would increase the BHP subsidies if an enrollee's actual income was less than the income determined at enrollment, and would decrease the BHP subsidies if an enrollee's actual income was greater than the income determined at enrollment. In the Exchange, each enrollee bears the risk of this variation in the retrospective premium and cost sharing, while in a BHP, the state bears this risk. In addition to the fact that the process for this adjustment remains undetermined at this stage, is the

inevitability of the further complications presented in cases of those BHP enrollees whose incomes drops below the 138% Medicaid eligibility threshold, as well as those BHP enrollees whose incomes rise above the 200% FPL threshold. The final HHS rules and process for this adjustment may have a significant impact on the financial feasibility of the BHP option.

The retrospective risk sharing adjustment presumably would increase the BHP subsidies if an enrollee's health status was calculated as higher than the average Exchange risk, and would decrease the BHP subsidies if an enrollee's health status was calculated as lower than the average Exchange risk. Assuming the final HHS rules and process for this adjustment follow this logic, the BHP retrospective risk adjustment would reduce the unknown risk a state would be taking by implementing a BHP, and would not have a significant impact on the financial feasibility of the BHP option, because federal subsidies would increase if the morbidity of the BHP enrollees was greater than the Exchange, and decrease if the morbidity of the BHP enrollees was less than the Exchange.

Mercer is not advocating for or against the BHP option. The results of this study indicate this may be a viable option for the State to consider as it decides how best to implement the many provisions of the PPACA. While the results of the analysis do show this to be financially feasible, clearly implementation of a BHP would not be without some element of risk to the State.

TASK 4g – The Cost of Connecticut Benefit Mandates That Are Above the Federal Essential Benefits in the Context of a Revised Insurance Market

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) provides for major health insurance market reforms and adds consumer protections to health plans offered both inside and outside of the Exchanges. One of the consumer protections contained in the ACA requires the establishment of a package of Essential Health Benefits (EHBs) which will provide a defined set of benefits that serve as the basis for the development of all premiums for non-grandfathered plans offered inside and outside the Exchanges, with some exceptions for self-insured and large groups.

The ACA also provides states the option to require that benefit packages include benefits in excess of those prescribed in the EHBs, such as state mandated benefits. However, states will have to assume the costs associated with these additional requirements for Qualified Health Plans (QHPs) offered in Exchanges.[1] In addition, Federal premium subsidies and tax credits will be based only on the EHBs and not include any credits or subsidies for additional benefits in excess of the EHBs.

Resources

For this report, general guidance for classifying mandates as an EHB or "unknown" is based on the report from the Institute of Medicine (IOM) to develop recommendations related to the methods and processes for determining and updating the EHBs.

Three important conclusions/recommendations from the IOM report include:

- State-mandated benefits should not receive any special treatment when developing the definition of the EHBs
- The EHBs should be defined as a package that will fall under a pre-defined cost target
- Services that fall within the ten general covered categories should not be automatically included within the definition of the EHB

The mandates for health insurance contracts are referenced in Chapter 700c of the General Statutes of Connecticut.[2] The estimated cost impact for each state-mandated health benefit for

[1] §1311(d)(3)(B) of the PPACA

[2] Chapter 700c – Health Insurance. http://www.cga.ct.gov/2011/pub/chap700c.htm (Accessed July 27, 2011)

both the individual and the group markets are taken from reports produced by the UConn Center for Public Health and Health Policy.[3]

Conclusions and Recommendations

Based on the assumptions contained within this report, and described in greater detail in the task report, the following conclusions and recommendations are made:

- For the individual market, almost one quarter of the total number of mandates are assumed to be an EHB which reflect over half of the total projected costs for all of the mandates
- For the group market, almost one quarter of the total number of mandates are assumed to be an EHB which reflect over half of the total projected costs for all of the mandates
- Decide to either fully enact the mandatory offer requirement for Comprehensive Rehabilitation services in the group market or exclude it entirely

The report identifies that 8.2% of claims in the individual market and 10.4% of claims in the group market are classified as "unknown." This can be viewed as a worst case scenario for the states exposure to benefits in excess of the EHBs based on the assumptions described in this report. However, it is much more likely that this value will decrease once the guidance from HHS related to the EHBs is provided as many of the mandates currently classified as "unknown" could be re-classified as an EHB either in whole or in part. Some of the mandates currently classified as "unknown" in this report have very strong, rational arguments as to why they should be considered an EHB. However, based on the IOM recommendations discussed in more detail in the Appendices, all of the "unknown" mandates could be at risk of being excluded from the EHBs or being included in the EHBs but not at the levels of coverage provided for in the state-mandates.

Options

The PPACA is a very complex and substantial piece of legislation. There are still many parts that have yet to be fully defined. Similarly, interpretations of the IOM report as well as the numerous regulations issued are still "evolving." There are many unknowns and various interpretations of many components of the legislation at the time this report is written, all of which could materially impact our conclusions. We have developed the following options based upon our knowledge and interpretations, and have endeavored to clearly state this throughout the report. Additional detail related to the review of state-mandated benefits is contained in the attached Appendices.

- Wait until further guidance related to the EHBs is provided by HHS to conduct and refine the analysis
- Decide to maintain all state-mandated health benefits and determine how to fund the costs

[3] http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304

- Define a process to assess, review and prioritize the state-mandated benefits, including the financial, medical efficacy and social aspects of the mandates

TASK 4h – Impact of the Exchange on Insurer Profitability and Potential Market Exit

Executive Summary

The Mercer team used financial statement data from the individual and small group carriers in Connecticut to examine these carriers' financial performance in these markets. For the individual market as a whole, the underwriting margin[1] was 8%, and the loss ratio, based on the definition of the loss ratio adopted for the calculation of rebates[2], was 0.755. Of the major carriers operating in Connecticut, only WellPoint had a loss ratio greater than 0.80, which is the federal minimum loss ratio in 2011 and forward. If we adjust premiums for those companies with loss ratios less than the federal minimum to the minimum, the underwriting margin declines to 2%. In the small group market, all the major carriers had loss ratios in excess of the 0.80 minimum.

The pricing and financing mechanisms and the operation of the Exchange could have a significant impact on insurers' profitability. To the extent the Exchange charges more for the services it delivers than carriers could provide those services for on their own, carrier profitability could be compromised, particularly if some carriers choose to stay out of the Exchange completely, as those carriers that choose to stay outside of the Exchange completely could charge lower premiums.

If the Exchange were financed through an assessment on the market as a whole, any misalignment between the Exchange's charges and the carriers' cost of providing services would be eliminated. However, there are other issues associated with implementing a broad-based fee, such as the question of equity as a broad-based fee would mean that individuals and groups purchasing their coverage outside of the Exchange would be paying for services they were not directly using.

To the extent that there is adverse selection in the Exchanges, insurer profitability could be affected, particularly if insurers are allowed to operate in the small group and individual markets in Connecticut without participating in the Exchanges. There is evidence that individuals with incomes below 200% federal poverty level (FPL) have higher morbidity than those with higher incomes.[3] Because subsidies are only available to individuals purchasing their coverage through the Exchange, we expect the Exchange to attract a disproportionate percentage of low-income individuals with relatively high morbidity. If some carriers operate in the individual market only outside of the Exchange, they would likely enjoy favorable selection and relatively high profitability, all other things equal.

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[1] The underwriting margin is equal to premium, less claims and expenses, divided by premium and is one measure of the profitability of the business.

[2] 45 CFR §158

[3] Bueno, D., The Relationship Between Income, Health Status, and Health Expenditures in the United States, M.B.A. Thesis, Sloan School of Management, 2011.

Risk adjustment will help mitigate this problem of adverse selection and carriers operating only outside of the Exchange, but is unlikely to completely eliminate it, as risk adjustment systems tend to underpay for high-cost claimants and overpay for low-cost claimants.[4]

Selection in the Small Business Health Options Program (SHOP) Exchange could come about if the small employer tax credits, which again, are only available for groups purchasing coverage through the Exchange, attract groups with higher morbidity into the Exchange. This is a real possibility, as the tax credits are most attractive to the smallest employers, and small employers tend to have the highest morbidity.[5]

Two other factors will likely put significant pressures on carriers' profitability. First, the premium subsidies available in the individual market are based on the difference between the second lowest cost Silver level plan and a given percentage of an individual's income; the cost of purchasing a plan more expensive than the second lowest cost Silver level plan is completely borne by the insured. For this reason, we expect that carriers operating in the individual Exchange will take whatever measures they can to keep prices low.

The second factor that we believe will put pressure on profitability is the additional transparency that the Exchange will bring to the market.[6] This transparency will result from two changes. First, people will be able to comparison shop with ease. Second, products will be somewhat standardized as they will have to meet certain actuarial values and be required to cover the Essential Health Benefits package.

The Mercer team expects the result of these forces will be to favor those insurers that are most effective at managing the care delivered to their members, at managing administrative expenses and those who are best able to negotiate provider contracts that result in a unit cost advantage relative to the competition or that most successfully engage providers in managing patient care, each of which typically require scale and favor larger carriers.

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[4] Hsu, J., et al. Distributing $800 Billion: An Early Assessment of Medicare Part D Risk Adjustment, Health Affairs, Vol. 28, No. 1, January/February 2009

[5] See, for example, Gorman, B., Preliminary Data Analysis, Wisconsin Small Group Market, July 16, 2008, available at www.statecoverage.org/files/Appendix%201.pdf.

[6] See, for example, the Massachusetts HealthConnector website for an example of this transparency.

TASK 4i – Impact of the Exchange on Household Budgets

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) provides premium tax credits (premium subsidies) for individuals with income up to 400% of the federal poverty level (FPL) and cost sharing subsidies for individuals with incomes up to 250% of the FPL.[1]

The premium subsidy is equal to the cost of the second lowest cost Silver Level plan in the Exchange, less the applicable percentage of income. At 150% of the FPL, the applicable percentage is 4% of income. At 250% of the FPL, the applicable percentage is 8.05% of income. At 300% to 400% FPL, the applicable percentage is 9.5%.

The cost sharing subsidies increase the actuarial value of the insured's benefit plan above the Silver Level so that the individual will be responsible for lower cost sharing amounts. Cost sharing subsidies are available to individuals with incomes less than 250% FPL.

Considering the total universe to be those who are uninsured and those with individual or small group coverage, we are expecting the percentage of the market represented by the uninsured to decline between 2010 and 2014 from roughly 48% (343,000) to 21% (149,000). The individual market will grow during that time from 16% (117,000) to 48% (330,000), and the small group market will decline from 36% (263,000) to 31% (214,000). The movement of the population to the individual market is driven largely by the availability of subsides, which primarily draw those who were previously uninsured. Note that these figures do not include the majority of Connecticut residents who are covered by mid-sized and large employers or government programs like Medicaid.

This shift has important implications for household expenditures on health care services. Even for those eligible for subsidies, the cost of paying the premium net of subsidies and the associated cost sharing will consume a material portion of their household income.

Consider, for example, a family of four with income at 251% of the FPL. At this level of income, the applicable percentage of income would be 8.05%. Using 2010 dollars, at this level of the FPL their income would be roughly $55,000, so they would be expected to contribute 8.05% of their income, or $4,428, towards the cost of a premium. (For this example, we assume a premium for this coverage of $14,000.) Out-of-pocket cost sharing at the Silver Level would be roughly $4,800 on average.[2] These two amounts taken together total $9,228 or roughly 18% of income. While this represents a material portion of income, the presence of health insurance provides important benefits, including limits on out-of-pockets costs, access to negotiated provider discounts and improved access to medical care. In addition, the plans that will be offered in 2014 will generally be more comprehensive than many plans currently available in the market.

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[1] PPACA Sec. 1412.

[2] Calculated as 30% cost sharing x $14,000 premium x 0.80 loss ratio / 0.70 actuarial value for Silver Level plan.

As discussed in greater detail in this task report, there is an affordability exemption to the penalty associated with not maintaining coverage. Individuals with incomes less than the filing threshold would not be subject to the mandate, nor would individuals for whom the required contribution for self-only coverage exceeds 8% of household income. In this context, the required contribution for an individual-offered employer coverage is the employee's contribution for self-only coverage or, in the case of individuals not offered employer coverage, the required contribution is the premium for the lowest cost Bronze Level plan available in the Exchange after premium credits.[3]

A second important consequence of the change in the make-up of the market illustrated above is the shift away from employer coverage as employers react to health insurance premiums increasing more rapidly than wages.[4] In the small group market in Connecticut, employers pay roughly 75% of the cost of premiums and employees are asked to pay roughly 25% of the cost; this 25% is tax-advantaged.[5] For those receiving subsides in 2014 in the Exchange, we expect the subsidies to cover roughly 60% of the cost of premiums and the enrollees will be responsible for roughly 40% of the cost. So, even for those who are subsidy eligible, the out-of-pocket cost of premiums will be generally higher in the individual market than in the small group market.

There are several factors other than the premium and cost sharing subsidies that will likely impact household budgets. The mandate to maintain coverage and the penalty associated with not doing so would be among the other factors. In addition, it is likely that employers dropping coverage would increase their employees' wages by some amount to compensate for the loss of health care coverage.

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[3] Chaikind, H. and Peterson, C., Individual Mandate and Related Information Requirements under PPACA, Congressional Research Services, August 16, 2010.

[4] Data from the Kaiser Family Foundation shows that between 2001 and 2011, the percentage of small firms (3-199 workers) offering insurance declined from 67% to 59%. See Employer Health Benefits: 2011 Summary of Findings, The Kaiser Family Foundation and Health Research & Educational Trust.

[5] MEPS 2010, Table II, available at http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=6&year=2010

TASK 5 – The Effect if the Large Employer Market (>100 Employees) Seeks Participation in the Exchange After 2017

Executive Summary

Under the Patient Protection and Affordable Care Act (PPACA), states have the option to allow health insurers to offer large employers, those with more than 100 employees, qualified health plans (QHP) through the Exchange beginning in 2017.[1] The large employer pool and its products and pricing can remain separate from the individual and small group pools.

Plans offered through the Exchange must be QHPs requiring, among other things, that products sold inside the Exchange be offered at the same price as those sold outside of the Exchange. This provision will require that large employers be offered coverage through the Exchange using some form of modified community rating.

In 2009, roughly 27% of employers with 100 to 499 employees in Connecticut chose to self-insure their medical plans. For Connecticut employers with 500 or more employees, the rate was 82%. Large employers choose to self-insure their medical plans for a number of reasons, but most of these reasons relate to cost savings; for example, avoiding risk charges and premium taxes. These reasons will remain in 2014 when the PPACA becomes fully effective, but the insurer tax that we discussed at the beginning of this section will add an additional 2% to 3% to the cost of purchasing insurance relative to self-funding.

Large employers are relatively sophisticated purchasers, able to weigh various options regarding the provision of health benefits to their employees. If large employers are given the choice of a community-rated product in the Exchange and self-funding or an experience-rated product outside of the Exchange, they will choose the lowest cost option. This responsiveness to incentives among large group employers has the potential to lead to considerable adverse selection against the plans offered through the Exchange.

Opening the Exchange to large employers would allow for the spread of the Exchange's fixed costs over a broader base and may lower the per-person cost of operating the Exchange. However, large employers' needs are very different from those of a small employer, and trying to service both markets could complicate the operation of the Exchange.

[1] PPACA Sec. 1312.

TASK 6 – The Impact of the Exchange in Regards to the Interaction with Health Coverage Initiatives in Connecticut

Executive Summary

Careful analysis of the health coverage initiatives in the context of the new Health Insurance Exchange (Exchange) is essential to ensure each system is taken into consideration appropriately, in accordance with its unique characteristics. Ultimately, the analysis of the health coverage initiatives coinciding with the Exchange implementation enables Connecticut to prevent duplication of service delivery, reduce administrative costs and provide improved customer service for Connecticut's citizens.

Connecticut began early to plan for health care reform with the creation of the multi-stakeholder Health Care Reform Advisory Board by the Governor in July 2009. The Final Report of the Board, presented to Governor Rell and the General Assembly on June 30, 2010, emphasized the role of the Exchange as the mechanism to provide consumers with the information they need to make informed health care choices. The report also highlighted the Patient Protection and Affordable Care Act's (PPACA) requirement that the Exchange allows consumers eligible for Medicaid and the Children's Health Insurance Program (CHIP) to enroll through its web portal.

The Exchange will function as the hub of access to public and private insurance products – providing comparative information about all health plans available to Connecticut's residents, offering a choice of enrollment in Exchange-sponsored health plans and establishing common guidelines for insurance offerings and pricing. It is important for the Exchange to not operate in isolation; otherwise, it cannot be effective without information and appropriate levels of interaction with other health initiatives in Connecticut. These health initiatives are varied – from major government programs like Medicaid and CHIP or newly planned initiatives for certain segments of the population like Partnership Plans or other, as of yet unknown, service delivery initiatives.

The analysis conducted for this task considered a wide range of health coverage initiatives expected to exist in the marketplace at the time of the Exchange. Some of these systems have been around for years, and others are just now being planned. Some are administered by government entities, and others are privately administered. Some are statewide, affecting large numbers of individuals, and others affect only certain limited populations. The table in the report lays out these different variables of the health coverage initiatives, including:

Health Coverage Initiatives

Health Coverage Initiative	Description and Eligibility	Type of Health Coverage		Length of Operation		Governing Source		Service Area		Current Enrollment
		Partial	Full	Less than 5 Years	More than 5 Years	Public	Private	Statewide	Regional	
Exchange	State-based competitive marketplace for individuals and small businesses to purchase private health insurance		✓	✓		✓	✓	✓	✓	Unknown[1]
Partnership Plans	Health care benefit plan offered to non-state public employers or nonprofit employers and their retirees		✓	✓		✓		✓	✓	Unknown[2]
Health Connections	Exchange for small employers with 3 to 100 employees to purchase health insurance at competitive pricing		✓		✓		✓	✓	✓	87,000
PCIP	Health benefit package for those with a pre-existing qualified, diagnosed medical condition and uninsured for six months		✓	✓		✓		✓	✓	103
COHP	State subsidized health benefit plan on a guaranteed basis with no pre-existing condition exclusion periods		✓	✓		✓		✓	✓	8,000
CADAP	Medication program for enrollees HIV/AIDS and with incomes below 400% FPL	✓			✓	✓		✓	✓	1,600
HUSKY B >300% FPL	Connecticut's health insurance program for children in families with incomes over 185% FPL. Those over 300% FPL may "buy into" HUSKY B		✓		✓	✓		✓	✓	1,730

[1] Implementation to occur in January 2014.

[2] Implementation to occur in January 2012 but may be delayed due to concerns raised by Office of Policy and Management Secretary Barnes.

Key Considerations

The Connecticut Exchange Board (Board) will need to carefully consider the requirements of the Exchange as established by PPACA and the mandated requirements of state-run programs or those relationships with privately run programs. There are sensitivities, both politically and programmatically, that the Board will need to consider in their final decisions. The analysis in the accompanying report outlines programmatic and administrative efficiencies that can be gained by incorporating the health coverage initiative into the Exchange. It also outlines where the interaction with the Exchange is hindered by existing rules and regulations.

The Mercer team has determined through this analysis that the Exchange is expected to impact several of these existing programs that were reviewed as part of this task in varying degrees. Impacts can be summarized in the following areas:

- Overlap of eligible enrollees:
  - Current populations covered by Health Connections, Pre-Existing Condition Insurance Plan (PCIP), Charter Oak, the Connecticut AIDS Drug Assistance Program (CADAP), Healthcare for Uninsured Kids and Youth (HUSKY) B and, potentially, the Partnership Plans would be also eligible for coverage under the individual and small business Exchange and qualify for subsidies or tax incentives
- Competition of products/services:
  - Products and services currently being offered through Health Connections, a PCIP, Charter Oak, CADAP, HUSKY B and, potentially, the Partnership Plans would also be offered under the individual and small business Exchange
  - The Exchange can consider incorporating some or all these initiatives into their program to streamline offerings of products for potential enrollees
- Duplicate administrative functions:
  - Connecticut could potentially achieve some administrative budget savings by incorporating some of these coverage initiatives into the Exchange and streamlining consumer assistance, marketing, enrollment and eligibility functions

It is recommended that the Board carefully weigh each option and determine what is best for the State, the Exchange, the individual and small employers and the established coverage initiatives. While there are other State programs whose impacts were analyzed in Task 10 of this report, there may be other State programs the Board would like to further analyze utilizing a similar approach. This analysis will assist the Board in their role in providing accessible and affordable health care coverage to the residents and small employers in Connecticut.

TASK 7 – Assessment of Technical Requirements and Development of Specifications for Accounting and Financial System Functions for the Exchange

Executive Summary

Accurate financial projections are necessary to support the planning and implementation of Connecticut's Health Insurance Exchange (Exchange). This paper provides a comprehensive estimate of the likely costs and revenues associated with the operation of Connecticut's Exchange between calendar years 2012 and 2016. Provided in Table ES7-1 is a consolidated view of the projections generated through our financial model. Annual cost projections included in this table are consistent with the higher bound estimates generated through our budget model and assumed revenues are calculated based on our recommended financing approach of a premium assessment on Exchange health plans and a carrier non-participation fee.

Table ES7-1: Five Year Budget Projection 2.8% Premium Assessment on Exchange Coverage

	2012	2013	2014	2015	2016
CASELOAD					
INDIVIDUAL MARKET CONTRACTS	0	56,000	72,118	110,793	138,600
SHOP CONTRACTS	0	5,500	11,963	18,549	24,750
MEMBERS	0	90,000	124,775	192,000	243,000
MEMBER MONTHS	0	270,000	1,497,300	2,304,000	2,916,000
EXCHANGE PREMIUMS	$0	$0	$603,842,500	$980,235,000	$1,330,200,000
OPERATING REVENUE					
FEDERAL EXCHANGE GRANTS	$19,761,230	$30,323,664	$34,281,826	$0	$0
PREMIUM ASSESSMENT	$0	$0	$16,907,681	$27,446,795	$37,245,550
CARRIER NON-PARTICIPATION FEE	$0	$0	$1,000,000	$1,000,000	$1,000,000
TOTAL OPERATING REVENUE	*$19,761,230*	*$30,323,664*	*$52,189,507*	*$28,446,795*	*$38,245,550*
NON OPERATING REVENUE					
INVESTMENT INCOME	$0	$0	$179,077	$327,274	$320,460
OTHER NON-OPERATING REVENUE	$0	$0	$0	$0	$0
TOTAL NON-OPERATING REVENUE	*$0*	*$0*	*$179,077*	*$327,274*	*$320,460*
OPERATING EXPENSES					
HUMAN RESOURCE EXPENSE	$3,295,550	$5,411,940	$8,125,183	$8,822,375	$9,565,685
CONSULTING COSTS	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
EXCHANGE ADMINISTRATIVE EXPENSE	$120,680	$308,094	$339,660	$294,960	$294,960
CALL CENTER /PREMIUM BILLING	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
WEB SITE CREATION/MAINTENANCE	$1,200,000	$1,800,000	$1,000,000	$750,000	$500,000
STATE ELIGIBILITY CHARGEBACK	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
APPEALS PROGRAM	$0	$0	$903,381	$432,736	$422,375
COMMUNICATIONS / MARKETING	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
NAVIGATOR EXPENSE	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
OUTREACH EXPENSE	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
IT DEVELOPMENT COST	$10,695,000	$9,250,000	$3,392,500	$1,357,125	$1,424,975
TOTAL OPERATING EXPENSES	*$19,761,230*	*$30,323,664*	*$34,281,826*	*$31,892,915*	*$36,135,375*
OPERATING PROFIT / (DEFICIT)	***$0***	***$0***	***$18,086,758***	***($3,118,846)***	***$2,430,634***
NET ASSETS BEGINNING OF YR	***$0***	***$0***	***$0***	***$18,086,758***	***$14,967,912***
NET ASSETS END OF YEAR	***$0***	***$0***	***$18,086,758***	***$14,967,912***	***$17,398,546***

Key assumptions

The financial model provided above is based upon a number of assumptions about the structure of the Exchange and likely changes in the insurance market in Connecticut. Major assumptions used to generate this financial model include:

- MEMBERSHIP: The number of individuals participating in the American Health Benefits Exchange (ABHE) (individual market) and Small Business Health Options Program (SHOP) (small group) Exchanges are consistent with the membership estimates provided in the appendices of this report. These numbers depend upon a robust outreach and marketing campaign, the participation of key health insurance carriers, the availability of a sufficient choice of health plans and partnering with health insurance brokers

- STRUCTURE OF THE EXCHANGE: Connecticut's Exchange will operate consistently with the requirements outlined in Public Act 11-53. The Exchange will be structured as a quasi-public entity affiliated with Connecticut State government. Operation of the Exchange will not be deferred to the federal government. Connecticut will not partner with other states for the complete operation of the Exchange and multiple subsidiary Exchanges will not be established throughout Connecticut

- ADMINISTRATION OF THE INDIVIDUAL EXCHANGE AND SHOP: The model assumes that administration of the Individual and SHOP Exchanges will be consolidated

- INSURANCE BROKER REIMBURSEMENT: The model assumes that commissions provided to insurance brokers for health coverage purchased through Connecticut's Exchange are built into existing health coverage premiums. The model provides additional funds for marketing which could be utilized to provide additional reimbursement to insurance brokers for enrolling eligible individuals and entities into Connecticut's Exchange

- INFORMATION TECHNOLOGY (IT) DEVELOPMENT: The model assumes that development of necessary information technology tools to support Connecticut's Exchange will not be undertaken through the New England States Consortium. Connecticut's Exchange may incur lower costs in IT development through coordination of IT planning through the New England States Consortium

- CONNECTICUT ELIGIBILITY SYSTEM MODIFICATIONS: The budget model does not assume Exchange costs associated with major modifications or replacement of Connecticut's existing eligibility system. To date, Connecticut has not identified the plan for enhancing or replacing the existing eligibility system

Key Findings

Table ES7-2: Connecticut Exchange Assumed Costs and Staff 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	12.0	22.0	44.0	44.0	44.0
GROSS COST	$19,761,230	$30,323,664	$34,281,826	$31,892,915	$36,135,375
STATE/EXCHANGE COST	$0	$2,020,565	$2,186,463	$31,627,761	$35,848,291
LOW ESTIMATE					
FTE	12.0	21.5	30.0	30.0	30.0
GROSS COST	$16,523,139	$22,392,970	$24,661,194	$24,796,794	$28,347,015
STATE/EXCHANGE COST	$0	$1,014,396	$1,130,524	$24,611,186	$28,146,056

- Connecticut's Exchange, when fully implemented, will need a staff of 30.0 to 44.0 FTEs to appropriately support Exchange operations
- The cost of operating an Exchange in Connecticut, when fully implemented, is assumed to be between $28.3 million and $36.1 million in 2016
- The Exchange can be sustainable by 2015. An assessment equivalent to 2.8% of Exchange-purchased coverage would be sufficient to support Exchange operations

Recommendations

- Financial support for Connecticut's Exchange should be generated through a combination of the following two mechanisms:
  - The creation of a fee[1], equivalent to 2.8% of health premium cost purchased through the Exchange, imposed upon participating health insurance carriers or consumers
  - The imposition of an assessment upon health insurance carriers who choose not to participate in Connecticut's Exchange
- A carrier non-participation fee would likely generate modest revenues, but would serve the policy purpose of encouraging carriers to participate in Connecticut's Exchange, to ensure a broader choice of options for consumers
- Connecticut should allocate sufficient staff to its Exchange to support high-level functions and administrative tasks. Staff-intensive functions involving interaction with Exchange

[1] This report assumes that any Exchange fees will be exempt from the calculation of insurers' MLRs, based on an interpretation of language in the PPACA. This needs to be confirmed once there is definitive federal regulatory guidance.

consumers and skilled functions that are needed on a limited or short-term basis should be purchased through contractual arrangements with third party entities and professional consulting firms

To ensure financial sustainability by January 2015, Connecticut should invest in education and outreach activities to improve statewide awareness of coverage opportunities through the Exchange. The primary benefit of an early effective outreach effort is increased awareness of lower-cost or subsidized health coverage for those currently uninsured; an outreach effort will also drive up initial Exchange caseload, generating more premium assessment revenue to assist the Exchange in becoming financially self-sufficient in time to meet federal deadlines.

TASK 8 – Assessment of Technical Requirements and Development of Specifications for Accounting and Financial System Functions for the Exchange

Executive Summary

As part of its planning activities related to implementation of a Health Insurance Exchange (Exchange) in the State of Connecticut (State), the Mercer team assessed the capabilities of pertinent State-owned and operated information systems against federal guidance for the financial management Exchange business process area. Specifically, our assessment covered Core-CT, the instance of the PeopleSoft Enterprise Resource Planning (ERP) suite of applications used by State agencies. Our assessment covered:

- Identifying the potential for leveraging capabilities of Core-CT in support of Exchange financial management functions as defined in the Patient Protection and Affordable Care Act (PPACA) and subsequently categorized by the Centers for Medicare & Medicaid Services (CMS). Exchange financial management functions per the PPACA include premium and subsidy administration, exchange of funds between the Exchange and Exchange plans, and some of the activities related to risk management and critical data collection and reporting activities, including encounter data management. Although the Request for Proposal (RFP) and the revised scope of work for this task as approved by the State did not call for the following, our assessment also touched on Core-CT´s capabilities related to internal controls and functionality that would specifically support audits and related program integrity activities.

- Determining whether Core-CT could be utilized in support of the administrative functions of the Exchange entity. These functions include financial accounting, human resources and payroll, supply chain management and asset management. All of these are functions that any self-sustaining business entity needs to be able to perform.

Our assessment activities were grounded on the most up-to-date federal guidance available at the time of the assessment on Exchange establishment, operations and the role of information technology (IT) in key functions.

To complete our analysis, Mercer/HMA team built a tool for assessing the extent to which Core-CT could support Exchange financial management and administrative functions. The tool was based on Mercer's/HMA team's understanding of federal guidance, our extensive knowledge of ERP products, and our experience managing ERP projects (including, most recently, in Georgia where PeopleSoft was also deployed). The outputs of this assessment were a profile of Core-CT and an evaluation of this system, along the following six information system domains: *Functionality*, *Interoperability*, *Security*, *Capacity and Availability*, *Accessibility by External Users* and *Conformance with CMS Information Systems Standards and Conditions*.

Our assessment was completed through interviews with key State staff, completion by State staff of the aforementioned assessment tool and our evaluation of Core-CT based on experience in several PeopleSoft implementations.

The outputs of our activities were designed to serve as the starting point for business operations and IT requirements elaboration activities to be funded out of the Level 1 Exchange Establishment grant and as described in the *Business Operations and IT Planning* RFP issued on October 17, 2011.

Key Findings

Based on the assessment, we have ascertained the following:

1. **FUNCTIONALITY**: Core-CT lacks needed Exchange financial management functionality; in fact, the system does not possess any of the expected functionality. Moreover, the system's architecture and constrained system support resources limit the ability to build or enhance existing functionality. Furthermore, the lack of functionality to perform Exchange financial management functions would severely limit the ability of this system to support program integrity functions. On the other hand, Core-CT does possess most of the ERP functionality which the Exchange entity would need to support its own administrative functions. Additionally, PeopleSoft functionality as it relates to data management, including the system's inherent ability to track the history of transaction records, including who may have accessed or altered a particular record, could support some program integrity activities such as audits of the use of federal funds for certain functions.

2. **INTEROPERABILITY**: As an ERP solution, PeopleSoft is designed to provide "built-in" interoperability across all entity financial management functions, e.g., with interfaces to State banking and through built-in work flow and transaction management between purchasing, accounts payable and asset management activities. However, the system does not provide native support to Exchange-specific functions such as eligibility and enrollment and plan management.

3. **SECURITY**: PeopleSoft's security and user access models are both very robust. PeopleSoft products are widely utilized by both private and public sector organizations without any significant reports of security breaches or concerns. Moreover, PeopleSoft already possesses internal controls and audit support capabilities that are aligned with guidance contained in the Statement on Standards for Attestation Engagements (SSAE) No. 16 and consistent with requirements contained in Section 404 of the Sarbanes-Oxley Act. These are important considerations for determining the suitability of a financial management system.

4. **CAPACITY AND AVAILABILITY**: The system does not appear to have significant transaction processing or data storage capacity issues, nor does it appear to have availability issues. The system resides in a stable operating environment in the State's data center, which is a secure facility. Provisions for business continuity are in place with recovery time objectives that are in line with generally accepted industry practices.

5. **ACCESSIBILITY BY EXTERNAL USERS**: Since this system would not have a "consumer-facing" aspect to it – i.e., given the business functions that would support it would not be directly accessed by external users – the assessment of Core-CT did not have an accessibility component.

6. **CONFORMANCE WITH CMS INFORMATION SYSTEMS' STANDARDS AND CONDITIONS**: Core-CT conforms with some but not all of the CMS information systems standards and conditions referenced above. Specifically, PeopleSoft does not conform with the *Modularity* and *Reuse/Leverage* conditions – which call for a system to be built primarily as easily replaceable "components" or from "services" available in and accessible through the Internet or residing in a "cloud computing" environment. While PeopleSoft is often referred to as a "commercial off-the-shelf" solution, it is a very complex application with multiple modules which, while flexible, requires extensive (often very costly) configuration for it to be deployed effectively.

Overall, Core-CT falls short in terms of its capabilities when assessed against CMS guidance regarding the numerous and complex financial management functions required of an Exchange. As a result, Mercer/HMA has concluded that Core-CT is not a viable financial management solution for Connecticut's Exchange. However, given PeopleSoft's robust ERP capabilities, we believe that it could be a viable administrative system solution for the Exchange entity.

Recommendations

At the State's direction the scope and outputs of this task were structured to "pave the way" for more detailed planning, cost-benefit analysis and procurement work that will be funded through the Exchange Level 1 Establishment grant. As such the following recommendations, which are discussed in detail in the Task 8 Report, are aimed at informing the upcoming detailed planning work:

1. Acquisition and/or development of an Exchange financial management system should be explored from a cost benefit standpoint.

2. The State should explore an approach to acquiring Exchange operational capabilities through business process outsourcing rather than through acquisition or development of information systems.

3. The State could explore leveraging "information system components" being developed out of the Exchange Early Innovator projects, including the New England States Collaborative Insurance Exchange Systems (NESCIES).

4. The Exchange entity could explore utilizing Core-CT as its ERP solution for administrative functions.

TASK 9 – Assessment of Existing Medicaid Eligibility System and Identification of Interface Issues and Necessary Requirements for Integration with the Exchange Information Technology (IT) Infrastructure

Executive Summary

As a key component of its Health Insurance Exchange (Exchange) planning initiative, the State of Connecticut engaged the Mercer/Health Management Associates (HMA) team to conduct the following activities:

1. Identify key IT requirements for enabling the eligibility and enrollment (E&E) business processes of Exchange(s), including interfaces to relevant programs such as Medicaid and the Children's Health Insurance Program (CHIP).

2. Assess Connecticut's existing IT capabilities and associated gaps related to Exchange E&E management, specifically with regards to the *Eligibility Management System (EMS)*, the State-owned-and-operated information system maintained by the Connecticut Department of Social Services (DSS) and used to determine and manage eligibility for Medicaid as well as other health and human services programs. By extension this assessment also included Web-accessible capabilities and functionality which DSS has already deployed in support of eligibility and enrollment management for existing programs.

These activities were grounded on (1) recently issued federal guidance on Exchange establishment, operations and the role of IT in key functions, and (2) authoritative sources of relevant guidance other than Exchange-specific guidance.

To complete our analysis, our team built tools for assessing the extent to which EMS and the aforementioned Web-based functionality could support Exchange E&E functions; the assessment tools were built on our understanding of interface requirements between Exchange and Medicaid E&E functions and systems based on federal guidance, and on our review of all applicable and available federal laws, regulations and guidance related to expected E&E functionality including online "customer-facing" functionality. The outputs of this assessment were an evaluation of existing DSS online E&E functionality and a profile of EMS along the following six information system domains: *Functionality*, *Interoperability*, *Security*, *Capacity and Availability*, *Accessibility by External Users*, and *Conformance with CMS Information Systems Standards and Conditions*.

Our assessment was completed through interviews with key state staff, completion by state staff of the aforementioned system profiling and assessment tool for EMS, our review of an *EMS Risk Assessment Report* produced by Gartner and published in September 2011, and our independent evaluation of existing DSS "customer-facing" Web functionality.

The outputs of our activities were designed to serve as the starting point for business operations and IT requirements elaboration activities to be funded out of the Level 1 Exchange Establishment grant and as described in the *Business Operations and IT Planning* RFP issued on October 17, 2011.

Key Findings

Based on our assessment we have ascertained the following:

- **FUNCTIONALITY**: EMS lacks needed Exchange E&E functionality – less than 25 percent of expected functionality, as determined by the count of unique requirements captured in the assessment tool and met by the system as a percentage of all pertinent requirements, is in place and only partially at that. Moreover, EMS is a very old system (originally deployed in 1989) whose limited support resources are already challenged to meet existing needs and changes to existing programs.

- **INTEROPERABILITY**: The system, as architected, is not highly interoperable.

- **SECURITY**: The system as architected makes it difficult to restrict access to information on an absolute need-to-know or use basis as expected under federal law and other guidance.

- **CAPACITY AND AVAILABILITY**: The system does not appear to have significant transaction processing or data storage capacity issues, it does it appear to have availability issues, and it resides in a stable mainframe environment in a secure State data center with robust provisions for business continuity and disaster recovery.

- **ACCESSIBILITY BY EXTERNAL USERS**: EMS functionality is very limited in the area of "consumer-facing" E&E functionality, and considerably less than what federal law and guidance have established for Exchanges.

- **CONFORMANCE WITH CMS INFORMATION SYSTEMS STANDARDS AND CONDITIONS**: EMS does not conform to any of the CMS information systems standards and conditions.

Based on the aforementioned assessment, our team has concluded that EMS is not a viable E&E solution for Connecticut's Exchange. Moreover, the Web-based functionality that DSS has deployed is primarily static content which is beneficial but very limited when compared to federal expectations for an Exchange Web portal which would support eligibility determination and enrollment across multiple programs.

Recommendations

As noted earlier in the report, we structured this task to pave the way for more detailed planning, cost-benefit analysis and procurement work that will be funded through the Exchange Level 1 Establishment grant. The following recommendations are designed to further inform this work:

1. Acquisition and/or development of a new Medicaid E&E solution should be explored from a cost benefit standpoint. Alternatively, an "integrated eligibility system" solution that would replace and improve upon the functionality currently available in EMS should be explored. It is our understanding that the State is actively exploring one or both of these options and planning to leverage federal funding opportunities which are currently available.

2. The State could explore leveraging "information system components" being developed out of the Modernization of Client Service Delivery (MCSD) project, particularly those related to "consumer facing" online functionality. For instance, the State could design a "portal" that would support applying for multiple health and human services programs and the Exchange. To accommodate this change, the scope of the State's contract with the MCSD vendor might have to be amended. Adding an Exchange component to the MCSD could have an impact on the project timeframe as the MCSD would have to accommodate the timeline for establishing Connecticut's Exchange.

3. The State could explore leveraging "information system components" being developed out of the Exchange Early Innovator projects, including New England States Collaborative Insurance Exchange Systems (NESCIES). CMS expects these components to be designed to be relatively easy and inexpensive to integrate for states to assemble a complete information systems stack that would enable all Exchange functions, including E&E.

4. The State could explore an approach to acquiring Exchange operational capabilities through business process outsourcing rather than through acquisition or development of information systems. CMS encourages states, particularly those with limited IT resources or management capabilities, to explore an approach in which they focus on outsourcing and integrating Exchange business processes (e.g., call center operations, application intake and processing, premium processing and aggregation) rather than developing and/or integrating information systems. This approach positions the State as manager of business process outsourcing (BPO) vendors rather than as an integrator and manager of information systems. A variation of this approach is the use of an application service provider for some of these capabilities based on a "software as a service" (SaaS) model. In such an arrangement, the large upfront outlays traditionally associated with information systems projects can be minimized.

TASK 10 – Impact of the PPACA on Connecticut Medicaid & CHIP Programs and the Interaction with Exchange Plans

Executive Summary

Estimates of the enrollment and cost impacts of the Patient Protection and Affordable Care Act (PPACA) on Connecticut's Medicaid and Children's Health Insurance Program (CHIP) programs, as well as the possible interactions of those programs with the Exchange is a critical step in Connecticut's Exchange planning efforts. The analysis undertaken as part of this task provides enrollment and cost projections for newly eligible and previously eligible adults and children from 2014 to 2020.

Expanded Medicaid Eligibility

Under the PPACA, Medicaid eligibility will be expanded to cover nearly all individuals under the age of 65 with household modified adjusted gross incomes (MAGI) up to 133% of the federal poverty level (FPL) effective January 1, 2014. The Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) estimate that 16–18 million new individuals, respectively, will enroll in Medicaid as a result of the eligibility expansion. A more recent study by researchers at the Harvard School of Public Health estimates that the number of new Medicaid enrollees may range from 8.5 million to 22.4 million people nationally, a wider range of values. [1] The number of individuals who enroll in Medicaid will be influenced by a number of factors, including the extent to which government efforts encourage or discourage people from enrolling.

Increased Federal Reimbursement

In recognition of the expanded cost of covering the newly eligible Medicaid population, the PPACA provides enhanced federal matching dollars to states. For individuals who become newly eligible for Medicaid under the PPACA, the federal government will pay 100% of health care costs between 2014 and 2016. This percentage will phase down to 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and thereafter. By contrast, Connecticut will continue to receive 50% federal financial participation for most existing Medicaid covered populations, including those who were previously eligible but unenrolled in the program. The law also increases federal financial participation for most CHIP expenditures by an additional 23 percentage points for fiscal years 2016– 2019 (FY16–FY19). Connecticut's CHIP federal financial participation rate is scheduled to increase from 65% to 88% during that time period.

Exchange Interactions

While the PPACA expands Medicaid eligibility to previously ineligible individuals, it also creates an environment where states may wish to reduce state budget costs by transitioning current non-elderly adult enrollees from Medicaid to a Qualified Health Plan (QHP) on the Exchange or a Basic Health Program (BHP – a state-optional program for individuals with MAGIs between

[1] Sommers B, K Swartz, A Epstein. Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians Under Health Reform. Health Affairs, 2011;30(11):2186

134% and 200% FPL) as early as January 1, 2014. The health reform law includes a children's maintenance of effort (MOE) requirement in which states are also required to maintain Medicaid and CHIP income eligibility standards for children through September 30, 2019 as a condition of receiving Medicaid federal financial participation. Therefore, only adults could be transitioned to a QHP or a BHP beginning in 2014.

Data and Methodologies

Using 2008–2009 Current Population Survey (CPS) data available through the Kaiser Family Foundation's "statehealthfacts.org" website, Connecticut's Department of Social Services' historical enrollment and cost files and publicly available research on Medicaid take-up rates as well as the likelihood of employers dropping coverage, this analysis estimates the number and cost of new enrollees entering Connecticut's Medicaid and CHIP programs beginning in 2014, as well as the number and cost of enrollees who could be transitioned to a QHP or the BHP. Other national studies have employed micro-simulation models to estimate Medicaid enrollment and cost impacts. Such modeling techniques were beyond the scope of this analysis; however, a full accounting of the underlying assumptions in this analysis is included in the detailed report for Task 10.

Key Findings

Anticipated Medicaid and CHIP Growth

This analysis suggests that as many as 62,000 adults, the majority of whom are currently uninsured, could enroll in Medicaid in 2014. Net state costs for the newly enrolled adults would remain relatively low in the first three years of implementation ($14 to $24 million annually). State cost impacts are primarily influenced by several factors:

1. The federal government will pay 100% of the costs for the newly Medicaid eligible between 2014 and 2016. This includes an increase in federal financial participation from 50% to 100% for current Medicaid for Low Income Adult (MLIA) enrollees.

2. Connecticut will only receive 50% federal financial participation for Medicaid-covered populations who were previously eligible but unenrolled in the program. Assumptions regarding the size of this population and their rate of enrollment into Medicaid significantly influence estimated total State costs.

3. Connecticut will save State-only costs on what it would otherwise have spent for newly Medicaid eligible individuals previously enrolled in the Charter Oak Health Plan. Savings are estimated at approximately $12 million in 2014.

Net State costs for approximately 37,000 new child enrollees in 2014 will be considerably higher than for adults because none of the new health care costs are eligible for the enhanced Medicaid federal financial participation. The PPACA does increase federal financial participation for most CHIP expenditures by an additional 23 percentage points for FY16–FY19. Connecticut will still realize a net cost increase – estimated above $40 million in 2014. Estimates regarding

the number of uninsured children eligible for HUSKY A or B significantly influence estimated total State costs.

Health Insurance Alternatives for Existing Medicaid and CHIP Enrollees

This analysis suggests that as many as 18,000 adults could be transitioned to a QHP in the Exchange or a BHP alternative, depending on income, for a savings of nearly $64 million in 2014 State spending. Non-elderly adult enrollees and cost estimates are shown in Figure 10-7. Estimates for children are shown in Figure 10-8. Due to the children's MOE requirement, estimates of the number of children who could be transitioned to a QHP or BHP do not begin until 2019. Enrollment and savings estimates should be considered as somewhat more tentative and approximate in light of the long time horizon and the numerous required assumptions that make forecasting difficult.

Recommendations

The net total impacts to enrollment in Connecticut's Medicaid and CHIP programs, as well as the State budget, will be influenced by decisions the State makes with regard to Medicaid and CHIP eligibility standards through 2020, as well as outreach and enrollment efforts. Three potential scenarios are summarized on the following page:

1. Maintain Medicaid/CHIP eligibility requirements through 2020

2. Reduce adult Medicaid eligibility in 2014; maintain children's eligibility requirements through 2020

3. Reduce adult Medicaid eligibility in 2014 and children's eligibility in 2019

It is recommended that the State review the analysis detailed in the appendices, understanding that the results rely on a series of assumptions and data sources each of which has its own advantages and disadvantages. The results provide a directional sense of enrollment and cost impacts and give an estimate of order of magnitude of those impacts.

Population estimates should be updated using 2010 CPS data once CPS data with the Urban Institute's health insurance unit adjustment is available on the Kaiser Family Foundation's website. All estimates, including State Medicaid and CHIP enrollment and cost data, should be updated annually during the Exchange planning and implementation process in order to capture changes in the baseline data.

To the extent Connecticut decides to transition existing Medicaid enrollees into a QHP or BHP, the State will have to consider how benefits and out-of-pocket expenses may be different for those enrollees who are affected by the change.

Medicaid & CHIP Enrollment and Cost Scenario Estimates Under ACA

IMPACTS	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2020
TOTAL Base Enrollment (with Individual Mandate)	**544,777**	**587,544**	**615,920**	**635,372**	**648,076**	**680,930**	**703,292**	**717,693**	**723,647**	**727,376**	**729,258**	**730,771**
Annual % Change		*8%*	*5%*	*3%*	*2%*	*5%*	*3%*	*2%*	*1%*	*0.5%*	*0.3%*	*0.2%*
SCENARIO 1: Maintain Current Medicaid/CHIP Eligibility Requirements												
Net Enrollment Increase/(Decrease)						99,288	106,976	116,351	124,293	132,210	139,882	147,208
TOTAL Medicaid/CHIP Enrollment						**780,218**	**810,268**	**834,044**	**847,940**	**859,586**	**869,141**	**877,979**
Annual % Change						*20%*	*4%*	*3%*	*2%*	*1.4%*	*1.1%*	*1.0%*
State Cost Increase/(Decrease) in $1,000s						**$ 56,910**	**$ 62,553**	**$ 61,929**	**$ 96,746**	**$115,604**	**$140,938**	**$196,834**
SECNARIO 2: Reduce Adult Medicaid Eligibility in 2014; Maintain Current Children's Eligibility Requirements												
Net Enrollment Increase/(Decrease)						81,403	88,407	97,310	105,013	112,828	120,437	127,705
TOTAL Medicaid/CHIP Enrollment						**762,333**	**791,699**	**815,002**	**828,660**	**840,204**	**849,695**	**858,476**
Annual % Change						*18%*	*4%*	*3%*	*2%*	*1.4%*	*1.1%*	*1.0%*
State Cost Increase/(Decrease) in $1,000s						**$ (7,004)**	**$ (6,165)**	**$(11,111)**	**$ 20,016**	**$ 35,788**	**$ 58,034**	**$110,736**
SENARIO 3: Reduce Adult Medicaid Eligibility in 2014 & Children's Eligibility in 2019												
Net Enrollment Increase/(Decrease)						81,403	88,407	97,310	105,013	112,828	75,471	80,825
TOTAL Medicaid/CHIP Enrollment						**762,333**	**791,699**	**815,002**	**828,660**	**840,204**	**804,730**	**811,596**
Annual % Change						*18%*	*4%*	*3%*	*2%*	*1.4%*	*-4.2%*	*0.9%*
State Cost Increase/(Decrease) in $1,000s						**$ (7,004)**	**$ (6,165)**	**$(11,111)**	**$ 20,016**	**$ 35,788**	**$ 42,051**	**$ 41,450**

**Medicaid/CHIP Children MOE requirements through 9/30/19*

TASK 11 – Multi-state Exchanges

Executive Summary

Section 1311 of the Patient Protection and Affordable Care Act (PPACA) authorizes states to establish Health Insurance Exchanges (Exchanges), defer to the federal government for Exchange operation or participate in multi-state Exchanges. In addition to the option of a multi-state Exchange, there are opportunities for Connecticut to leverage external resources in designing, implementing and operating its Exchange.

This report will provide an assessment of the benefits and challenges of joining a multi-state Exchange and will assess the possibility of a partnership with the federal government under which Connecticut would share Exchange responsibilities with the Center for Consumer Information and Insurance Oversight (CCIIO). The report also analyzes an effort now underway to engender collaboration on information technology systems called the New England States Collaborative Insurance Exchange Systems (NESCIES) project.

Key Findings

- Joining a multi-state Exchange will necessitate a close review of, and likely a modification of, Connecticut's health insurance regulatory environment, require state legislative authority, and introduce operational and political complexity into the Exchange planning process. The Mercer/Health Management Associates (HMA) team is closely monitoring activity nationwide and we do not see serious activity underway to establish multi-state Exchanges. In the northeastern states and New England, most states (like Connecticut) are well underway in planning for in-state Exchanges.

- Department of Health and Human Services (HHS) and CCIIO have indicated a willingness to explore ways to work with states on partnership approaches that incorporate shared business functions from other states or the federal government. Those approaches, conceived as an alternative for states to a fully federally-operated Exchange, could involve federal performance of significant functions of the Exchange.

- Limited guidance is available on these "partnership" approaches. CCIIO will allow states to choose among three options, defined in relationship to the five core functions of the Exchange: consumer assistance, plan management, eligibility, enrollment and financial management. Under one option, states would perform plan management functions only. Under a second option, states would perform consumer assistance functions. A third option allows states to perform both plan management and consumer assistance functions.

- In all cases there would be significant federal involvement in the Connecticut market, and Connecticut consumers would be interacting in important ways with federally-run components of the Exchange over which the Connecticut Exchange will have little control, including: 1) the Exchange website; 2) the range of consumer interactions involving applications, eligibility determinations and plan enrollment, including open enrollment; and 3) the customer service and call center operation.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

- Connecticut faces significant operational challenges in setting up its Exchange, many of which revolve around information technology (IT) needs. It is possible that beginning implementation in partnership with CCIIO could allow for an easier transition to full state operation in later years while retaining state authority over critical functions at the outset. At the same time, there are potentially negative consequences to establishing an Exchange using one set of operational infrastructure and then transitioning to a state-operated environment.

- This NESCIES project holds significant promise for collaboration on Exchange implementation. Adopting technology developed through the NESCIES effort would be, as compared to a multi-state Exchange or participation in an Exchange partnership model, less intrusive to existing expectations, state goals and governance structures. Nevertheless, given the mandatory timelines involved and the complexity of the issues in each state, utilizing NESCIES will be challenging, so complete reliance on technology coming out of the project carries very high risk.

- As with all Exchange IT development work, the project is organized according to a framework established by CMS. Six CMS-defined business areas are used to define the functions that participating states may consider reusing:

  - Eligibility and enrollment
  - Plan management
  - Financial management
  - Customer service
  - Communications
  - Oversight

- The appropriateness of Connecticut adopting NESCIES-based IT systems for each, or any, of these Exchange business areas is dependent on interrelated strategic and technical considerations. An initial assessment of existing systems in the State appears to demonstrate that Connecticut will need to develop or acquire new technology to run its Exchange. NESCIES technology components may support Connecticut's need to address gaps in IT infrastructure. At the same time, NESCIES is facing an extremely challenging timeline to complete the project in time for states other than Massachusetts to adopt its technology. Moreover, outside of NESCIES, the IT software and business process implementation vendor community is developing solutions that meet federal Exchange requirements.

- Similar opportunities to leverage external functionality may come not from NESCIES but from other states. Connecticut may also benefit from experience and materials produced in other states that are more advanced in their planning, both in terms of "lessons learned" and in the development of business requirements or procurement approaches that may be reusable or adaptable.

Recommendations

- Connecticut should not focus its limited resources on exploring a multi-state Exchange because there are substantial complexities to joining a multi-state Exchange and very little activity underway to establish such Exchanges in other states. However, Connecticut should seek to engage other states and the federal government in the idea of multi-state collaborations where partnerships can be formed which reduce cost and improve quality by leveraging redundant components (i.e., cost calculators), sharing intellectual capital and developing efficient business processes.

- Connecticut should monitor developments on the federal-state Exchange partnership model to determine whether they create the potential for models that will ease the path to implementation.

- Connecticut should continue to devote resources to active participation and engagement with the NESCIES project, including participation on the NESCIES Interstate Collaborative Steering Committee and in appropriate subgroups. Connecticut can prioritize areas of focus based on its own assessment of potential priority business areas, and should also be involved in project discussions about how best to ensure reusability of project components that could support the Connecticut Exchange.

Connecticut should monitor other state developments closely, including both the potential of adapting state-developed Exchange technology and the information available from other states concerning business function development and procurement approaches.

4

Detailed Task Reports

Following are detailed task reports for each of the eleven task areas reviewed under the Connecticut Exchange Planning project.

TASK 1 – Assessment of the Uninsured in Connecticut

Introduction

There is no single source of data about health insurance coverage in Connecticut. As part of this task, the Mercer/HMA team was asked to review existing reports and survey data to develop an estimate of the number of uninsured in Connecticut. Appendix 1D includes a discussion of the alternative population surveys and the relative merits of each data source. Appendix 1E includes data from existing reports.

Number of Uninsured in Connecticut

Population survey results are the only available source for much of the information needed for planning for Connecticut's Exchange. Estimates of the number of uninsured individuals vary because of differences in the survey sample size and the times at which the surveys were administered. For this report, we have chosen to use, primarily, data from the Current Population Survey (CPS). Raw CPS data from 2008/2009, in combination, shows 377,000 uninsured individuals in Connecticut. The State Health Access Data Assistance Center (SHADAC) at the University of Minnesota has generated single-year CPS estimates that account for observations in data trends over time. Their estimate of the number of uninsured in Connecticut in 2009 is 365,000 individuals. These two values are close enough that data from both sources will be used in this report.[1]

While the increased unemployment rate since 2009 is expected to have resulted in a reduction in employer-based health coverage, the implementation of the low-income adult component of Connecticut Medicaid in April 2010 and the growth of enrollment in existing Medicaid and HUSKY programs since 2009 is expected to have reduced the number of uninsured. Therefore, we are comfortable with using the 2009 data. When the 2010 data at the state level becomes available, a review of the new data may be appropriate.

Characteristics of the Uninsured from Household Survey Data

Among various characteristics of the uninsured, the most important issues for Exchange and Medicaid expansion planning are income levels and expected healthcare costs. Estimates of expected healthcare costs will be provided as part of Task 10.

CPS data with enhancements from SHADAC were used to generate the summary data for 2009 in Table 1-1 that follows.

[1] The value of using the SHADAC information is that it provides more detailed tabulations of coverage by age and income.

Table 1-1 (data in thousands)

Health Insurance Coverage Estimates, CPS (SHADAC-enhanced), Non-Elderly, Connecticut: Calendar Year 2009												
	Total Pop.	Un-insured	Insured Total	Private Coverage			Government Coverage				Both Gov't & Private	% Both
				Total	Employer	Indiv.	Total	Medicaid	Medicare	Military		
0-138% FPL	347	112	235	103	76	22	148	128	30	3	16	6.8%
139-199% FPL	219	57	162	91	75	15	82	73	10	3	11	6.8%
200-399% FPL	766	111	655	593	550	42	100	66	15	18	38	5.8%
400%+ FPL	1,679	83	1,596	1,563	1,485	89	78	42	17	21	45	2.8%
Total	3,010	363	2,647	2,351	2,185	168	407	309	71	45	111	4.2%
Filtered Total	3,017	365	2,652	2,354	2,187	169	410	311	71	45	112	4.2%

Source: Downloaded from www.shadac.org on July 15, 2011[2].

It should be noted that some individuals have more than one source of health care coverage. Table 1-1 indicates that in the CPS survey, there are about 112,000 non-elderly individuals with both government and private coverage.

The key information from Table 1-1 is the number of low-income uninsured individuals. More than 110,000 of the uninsured in Connecticut are in families with incomes at or below 138% of the federal poverty level (FPL). The proportion of the uninsured at or below 138% of FPL is a critical statistic, since all citizens and legal immigrants with five or more years of US residency with income at that level will be eligible for Medicaid under the PPACA.[3]

An accurate income distribution for the uninsured is critical for planning for Exchange and Medicaid expansion under PPACA. One of the values of using CPS data available through the Kaiser Family Foundation's "statehealthfact.org" website is that the Urban Institute has adjusted the data to account for the fact that not everyone in a household is part of the same Health Insurance Unit (HIU). This is an important consideration in assessing who might be eligible for Medicaid expansion under PPACA or for subsidized coverage through the Exchange. An individual that is part of a household or even related to the head of the household (for example, an adult child of the head of the household) might well be treated separately for health insurance purposes and have a lower income. Unadjusted CPS data categorize every member of the household as having the income of the full household. Similarly, the American Community Survey (ACS) looks at "families" and assigns everyone related to the head of the household to a

[2] While the "Total" is the sum of the values for the four income strata, the "filtered total" is the estimated total for that coverage source, irrespective of assignment to specified income strata. CPS data has been enhanced by researchers at the SHADAC at the University of Minnesota. SHADAC's enhanced CPS health insurance estimates are CPS data re-weighted and adjusted to account for historical changes in the survey's methodology. These estimates do not correspond to estimates published by the Census Bureau; however, they can provide a consistent assessment of coverage estimates over time. CPS methodology note: The CPS asks respondents about their health insurance coverage at any point in the last calendar year. For technical documentation on the CPS, please visit http://www.shadac.org/content/cps-info-and-resources.

[3] As previously noted, gross income at 138% of the FPL is expected to be the actual income limit for the Medicaid expansion under PPACA since the statute provides that 5% of income will not be counted.

family unit with composite income. Table 1-2 shows that a significantly higher portion of the Connecticut population has income under 139% of FPL when the HIU is used to assign income.

Table 1-2 Connecticut Coverage Status – All Non-elderly with Incomes Below 139% FPL

	Uninsured	Employer	Individual	Medicaid	Other Public (incl. Medicare)	Total Population	Multiple Coverage
2008–2009 CPS with urban adjustment	155,700	116,300	37,900	198,900	23,900	532,800	N/A
2008–2009 CPS with SHADAC enhancement	98,000	87,000	18,000	158,000	37,000	381,000	17,000
2008–2009 raw CPS	111,000	96,000	20,000	156,000	36,000	399,000	20,000
CPS 2009 with SHADAC enhancement	112,000	76,000	22,000	128,000	33,000	347,000	24,000
2009 ACS	88,000	3,000	31,000	214,000	24,000	411,000	29,000

As shown in Table 1-2, the total number of individuals with incomes below 139% of FPL increases dramatically, by more than one-fourth when the Urban Institute adjustment is applied. Even more dramatic is the increase in the portion of the uninsured that are low-income individuals with the Urban Institute adjustment – an increase to nearly 156,000 persons.

The fact that there are many individuals with employer-based coverage and income below 139% of FPL is also significant. As of January 2014, PPACA would allow these individuals to drop employer-sponsored coverage and enroll in Medicaid without any penalty. HMA recommends that the CPS data with the Urban Institute HIU adjustment be used for any analysis that estimates eligibility and/or participation in programs that are specific to certain income groups.

Unfortunately, the detailed income categories shown in Table 1-1 are not available for this source. The data in Table 1-3 provide a complete picture of the coverage of low-income individuals in Connecticut. These are individuals that would be eligible for Medicaid under PPACA (up to 138% of FPL) and another group that might be eligible for either a BHP or significant subsidized coverage through an Exchange (between 139% and 200% of FPL).[4] Table 1-3 also shows the distribution of coverage for those with income above 200% of the FPL.

[4] HMA derived the group between 139% and 200% of FPL by subtracting reported values for those “up to 138% FPL” from those “up to 200% FPL”. It is likely that some of these values have large values for the “standard error of the estimate”, given the small size of the CPS sample for Connecticut.

Table 1-3

Distribution of the Non-elderly in Connecticut by FPL and Coverage Source, 2008-2009 CPS Data With Kaiser/Urban HIU Adjustment

	Uninsured	Employer	Individual	Medicaid	Other public	Total population
Up to 138%	155,700	116,300	37,900	198,900	23,900	532,800
Between 139% and 200% FPL	*65,400*	*85,700*	*18,300*	*58,000*	*9,700*	*237,000*
Total up to 200% FPL	221,100	202,000	56,200	256,900	33,600	769,800
Above 200% FPL	155,900	1,863,100	93,000	95,500	17,100	2,224,500
Total	377,000	2,065,100	149,200	352,400	50,700	2,994,300

Source: Downloaded from www.statehealthfacts.org on July 15, 2011.

The data in Table 1-3 suggest that the following coverage changes could occur when people become eligible for new PPACA coverage and subsidies in 2014:

- About 155,000 of the currently uninsured would qualify for Medicaid. Most likely, these are primarily “childless adults”. Additionally, an estimated 3,500 of the uninsured individuals between 139% and 200% of FPL are low-income children that would qualify for HUSKY B with CHIP funding today.

- More than 110,000 individuals might be able to move from employer-based coverage to Medicaid. The likelihood that this would occur warrants further study in subsequent tasks of this project.

- Nearly 40,000 persons with individual coverage might be able to drop those policies and enroll in Medicaid expansion. (However, it is likely that a large portion of this population was enrolled in SAGA medical assistance in 2009.)

It should also be noted that any undocumented immigrants or legal immigrants with fewer than five years US residency will not be able to enroll in the Medicaid program unless they are children or pregnant women.[5] In addition, the take-up rate of those that actually enroll in coverage will be less than 100%. Many low-income uninsured individuals in Connecticut are already eligible for Medicaid or other State-sponsored coverage but have not enrolled. While PPACA includes an individual mandate with penalties, the penalties do not apply to children or low-income individuals. Current national experience with Medicaid enrollment in the states indicates that many eligible individuals are not enrolled. The original Congressional Budget

[5] Medicaid coverage for legal immigrant children and pregnant women with less than five years US residency is optional. Connecticut chose to implement this option in 2009.

Office analysis of PPACA assumed a take-up rate of 57% for Medicaid.[6] More recent analysis by the Urban Institute assumes that 73% of those eligible for coverage under Medicaid expansion will actually enroll.[7] This topic will be addressed in more detail in Task 10.

For three components of the coverage distribution, namely employer coverage, Medicaid and uninsured, Kaiser found that there are sufficient CPS data across the states to prepare tables with enrollment distributions that further divide the population with incomes above 200% of FPL.

Table 1-4

Distribution of the Non-elderly in Connecticut by FPL and Some Sources of Coverage, CPS 2008-2009

	Uninsured	Employer coverage	Medicaid
Under 100%	121,600	65,000	152,400
100% – 138%	34,100	51,400	46,500
139% – 199%	65,400	85,700	58,000
200% – 399%	100,500	477,800	62,300
400%+	55,400	1,385,200	33,140
Total	377,000	2,065,100	352,340

Source: Table 1-4 provides data that were generated by combining several separate tables from the www.statehealthfacts.org website.

Because Connecticut has a relatively generous Medicaid program and offers other supports through HUSKY (including unsubsidized HUSKY), Charter Oak and SAGA medical assistance (which became part of Medicaid in April 2010), the income distribution of the uninsured in Connecticut is different than the income distribution of the uninsured for the nation as a whole, as seen in Table 1-5.

[6] March 18, 2010 letter from Douglas W. Elmendorf, Director of the Congressional Budget Office to Speaker Nancy Pelosi.

[7] Matthew Buettgens, John Holahan and Caitlin Carroll, *Health Reform Across the States: Increase Insurance Coverage and Federal Spending on the Exchanges and Medicaid,* March 2011, Robert Wood Johnson Foundation, State Coverage Initiatives, Urban Institute.

Table 1-5

Distribution of the Non-elderly Uninsured by FPL, CT, MA and NY (2008-2009); US (2009)					
	CT number	**CT %**	**MA %**	**NY %**	**US %**
Under 100%	121,600	32%	37%	34%	40%
100% – 138%	34,100	9%	NSD	9%	12%
139% – 250%	108,800	29%	24%	27%	26%
251% – 399%	57,100	15%	NSD	16%	13%
400% +	55,400	15%	17%	14%	10%
Total	377,000	100%	100%	100%	100%

Source: Downloaded from www.statehealthfacts.org on December 16, 2011

While Connecticut has a lower rate of uninsured than the nation as a whole, a smaller portion of those that are uninsured will qualify for Medicaid expansion, a BHP or significant subsidization under PPACA. The average income of Connecticut's uninsured is higher than the income of the uninsured in other states. While states in the Northeast generally have a lower proportion of low-income uninsured than the nation as a whole, this is especially true in Connecticut. (Table 1-5 shows comparisons to Massachusetts and New York as illustrations.)

Future reports in this project will assess the number of individuals that are likely to actually enroll in these programs. In particular:

- Data from Task 2 on the insurance market in Connecticut should be used to revise the counts of employer-based and individual coverage insurance (and also modify the number of uninsured if appropriate) and ascertain the extent of any coverage limits, including high deductible plans and limits on coverage that might result in underinsurance.

- Data from Task 10 on Medicaid should be used to revise the counts of Medicaid and uninsured.

- Future analyses should also focus on the following "migration" potential:

  - Estimates of the proportion of the uninsured eligible for Medicaid today or under Medicaid Expansion that will enroll in Medicaid

  - Assessment of the likely number of low-income individuals that will move from employer coverage to Medicaid

- Estimates of the likely number of low-income individuals that will move from individual coverage to Medicaid, a BHP or the Exchange.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Appendix 1A

As part of the Exchange planning project, Connecticut seeks information on the number of State residents that are underinsured. There is no standardized definition of underinsurance. As part of Task 2, the Mercer team reviewed existing insurance policies in Connecticut with respect to the actuarial value of the plans, including an assessment of the levels of premiums, deductibles and copayments.

Survey of the Connecticut Health Insurance Market

The PPACA assigns various "precious metal" tiers to health insurance policies based on the actuarial value of the policy. Any policy for which the premium covers between 60% and 69% of the actuarial value (average expected cost) of health care is a Bronze Level plan, which is the lowest actuarial value that can be offered on an Exchange. The survey of current health insurance in Connecticut found that 44% of current health insurance is below the Bronze Level. In particular, 47% of individual policies and 45% of policies for employees of firms with fewer than 50 employees were below the Bronze Level. (The proportion of policies below the Bronze Level is only 7% for persons insured through firms with 50 to 99 employees and 5% for those whose employers have 100 to 499 employees.)

The insurance survey found that individual deductibles are quite high, not only in the individual market (where more than 90% of policies have deductibles in excess of $1,000 per year), but also for those insured through small and mid-size employers. In fact, the *average* deductible is $1,044 for those covered through employers with between 50 and 499 employees.

If coverage below a 60% actuarial value (or Bronze Level plan) is used as a definition of underinsurance, 47% of those purchasing individual insurance policies, or about 123,000 individuals, and 45% of those covered through employers with fewer than 50 employees, or 84,000 individuals, are underinsured in Connecticut. (See Task 2 report for additional detail.)

As Connecticut moves forward with planning for Exchange implementation, additional research on the individual and small group market is required. One particular need is an estimate of the number of enrollees in the individual and small group markets that are currently covered by health plans that do not meet PPACA requirements, either with respect to coverage of required "essential benefits" or with respect to the portion of the actuarial value of the plan that is covered by the premium (which includes an evaluation of the copayment and deductible structure of the plan). Ideally, this analysis would also take account of individual or family income in order to determine whether those identified as "underinsured" are candidates for premium and cost sharing subsidy under the Exchange.[8]

[8] It is unlikely that such information will be available for those purchasing individual coverage. For those enrolled in employer-sponsored coverage, it is possible that average wages paid by that employer could be used as a rough proxy measure to assess the potential number of individuals that might move from employer-based coverage to the Health Benefits Exchange.

Appendix 1B

Using CPS data from 2008/2009, the Kaiser Family Foundation's www.statehealthfacts.org website provides descriptive data on some of the demographic characteristics of the uninsured in Connecticut.

Age and Gender

The uninsured in Connecticut are primarily adults, as in the US, as a whole.

Table 1B-1

Distribution of the Non-elderly Uninsured by Age, CT (2008-2009), US (2009)

	CT	CT	US	US
Children	58,400	15%	8,284,500	17%
Adults	318,600	85%	41,713,400	83%
Total	377,000	100%	49,997,900	100%

Source: Downloaded from www.statehealthfacts.org on July 15, 2011.

The uninsured are more likely to be male than female. The extent of the disparity is greater in Connecticut than in the US, as a whole, as seen in Table 1B-2.

Table 1B-2

Distribution of the Non-elderly Uninsured by Gender, CT (2008-2009), US (2009)

	CT	CT	US	US
Female	158,100	42%	22,804,600	46%
Male	218,900	58%	27,193,300	54%
Total	377,000	100%	49,997,900	100%

Source: Downloaded from www.statehealthfacts.org on July 15, 2011.

Work Status

As shown in Table 1B-3, more than 60% of the uninsured in Connecticut and nationally live in families with at least one full-time worker. As a result, the interaction of PPACA provisions with employer decisions to offer insurance could affect many of these individuals.

Table 1B-3

Distribution of the Non-elderly Uninsured by Family Work Status, CT (2008-2009), US (2009)

	CT	CT	US	US
At least one full-time worker	239,200	63%	30,663,900	61%
Part-time workers	61,000	16%	8,049,800	16%
Non-workers	76,900	20%	11,284,200	23%
Total	377,000	100%	49,997,900	100%

Source: Downloaded from www.statehealthfacts.org on July 15, 2011.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Appendix 1C

Methodology – Population Surveys

This report focuses on the structure of health care coverage in Connecticut in 2009. Data for 2010 are not yet available for most components of the health insurance/coverage system; data on the uninsured in 2010 will not be available until late in 2011. For most components of this analysis, data for 2010 will likely not be significantly different from 2009 data. However, we do know that Medicaid enrollment in Connecticut increased by nearly 95,000 individuals between the end of 2009 and the end of 2010. While most of the increase is due to the enrollment of nearly 59,000 individuals in the new low-income assistance component of Medicaid, 36,000 enrollees were added to the roles of existing Medicaid categories, a growth of nearly 8%. Increases in the unemployment rate likely produced an increase in the number of uninsured. The use of 2009 data for planning purposes should be tempered by this knowledge, and plans should be refined as later data become available or as models are developed that adjust the historical data for changes in employment and other known trends.

The relevant population for Exchange planning is all non-elderly individuals, since coverage for the elderly is not affected by health care reform. Unfortunately, there is no ideal source of information about coverage status. Since insurance status is not reported to any single agency, population surveys are the best source of data on the uninsured. Most population survey results show an under-reporting of Medicaid enrollment. Two primary sources were considered for the data on the landscape of health insurance and health coverage in Connecticut. Both are surveys administered by the US Census Bureau.

The first is the CPS. The CPS is a monthly survey that the Census Bureau conducts for the Bureau of Labor Statistics to provide data on labor force participation and unemployment. As the official source of government statistics on employment status and income, data on health insurance coverage is collected through the Annual Social and Economic Supplement (ASEC), which was initially added to the CPS in March of each year and was expanded to February through April beginning in 2001. (The ASEC is sometimes referred to as the "March Supplement"). Data are collected through a combination of telephone and in-person modes using computer-assisted instruments. The CPS has included approximately 77,000 households per year since 2000. The CPS asks respondents to recall their insurance status for the prior calendar year (January through December). The CPS was modified several years ago with the addition of a verification question to eliminate a prior tendency to overstate the number of uninsured.

The ACS is a general household survey conducted by the US Census Bureau and has replaced the decennial census "long form" survey. An important feature of the ACS is that it includes a large enough sample for state-level and sub-state health insurance coverage estimates. ACS data are collected on an ongoing basis using monthly mailings to a sample of US households. It is a mixed-mode incremental survey, with mail non-respondents being called for a computer-assisted telephone interview (CATI), and phone non-respondents sampled for an in-person computer-assisted personal interview (CAPI). The ACS draws a sample of three

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

million addresses, yielding about two million responses. This is roughly 30 times larger than the sample size of the CPS.

The larger size of the ACS would argue for its use as the most robust source of information. The ACS also has a more accurate count of Medicaid enrollment than the CPS. For Connecticut, the ACS shows 414,000 non-elderly Medicaid enrollees for calendar year 2009 and 464,000 total Medicaid enrollees, with the elderly included. This count of 464,000 is based on 12 monthly snapshots and, therefore, reflects the "average" Medicaid enrollment for the year as reported in the survey. This number is actually slightly higher than the number of individuals with full benefit Medicaid or coverage as dual Medicare/Medicaid beneficiaries in Connecticut in 2009, which reached 456,000 in December 2009. The "Medicaid over count" on the survey may be due to the existence of the SAGA medical assistance program, which provided State-funded medical assistance to individuals receiving financial support from Connecticut's SAGA program. With the enactment of PPACA in March 2010, Connecticut chose to be an "early adopter" of the new option to expand Medicaid to cover these individuals with State and federal Medicaid funds.[9]

Since the ACS is a rolling monthly point-in-time survey over 12 months, the ACS results provide a snapshot of coverage. For 2009 for Connecticut, the ACS estimate is that there were 304,000 uninsured elderly individuals in Connecticut.[10] Nearly 90,000 of these individuals appear to meet the income eligibility for the expansion of Medicaid under health care reform. The data from the ACS also indicate that about 150,000 currently uninsured individuals would qualify for subsidized coverage through the Exchange. The remaining 65,000 uninsured individuals would be required to purchase health insurance without any subsidization or be subject to a penalty.

Use of the CPS data results in a 20% greater number of uninsured individuals (a difference of 63,000) attributable to a lower count of the number of Medicaid enrollees by 103,000, which is partially offset by a higher number of Medicare and privately insured individuals.

Neither of these surveys generates a perfect picture of the number of uninsured in Connecticut. Across states, the ACS appears to systematically generate an overstated number of individuals with private coverage that is individually purchased. The CPS provides more robust information about military coverage, which is not insignificant in Connecticut.

While the significantly larger size of the ACS sample allows researchers much more flexibility in deriving estimates related to insurance coverage at the national, state and even regional levels, the insurance validation question would argue for use of the CPS data. One of the values of using CPS data available through the Kaiser Family Foundation's "statehealthfact.org" website is that the Urban Institute has adjusted the data to account for the fact that not everyone in a household is part of the same HIU. This is an important consideration in assessing who might be

[9] The SAGA program had an enrollment of 43,031 in December 2009. The new Low-Income Adult Medicaid category had an enrollment of 46,166 in June 2010 and 58,686 in December 2010.

[10] A subset of the uninsured is comprised of unauthorized immigrants that are not eligible for either Medicaid (with the exception of emergency services) or subsidy through the Exchange. We estimate that this number is between 10,000 and 15,000 in Connecticut.

eligible for Medicaid expansion under PPACA or for subsidized coverage through the Exchange. An individual that is part of a household or even related to the head of the household (for example, an adult child of the head of the household) might well be treated separately for health insurance purposes and have a lower income. Unadjusted CPS data categorizes every member of the household as having the income of the full household. Similarly, the ACS looks at "families" and assigns everyone related to the head of the household to a family unit with composite income.

As a result, HMA recommends that the CPS data with the Urban Institute HIU adjustment should be used for any analysis that estimates eligibility and/or participation in programs that are specific to certain income groups. Unfortunately, some cross-tabulations are not available for this source. The data with the Urban Institute HIU adjustment are available only from www.statehealthfacts.org. Since we do not have access to the raw data or even a table generator, we are limited to the data distributions that have been chosen by the Kaiser/Urban team.

There are at least four key differences in reporting of income by coverage status in these data. One is that the income categories for the Kaiser/Urban data are not the same as those HMA was able to gather from ACS, raw CPS and SHADAC-enhanced CPS data.[11] Another is that the Kaiser Family Foundation does not report data values for cells that are too small to have statistical significance. The third is that the Kaiser/Urban methodology assigns each individual to a primary source of health coverage. As a result, the Kaiser/Urban data do not have the duplication that exists with the CPS and ACS data. And finally, not all types of coverage are reported on the Kaiser website with detailed income distributions.

Total Number of Uninsured – Comparison of Surveys

Because Connecticut is a relatively small state, surveys like the CPS have a relatively small sample of Connecticut residents since these surveys include roughly the same percentage of the population in every state. As a result, the small sample sizes result in single-year estimates that have low statistical validity. When combined with other survey issues, such as the under-reporting of Medicaid coverage that has always been true of CPS data, getting an accurate estimate of the total number of uninsured is the first challenge. The SHADAC of the University of Minnesota, with support from the Robert Wood Johnson Foundation, provides tabulations of ACS and CPS data, as well as "SHADAC enhanced" version of CPS data that reweights and adjusts CPS data to account for changes in the CPS survey's historical methodology.

[11] The Kaiser/Urban data is reported for the following income categories: under 100% FPL, 100% to 138% FPL, 139% to 250% FPL, 251% to 300% FPL, and 400% FPL or greater. In addition, several tables are available for those below 200% of FPL which facilitates creation of the data in Table 1D-1.

Table 1C-1

Comparison of Surveys			
	Year(s)	**Uninsured**	**Medicaid**
American Community Survey (ACS)	2008 only	294,000	373,000
Current Population Survey (CPS)	2008 only	341,000	388,000
CPS-SHADAC Enhanced	2008 only	312,000	379,000
American Community Survey (ACS)	2009 only	304,000	414,000
Current Population Survey (CPS)	2009 only	413,000	315,000
CPS-SHADAC Enhanced	2009 only	365,000	311,000
American Community Survey (ACS)	2008 & 2009	299,000	394,000
Current Population Survey (CSP)	2008 & 2009	377,000	352,000
CPS-SHADAC Enhanced	2008 & 2009	338,000	345,000

Because of its larger sample size, the ACS shows less year-to-year variation. In 2009, the ACS has a more accurate Medicaid value, while the CPS value is significantly understated relative to administrative data on the actual non-elderly Medicaid enrollment in Connecticut. In 2008, the Medicaid number is comparable for both ACS and CPS and is understated. In 2009, the Medicaid number for ACS is close to the administrative value, while the CPS and SHADAC-enhanced CPS values are much lower. For 2009, SHADAC adjusted the number of individuals with employer-based coverage by about 50,000 to make the one-year data more consistent with historical trends. The result is a much lower uninsured count.

A key question in Connecticut prior to 2010 is how individuals enrolled in the medical assistance component of the SAGA program were counted in population surveys. After the passage of PPACA in 2010, Connecticut was the first state to submit a Medicaid state plan amendment to modify its program, and effective April 1, 2010, the State moved the SAGA enrollees into Medicaid as low-income adults (LIA) with incomes below 56% of FPL.[12] For population surveys, it appears that these individuals might have reported their status as having individual coverage or as uninsured in 2009.

Accurate counts of those with and without insurance in Connecticut are also more challenging because of the existence of other State-subsidized coverage programs. One such program is the HUSKY program that includes HUSKY A and HUSKY B components, which are funded by Medicaid and CHIP, respectively. In addition, any family in Connecticut with an uninsured child, whose family income exceeds the thresholds for subsidization, can choose to purchase unsubsidized enrollment in HUSKY B. Charter Oak is another program in Connecticut that provides subsidized coverage specifically for uninsured adults. HMA assumes that

[12] Individuals living in Southwest Connecticut receive an income disregard equal to 12% of FPL, making the gross income limit for LIA in that area 58% of FPL.

individuals/families that are purchasing health coverage through HUSKY B or Charter Oak have most likely reported that coverage as individual insurance.

Another key consideration in estimating the total number of uninsured in Connecticut is that the number of unemployed individuals was increasing throughout 2009 (from 7.1% in January to 9.0% in December); the number peaked at 9.2% in February 2010. Since that time, the unemployment rate has been basically flat and is estimated to be 9.1% in June 2011. We would expect that the number of uninsured and the Medicaid enrollment will be higher in mid-2011 than the levels experienced in 2009 because of the higher unemployment rate. To the extent feasible, we will update our estimates of coverage and uninsurance for later reports in this project based on population survey data for 2010 and more recent enrollment in Medicaid, HUSKY B and LIA.

Since the ACS numbers for uninsured in Connecticut are so much lower than the CPS data and since the number of uninsured is likely to have risen with the increase in unemployment, HMA recommends that any data analysis for Connecticut should either use the CPS data as reported on the Kaiser Family Foundation website or, if based on other sources, should tie to these data in the aggregate. A secondary source for consideration is the SHADAC-enhanced CPS values for Exchange planning purposes. Since the CPS survey is so small, a multiple-year value is most appropriate for most demographic characteristics. However, for the total number of uninsured, the 2009 single year SHADAC-enhanced value seems appropriate since SHADAC accounts for trend information in “smoothing” this data. Thus, the estimated number of uninsured in Connecticut is between 365,000 (SHADAC-enhanced CPS for 2009) and 377,000 (raw CPS for 2008 and 2009 in combination).

Medical Expenditure Panel Survey

The Medical Expenditure Panel Survey (MEPS) is an annual survey administered through the Agency for Healthcare Research and Quality (AHRQ) at the Federal Department of Health and Human Services. In addition to the insurance component of the MEPS survey, MEPS also includes a household component.

MEPS data provide one more opportunity to validate the accuracy of the data we are using from the CPS. We requested and received 2008 MEPS data from the AHRQ. Given the small size of the MEPS sample for Connecticut, AHRQ also provided the data for the Northeast region. The MEPS data (which include the elderly) generated an estimate of 349,000 individuals that had been uninsured for all of 2008. However, the income distribution has more than half of the uninsured in households with incomes above 400% of FPL. MEPS confirmed the importance of TriCare in Connecticut, with an estimate that more than 118,000 Connecticut residents were covered by TriCare at some point during 2008. As an indication of the “churn” rate for Medicaid, MEPS found that while 725,000 individuals were covered by public health insurance for the entire year, 495,000 had Medicaid coverage at some point, 738,000 had Medicare at some point and 20,000 had other public coverage at some point.

AHRQ expressed great reservations about single-year data for such a small state. As a result, the detailed MEPS data are not included in this report.

Other Data Analysis Options

As Connecticut moves forward with planning for PPACA implementation, the State may want to consider additional analyses that could further refine understanding of the nature of current coverage in Connecticut and changes that are likely to occur.

Underinsured

As noted above, Task 2 data on the Connecticut insurance market may provide additional information on underinsurance. Other data sources that also might be considered are described below.

Potential Use of the National Health Interview Survey Database

The National Health Interview Survey (NHIS) of the Centers for Disease Control and Prevention (CDC) asks questions that would enable a description of individuals covered by single condition plans (such as cancer policies), high deductible plans and/or those for whom out-of-pocket expenditures consume more than 10% of the family income (or 5% for low-income families). These data are available in the aggregate for the Northeast region. The 2009 NHIS is available.

Uninsured

Other Potential Data Sources

Data from the NHIS public use files would permit stratification of the uninsured by reported reasons for not having health insurance coverage. The NHIS data also include health status variables that could inform the planning process. As noted above, the 2009 NHIS is available from the CDC.

A Connecticut household survey (similar to one that was performed in the past for the State Planning Grant from the Health Resources and Services Administration of the US Department of Health and Human Services) would provide the opportunity to gather additional information about the reasons individuals are uninsured and their willingness to purchase coverage. For example, state surveys have asked respondents the primary reason that they and members of their household were without health insurance. The most common reasons were affordability, changes in employment status (having lost or left a job with coverage) and becoming ineligible for coverage. Such surveys have also gathered information about the amount of premium that the uninsured would be willing to pay to get coverage.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Appendix 1D

Data from Existing Reports

More studies on health care coverage have been conducted for Connecticut than for most states. Data from US Census Bureau surveys have been compiled by the Connecticut Department of Public Health and by the Center for Health Law and Economics of the University of Massachusetts Medical School. Both the RAND Corporation and Dr. Gruber from the Massachusetts Institute for Technology have used their micro-simulation models to assess the impact of the PPACA on Connecticut. The Urban Institute, which has its own micro-simulation model, worked closely with the SustiNet Partnership Board and made presentations on PPACA implications for Connecticut based, in part, on Dr. Gruber's work. For this report, the Mercer team is including relevant information from these existing reports, as appropriate.

Center for Health Law and Economics – University of Massachusetts Medical School

The Center for Health Law and Economics of University of Massachusetts Medical School prepared a profile of the uninsured in Connecticut. With the exception of county-level estimates of the number of uninsured, all data in the report came from the 2008 and 2009 CPS, as reported on the Kaiser Family Foundation's website. The CPS survey data are addressed in the next section of this report. County-level estimates can be prepared by the Mercer/HMA team at any time that they would be valuable to the State. At the moment, our focus is on developing the most robust possible State-level estimates of the uninsured and a profile of coverage.

Department of Public Health Office of Health Care Access

In January 2011, the Office of Health Care Access within Connecticut's Department of Public Health (DPH) posted a Fact Sheet on health insurance coverage in Connecticut in 2009. This Fact Sheet is based on the CPS data for Connecticut for 2006 through 2009. Two-year data sets are used to increase the statistical significance of the findings. A key observation is that while there was a slight decline in State population from 2006/2007 to 2008/2009, the number of uninsured increased by 55,000 individuals. The rate of uninsurance increased from 9% to 11%, a significant change at a 98% level of confidence. The DPH Fact Sheet does not distinguish between the elderly and non-elderly population segments.

RAND Corporation

Connecticut was one of five states (California, Connecticut, Illinois, Montana and Texas) chosen for a demonstration of RAND modeling of state-level impacts of PPACA. The Council of State Governments sponsored this work. The Connecticut report[1] provides an assessment of PPACA

[1] Auerbach, David , Sarah Nowak, Jeanne S. Ringel, Federico Girosi, Christine Eibner, Elizabeth A. McGlynn and Jeffrey Wasserman. The Impact of the Coverage-Related Provisions of the Patient Protection and Affordable Care Act on Insurance Coverage and State Health Care Expenditures in Connecticut: An Analysis from RAND COMPARE. Santa Monica, CA: RAND Corporation, 2011. http://www.rand.org/pubs/technical_reports/TR973z1. Cited with permission from RAND.

impact in Connecticut, as well as estimates of coverage under a status quo scenario by year for 2011 through 2020.

Even though the RAND report was released in 2011, the estimates do not reflect the movement of the SAGA program to Medicaid as LIA under PPACA. The estimates are the product of the RAND Corporation's RAND COMPARE (*Comprehensive Assessment of Reform Efforts*) micro-simulation model. The values for 2011 for the non-elderly population in a status quo scenario are shown in Table 1D-1.

Table 1D-1

Total non-elderly population	3,040,000
Insured:	2,690,000
Employer-sponsored insurance	2,050,000
Traditional employer policies	1,970,000
State employer policies	80,000
Medicaid	390,000
SAGA	40,000
Non-group/other	210,000
Uninsured	350,000

The number of uninsured in the RAND report is lower than the number from the 2008 and 2009 CPS surveys. However, RAND includes SAGA as a separate insurance category. It is not clear how SAGA enrollees would have reported their coverage as part of a population survey.

SustiNet Reports from the Urban Institute and Jon Gruber Micro-simulation

The SustiNet Partnership Board received multiple reports and briefings from the Urban Institute that included modeling of the effect of various reform scenarios on enrollment and spending. These reports will be reviewed in more detail as part of Task 10. For this task, the most interesting information is from the presentation titled *SustiNet Policy Options: Cost and Coverage Estimates,* which was presented to the SustiNet Partnership Board on November 18, 2010 by Stan Dorn, Senior Fellow at the Urban Institute. The presentation includes an assessment of coverage of the non-elderly in Connecticut in 2017, with and without reform. Without reform, the estimated distribution of coverage for 2017 is:

- Employer-sponsored insurance 72%
- Individual coverage 4%
- Public coverage 12%
- Uninsured 12%

This estimate for the proportion of uninsured varies only slightly from the estimated current 11% rate from the 2009 CPS, as reported on the DPS Fact Sheet. In addition, Mr. Dorn's presentation assumes a current level of 376,000 uninsured in Connecticut.

Appendix 1E
ACS and CPS Detail for 2009

Current Population Survey
The CPS is a monthly survey that the US Census Bureau conducts for the Bureau of Labor Statistics to provide data on labor force participation and unemployment. As the official source of government statistics on employment status and income, data on health insurance coverage are collected through the Annual Social and Economic Supplement (ASEC), which was initially added to the CPS in March of each year and was later expanded to February through April. Data are collected through a combination of telephone and in-person modes using computer-assisted instruments. The CPS has included approximately 77,000 households per year since 2000 and had a response rate of 84% for 2007.

Health insurance estimates from the CPS provide an estimate of those who are uninsured for all of the previous calendar year. The CPS asks respondents to recall their insurance status for the prior calendar year (January through December). The CPS asks about a comprehensive list of insurance options that include public program names specific to the state in which the interview is conducted. To improve the accuracy of the estimates of the number of uninsured, a verification question has been added to confirm that respondents who did not indicate that they were enrolled in any insurance programs are, in fact, uninsured.

Acquisition Cost Survey
The newer ACS is a monthly mail survey with some limited telephone and in-person follow-up. The ACS draws a sample of three million addresses, yielding about two million responses per year. This is more than 25 times larger than the sample size of the CPS. The health insurance question asks about the insurance status of all people in the household separately. The question includes only a limited range of options (e.g., through an employer, Medicare, etc.) with no state-specific program names included. A verification question is not included. Since the primary mode of sampling is a mail survey, there is also no interviewer to assist in understanding the questions.

Comparisons of the Two Surveys
An important feature of the ACS is that it includes a large enough sample for state-level and sub-state health insurance coverage estimates. Both surveys produce annual releases of state-level health insurance coverage estimates in the fall of each year, reflecting the prior year's coverage rates. As previously noted, the CPS includes a verification question to avoid overstating the number of uninsured. As previously noted, the ACS sample includes about two million households nationally, which represents more than 25 times the number of households in the CPS ASEC. HMA has access to the public use files for 2009 for either the CPS or the ACS. Use of either of these data sets can provide additional detail on characteristics of the uninsured at the State level. In particular, analysis of these data would indicate what level of subsidization might be available to individuals through the Exchange, based on their income levels.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Table 1E-1

Health Insurance Coverage Estimates, ACS, Non-Elderly, All Poverty Levels, Connecticut: Calendar Year 2009

	Total Population	Uninsured	Insured Total	Private Coverage Total	Private Coverage Employer	Private Coverage Individual	Private Coverage Both	Government Coverage Total	Government Coverage Medicaid	Government Coverage Medicare	Both Gov't & Private	Percent With Both
Age (detailed)												
0-5	249	9	239	171	162	15	6	75	74	1	7	2.9%
6-17	558	22	536	419	389	48	18	133	132	1	16	3.0%
6-18	610	27	584	457	422	56	21	143	143	1	16	2.7%
18-25	372	71	301	256	220	49	13	52	48	3	7	2.3%
19-25	321	67	254	219	187	41	9	41	38	3	6	2.4%
26-34	360	67	292	248	232	25	9	51	48	4	7	2.4%
35-44	483	54	429	384	359	42	17	51	46	8	6	1.4%
45-54	559	50	508	462	425	54	17	57	40	20	11	2.2%
54-64	416	29	387	353	316	53	16	53	26	26	19	4.9%
Total	2,997	304	2,693	2,293	2,102	286	95	470	414	62	70	2.6%
Age (summary)												
0-17	807	31	776	590	551	63	24	207	207	2	21	2.7%
0-18	859	36	823	628	583	71	26	218	217	2	23	2.8%
18-64	2,190	272	1,918	1,703	1,551	223	71	263	208	60	48	2.5%
19-64	2,138	268	1,870	1,666	1,519	215	68	253	197	60	49	2.6%
0-64	2,997	304	2,693	2,293	2,102	286	95	470	414	62	70	2.6%
Total	2,997	304	2,693	2,293	2,102	286	95	470	414	62	70	2.6%
Poverty Level (detailed)												
0-138% FPL	411	88	323	109	83	31	5	228	214	24	14	4.3%
139-199% FPL	204	41	163	103	89	18	4	69	63	9	9	5.5%
200-399% FPL	760	108	652	562	518	63	19	113	97	17	23	3.5%
400%+ FPL	1,568	65	1,503	1,473	1,378	157	62	54	35	13	24	1.6%
Total	2,943	301	2,642	2,247	2,068	269	90	465	408	62	70	2.6%
Filtered Total	2,997	304	2,693	2,293	2,102	286	95	470	414	62	70	2.6%

Source: American Community Survey (ACS), 2009 Counts are presented in thousands.

Insurance coverage note: Listed Medicaid rates include SCHIP and state-specific public programs. Those who report multiple types of insurance coverage (i.e., private or public) are included in each category; therefore, row totals may add to more than 100 percent. ACS methodology note: The ACS asks respondents about their health insurance coverage at the time of the interview. For technical documentation on the ACS please visit: http://www.shadac.org/content/acs-info-and-resources

Data revision: 11/29/2010

Table 1E-2

Health Insurance Coverage Estimates, CPS (SHADAC-enhanced), Non-Elderly, Connecticut: Calendar Year 2009												
	Total Population	Uninsured	Insured Total	Private Coverage			Government Coverage				Both Gov't & Private	Percent With Both
				Total	Employer	Individual	Total	Medicaid	Medicare	Military		
Age (detailed)												
0-5	276	7	268	209	197	15	74	69	2	4	15	5.6%
6-17	536	33	503	424	390	27	107	94	5	9	28	5.6%
6-18	581	38	544	461	421	33	113	100	5	10	30	5.5%
18-25	360	86	274	242	212	20	39	34	1	4	7	2.6%
19-25	314	81	233	205	180	14	33	28	1	3	5	2.1%
26-34	397	71	327	287	264	23	49	37	7	7	9	2.8%
35-44	467	71	396	367	353	19	37	32	8	1	8	2.0%
45-54	542	69	473	442	421	26	41	26	14	7	10	2.1%
54-64	440	28	413	383	352	39	63	20	34	15	33	8.0%
Total	3,017	365	2,652	2,354	2,187	169	410	311	71	45	112	4.2%
Age (summary)												
0-17	811	40	771	632	586	43	181	163	7	13	42	5.4%
0-18	857	45	812	670	618	48	187	169	7	14	45	5.5%
18-64	2,206	324	1,882	1,721	1,601	126	229	148	64	32	68	3.6%
19-64	2,160	320	1,841	1,684	1,570	121	222	143	64	32	65	3.5%
0-64	3,017	365	2,652	2,354	2,187	169	410	311	71	45	112	4.2%
Total	3,017	365	2,652	2,354	2,187	169	410	311	71	45	112	4.2%
Poverty Level (detailed)												
0-138% FPL	347	112	235	103	76	22	148	128	30	3	16	6.8%
139-199% FPL	219	57	162	91	75	15	82	73	10	3	11	6.8%
200-399% FPL	766	111	655	593	550	42	100	66	15	18	38	5.8%
400%+ FPL	1,679	83	1,596	1,563	1,485	89	78	42	17	21	45	2.8%
Total	3,010	363	2,647	2,351	2,185	168	407	309	71	45	111	4.2%
Filtered Total	3,017	365	2,652	2,354	2,187	169	410	311	71	45	112	4.2%

Source: Current Population Survey Annual Social and Economic Supplement (CPS), 2010 Counts are presented in thousands.

Insurance coverage note: Listed Medicaid rates include SCHIP and state-specific public programs. Those who report multiple types of insurance coverage (i.e., private, public, or military) are included in each category; therefore, row totals may add to more than 100 percent. Note: SHADAC's enhanced CPS health insurance estimates are CPS data reweighted and adjusted to account for historical changes in the survey's methodology. These estimates do not correspond to estimates published by the Census Bureau; however, they can provide a consistent assessment of coverage estimates over time. CPS methodology note: The CPS asks respondents about their health insurance coverage at any point in the last calendar year. For technical documentation on the CPS please visit http://www.shadac.org/content/cps-info-and-resources

Data revision: 09/20/2010

TASK 2 – Survey of Connecticut Health Insurers

Introduction

As the Exchange Board (Board) begins to consider the potential range of products that are offered through the Exchange, it is important that it be grounded in the types of products that individuals and small employers are purchasing today. There has been limited Connecticut-specific data available on the types of plans that individuals and small employers have been purchasing. To fill this gap, Mercer conducted a survey of Connecticut's major health insurers.

Survey Design

Based upon publicly available market share data, Mercer recommended surveying the five largest health insurers in the state: Aetna, Anthem, CIGNA, Connecticare and United/Oxford.

Connecticut Health Insurer Market Data[1]

	Total Membership	Fully Insured HMO Membership	Fully Insured Non-HMO Membership	Total Fully Insured Membership	Total Non-fully Insured
Aetna	**575,68**	**42,348**	**181,218**	**223,566**	**352,114**
Anthem	**1,350,974**	**224,607**	**312,121**	**536,728**	**814,246**
CIGNA	**134,817**	**14,845**	**60,432**	**75,277**	**59,540**
Connecticare	**219,155**	**154,313**	**22,189**	**176,502**	**42,653**
Healthnet	**206,558**	**94,390**	**19,256**	**113,646**	**92,912**
United/Oxford	**345,080**	**23,525**	**179,827**	**203,352**	**141,728**
Total	**2,832,264**	**554,028**	**775,043**	**1,329,071**	**1,503,193**

	Total Membership	Fully Insured HMO Membership	Fully Insured Non-HMO Membership	Total Fully Insured Membership	Total Non-fully Insured
Aetna	**20%**	**8%**	**23%**	**17%**	**23%**
Anthem	**48%**	**41%**	**40%**	**40%**	**54%**
CIGNA	**5%**	**3%**	**8%**	**6%**	**4%**
Connecticare	**8%**	**28%**	**3%**	**13%**	**3%**
Healthnet	**7%**	**17%**	**2%**	**9%**	**6%**
United/Oxford	**12%**	**4%**	**23%**	**15%**	**9%**

[1] Connecticut Insurance Department, Consumer Report Card on Health Insurance Carriers in Connecticut, 10/2010

Mercer recommended that the information requested from the health insurers be focused on:

- Types of plans being offered
- Key plan features: copays, deductibles, out-of-pocket maximums, prescription drug cost-sharing
- Premiums by market segment

The survey requested that insurers report their findings by the following market segments:

- Individual
- Small employer, with less than 50 employees
- Small employer, with 50–99 employees
- Mid-sized employer, with 100–499 employees

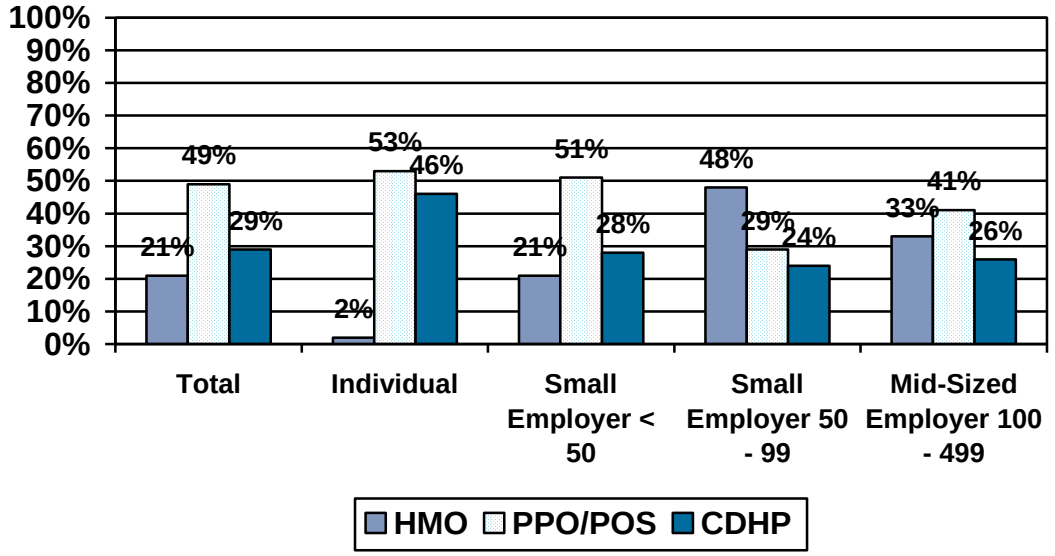
And product types:

- HMO – Coverage is only available if network providers are used
- PPO/POS – Coverage is not restricted to network providers; however, reimbursement is higher if network providers are used
- Consumer-driven health plan (CDHP) – Similar to PPO/POS plans, except that deductibles are typically higher, and a fund may be available to help meet the deductible. This category includes both health reimbursement accounts and health savings accounts. CDHP plans may also be offered through a HMO

Survey Results

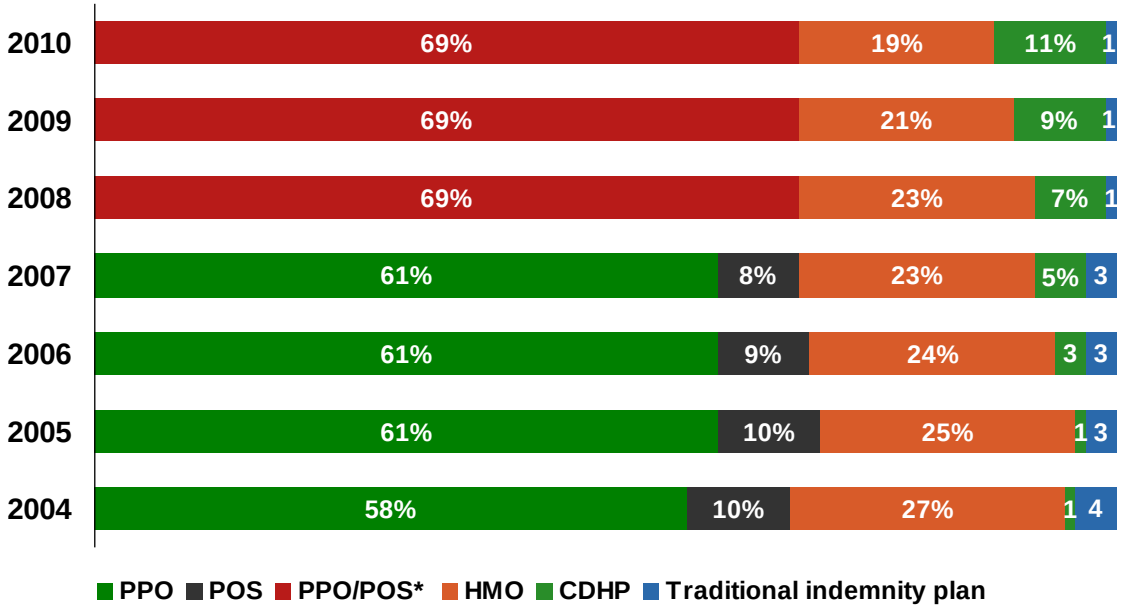
The types of products that Connecticut citizens are enrolled in varies by market segment. For the total market studied, HMO enrollment is similar to the results found in the most recent Mercer national survey. The percentage of members enrolled in employer sponsored CDHP plans in Connecticut is double what the national enrollment numbers are. The following chart shows the enrollment by product type and market in Connecticut:

Connecticut, Enrollment by Product Type and Market



Nationally, enrollment in CDHP plans has been rising as enrollment in HMOs has fallen. This pattern is true in Connecticut as well, with CDHP enrollment in the individual market at 46% and 28% in the small employer market.

National Enrollment Statistics – Percentage of all Covered Employees Enrolled in Each Plan Type (2010 Mercer Study)



Please reference Section 2 of this report, *Health Care Reform Disclosures.*

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Product Availability – Inside and Outside the Exchange

The PPACA establishes tiers of health insurance coverage that will be offered in the Exchanges – they'll be standardized so that insurers are covering the same package of essential benefits without dollar limits in each of the five types of plans: Bronze, Silver, Gold, Platinum and the catastrophic plan, which will be available only to people under age 30 and individuals who have a financial hardship exemption from the individual coverage mandate.

The levels of coverage are defined by their actuarial value. Actuarial value represents the percentage of medical expenses that an insurer is expected to cover for a "standard" population.

The chart below illustrates the actuarial values, increasing from 60% for a Bronze plan to 90% for a Platinum plan. Deductibles and out-of-pocket maximums can vary, but all the plans must be at or below the same deductible maximum, which will be based on the health savings account (HSA) levels in 2014.

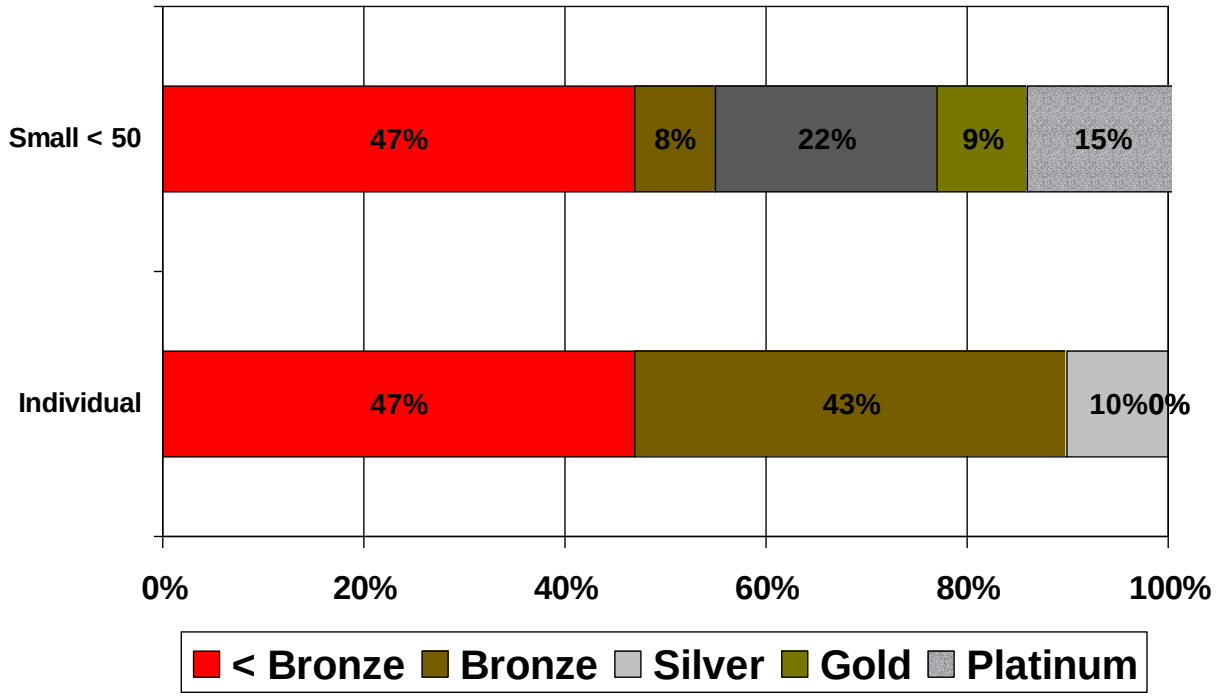
Features	Exchanges					Group
	Bronze	Silver	Gold	Platinum	Catastrophic (age <30)	Plan design[1]
Plan value	60%	70%	80%	90%	HSA rules	≥60%
Covered services	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential & preventive benefits	Essential benefits not required
Essential benefits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limits	No dollar limit if covered
2014 deductible maximums[2]	HSA rules	HSA rules	HSA rules	HSA rules	HSA rules	$2,000 (I) $4,000 (F)

Figure notes:
1. Some provisions apply differently for grandfathered and non-grandfathered plans.
2. Appear to apply to employer plans and are based on current understanding, subject to change based on further guidance and regulations. Individuals who have a financial hardship exemption from the individual coverage mandate may also select the Catastrophic plan

As the Board considers the types of plans it might offer on the Exchange, it is useful to understand the actuarial value of plans that Connecticut citizens are buying. The Mercer insurer survey requested that insurers provide the actuarial value of the products being sold. The chart below summarizes what the insurers (four of five responded) reported.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Connecticut Insurer Survey – Actuarial Value of Plans Sold Today, Based Upon Membership[2]



Actuarial value and price are closely related to one another. All other things being equal (group demographics, network discounts, administrative costs, etc.), premiums will be lower if the insurer has less responsibility for paying for covered services.

A note of caution as we look at the relatively high percentage of Connecticut individuals and small employers offering plans at Bronze or less actuarial values: insurers do not report the value of employer self-insured contributions to CDHP savings accounts. The actuarial value of CDHPs will be understated for those plans where employers are making a contribution, and Connecticut has meaningful enrollment in CDHPs.

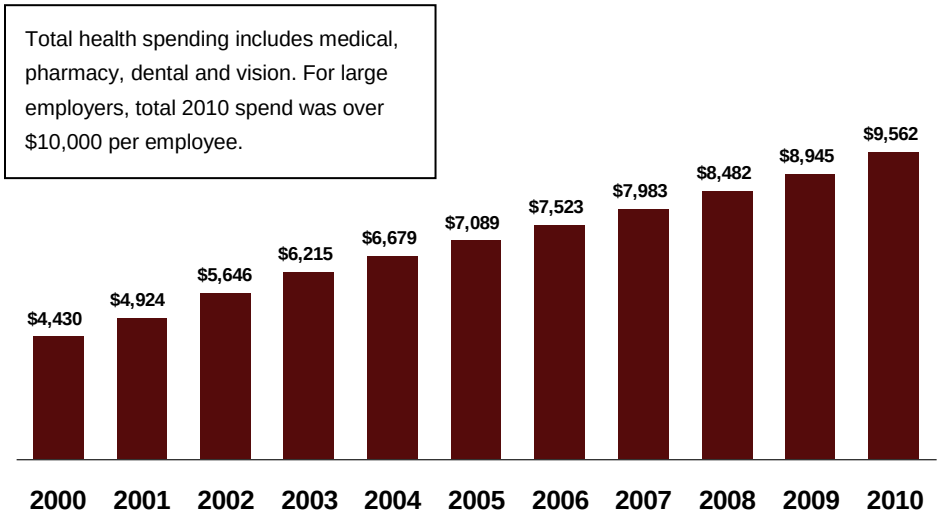
The finding that small employers are purchasing lower value plans is consistent with existing survey data that reflects those purchasing plans with higher out-of-pocket features (copays, deductibles and out-of-pocket maximums). Benchmark data on the prevalence of plans by actuarial value is not available.

[2] Mercer/Oliver Wyman 2011 survey of Connecticut Health Major Insurers. Four of the five surveyed insurers provided their calculated actuarial values for the small employer < 50 market. Actuarial value for the individual market was derived from rating data provided by insurers.

Premiums

Nationally, employers have seen their health care spending double in the last ten years. The chart below reflects total employer health spending (medical, pharmacy, dental and vision).

Total 2010 Health Spend per Employee Surpasses $9,500 National, All Employers (Mercer Survey)

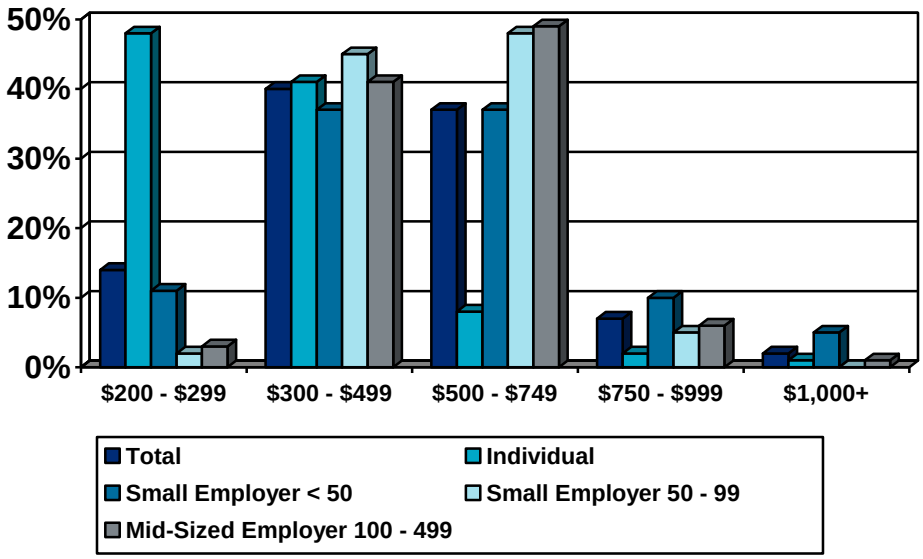


In 2010, the national average "single" (one adult) plan cost for a preferred provider organization (PPO) was $448 per month and $413 for an HMO[3]. For the 2010 tax year, the IRS reported that the average annual premium for the Connecticut small group market was $5,419 ($452 per month) for single coverage and $13,484 ($1,124 per month) for family coverage.[4] The Connecticut insurer survey found that the majority of policies for single coverage ranged in price from $300 to $749.

[3] Mercer 2010 National Survey of Employer-Sponsored Health Plans

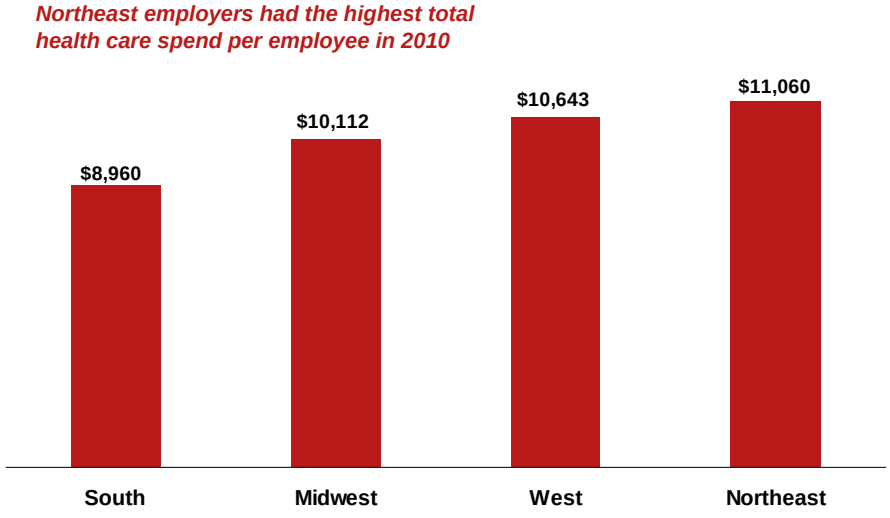
[4] IRS Code, Part 1, Section 45R, available at www.irs.gov/pub/irs-drop/rr-10-13.pdf

Connecticut – Monthly Premium for "Individual" or "Employee Only" Coverage



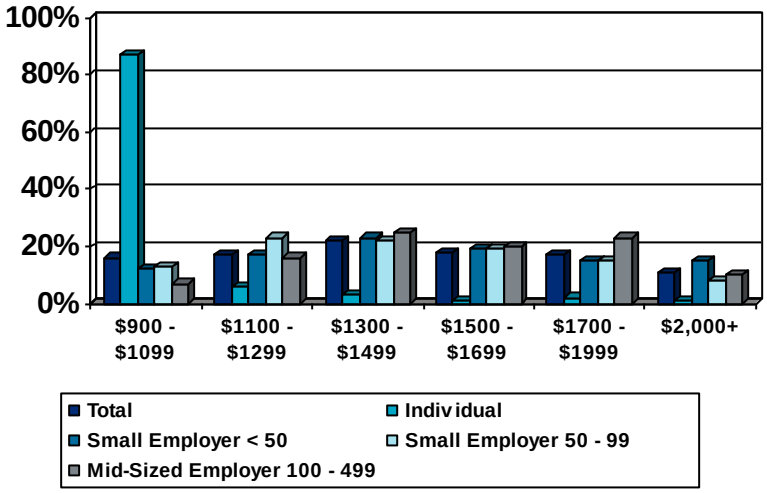
Connecticut premiums are slightly higher than national averages, consistent with survey data represented in the chart below that finds that health care costs in the Northeast are the highest in the country.

Total 2010 Health Spend by Region (large employers)



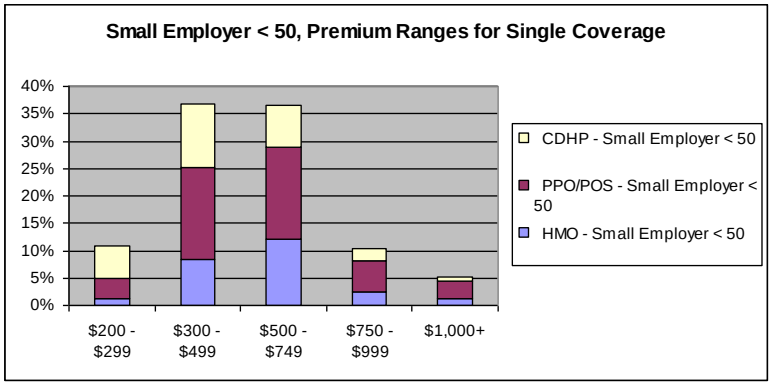
When looking at Connecticut-specific premium data, note the high percentage of policies in the individual market that are less than $299 for "Individual" coverage and less than $1,099 for "Two Adult and Children" coverage in the following chart.

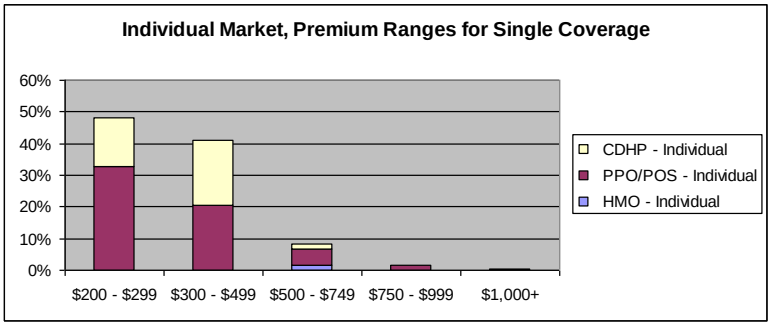
Connecticut – Monthly Premium for "Two Adults and Children" Coverage



As the Board considers the products it offers on the Exchange, it will be important to offer products that recognize the lower premium levels that individuals and small employers have been purchasing. Of particular interest to individuals and small employers will be products that appear to only be available through CDHP and PPO/POS plan designs, as indicated in the following chart.

Enrollment by Market Segment, Premium Range and Plan Type

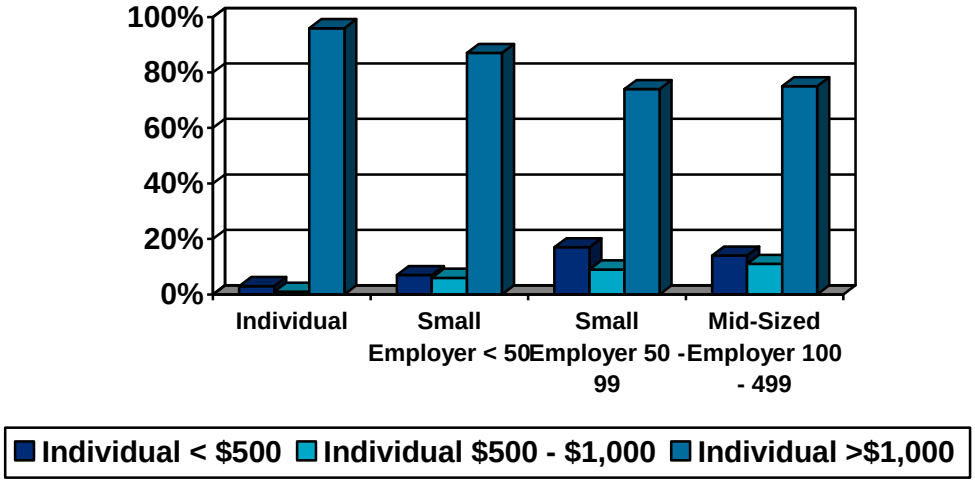




Plan Design Elements

While the notion of "actuarial value" is new to most of us, common plan design features like deductibles, copays, and out-of-pocket maximums are things that we can all relate to. The survey data below illustrates that individuals and small employers are purchasing plans with relatively high deductibles, copays and out-of-pocket maximums.

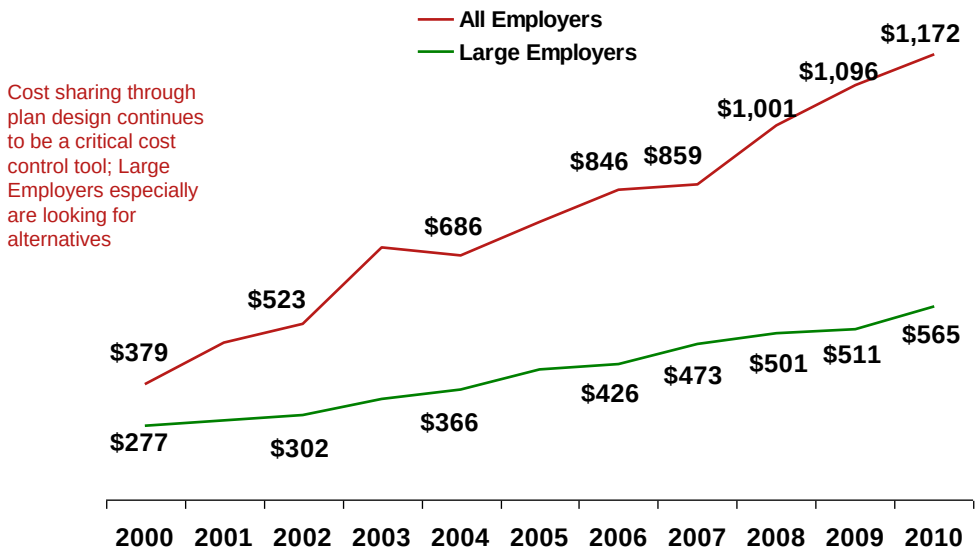
Connecticut – Deductible Levels for One Adult



Connecticut individuals and small employers are purchasing plans that have deductibles for single adults in excess of $1,000. This data is consistent with results from the most recent Mercer survey, illustrated in the chart below. Large employers have significantly lower deductibles.

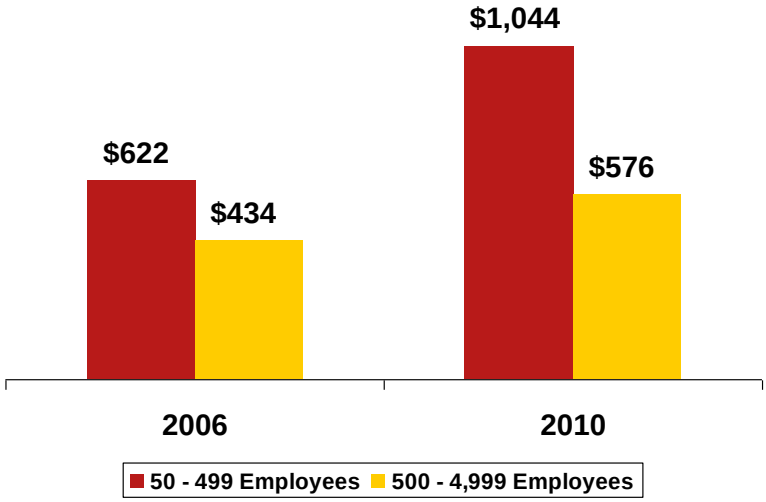
Some of these plans are associated with HSAs that require high deductible levels. To be eligible for a HSA in 2012, an individual must have a minimum annual deductible of $1,200. Purchasing coverage at this level allows people to establish personal HSAs through their insurer or bank. Because these accounts are individual accounts, insurers do not have accurate records of the number of accounts established in Connecticut.

National – PPO Average Individual In-network Deductible (2010 Mercer Survey)



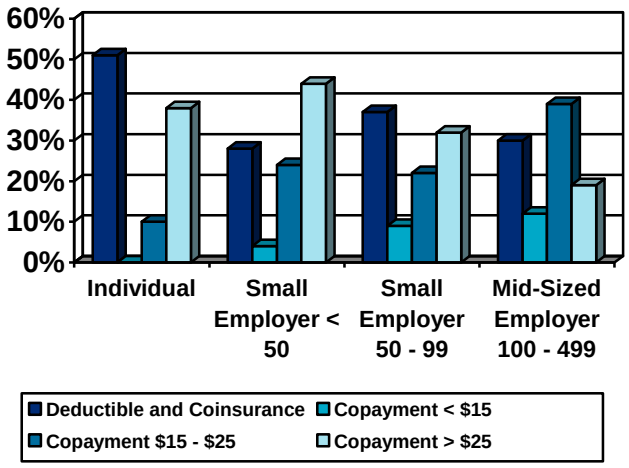
This chart offers another perspective on how quickly deductible levels have been increasing and differences in level by company size.

National PPO – Average Deductibles for Mid-size Employers and Smaller (2010 Mercer Survey)



Connecticut individuals and small employers were more likely to have office copays in excess of $25 as the chart below demonstrates. The 2010 Mercer Survey national average copay was $22 for HMOs for employers with between 50 and 499 employees.

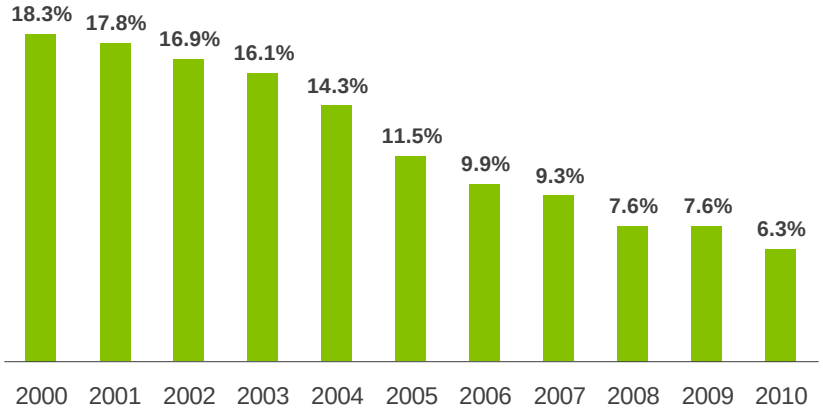
Connecticut – Office Copay Levels



Pharmacy

Nationally, prescription drug benefit cost is now growing at nearly the same rate as overall medical plan cost. Survey data on the Connecticut cost change in prescription drug benefits is not available; however, we believe that Connecticut's experience is similar to the national experience outlined in the chart below.

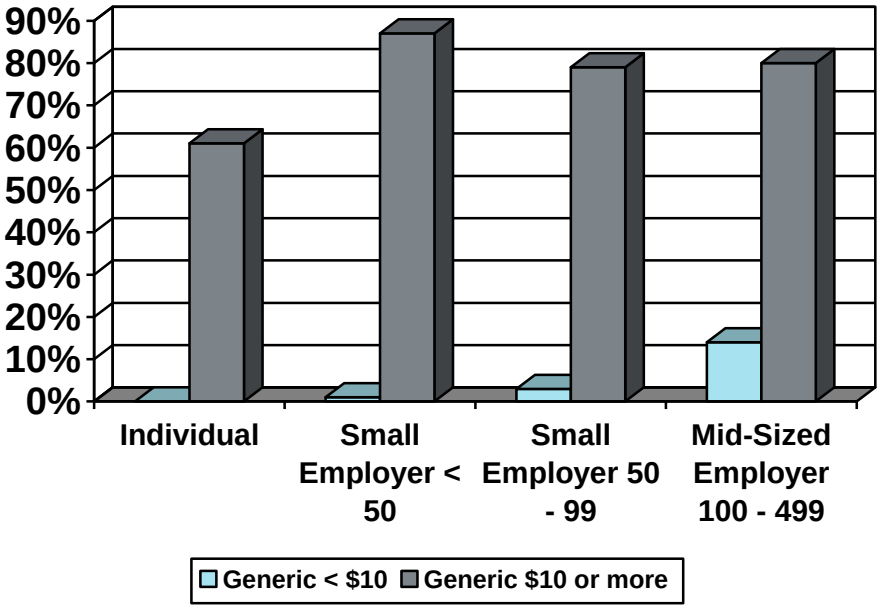
Cost Change in Prescription Drug Benefits Offered Through Primary Medical Plan for Large Employers (Mercer Survey, 500+ employees)



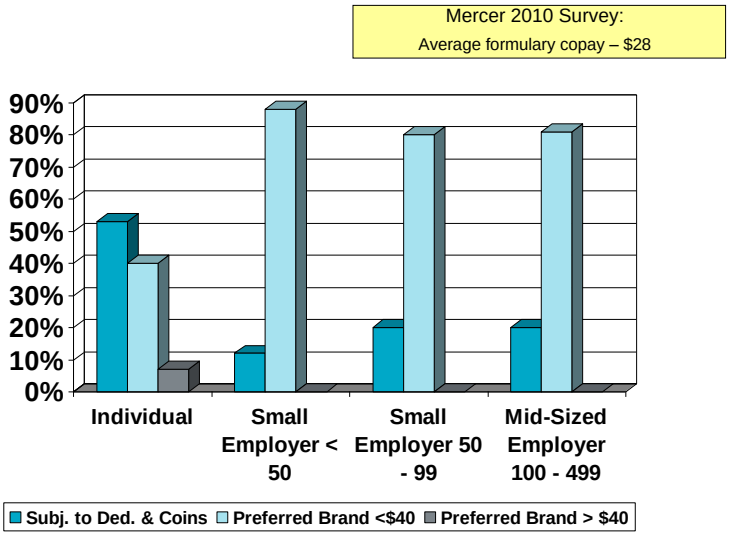
The most recent Mercer National Survey found that the majority of employers use a three-tier prescription coverage design in both retail and mail-order plans. Both retail and mail-order copays have been relatively stable over the past several years.

Copays for Connecticut generic and formulary (or "preferred") drugs appear to be in line with national benchmarks (see charts below). Connecticut caps the copay for prescription drugs at $40, below the $47 national benchmark.

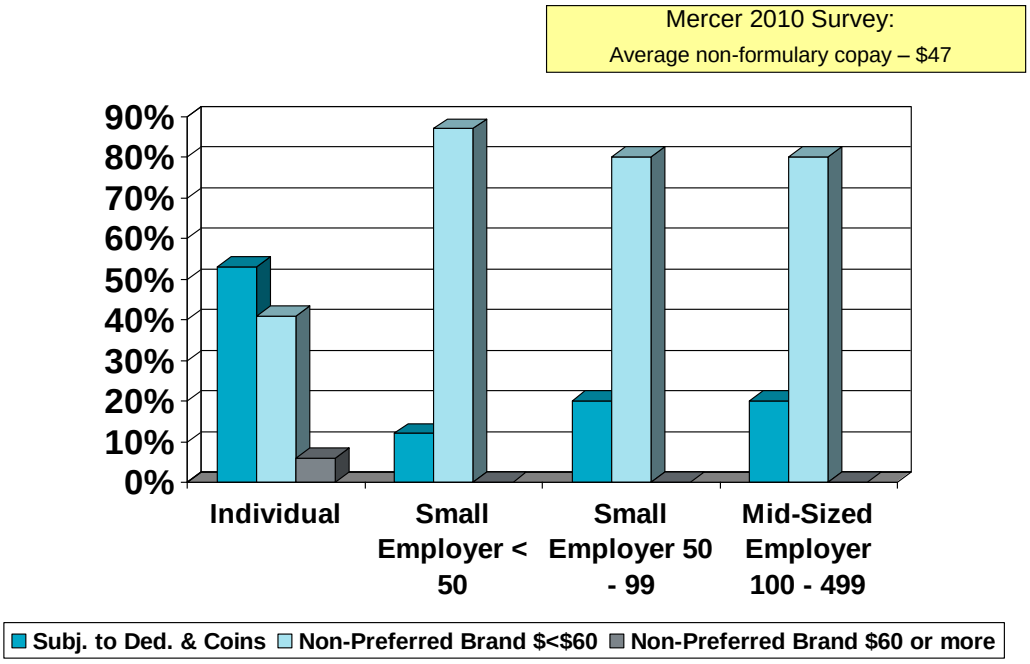
Connecticut – Generic Drug Copays



Connecticut – pharmacy formulary/"preferred" copays



Connecticut – Pharmacy Non-formulary/"Non-preferred" Copays



Note About Actuarial Value and Plan Design Features

To develop a better understanding of what the different actuarial bands might look like to consumers, the Kaiser Family Foundation provided three consulting firms with base assumptions and asked them to provide illustrative individual cost-sharing provisions for each tier. The table below contains the results.[5]

Table 2: Estimates of Plan Designs Meeting Selected ACA Actuarial Value Thresholds, 2014

			Actuarial Research Corporation		Aon Hewitt		Towers Watson	
	Actuarial Value	Out-of-Pocket Maximum	Deductible	Coinsurance	Deductible	Coinsurance	Deductible	Coinsurance
A	60%	$6,350	$6,350*	0%	$4,350	20%	$2,750	30%
B	70%	$6,350	$4,200	20%	$2,050	20%	$1,850	20%
C	70%	$4,200	$4,200*	0%	$2,650	20%	$1,550	30%
D	70%	$3,200	$3,200*	0%	$3,200*	0%	$2,050	30%
E	73%	$3,200	$3,200*	0%	$3,200	0%	$1,750	25%
G	87%	$2,100	$1,050	20%	$250	20%	$150	20%
I	94%	$2,100	$60	10%	$200	5%	$0	8%

Note: Amounts shown for the out-of-pocket maximum and deductibles are per person; figures for families would be double these amounts. Where an asterisk appears, the firm was unable to construct a plan design within the constraints of the actuarial value and out-of-pocket maximum. The deductible shown in these cases is equal to the out-of-pocket maximum, which is the highest it can be. The out-of-pocket maximum amounts are based on those for high-deductible plans that qualify to be paired with a Health Savings Account, inflated forward to 2014.

The Kaiser study illustrates that, even within actuarial bands, a wide range of plan design features can be offered. From the chart above, a 70% plan could have deductibles that range from $1,550 to $4,200.

While the use of actuarial values may provide additional information to help a consumer make a better informed choice, the “right” choice for an individual will depend upon their individual circumstances. As the Board considers the types of plans that it offers on the Exchange, it is important for them to consider this and know that there are multiple plan options available within a given actuarial value level.

Survey Process and Notes

Based upon publicly available market share data, Mercer recommended surveying the five largest health insurers in the state: Aetna, Anthem, CIGNA, Connecticare and United/Oxford.

Mercer recommended that the information requested from the health insurers be focused on:

- Types of plans being offered
- Key plan features: copays, deductibles, out-of-pocket maximums, prescription drug cost-sharing

[5] Kaiser Family Foundation, “What the Actuarial Values in the Affordable Care Act Mean”, April 2011

- Premiums by market segment

The state's insurers were under no obligation to provide the information requested, but all of the insurers expressed their willingness to participate. Insurer contact was coordinated with the Connecticut Association of Health Plans (CAHP).

While all of the carriers provided responses, the level of detail that individual insurers provided varied:

- One of the carriers did not provide detailed actuarial value information.
- Carriers provided sufficient detailed data to allow the calculation of actuarial value by plan type in the small employer <50 market.
- At least one of the carriers treated the Connecticut Business and Industry Association enrollment as a large group, greater than 500 employees.
- For CDHPs, carriers did not report the value of employer self-insured contributions to employee "savings" accounts. While an underlying health plan may be fully-insured, employer funding of savings accounts is commonly self-insured. The actuarial value of CDHPs will be understated for those plans where employers are making a contribution.
- One carrier provided separate data on student plans. This information was not included in the data presented.

Appendix 2A

See attached file labeled: *Appendix 2A – Mercer 2010 Survey Charts*

TASK 3 – Small employer market assessment

Introduction

The purpose of this report is to provide the Board with insight into the current and future needs of the small employer market. This insight will allow the Board to position its products and services to meet the needs of the small employer market.

Connecticut Small Employer Health Marketplace

In 2012, four health insurers will be competing for Connecticut's small employer business. This is down from six insurers in 2010 due to the following:

- Health Net announced its withdrawal from the Northeast in 2009. At the time it had more than 200,000 total members in Connecticut. UnitedHealthcare bought Health Net's licenses and the right to renew their customers. Health Net ceased its Connecticut operations in 2011.

- CIGNA has announced its intent to withdraw its insured small group medical products from selected markets around the country, including Connecticut.

Connecticut's insurers report that 85%+ of their health insurance policies are distributed through brokers.[1]

The table below demonstrates Connecticut's membership breakdown in 2010.

Connecticut Health Insurers – Insured Health Product Membership

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

Source: 12/31/2010 supplemental health care exhibits filed with statutory financial statements.

Rising Health Care Costs

Before plan design changes, national employer health benefit costs have been increasing 9% on average for the last 5 years. The chart below illustrates the net change in annual health care costs after employers have made the equivalent of 3% worth of changes to their plans.[2] Comparable Connecticut statistics are not available; however we believe that Connecticut cost

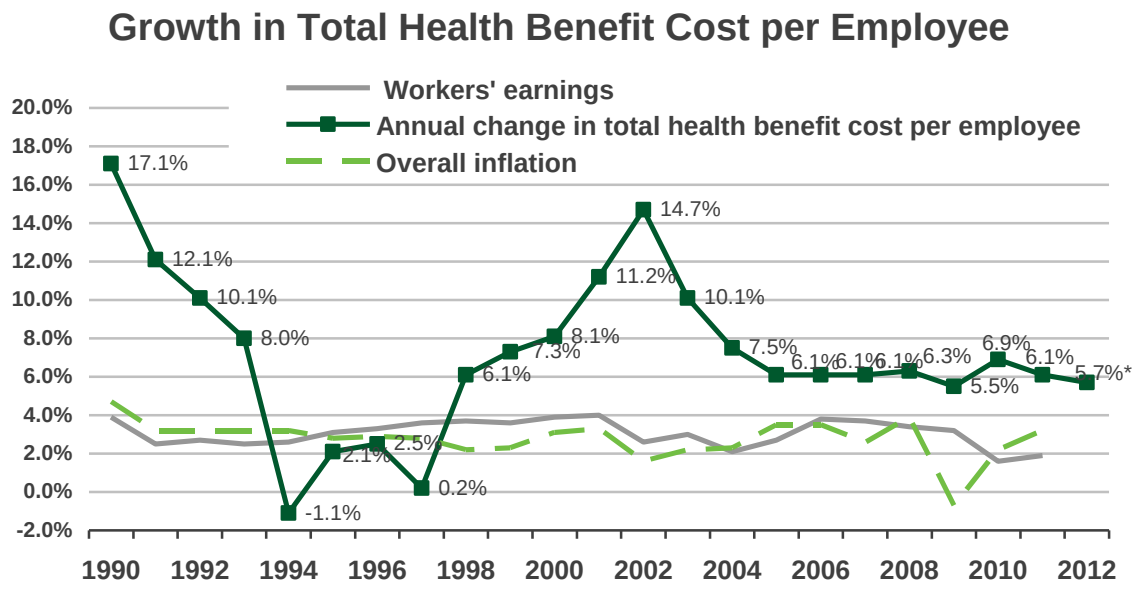
[1] Interviews with Connecticut health insurers

[2] 2010 Mercer National Survey of Employer-Sponsored Health Plans

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

changes are comparable to the national experience. At the same time, increases in overall inflation and workers wages have been rising at much lower rates, as show below:

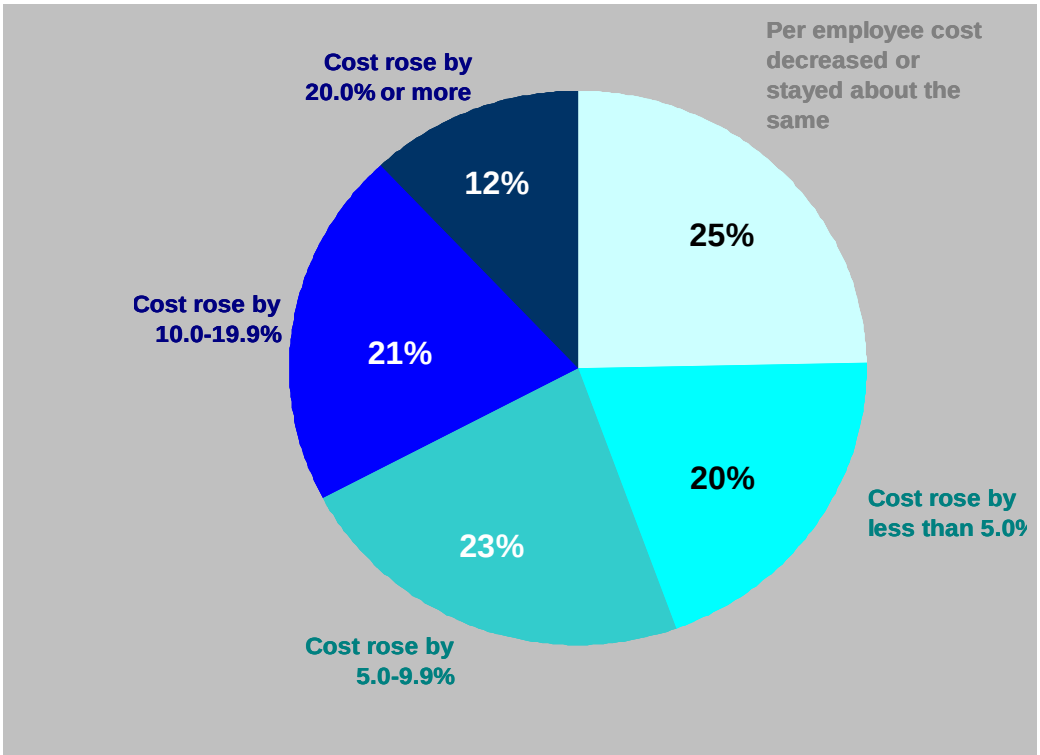
Growth in Total Health Benefit Cost Per Employee



*Projected.

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

Some employers have been experiencing increases well in excess of the 9% average (before plan design changes). The following chart illustrates the distribution of rate increases that employers experienced in 2010.



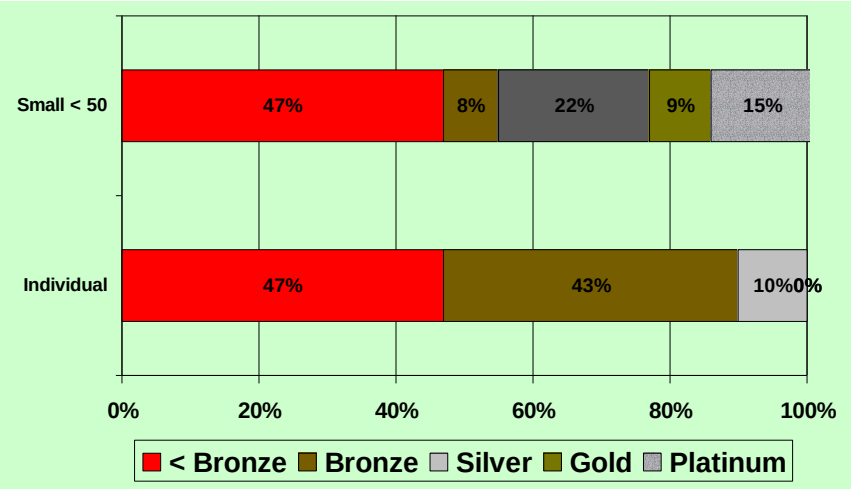
Based on all employers providing 2009 and 2010 costs under the Mercer Health Care Survey

Small employers have responded to health insurance premiums by decreasing the value of the benefits that they purchase by increasing employee out-of-pocket features – copays, deductibles, out-of-pocket maximums. The consequences of these decisions were revealed when Mercer surveyed Connecticut health insurers. The following chart illustrates the actuarial value of Connecticut small employer purchases.[3] Additional details on the types of products, premiums, and plan design features being purchased in Connecticut are available in the Task 2 report.

Actuarial value represents the percentage of medical expenses that an insurer is expected to cover for a “standard” population.

[3] Mercer/Oliver Wyman 2011 survey of Connecticut major health insurers. Four of the five surveyed insurers provided their calculated actuarial values for the small employer < 50 market. Actuarial value for the individual market was derived from rating data provided by insurers.

Connecticut Insurer Survey – Actuarial Value of Plans Sold Today, Based Upon Membership by Market Segment[4]



Actuarial value and price are closely related to one another. All other things being equal (group demographics, network discounts, administrative costs, etc.), premium will be lower if the insurer has less responsibility for paying for covered services.

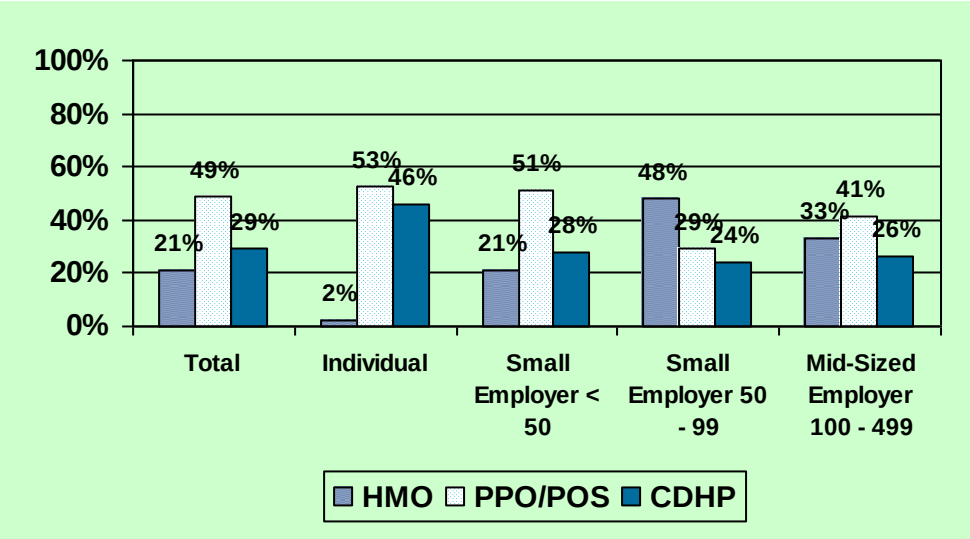
A note of caution as we look at the relatively high percentage of Connecticut individuals and small employers offering plans at Bronze or less actuarial values reported by Connecticut's insurers. Insurers have not reported the value of employer self-insured contributions to CDHP savings accounts. The actuarial value of CDHPs will be understated for those plans where employers are making a contribution, and Connecticut has meaningful enrollment in CDHPs, with 28% of small employers enrolled in them.

Connecticut-specific CDHP employer account contribution information is not available. The most recent Mercer national survey found that:

- 61% of employers make contributions to their employee's Health Savings Accounts, with median contributions of $500 for individual coverage and $1,000 for family coverage.
- All employers use notional accounts to help satisfy Health Reimbursement Account deductibles, with median employer contributions of $750 for individual coverage and $1,500.

[4] The actuarial value for the Individual market has been derived from detailed rating data provided to Oliver Wyman. The small employer <50 market is based upon carrier responses to Mercer, with the subscribers and assumed members reported representing approximately 79% of the members reported on federal insurer filings. The data provided for employers with more than 50 employees is not credible. Insurers in the 50+ market offer employers more plan design flexibility, making it difficult to calculate the actuarial value of their offerings.

Connecticut, Enrollment by Product Type and Market



Employers are trying to balance providing comprehensive coverage to their employees with controlling their business expenses. As health insurance costs have gone up, they have been increasing employee out-of-pocket expenses to reduce premiums.

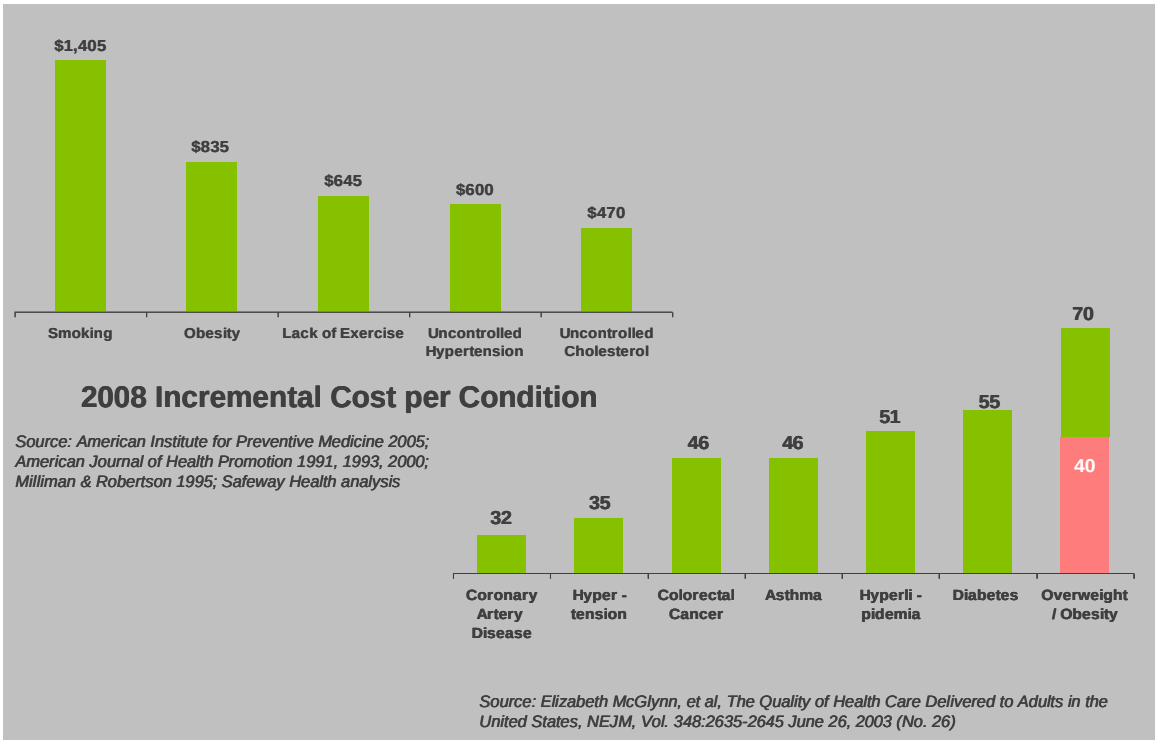
Unfortunately, the cost-shifting that small employers have been utilizing to reduce premiums does little to address the underlying drivers of health care cost.

Health Insurance Premium Cost Drivers

As the Board considers how to reduce the number of uninsured and provide affordable coverage, it is important to understand what is driving up health care costs. There are many reasons for the increases, but important factors include:

- As a state we are less healthy and the primary problem is excess weight[5]. Excess weight increases the likelihood that someone will have high cholesterol, high blood pressure and diabetes. People with excess weight have more heart attacks, more strokes, more knee and hip replacements, etc. Treating these conditions is expensive and, in many instances, avoidable. Just as significant is the fact that many of us do not even know that we have these health risks and the first time that we learn about it is when we end up in the hospital – incurring significant medical expenses. Individuals must become more accountable for their health risk awareness, controllable risk factors, and compliance with treatment plans.

[5] Connecticut Health Scorecard, The Business Council of Fairfield County



- Our health care system is not as efficient or effective as it could be. The quality provided by doctors and hospitals varies greatly, as has been documented by Elliott Fisher at Dartmouth and others. As a society, we are not as aware of this as we should be and there are limited credible sources of objective independent information on quality. The consequence is that we are paying doctors and hospitals for less than optimal results.[6]

- The methods we use to pay doctors and hospitals is another problem[7]. In most instances, the more a medical provider does, the more they are paid, without regard to outcome. There is recognition that payment reform is needed, but it is hard. The biggest challenge to payment reform is the need for collaboration among payers (insurers, self-insured employers, state government), because individually their members represent a fraction of a doctor's or hospital's patients. Most doctors and hospitals aren't going to change the way that they practice if only a small percentage of their "payers" wants to reward them differently.[8]

- Connecticut's primary care system is under tremendous strain.[9] Too few students graduating from medical schools choose to become primary care physicians. Primary care physicians are retiring or selling their practices to large hospital systems. The fundamental problem with

[6] Elliott Fisher Statement to Senate Finance Committee, 6/2008

[7] Final Report of the Sustinet Quality and Provider Advisory Committee

[8] From Volume to Value, Network for Regional Healthcare Improvement, 1/2009

[9] Statewide Primary Care Access Authority Interim Report to the General Assembly, 2/2010

primary care is that physicians have been inadequately compensated for at least the last 10 years. We all feel the consequence when we go in for our very unsatisfying eight-minute visit with our primary care physician. Other consequences are less obvious – unnecessary care performed in expensive specialist settings.

Of course, this is just a snapshot of the problems in our health care system. But it is important for the Board to understand that the key to reducing premiums is not simply shifting cost indiscriminately to employees as the small employers have been doing. Cost shifting does nothing to address the underlying drivers of health care cost increases.

Large Employer Innovation

Large employers, working closely with the vendors (typically large insurers) who administer their medical plans, are frequently the catalyst for innovative approaches to improving health and reducing health care costs. Sometimes the impact of these innovative ideas are felt in the small employer market, other times they are not.

In Mercer's most recent survey of employer health plans, we asked employers about more than 20 "best practices" in managing health plans – strategies intended to control cost such as providing incentives to improve healthy habits or contracting with smaller, high-quality, cost-efficient provider networks. When large employers were divided into three roughly equal groups based on the number of best practices they have incorporated, the average per-employee medical plan cost was 7% higher for those using no more than six best practices compared to those using 10 or more. The average cost of the health benefit program as a percentage of payroll was higher as well in the group using fewer best practices – 16% compared to 14%.

The table below lists cost management best practices as supplied by survey respondents.

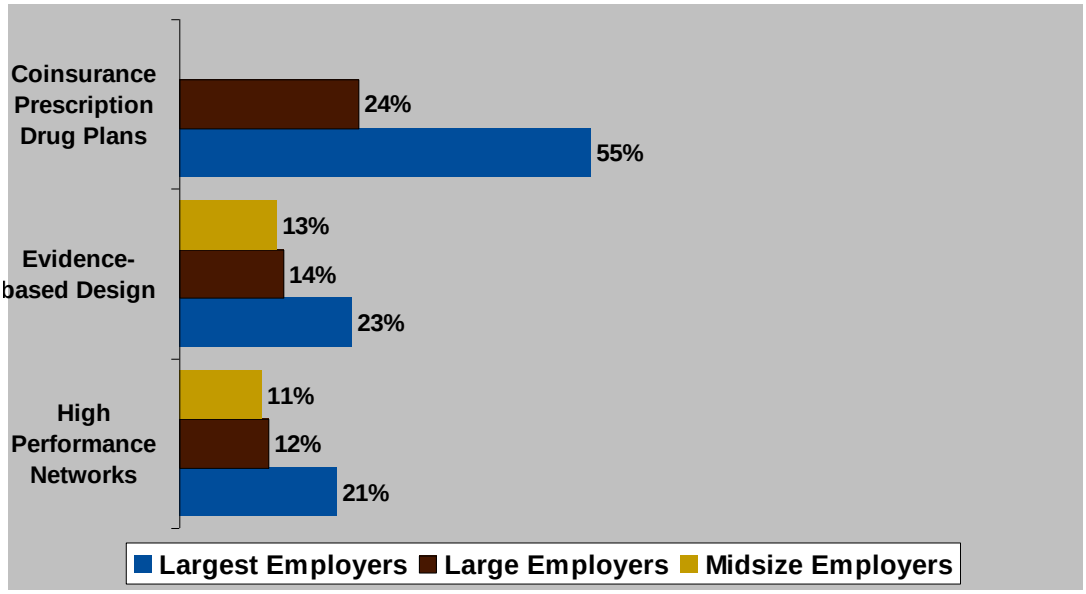
Mercer analyzed 2011 survey respondents' cost based on their use of cost-management best practices

Contribution for family coverage in primary plan is at least 20% of premium	Spousal surcharge	Value-based design
Four or more employee contribution tiers	Smoker surcharge	On-site clinic
PPO in-network deductible is $300 or more	Offer optional HM services through plan or vendor	One or more Rx strategies (i.e. mandatory generics)
PPO plan has higher cost-sharing for specialists	Use incentives for HM programs	One or more specialty drug provisions (i.e., step therapy)
Offer a CDHP	Use incentives for health status targets	One or more health plan innovations:
Make contribution to an HSA	Offer an EAP	–Surgical centers of excellence
Rx mail-order copay is at least 2.5x retail copay	Voluntary benefits integrated with core benefits	–Retail clinics
Part of an Rx purchasing coalition	High-performance networks	–Telemediated care
	Data warehousing	–Medical homes
	Collective purchasing	

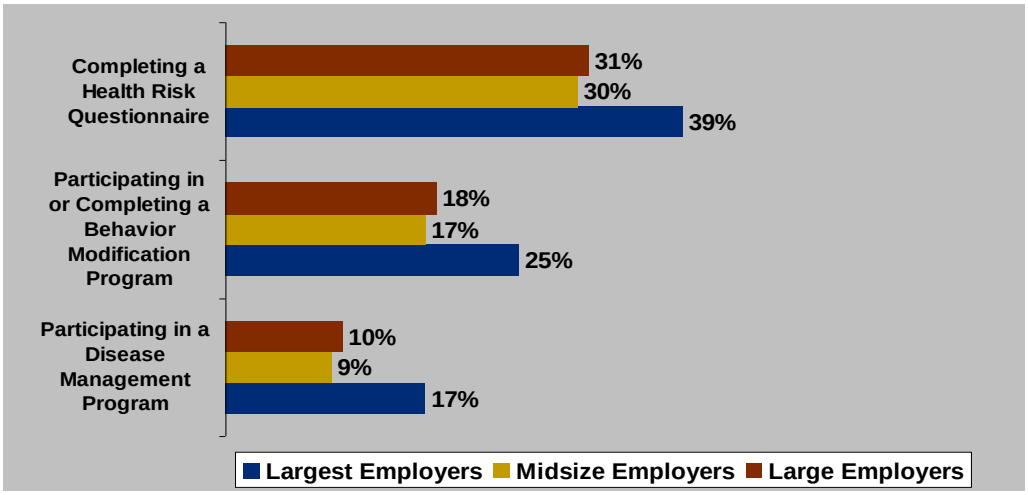
Please reference Section 2 of this report, *Health Care Reform Disclosures.*

The charts below, based upon the 2010 Mercer National Survey of Employer-Sponsored Health Plans, highlights the increasing prevalence of some of these innovative approaches.

Newer Initiatives Expand Employers' Approaches to Control Costs



Special Attention is Being Paid to Incentives – Do You Use an Incentive to Build Program Engagement?



Please reference Section 2 of this report, *Health Care Reform Disclosures.*

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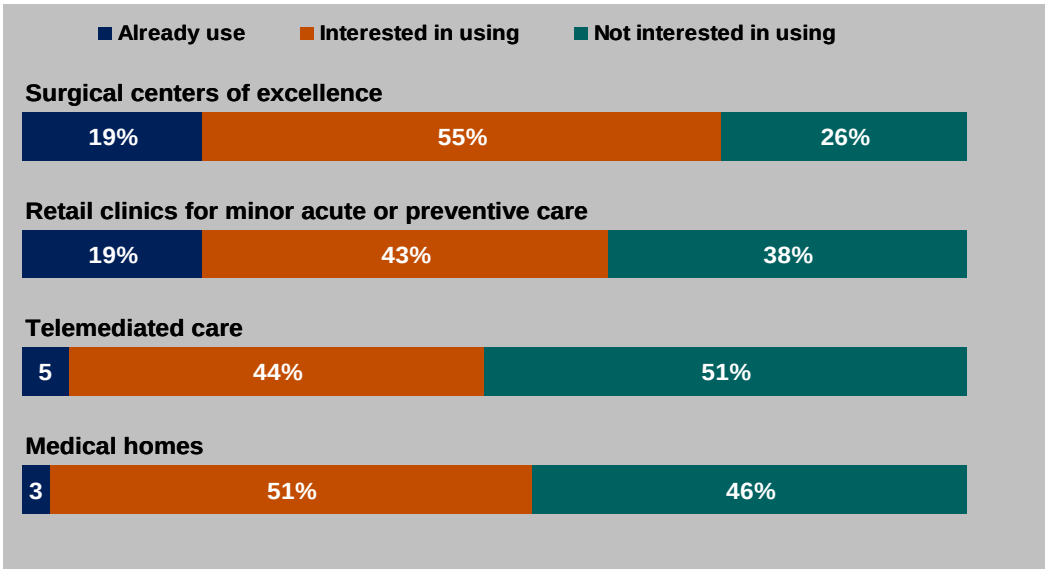
Emerging Cost-management Strategies Target Quality and Cost Efficiency Employers with 5,000 or More Employees



Large employers are investing in these strategies because they believe that doing so will result in improved health and lower cost.

Survey of the Uninsured

Interestingly, the uninsured are open to innovation as well. During the summer of 2011, Oliver Wyman conducted a survey of 800 currently uninsured individuals.[10] They asked about their health status, their income and their attitudes toward the health system. To discover how they would make buying decisions, the individuals were presented with a battery of choice scenarios featuring realistic descriptions of the sort of products Oliver Wyman expect to see offered when the Health Insurance Exchanges (Exchanges) open in 2014. These fictional offerings carried actuarially appropriate pricing, subsidies that reflected respondents' actual income levels and the penalties consumers would actually pay if they chose not to buy. They included a variety of coverage options, including some innovative ones such as discounts for losing weight, options for patient-centered medical homes, 24/7 access, web-based doctor visits and so forth. The high level results of their work revealed that the uninsured:

- Are ready to buy coverage
- Are acutely price sensitive
- Have different needs and preferences

[10] Inside the Uninsured, Oliver Wyman, 8/2011

When Oliver Wyman explored participant interest in "customizing" their coverage they found that when offered a $50 a month discount:

- 52% were willing to reach a healthy body weight
- 41% were willing to receive a majority of their medical care at a retail clinic located in a pharmacy or retail store
- 38% of those who smoked were willing to quit
- 48% were willing to interact with their doctor primarily online

When offered an opportunity to purchase a $50 buy-up:

- 40% wanted the ability to see doctors who provide the best quality of care and service
- 36% wanted access to a doctor anytime, 24/7
- 21% wanted one doctor who champions your medical care across all doctors you see

Opportunity for the Board to Support Innovation

Developing affordable Exchange coverage options for the uninsured and small employers provides an opportunity to take a fresh look at the products offered to meet their needs. New products should consider:

- The underlying drivers of health care costs
- The innovative approaches that large employers have taken
- The price sensitivity of these populations
- The willingness of these participants to try new approaches if it saves them money

Insurers have already developed products that would appeal to both individuals and small employers that are currently not available in Connecticut. Three examples are provided below:

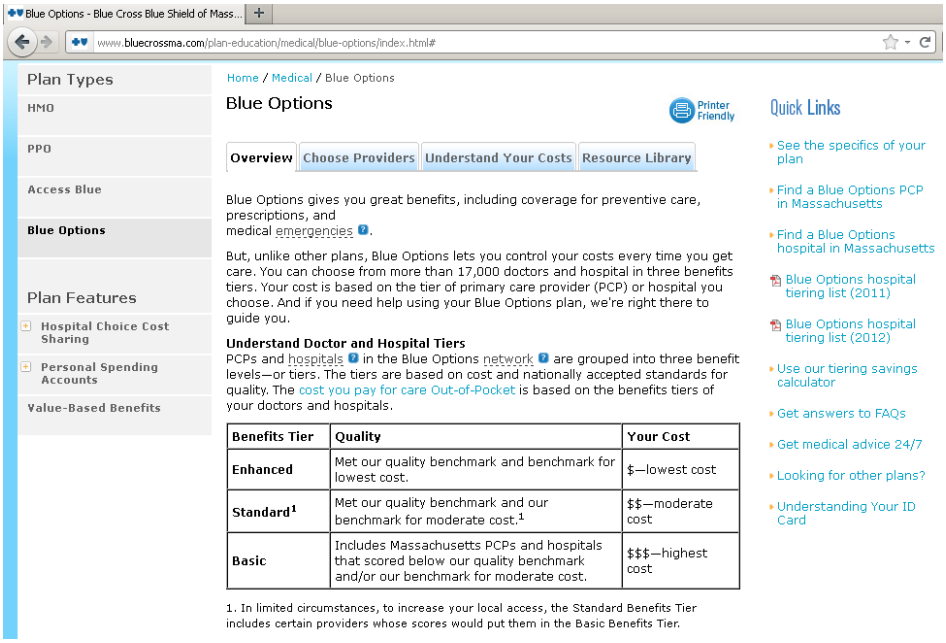
- Tiered networks
- Prescription drug plan designs with coinsurance and minimums and maximums
- Engaged employees

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Tiered Networks

High performance networks (HPN) have been developed by insurers to promote the utilization of providers who have been put into groups based on quality, efficiency or other factors. In tiered networks, members would have lower out-of-pocket costs if they utilized the HPN. In limited networks only the HPN providers are available to members.

HPNs are being utilized by large self-insured employers and are available as fully-insured plans in Massachusetts[11] and other states. A recent Boston Globe article reported that tiered network products represent 15% of the Massachusetts market. Premiums for these plans are 12% below "standard" plans.[12]



Blue Options - Blue Cross Blue Shield of Mass...

www.bluecrossma.com/plan-education/medical/blue-options/index.html#

Plan Types

HMO

PPO

Access Blue

Blue Options

Plan Features

Hospital Choice Cost Sharing

Personal Spending Accounts

Value-Based Benefits

Home / Medical / Blue Options

Blue Options

Printer Friendly

Overview | Choose Providers | Understand Your Costs | Resource Library

Blue Options gives you great benefits, including coverage for preventive care, prescriptions, and medical emergencies.

But, unlike other plans, Blue Options lets you control your costs every time you get care. You can choose from more than 17,000 doctors and hospital in three benefits tiers. Your cost is based on the tier of primary care provider (PCP) or hospital you choose. And if you need help using your Blue Options plan, we're right there to guide you.

Understand Doctor and Hospital Tiers

PCPs and hospitals in the Blue Options network are grouped into three benefit levels—or tiers. The tiers are based on cost and nationally accepted standards for quality. The cost you pay for care Out-of-Pocket is based on the benefits tiers of your doctors and hospitals.

Benefits Tier	Quality	Your Cost
Enhanced	Met our quality benchmark and benchmark for lowest cost.	$—lowest cost
Standard[1]	Met our quality benchmark and our benchmark for moderate cost.[1]	$$—moderate cost
Basic	Includes Massachusetts PCPs and hospitals that scored below our quality benchmark and/or our benchmark for moderate cost.	$$$—highest cost

1. In limited circumstances, to increase your local access, the Standard Benefits Tier includes certain providers whose scores would put them in the Basic Benefits Tier.

Quick Links

- See the specifics of your plan
- Find a Blue Options PCP in Massachusetts
- Find a Blue Options hospital in Massachusetts
- Blue Options hospital tiering list (2011)
- Blue Options hospital tiering list (2012)
- Use our tiering savings calculator
- Get answers to FAQs
- Get medical advice 24/7
- Looking for other plans?
- Understanding Your ID Card

[11] BCBS of MA website, 12/2011

[12] Boston Globe, "Tiered health plans cutting costs, restricting options," November 28, 2011

Prescription Drug Plan Design Using Low Copays for Generic and Coinsurance with Minimums and Maximums for Brand Drugs

The lack of pricing transparency in pharmacy programs regularly results in the purchase of drugs that are unnecessarily expensive. The website Consumer Reports Best Buy Drugs (http://www.consumerreports.org/health/best-buy-drugs/index.htm) provides objective information comparing effectiveness, safety and price. Many insurer websites provide this same information.

Large employers have found that introducing coinsurance into plan design results in members making more informed choices. An illustration of an effective plan design:

- Generic Drug, copay $10
- Non-formulary brand, 30% coinsurance with a minimum of $20 and a maximum of $50
- Formulary brand, 30% coinsurance with a minimum of $35 and a maximum of $80

Engaged Employees

Large employers, including the State of Connecticut, are holding their employees more accountable for becoming aware of their own health risk and taking action to live healthier lives. Programs offer a range of incentives and penalties focused on personal health risk awareness, maintaining a healthy weight, being tobacco-free, complying with treatment regimens, etc. The expected return is lower future health care costs and improved member well being.

Innovation in Connecticut

Unfortunately, small employers in Connecticut cannot reduce their premiums by adopting these innovative approaches. Products offered to Connecticut's small employers are subject to the State's health insurance laws and regulations by the Connecticut Insurance Department (CID). Connecticut's existing insurance laws and/or their interpretation by the CID have prevented these products from being offered in Connecticut.

As advocates for the uninsured and small employers, the Board could play an important role advocating for the development of innovative products that meet the unique needs of these citizens.

Regulation Relating to Products and Pricing

The Board's ability to influence price and offer insurance products is subject to federal and state rating and insurance laws, and regulatory interpretation by the CID.

CID recently published a report focused on state and federal regulation of small employer health insurance (October 2011)[13]. Many of the reform elements in PPACA were already in place in Connecticut's small employer market:

[13] Working Group on Small Business Health Care, October 24, 2011, State and Federal Regulation of Small Employer Health Insurance

- Plans were guaranteed renewable
- Plans were offered on a guarantee issue basis (facilitated by the Connecticut Small Employer Health Reinsurance Pool)
- Carriers pooled small employer business, with the following rating adjustments available to them
- Age, Gender, Geographic Area, Industry, Group Size, Family Composition

The chart below summarizes CID's projection of the potential pricing impact of PPACA on Connecticut's small employer market.

Potential Small Employer Pricing Impact of PPACA

	Current Connecticut law	**2014**	**Impact**
Age	Approximately 6 to 1 ratio	3 to 1 ratio	Very old bracket premiums could reduce by up to 20% Very young age bracket premiums could increase at least 80%
Smoking	Not allowed	Smoking factor of 1.5	Rates for smokers could increase 50%
Industry	Allowed	Not allowed	Will increase some industries by as much as 15% while decreasing other industries by the same amount
Group size	Allowed	Not allowed	Could decrease the very small cases (1's and 2's) by as much as 15% to 20%, while increasing other sizes by approximately the same amount
Gender	Allowed	Not allowed	Will have varying impacts on the male and female rates based upon age

As a result of the difference between existing Connecticut rating rules, and proposed PPACA rules that will become effective in 2014, certain segments of the small employer market will see meaningful changes in their premiums.

In addition to specific rating rules, other PPACA rules will affect product pricing and availability, including the following[14]:

- PPACA permits both an individual and group health insurance market to continue to exist outside of the Exchange

[14] PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange, Congressional Research Service, June 2010

- Issuers of qualified health plans must agree to charge the same premium rate for a qualified health plan whether it is offered through an Exchange or offered directly from the issuer or through an agent

- Health plans must treat members in their plans as a single risk pool for members both in and out of the Exchange

The intent of these rules is to prevent the destabilization of the small employer health insurance marketplace through adverse selection.[15] These same rules, as well as Connecticut's existing insurance laws, as described below, limit the Board's ability to compete with the external market based upon price.

Connecticut insurers report that section 8 of the state insurance law has been an obstacle to offering innovative health insurance products that could lower small employer premiums. This will be an obstacle to the Exchange as well, because the law creating the Exchange specifically requires that plans offered through the Exchange comply with applicable health insurance laws and regulations adopted and orders issued by the insurance commissioner.

> *Connecticut insurance law: Sec. 38a-567. Provisions of small employer plans and arrangements. (8) Differences in base premium rates charged for health benefit plans by a small employer carrier shall be reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans."*

A strict interpretation of "plan design" would appear to limit the ability of the CID to permit pricing differentials for things like tiered networks and employer adoption of plans that promote wellness and employee engagement.

As the insurer survey has indicated, small employers are looking for affordable coverage. The Exchange Board is in a unique position to evaluate the needs of the small employer market and to advocate for changes to insurance law and regulation that will allow the needs of the small employer market to be better met. This advocacy should consider an appropriate level of "patient protections" mandated by law.

[15] National Association of Insurance Commissioners, 6/22/11 White Paper on Adverse Selection and Health Insurance Exchanges Under the Affordable Care Act

Other Exchange experiences

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

August 12, 2006 Victoria Colliver, Chronicle Staff Writer

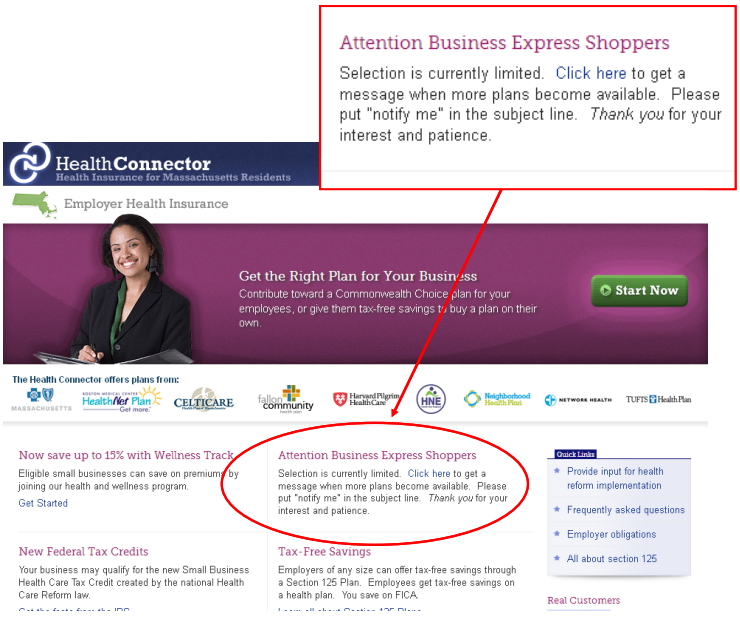
Pacific Health Advantage, a statewide health-insurance purchasing pool serving 6,200 small businesses, said Friday it will shut down at the end of the year. The purchasing group, known as PacAdvantage, has 116,000 members in the state. It is dissolving because one of its insurers, Blue Shield of California,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

It is hard to effectively run an Exchange

- The Pacific Health Advantage, a California based private health Exchange, was started in 1992 by the State of California and taken over by the Pacific Business Group on Health (PBGH) in 1998. It was an independent, non-profit voluntary purchasing pool for small businesses with 2–50 employees. At its height it covered over 150,000 members. Coverage for its 116,000 members ended on December 31, 2006. Its downfall has been attributed to the withdrawal of a major health insurer who said that they were losing money. Only two carriers would have been left in the Exchange, too few for such a big market

- The Massachusetts Connector has been unsuccessful attracting small employers to its small employer Exchange. It currently has less than 5,000 members. This limited success has been attributed to the delayed opening of a “contributory” plan in 2009 and its subsequent closure to new business in February 2010, limited product choice, limited insurer participation and selected broker distributors[16] [17] [18]

[16] Connector Quarterly Program Summary Report FY12 Q1 – Commonwealth Connector, 10/17/2011
[17] Fixing the Massachusetts Health Exchange, A Pioneer Institute White Paper, Amy Lishko, PHD, March 2011
[18] A HEALTH INSURANCE EXCHANGE FOR MARYLAND? – Comparing Massachusetts and Maryland, Robert Carey and Jonathan Gruber, PhD, and Maryland Association of Health Underwriters, National Association of Insurance and Financial Advisors of Maryland, 2010



- Utah's new Exchange has also been slow to attract small businesses[19]

A July 2009 report by the California HealthCare Foundation[20] describes the creation and demise of the California Exchange that ultimately became Pac Advantage. The report describes the Exchange's initial goals of providing easy access, reducing the cost of coverage, and enhancing the portability of coverage. It then goes on to discuss the hard realities, including the challenge and importance of health plan participation, the difficulty of achieving economies of scale in administration, and the likelihood of adverse selection.

[19] The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned – By Sabrina Corlette, Joan Alker, Joe Touschner and JoAnn Volk

[20] Building a National Insurance Exchange: Lessons from California, California HealthCare Foundation, July 2009

PBGH produced a similar report based upon their experience running Pac Advantage. The report identifies the following issues as critical to Exchange success[21]:

- The key value proposition of SHOP[22] Exchanges is meaningful consumer choice
- Adverse selection will remain a significant concern post-PPACA
- Policymakers must be vigilant and adaptable in preventing risk selection against SHOP Exchanges
- Participation in SHOP Exchanges must be attractive for health plans
- Successfully marketing SHOP Exchanges means building partnerships. SHOP Exchanges must build strong partnerships with health insurance brokers and other established delivery channels

The recommendations of the PBGH are consistent with other recent exchange studies.

Here are some insightful additional thoughts from Leesa Tori, a former PacAdvantage executive now studying at Harvard.[23]

> Excerpts from Leesa Tori's blog at Health Affairs about effectively running an Exchange:
> The small business insurance market is highly elastic – even small pricing changes trigger big changes in demand
> 1. To remain solvent and sustainable, a small business exchange must remain in synch with outside market practices, especially when enforcing eligibility rules and monitoring enrollment
> 2. Price can't fix everything if there is adverse selection. If an exchange gets on the wrong side of price, it's a fast and nearly-impossible-to-stop spiral to the bottom. In those cases, pricing can't be raised high enough to cover expenses and still keep membership. As prices are raised, employers and consumers drop coverage. Then, the overall numbers drop and the pool shrinks, and – crucially – the insured who are most likely to stay are more than likely the ones who need it most. The pool becomes increasing high risk and eventually unsustainable.
>
> To say it's complicated is an understatement. Understanding the economics of supply and demand will be critical to truly developing an exchange that adds real value to the market.

A number of studies have been written about Massachusetts' small business exchange. In addition, members of the Mercer team preparing this report have had involvement with the Massachusetts exchange.

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[21] Building Successful SHOP Exchanges, Lessons from the California Experience – Micah Weinberg, PhD and Bill Kramer, MBA – Pacific Business Group on Health

[22] Small Business Health Options Program (SHOP), the formal name for PPACA small business exchanges

[23] http://healthaffairs.org/blog/2011/09/22/insurance-exchanges-lessons-from-the-life-and-death-of-pac-advantage/

The Massachusetts small business exchange has not attracted unsubsidized small businesses because they are not offering anything meaningfully different from what is available in the non-exchange market. It also failed to obtain the support and participation of the state's major health insurers and alienated insurance brokers by excluding most of them.

Connecticut Existing and Successful Private Exchange

The creation of a SHOP Exchange in Connecticut is complicated by the presence of an existing private Exchange. The Connecticut Business and Industry Association's "Health Connections" Exchange has been in existence since 1995 and currently has more than 75,000 members.[24] Key facts:

- Robust "contributory" plan that offers individual employee choice
- Product choice of 25 plan options
- Insurer choice of two prominent carriers
- Brokers are their key distributors
- Started privately in 1995
- Small group rates subject to the same rating rules as those outside of the Exchange. (The price for a product sold by one of the carriers inside or outside the Exchange will be exactly the same)
- Additional access to other group insurance products and human resource support

Contributory Approach

The chart below[25] illustrates the "contributory" approach that CBIA takes.

An employer offering Health Connections defines the amount of money that they are going to contribute toward an employee's health coverage. This is typically expressed as a fixed dollar amount or a specific percentage of premium. The employee then has the ability to select the carrier and the plan design that best fits their needs.

Employees learn about their plan options during open enrollment meetings where their options are presented by an insurance broker. The broker then assists with the enrollment process and CBIA then provides the employer with a single bill.

[24] 2011 Connecticut Business and Industry Association Annual Report

[25] CBIA website

3 to 9
EMPLOYEES
Male

Area 3
New Haven
October - December 2010

Employee

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

CBIA Health Connections offers the kind of SHOP Exchange envisioned in the PPACA law. Their experience providing employers and employees with meaningful choice, judiciously managing adverse selection, working constructively with health insurers and effectively administering plans will make it difficult for the Exchange to attract non-subsidized small employers.

In Task 6, Mercer reviews options that the Board has for working with CBIA.

Targeting Small Employers

As the Board pursues its goal of reducing the number of uninsured in the state, the information developed should focus on those industries and firms that are most unlikely to offer coverage.

The Small Business Administration recently published a report that includes useful information on employer-based insurance in Connecticut.[26] The rate at which employers "offer" coverage varies by employer size and industry. The rate that employees "take up" or participate in coverage does not vary as much.

It is interesting to see that the rate that companies have been offering health insurance in Connecticut has not varied significantly in the reported time period.

[26] Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives, Quantria Strategies, LLC for Small Business Administration, Office of Advocacy, 9/2011

Percent of Connecticut Private Sector Establishments That Offer Health Insurance, 1998 to 2009[27]
(MEPS did not release 2007 estimates)

	2000	2001	2002	2003	2004	2005	2006	2008	2009
Fewer than 10 employees	57	49	43	46	52	44	45	44	44
10 to 24 employees	73	82	81	88	79	78	83	83	74
25 to 99 employees	94	92	98	85	93	98	96	91	92
100 to 999 employees	96	100	100	99	100	98	100	94	97
1000+ employees	97	100	100	97	97	99	99	100	100

However, the rate at which that coverage is offered does vary significantly by employer size and industry.

National Percentage of Private Sector Establishments Offering Health Insurance to Employees, 2009[28] – by Firm Size and Industry Group

Industry Group	All Firms	Less Than 10 Employees	10–24 Employees	25–99 Employees	100–999 Employees	1,000 or More Employees
Agriculture, fishing, forestry	26.4	20.6	39.1	83.1	68.2	100.0
Mining and manufacturing	67.7	43	79.2	90.4	97.9	99.8
Construction	42.3	31.1	73.5	87.8	87.8	100
Utilities and transportation	57.1	26.7	67.8	84.5	94.2	99.3
Wholesale trade	66.6	44.9	81.8	90.2	98.5	99.0
Financial services and real estate	67.8	39.0	75.7	90.0	97.4	98.5
Retail trade	59.1	25.5	60.4	84.7	93.0	99.6
Professional services	58.8	40.7	72.3	88.1	97.8	99.4
Other services	45.4	28.1	43.4	65.2	86.1	99.4

[27] Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives, Quantria Strategies, LLC for Small Business Administration, Office of Advocacy, 9/2011

[28] Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives, Quantria Strategies, LLC for Small Business Administration, Office of Advocacy, 9/2011

Potential Targets for Exchange Outreach

Using the national "offer" rate by industry, Connecticut-specific industry employment rate levels and the national "take-up" rate by employer size, we can estimate the number of Connecticut employers with less than 10 employees that do not have health insurance coverage, by industry, as follows:

Connecticut Estimate of Insurance Participation, Employers With Less Than 10 Employees, by Industry

Industry Group	1 National "offer" Rate: Less Than 10 Employees	2 Number of Connecticut Firms[29]	3 Connecticut Employment	4 National "take-up Rate"	5 (1 x 2) Firms Offering	6 (1 x 3 x 4) Employees Participating	7 (3–6) Employees Not Participating
Agriculture, fishing, forestry	20.6%	78	216	70%	16	31	185
Mining and manufacturing	43.0%	2,496	8,947	70%	1,073	2,693	6,254
Construction	31.1%	7,919	19,521	70%	2,463	4,250	15,271
Utilities and transportation	26.7%	878	2,414	70%	234	451	1,963
Wholesale trade	44.9%	2,514	7,419	70%	1,129	2,332	5,087
Financial services and real estate	39.0%	4,944	12,795	70%	1,928	3,493	9,302
Retail trade	25.5%	7,053	21,868	70%	1,799	3,903	17,965
Professional services	40.7%	7,499	19,080	70%	3,052	5,436	13,644
Other services	28.1%	7,217	22,993	70%	2,028	4,523	18,470
Total					13,722	27,112	88,141

[29] US Census, County Business Patterns, 2008

Small Employer Tax Credit[30]

The PPACA includes both tax credits for small employers with low-wage workers[31] and tax penalties for large employers.[32]

Small Employers

If an employer has fewer than 50 full-time equivalent employees, penalties do not apply for not providing coverage, but there is a tax credit to incentivize small employers with lower wage workers to provide health insurance. The tax credit is a portion of the premiums paid by the employer, subject to the limitation that premiums can be no more than the state average.

This tax credit is already in operation. For the 2010 and 2011 tax years, the average annual premium for the Connecticut small group market was $5,419 for 2010 and $5.640 for 2011 for single coverage; $13,484 for 2010 and $14,096 for 2011 for family coverage.[33] The maximum tax credit for tax years 2010 and 2011 is 25% of the premium (limited to the state average) for tax exempt employers and 35% for other (taxable) employers. For 2014, the first year of Exchange operation, these percentages increase to 35% for tax-exempt organizations and 50% for other (taxable) employers. For those employers that elect it for tax year 2014, the tax credit continues for 2015 at the 2014 level, but then it expires so that there is no tax credit for tax year 2016.

The tax credit in all years is affected by the size of the employer and the average wage paid. Employers with ten or fewer full-time equivalent employees have no size-based reduction. For each additional employee over ten, there is a reduction of one-fifteenth, until the tax credit is eliminated for an employer of 25 full-time equivalent employees. There is also a reduction based on average wage. If the average annual wage is $25,000 or less, there is no reduction. The tax credit is reduced as the average wage increases, reaching zero at $50,000. See the graph and numerical chart below for how the reductions are combined. As an example, an employer with 13 full-time equivalent employees has a tax credit that is 80% of the maximum (for employers of ten or fewer) if the average annual wage is $25,000 but is reduced to $0 if the average annual wage is $45,000 or more.

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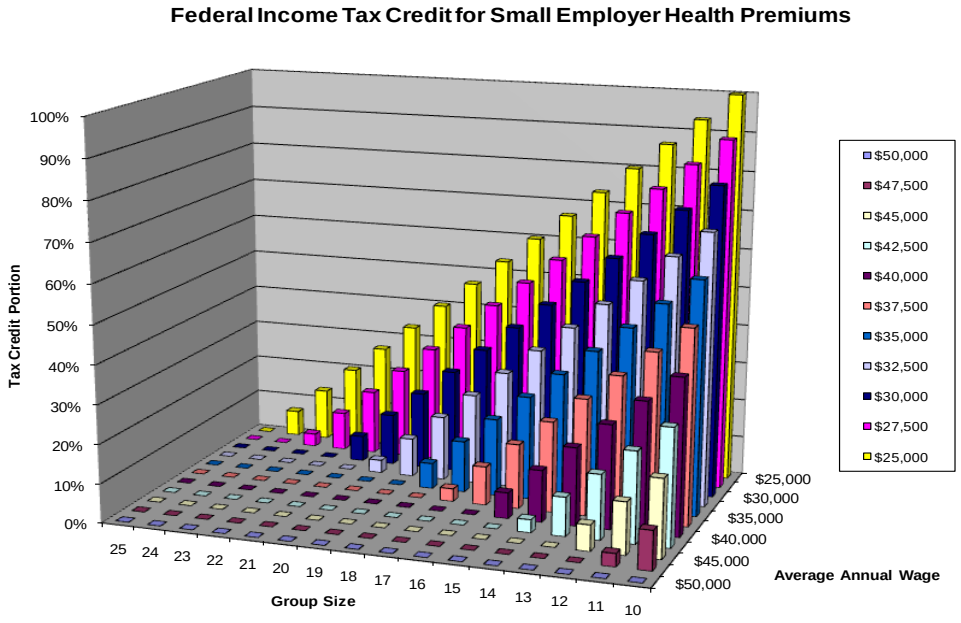
[30] This source for this information was developed in Task 4c

[31] PPACA Sec. 1421

[32] PPACA Sec. 1513

[33] IRS Code, Part 1, Section 45R, available at www.irs.gov/pub/irs-drop/rr-10-13.pdf



The tax credit for small employers will have a limited effect in maintaining levels of employer-provided insurance. Its main benefit goes to employers who pay low wages and are small (ten or fewer full-time employees or close to ten employees). Also, the tax credit may only be taken for two consecutive years after tax year 2013.

Small Employer Focus Groups

During the fall of 2011, Mercer conducted nine small employer focus groups with a total of 24 participants. Using the Hoovers Connecticut employer database they randomly solicited small employer participation in the focus groups. Over 1,200 employers were contacted and invited to participate in the focus groups that were being conducted in conjunction with the development of Connecticut's Exchange. Electronic polling devices were used for all of the face-to-face meetings.

The timing of the focus groups was negatively affected by Hurricane Irene and the October Nor'easter. However, beyond the weather, we found that it is extremely difficult to meet with small employers. Their focus is on running their businesses and, as interested as some of them were to provide suggestions, their schedules wouldn't permit attendance.

While the limited sample size would not be considered credible, our focus group findings are consistent with the Oliver Wyman uninsured survey referenced earlier.

Connecticut focus group findings:

- Small employers are extremely price sensitive
- Small employers are skeptical that a government-run entity will have a meaningful impact on making insurance more affordable and, based on what they know about the Exchange today, would not be interested in using the Exchange
- Participants who were eligible for a tax credit thought that it would be difficult to obtain; further, participants felt the short duration of the tax credit would not incent additional hiring
- Participants indicated an interest in having fewer choices within a given plan category (i.e., Platinum, Gold, Silver, Bronze, Catastrophic) to make comparison shopping easier
- Participants relied on their broker/agent to help them understand the option that best fit their needs

Aggregated answers to the focus group questions can be found in the following Appendix.

Appendix 3A

Additional Reading

- 2010 Instructions for Form 8941 Credit for Small Employer Health Insurance Premiums – Department of Treasury, Internal Revenue Services
- Simple Steps - Small Business Health Care Tax Credit – Internal Revenue Services
- Focus on Health Reform – A Profile of Health Insurance Exchange Enrollees – The Henry J. Kaiser Family Foundation – March 2011
- Lessons from the Implementation of Massachusetts Health Reform, Foundation Massachusetts, March 2011
- National Association of Health Underwriters – State Level Individual and Small Group Market Health Insurance Reforms – NAHU – February 2009
- Recommendations of the Special Commission on Provider Price Reform, Commonwealth of Massachusetts, February 9, 2011
- Table II.A.1(2009) Number of private-sector establishments by firm size and State: United States, 2009 – Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2009 Medical Expenditure Panel Survey-Insurance Component.
- Exchange Study – Minnesota Department of Health – February 2008
- Promoting Improved Quality and Value Through Purchasing Strategies in Health Insurance Exchanges – Pacific Business Group on Health
- Building a National Insurance Exchange: Lessons from California – California Healthcare Foundation
- What's in Healthcare Reform for Small Businesses? – Small Business Majority
- States Should Structure Insurance Exchanges to Minimize Adverse Selection – by Sarah Lueck – Center of Budget and Policy Priorities – August 17, 2010
- Summary of Small Business Health Insurance Tax Credit Under PPACA (P.L. 111-148) – Congressional Research Service – Chris L. Peterson Specialist in Health Care Financing, Hinda Chaikind Specialist in Health Care Financing – April 20, 2010
- The Effects of Health Reform on Small Businesses and Their Workers Timely Analysis of Immediate Health Policy Issues Stacey McMorrow, Linda J. Blumberg and Matthew Buettgens – June 2011
- Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010- Sara R. Collins, Karen Davis, Jennifer L. Nicholson, and Kristof Stremikis – The Commonwealth Fund – September 2010
- Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues - Timothy Stoltzfus Jost Washington and Lee University School of Law - The Commonwealth Fund – September 2010
- Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States and States, Totals: 2008 – Source: 2008 County Business Patterns. For information of confidentiality protection, sampling error, nonsampling error, and definitions, see http://www.census.gov/econ/susb/methodology.html
- Active Purchasing for Health Insurance Exchanges: An Analysis of Options, Sabrina Corlette and JoAnn Volk, Georgetown University Health Policy Institute
- Focus on Health Reform – What the Actuarial Values in the Affordable Care Act Mean, The Henry J. Kaiser Family Foundation, April 2011

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

- Health Insurance Agents and Brokers in the Reformed Health Insurance Market, Mark Newsom Specialist in Health Care Financing, Congressional Research Service, May 13, 2011
- Consumer Report Card on Health Insurance Carriers in Connecticut – State of Connecticut Insurance Department – October 2010
- The One Hundred Thirty Ninth Annual Report of The Insurance Commissioner 2010 Business Of 2009 – State of Connecticut
- Board of the Commonwealth Health Insurance Connector Authority Minutes – The Commonwealth of Massachusetts Commonwealth Health Insurance Connector Authority – Thursday, April 14, 2011
- Connector Quarterly Program Summary Report FY12 Q1 – Commonwealth Connector – 10/17/2011
- Frequently Asked Questions on Rate Filing, Rate Reviews and Approval of Health Insurance Rates in Connecticut – Insurance Department State of CT
- Federal Register / Vol. 76, No. 136 / Friday, July 15, 2011, Proposed Exchange Rules, Department of Health And Human Services
- Massachusetts Health Care Reform Has Left Small Business Behind: A Warning to the States – Joshua D. Archambault – Backgrounder Published by the Heritage Foundation – September 16, 2010
- How Can California Make Most of Volatile Marketplace? CaliforniaHealthline – Monday, November 28, 2011
- Small Business Health Care Tax Credit: Frequently Asked Questions – IRS.gov

Appendix 3B

See attached file labeled: *Appendix 3B – CT HIE Small Employer Focus Group*

TASK 4

Conduct Economic and Actuarial Modeling and Analyses to Project Trends in the Exchange – Reports 4a to 4i

Introduction

Mercer and its team conducted an economic and actuarial modeling and analyses to project trends within the Exchange for the State of Connecticut. As part of his modeling and analyses, the following scenarios were addressed:

- Task 4a: To integrate high risk pools in the non-group market or maintain high risk pools separately
- Task 4b: Advantages and disadvantages of expanding the definition of small group from 50 to 100 employees prior to 2016
- Task 4c: Impact of an Exchange on employer-provided insurance and, specifically, the impact of employer penalties and tax credits by the different scenarios
- Task 4d: Implications of merging the markets for pricing in the small group and the non-group markets
- Task 4e: Impact of the individual mandate to purchase health insurance and its influence on the markets and the assumptions made with respect to the models
- Task 4f: Feasibility of a basic health program (BHP)
- Task 4g: The cost of Connecticut benefit mandates that are above the federal essential benefits in the context of a revised insurance market
- Task 4h: Impact of the Exchange on insurer profitability and potential market exit
- Task 4i: Impact of the Exchange on household budgets

The Oliver Wyman's Healthcare Reform Micro-simulation Model (Oliver Wyman's HRM Model) was used to address a number of questions related to the operation of an Exchange in the State of Connecticut (State) as requested under Task 4. A considerable amount of data from various sources was gathered and synthesized to populate the model, which was then calibrated to reproduce the 2010 State population and insurance marketplace prior to projecting estimated enrollment and premium from 2014 through 2018.

The Mercer team has prepared these projections exclusively for the State of Connecticut, Office of Policy and Management (OPM). These estimates were based on draft regulations issued by

the Department of Health and Human Services (DHHS) as of December 15, 2011. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the Patient Protection and Affordable Care Act (PPACA) have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. (For example, some health care reform provisions will likely involve calculations at the individual employee level.) The OPM is responsible for all financial and design decisions regarding the PPACA. Such decisions should be made only after OPM's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly, OPM understands that Mercer is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute nor is it a substitute for legal advice. Accordingly, Mercer recommends that the OPM secure the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document and in any of the attachments is not intended by Mercer to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

Data and Reliance

In this report the Mercer team relied on information from the US Census Bureau, the Medical Expenditure Panel Survey (MEPS), Dun & Bradstreet (D&B), annual statutory financial statements of insurers issuing policies in the State and other sources. Most critically, we also relied on data provided by insurance carriers that participate in Connecticut's current insurance marketplace. We discuss these data sources below.

Population Data

The Mercer team relied on various data sources from the US Census Bureau in estimating both the overall size of the population in Connecticut as well as in segmenting the market by characteristics such as type of insurance coverage, age, gender and income. Our primary source for these data was the American Community Survey (ACS).

The Mercer team felt it important that we have one primary data source to provide a demographic characterization of the State's population. Had we instead relied on data from different sources as the basis for various aspects of our analysis, we would have faced potential inconsistencies in definitions, time periods and data collection techniques among these various sources.

Ultimately, we chose to rely on the ACS data for our purposes (i.e., instead of the Current Population Survey) for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. The ACS applies logical edits to the data to adjust for this 'Medicaid undercount.'[1] Second, the ACS questionnaire includes the question, "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[2] (Emphasis is from the survey.) In contrast, the Current Population Survey assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the model we present in this report as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the ACS; so, the response rate is quite high (i.e., 98% in 2009).[3] Fourth, and finally, the ACS includes measures that permit the calculation of standard errors from the sample.

Medical Expenditure Panel Survey and D&B

The Mercer team also used the Agency for Healthcare Research and Quality's MEPS Insurance/Employer Component data from 2009 and 2010 to develop characteristics of the State's small employer market. MEPS identifies key statistics for the small employer market by state, including employer offer rates, employee take-up rates and premiums by tier. All statistics in the MEPS data were available by various employer group sizes. We used the average of the 2009 and 2010 survey results to enhance the credibility.

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[1] http://www.census.gov/hhes/www/hlthins/publications/coverage_edits_final.pdf.

[2] http://www.census.gov/acs/www/Downloads/questionnaires/2009/Quest09.pdf.

[3] http://www.census.gov/acs/www/methodology/response_rates_data/.

We also used the D&B employer data to establish distributions of group sizes by major industry classification. These distributions were critical for accurately classifying employees in the State in appropriate pools or groups. In preparing the D&B data, we removed any groups that reflected government employers (either domestic or foreign).

Carrier Data Call

The primary data source for calibrating premium, benefits and other rating factors was provided by carriers as part of the carrier data call.

With the assistance of OPM we submitted a request for data and received responses from the major market participants in Connecticut. Our request for data focused on those rating elements that the PPACA was most likely to affect. Specifically, we requested that carriers provide distributions by enrollment, premium and claims by the following factors from the 2009 and 2010 experience periods:

- Age/gender/family composition
- Morbidity load (individual)
- Group size factor (for small group carriers)
- Industry load (for small group carriers)
- Actuarial values

Of the carriers that responded, we ultimately received enough information to reconcile the responses to financial statements for the market as a whole.

Annual Financial Statement Data

Annual financial statements were used to identify total enrollment, premium, claims and other data for the State's individual and small group insurance markets. Although prior years' data were also reviewed, the primary source for this work was the 2010 Annual Statutory Financial Statements filed on the Health blank or the Life, Accident and Health (LAH) blank. To support new insurer reporting requirements, 2010 annual statements include a new schedule, the Supplemental Health Care Exhibit. Insurers are required to report this schedule separately for each state in which they write comprehensive major medical business.[4] The Supplemental Health Care Exhibit reports detailed income statement data based on individual, small group

[4] Experience for individual plans sold through an association or trust is allocated to the issue state of the certificate of coverage. Experience for employer business issued through an association or trust is allocated based on the location of the employer. Experience for group plans with employees in more than one state is allocated to state based on the situs of contract.

employer, large group employer, government business, other business and other health and self-funded plans. Small group employers are defined as groups with up to 100 employees, except in states exercising an option under PPACA to define small groups up to 50 employees until 2016.[5] The large group employer category includes the Federal Employees Health Benefit Program (FEHBP) and State and local fully insured government programs. Access to the Annual Statutory Financial Statement data was obtained through a subscription service.

Carrier Rate Filing Data

In addition to the annual financial statements, we also relied on rate filings we obtained from the Connecticut Insurance Department website. These rate filings provided an independent source for the product offerings, premiums and rating structures employed by carriers offering coverage in the individual and small group markets.

While we have reviewed each of these data sources for reasonableness (and where discrepancies arose we performed further investigation to reconcile any differences), we have not independently audited any of these data.

Model Design, Methodology and Assumptions

In this section we describe the design, methodology and basic assumptions underlying the reform modeling performed for the State. We present a general overview of the model, describing the basic methodology employed. For the interested reader, we have included a technical discussion with additional detail in the Technical Appendix. The modeling was performed using Oliver Wyman's HRM Model. Many aspects of the model are similar to the Congressional Budget Office's (CBO's) and/or The RAND Corporation's simulation models. In this work, our model was calibrated to a much more granular level using very detailed, Connecticut-specific information on premium rates, benefits, demographics and group composition, and not to the higher level nationwide average information generally used in these other models. As a result, the model captures the many unique characteristics specific to the State such as the requirement that small group premiums be based on modified community rating.

Model Design and Methodology

The Oliver Wyman HRM Model is comprised of three primary modules. The first module generates a synthetic population made up of individuals, families, employer groups and government programs. The second module uses the synthetic population to calibrate the model by solving for various model parameters, such that the model reproduces the State's current insurance marketplace. Using the simulated population, the solved-for model parameters and many other economic variables, the third module introduces the changes to the marketplace that will come about as a result of the PPACA, and projects the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace.

[5] Connecticut used a 50-employee threshold for reporting small employer group in the 2010 Supplemental Exhibit.

Similar to the CBO's model, a key underlying assumption of our model is that it assumes decisions related to the purchase of health insurance are made at the health insurance unit (HIU)[6] level, and that the decisions made by these HIUs follow rational choice theory.[7] In reality, consumers will not always behave in an economically rational manner, and for this and other reasons, actual results will vary from those produced by our model. All options available to the HIU for obtaining health insurance are evaluated (i.e., they select among various insurance options with various premiums and out-of-pocket (OOP) cost sharing, public programs or chose to remain uninsured) and the option with the highest economic utility is selected. We have chosen to use a utility function consistent with that used by The RAND Corporation in its model,[8] but have calibrated it to reproduce Connecticut's current insurance marketplace. In modeling HIU behavior, we chose a utility function over an elasticity function (which postulates that behavior can be modeled on changes to historical prices) given the choices consumers will face in the reformed market are in many cases significantly different from those they have faced in the past.

While the individual purchasing decision will change significantly with the introduction of the individual Exchange, premium and cost-sharing subsidies, adjusted community rating and the individual mandate, the decision from the employer perspective will remain essentially the same. That is, the employer will choose between offering their employees health insurance benefits or higher wages based on price. Therefore, we have based the employer's decision of whether to offer employer-sponsored insurance (ESI) coverage to their employees and, if so, at what level, on demand price elasticity theory.

A significant portion of the cost of operating any business is related to employee payroll. Therefore, we assume employers view projected increases in payroll as budgeted costs of doing business, and base the elasticity of any insurance purchasing decision on the excess of rate increases they are being asked to pay over the increase in per capita payroll. For example, if the employer is faced with a 7% increase in insurance premiums and per capita payroll is projected to increase at 3%, the impact that the 4% excess cost will have on employer behavior is evaluated using the selected elasticity curve. For each year modeled, the elasticity curve is applied to this excess amount and the employer chooses to adjust the actuarial value of benefits offered in a manner consistent with the demand elasticity curve. In our modeling we assume that employers continue to "buy down" benefits until the point at which the actuarial value falls below

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[6] A Health Insurance Unit (HIU) is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy.

[7] Rational choice theory is based on the assumption that individuals act as if comparing the costs against the benefits of various choices to arrive at the action that maximizes their personal satisfaction.

[8] The utility function utilized by The RAND Corporation was previously justified by research performed by Goldman, Buchanan and Keeler (2000).

the minimum level of 0.60 that may be offered in the small group market in 2014 and later, at which point the employer elects to drop coverage.

Steady State Population

A key underlying assumption of the model is a steady State population. By this we mean that the underlying mix of the population does not change with respect to most variables. Annual increases in income and population growth are included, which also include anticipated changes in the distribution of the population by age to reflect the increasing age of the population as the baby boomers age. However, the distribution of the State's overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period. For example, we have not attempted to project rates of employment in 2014, but have assumed that rates of employment in 2014 will be the same as in 2010. This steady State assumption does not mean that the health status or specific individuals will not change over time, only that the overall relative health status by specific subsets of the population (e.g., by FPL and age) do not change. However, as described below, as people move between various insured statuses (e.g., small group, individual and uninsured), changes in the average morbidity of those markets will change.

Key Underlying Assumptions

The previous discussion focused on the model's underlying framework. We now turn to a discussion of the key assumptions used in the modeling process.

Carrier Participation and Product Offerings in Connecticut's Individual and Small Group Markets

We made the following assumptions regarding carrier participation:

- All major carriers participating in the State's individual and small group markets during the base period continue to participate in 2014 and beyond
- No new carriers enter the market and obtain significant market share
- All carriers participate in both the inside and outside Exchange markets
- Products offered inside the individual and SHOP Exchanges are similar to products offered outside the individual and SHOP Exchanges, and premium rates are the same inside and outside the Exchanges for the same benefit package

Individuals Currently Enrolled in Medicaid

Individuals currently enrolled in the State's Medicaid, CHIP or other publicly financed programs are not specifically included in our model and are assumed to remain enrolled in these programs in 2014 and beyond. Factors are applied to this set of individuals to reflect general population growth. Individuals who are currently eligible for these programs but are not enrolled are addressed later in this section.

Large Employers Continue to Offer ESI

We have assumed that large employers (defined as those with 101+ employees) continue to offer ESI coverage at the same rate they did in 2010, and we have assumed that employees who are eligible and enroll in this coverage do so at the same rate they do today. Employees who are not eligible to enroll, or those who are eligible to enroll but choose to remain uninsured, are reflected in our modeling.

Small Employers Not Offering Coverage During the Base Period Do Not Offer Coverage in 2014 and Beyond

The model assumes that small employers that did not offer coverage in 2010 will not begin to offer coverage in 2014. We note that the small employer tax credits were introduced in 2010 and it is assumed that any small employers electing to offer coverage as a result of these credits would have done so in 2010, and as a result are reflected in the base experience used for our modeling.

To the extent that coverage is newly offered by small employers in 2014 and beyond, the projected enrollment figures we develop in this report may be understated.

Government Workers

If either the primary ACS respondent or the spouse is identified as working for the government and the HIU is identified as currently having ESI coverage, we have assumed that the ESI coverage is provided through a government employer. Our model assumes that these individuals will continue to receive this coverage and will not enroll in the individual Exchange.

Grandfathered Policies

A recent survey found that out of 466 companies – representing 6.9 million employees – almost all (90%) expect to lose grandfathered status by 2014 because of health plan design changes (72%) and/or changes to company premium contribution levels (39%).[9] Given the limitations on benefit changes that can be made and still maintain grandfathered status and the pressure that the current economic conditions are putting on employers and individuals to limit premium increases, our model assumes that there will be no individual or small group policies with grandfathered status in 2014.

Self Insurance

The adjusted community rating methodology required by the PPACA will have the impact of increasing rates for young, healthy groups and individuals. In some cases these groups will have a financial incentive to self insure their benefits rather than purchase coverage through the fully insured risk pool. The exit of these healthier than average groups from the fully insured small group market could increase the average morbidity of those that remain and put upward

[9] http://www.aon.com/attachments/Employer_Reaction_HC_Reform_GF_SC.pdf.

pressure on rates. The impact of this phenomenon is not reflected in the baseline modeling that is the subject of this report.

Undocumented Individuals

Undocumented individuals will not be eligible to enroll in the State's individual Exchange. Our model does not specifically handle these undocumented individuals, as they are not separately identifiable in the ACS data. Rather, our modeling assumes that these individuals are not likely to respond to the ACS and are, therefore, not included in the ACS data used as a basis to develop the simulated marketplace.

Model Input Assumptions

In addition to the underlying assumptions upon which the model is built, there are numerous inputs and variables that can be adjusted in Oliver Wyman's HRM Model.

Guarantee Issue

Under the PPACA, coverage must be offered on a guarantee basis. In our modeling, we do not evaluate certain coverage options for individuals unless they meet eligibility requirements (e.g., meet Medicaid eligibility requirements or work for an employer that offers coverage). However, due to the guarantee issue provision in the PPACA, our model does not restrict individuals from evaluating coverage options due to their own health status, nor do the calculated premium rates vary based on their individual health status.

Medical Trend

We relied on the CBO's estimate for medical trends between 2010 and 2014 of 5.5%.[10]

Targeted Medical Loss Ratios

Health insurers were required to meet new loss ratio requirements of 80% beginning in 2011 in the individual and small group markets and 85% in the large group market. Our model assumes that insurers will prospectively develop their 2014 premiums based on loss ratio targets consistent with these loss ratios to which they will be held to on a retrospective basis.

PPACA Changes Effective September 23, 2010

The PPACA required several changes to eligibility, coverage and benefits effective on the first policy anniversary date on or after September 23, 2010. Given the base period experience used for our modeling reflects calendar year 2010, only a very small portion these changes are reflected in the experience. We increased the base period experience premiums by 5% in the individual market and 3% in the small group market to reflect the following changes:

[10] An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act, CBO, November 30, 2009.

- Coverage of dependents up to age 26
- Elimination of cost sharing on preventive services
- Removal of lifetime limits on Essential Health Benefits (EHBs)
- Restriction of annual limits on EHBs
- Increase in cost sharing for out-of-network emergency services to in-network levels
- Guarantee issue with no pre-existing condition exclusions for children up to age 19

Benefits and Actuarial Values

In order to model benefits and premiums in 2014 and beyond, we first needed to understand how current Connecticut insurance products compare to the PPACA coverage tiers. Oliver Wyman actuaries obtained information from the largest carriers in the State. For small group business, this information contained premium, claims, membership and the various rating factors (e.g., age/gender, group size and industry) assigned to each group in 2010. The actuarial value of the benefit plan underlying each small group's premium was not provided. Using the information obtained, each group's premium was normalized for all rating factors provided which, in effect, resulted in normalized premiums that reflected only benefit differences.

In 2010, carriers were not yet designing products targeted to specific actuarial values (as they will in the reformed market); the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimates of actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able to discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered in 2010. Small groups were then pooled into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. We performed a similar analysis for the current individual market.

The impact of the EHB package will have a significant impact on premiums in the State's individual market, where almost half of insureds have coverage with an actuarial value less than 60%. The CBO estimates that average premiums in the individual market in 2014 will be 27% to 30% higher because of greater coverage requirements. These increases result from the average insurance policy covering a substantially larger share of an enrollee's costs for health care and a wider range of covered benefits as a result of the EHB package.[11] Our modeling indicates that the average impact in the State will result in individual premiums that are roughly 20% higher for these items. The increase in Connecticut is relatively low due to the large number of mandates the State requires.

[11] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

Coverage for Women's Preventive Services

A 5% increase to premiums was applied to the individual market and a 1% increase was applied to the small group market to reflect the coverage of women's preventive services without cost sharing effective August 1, 2012.

Uninsured Utilization and Pent-up Demand

Individuals without current health insurance do not seek medical services at the same level as those with insurance. The CBO estimates that the uninsured currently use about 60% as much medical care as insured individuals, after taking into consideration differences in age and morbidity.[12] We have used this assumption in our model and, therefore, multiply an individual's expected claim costs by a factor of 0.60 when evaluating the utility associated with becoming or remaining uninsured in 2010.

Because of the fact that individuals who are currently uninsured do not utilize services at the same level as those with insurance, they will have pent-up demand and utilize services at a higher rate during their first year they are insured. We estimate the impact of pent-up demand will cause the expected claims costs for a newly insured individual, relative to an individual of the same age, gender and health status that has insurance, to be 10% higher in the first year. Therefore, when calculating the utility associated with various purchasing options for an individual that is currently uninsured, the individual's claim costs are multiplied by a factor of 1.10 for each health insurance option evaluated. The pent-up demand factor is not included in calculating the utility associated with the person remaining uninsured. If the individual elects to take-up coverage, their expected claims cost in subsequent years is assumed to be the same as the average insured individual of the same age, gender and health status. In other words, the pent-up demand adjustment is removed after the first year of insurance.

Adverse Selection Due to Risk Pool Composition Changes

A critical consideration in premium development is the relative morbidity associated with individuals and small group enrollees that depart the market, as well as new market entrants. To the extent that the risk pool composition changes, those changes will influence premium levels. Some of the factors impacting the average morbidity level of the pools are discussed below.

Residents With Current Individual Insurance Leaving the Pool

Residents currently covered by policies through the State's individual market that experience significant rate shock resulting from the adjusted community rating methodology may find it economically beneficial to become uninsured. Given young and healthy individuals will experience the most upward pressure on rates resulting from a shift in rating methodology, the exit of these healthy individuals can lead to an increase in the average morbidity of the individual pool.

[12] Ibid.

Residents Currently Uninsured Entering the Pool

Residents who are currently uninsured and were previously denied coverage in the individual market due to their health status will increase the average morbidity of the pool as they enter the individual market under guarantee issue rules. In addition, these individuals will have pent-up demand, as described above, which will put further upward pressure on the anticipated utilization rates of the individual pool. Further, low income individuals tend to have higher morbidity than those in higher income brackets. As the premium and cost-sharing subsidies draw the low-income individuals into the individual pool, experience will deteriorate.

Those With Current Employer-sponsored Coverage That Lose Coverage

Individuals with current ESI coverage will have the option to enter the individual Exchange if their employer terminates coverage. Employers with low-income employees may be more likely to terminate coverage as a result of premium and cost-sharing subsidies that will be available to their employees in the individual Exchange.

Our model assumes that health insurance carriers will anticipate adverse selection associated with the four items discussed above and prospectively price for it to the extent they are allowed. Assumptions for these relative morbidity levels were derived based on iterative testing by applying adverse selection loads to premiums and observing the resulting changes in morbidity of the pool due the new market entrants and exits. As significant enrollment of new market entrants who were previously uninsured bring a pent-up demand for services, as previously described, the impact of that phenomenon was also included in premium development. We found that the upward pressure on rates in the individual market resulting from this migration was 12% in the baseline scenario.[13] Therefore, rates in the individual market in 2014 were increased 12% in anticipation of this shift in average morbidity. We found no significant change in the risk pool composition of the small group pool in 2014 under the baseline scenario.

Increases in the Consumer Price Index

We have used increases in the Consumer Price Index (CPI) consistent with the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1.[14] The following table shows the estimates employed in our modeling for Connecticut.

Year	CPI Estimate
2010	1.6%
2011	1.2%
2012	1.7%
2013	1.9%

[13] The baseline scenario assumes separate individual and small group risk pools, and a small group definition of 50 employees until 2016.
[14] http://www.ssa.gov/oact/tr/2011/lr5b1.html.

Year	CPI Estimate
2014	2.0%
2015	2.0%
2016	2.0%
2017	2.2%
2018	2.6%

Penalties under the Individual Mandate

Penalties for 2014 through 2016 are prescribed in the PPACA. The PPACA specifies that after 2016 the flat dollar penalty is increased based on the cost of living, with any increase that is not a multiple of $50 rounded to the next lowest multiple of $50. Therefore, using this formula and the increases in CPI outlined above, we project that the penalties under the individual mandate will be as follows and have used these values in our model.

Year	Dollar Penalty	Percentage Penalty
2014	$95	1.00%
2015	$325	2.00%
2016	$695	2.50%
2017	$700	2.50%
2018	$700	2.50%

Increases in Annual Average Wage

We have used increases in the average annual wage from the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1, "Annual Percentage Change in Average Annual Wage in Covered Employment."[15] The following table shows the estimates employed in our modeling for the State.

Year	Salary Inflation
2010	4.0%
2011	4.1%
2012	4.5%
2013	4.6%
2014	4.2%
2015	3.9%
2016	4.0%
2017	4.0%

[15] http://www.ssa.gov/oact/tr/2011/lr5b1.html.

Year	Salary Inflation
2018	4.4%

Premium Subsidies

Premium subsidies consistent with those outlined in the PPACA were employed. Our model places individuals into income ranges and applies the same subsidy to all individuals within a given range. This is slightly different from the PPACA in that subsidies at specified income levels are prescribed and subsidies for HIUs are interpolated between these points based on the HIU's actual income. Therefore, we translated the subsidies included in the PPACA into an average premium subsidy for each income range used in our model. The income ranges used were selected to coincide with thresholds for eligibility for various public programs, premium subsidies and cost-sharing subsidies, and are narrow enough so as not to introduce bias or lack significant specificity. The following table compares the subsidy levels included in the PPACA with the income range subsidies employed in our model.

PPACA Subsidy		Modeled Subsidy	
Federal FPL Percentage	Maximum Premium Contribution	Modeled FPL Range	Maximum Premium Contribution
100%	2.00%	100%–138%	2.50%
133%	3.00%	139%–150%	3.50%
150%	4.00%	151%–200%	5.15%
200%	6.30%	201%–250%	7.18%
250%	8.05%	251%–300%	8.78%
300%	9.50%	301%–350%	9.50%
400%	9.50%	351%–400%	9.50%

Tax Considerations

An employee's premium contributions under an ESI health plan may be purchased with pre-tax dollars. Our model takes this into consideration when applying the utility function for individual purchasing decisions. We estimated State and federal tax rates for various modified adjusted gross income (MAGI) ranges. We used current tax rates from Connecticut. Federal tax rates were modeled using an analysis conducted by the CBO which examined federal tax rates by pre-tax income quintile.[16] We considered Federal Insurance Contributions Act (FICA) taxes at 2010 levels and assume the temporary reduction in the employee's portion of the rate from 6.2% to 4.2% for 2011 will not continue, and that 2014 rates will correspond with 2010 rates.[17] We have also considered Medicare taxes at the current 1.45% rate for both employees and employers.

[16] http://www.cbo.gov/publications/collections/tax/2010/AverageFedTaxRates2007.pdf

[17] http://ssa.gov/pubs/10003.pdf

In factoring FICA and Medicare taxes in, we have used both the employee and employer portion, recognizing that the employer-paid portion is effectively in the employee's wages. We have also reflected the income cap on which individuals and employers are required to pay FICA taxes, which results in a lower effective rate as income increases. Using this information we developed the following tax rates for various MAGI ranges and employed these estimates in our model.

Modified Adjusted Gross Income	Connecticut Tax Rate	Federal Tax Rate	FICA Tax Rate	Medicare Tax Rate	Total Tax Rate
$0–$10,000	3.00%	1.00%	12.40%	2.90%	19.30%
$10,001–$20,000	3.67%	2.00%	12.40%	2.90%	20.97%
$20,001–$30,000	4.20%	4.00%	12.40%	2.90%	23.50%
$30,001–$40,000	4.43%	6.00%	12.40%	2.90%	25.73%
$40,001–$50,000	4.56%	8.00%	12.40%	2.90%	27.86%
$50,001–$75,000	4.78%	11.00%	12.40%	2.90%	31.08%
$75,001–$100,000	4.99%	14.00%	12.40%	2.90%	34.29%
$100,00–1$200,000	5.37%	17.00%	8.83%	2.90%	34.10%
$200,00–1$300,000	5.72%	21.00%	5.30%	2.90%	34.92%
$300,00–1$350,000	5.95%	25.00%	4.07%	2.90%	34.10%
$350,001–$400,000	6.05%	25.00%	3.53%	2.90%	34.92%
$400,001–$500,000	6.16%	25.00%	2.94%	2.90%	37.92%
$500,001+	6.21%	25.00%	2.65%	2.90%	36.76%

Temporary Reinsurance Program

A temporary reinsurance pool will be established for three years (2014 through 2016) to transition to a modified community-rating environment in the individual market and to partially offset the impact of the adverse selection that will occur due to changes in the risk of the population insured in the individual market. The reinsurance program is anticipated to allocate $10 billion to carriers in the individual market in 2014, $6 billion in 2015 and $4 billion in 2016. These payments to carriers in the individual market are anticipated to be roughly 10% of premium in 2014, all else equal, and this reduction will be phased out over the next three years as the level of payments in each subsequent year is reduced. These payments to the individual market will result in assessments against all markets, including the individual market, of about 1% of premium in 2014. The following table shows the annual impact of the reinsurance program on premiums in the individual and small group markets that are built into our model. The 9.1% reduction in the individual market in 2014 is the net of the 10% reduction due to reinsurance payments to the market and a 1% of premium assessment against the individual market.

Year	Individual Market	Small Group Market
2014	-9.1%	1.0%
2015	4.1%	-0.3%
2016	1.9%	-0.2%
2017	3.7%	-0.4%

Take-up of Medicaid Coverage Among Those Eligible but Not Enrolled

As with most states, there are residents of Connecticut who are eligible for Medicaid but not enrolled today. There are many possible reasons why these individuals may choose not to enroll in Medicaid. Some may make this election based on the fact that they are healthy and do not currently need services, knowing they can enroll when they do. A US Government Accountability Office (GAO) study found that many do not enroll because of the perceived stigma associated with filing for public assistance.[18] The same study reported that some individuals found completing the application and gathering the required documentation to be burdensome.

With a “single front door” integrated approach to the Exchanges and Medicaid, some of the stigma associated with enrolling in Medicaid today may be reduced. In addition, the navigators and their mission to educate consumers, raise awareness of the Exchanges and facilitate enrollment may also increase the number of these individuals that enroll in Medicaid. For these reasons, we have included in our modeling the assumption that 20% of the individuals currently eligible for Medicaid, but not enrolled, will enroll by 2014.

Participation in the Individual Exchange

Premium and cost-sharing subsidies will only be made available within the individual Exchange. Therefore, individuals qualifying for subsidies will have strong financial incentives to purchase coverage through the Exchange rather than in the outside market. Our model assumes that individuals eligible for premium and cost-sharing subsidies will not enroll in the outside market.

Lower participation in the individual Exchange is assumed among HIUs with incomes in excess of 400% FPL. A recent Kaiser survey of people with individual insurance found that 36% purchased their coverage with the use of an insurance broker.[19] Roughly three-quarters of the remaining individuals purchased coverage directly from the insurance company while only one-quarter, or 13%, purchased coverage through the Internet. We note that the survey did not report these statistics separately by income range. A recent Pew Research study found that those with incomes over $40,000 are twice as likely to consider themselves high-access Internet users as compared to those with incomes under $40,000.[20] Therefore, we estimate that the rate at which individuals with incomes over 400% FPL purchase coverage over the Internet today is at least twice the average 13% figure reflected in the Kaiser survey.

[18] http://archive.gao.gov/t2pbat4/150626.pdf.
[19] http:/www.kff.org/kaiserpolls/upload/8077-R.pdf.
[20] http://www.pewinternet.org/~/media//Files/Reports/2007/Pew_UI_LibrariesReport.pdf.pdf.

Once the individual Exchange is up and running in 2014, there will be even more exposure to online purchasing of insurance than there is today. National attention given to Exchanges as an alternate vehicle for purchasing insurance is sure to increase the rate at which this method of purchase is used today. In addition, the Navigator's role in conducting public education and raising awareness of the availability of qualified health plans (QHP) will also increase awareness. Additional advertising and outreach by the State can work to increase the awareness even more. We have assumed in our modeling that 25% of the individuals with incomes over 400% FPL that purchase coverage in the individual market will do so through the State's individual Exchange.

Participation in the SHOP Exchange

Small groups that are eligible for the temporary small business tax credits must enroll in the SHOP Exchange in order to receive those credits beginning in 2014. However, the small business tax credits appear to be poorly understood and relatively few small employers have made an attempt to determine if they are eligible for the tax credits.[21] Therefore, our model assumes that 25% of small employers that are both eligible for the tax credits and are modeled as offering coverage will enroll in the SHOP Exchange. Once small employers have claimed the temporary tax credit for two years, the small employers will need to decide whether they can afford to continue to offer coverage. Given that premium rates must be the same inside and outside the SHOP Exchange for the same benefits, we think it is unlikely that employers will have access to plans with significantly lower benefits or premiums in the outside market. Therefore, our model assumes that if these employers continue to offer coverage, they will continue to do so within the SHOP Exchange.

Among employers that do not qualify for the tax credits, enrollment in the SHOP Exchange is projected to be much lower. Given the Exchanges created under the PPACA are new, there is no empirical evidence upon which to base an assumption related to employer participation. An examination of enrollment by small employers in the Massachusetts Connector, the Utah Health Exchange and HealthPass New York reveal that significantly less than 10% of the small groups are enrolled.[22] While these "exchanges" are different from Connecticut's planned SHOP Exchange that will be established under the PPACA, they do provide a starting point for setting enrollment estimates.

We have assumed in our modeling that 5% of small employers that offer coverage and do not qualify for the small business tax credit will enroll in the State's SHOP Exchange. This assumption is higher than the enrollment levels observed by existing Exchanges and reflects the fact that the employee choice option is expected to draw in some employers. We note this assumption is consistent with those employed by other states in similar modeling that we have reviewed. At the same time, these other states recognize the need to explore options to increase

[21] Employer Health Benefits: 2011 Summary of Findings, The Kaiser Family Foundation and Health Research & Education Trust. Available at http://ehbs.kff.org/pdf/8226.pdf

[22] http://www.smallbusinessmajority.org/reports/shop_exchange.pdf.

enrollment, such as strong outreach to insurers and employers, broker engagement and the value-added benefits and services that can be offered through the SHOP Exchange.

Insurer Tax

A new insurer tax equal to $8 billion in 2014 and increasing to $14 billion in 2018 will be allocated across all insurers based on net premiums written. Our analysis indicates that the value of this new tax as a percent of premium will be as follows and we have incorporated these increases into the projected premiums in both the individual and small group markets:

Year	Insurer tax as a % of premium
2014	2.10%
2015	2.70%
2016	2.70%
2017	3.30%
2018	3.30%

Inertia Factor

A 10% inertia factor was used in the model. This factor requires that the utility associated with any source of coverage evaluated be at least 10% greater than the utility associated with the HIU's current source of coverage in order for them to make a change to the new coverage status.

Modeling Results

We used the Oliver Wyman HRM Model to address several questions related to the design and operation of the individual and SHOP Exchanges. As previously described, the model is based upon the assumption that consumers will select the option that maximizes the utility for the HIU. Employers' decisions to offer or continue offering coverage is based on a demand elasticity curve. Significant rate shock for some small groups and individuals in the State will result in dropped coverage or movement among coverage levels in the new market, as healthier consumers react to premium increases associated with the new rating rules. Other consumers who are currently not covered may be attracted to the marketplace as premiums become more affordable for them, or as financial penalties associated with the individual mandate reduces the utility associated with remaining uninsured. Finally, other consumers, many of whom will be newly eligible for Medicaid, will leave the insurance market to participate in that program.

Connecticut asked us to address, among other things, the impact of merging the small group and individual markets, and changing the definition of small group from 50 to 100 prior to 2016. A merger of the small group and individual markets would require carriers to blend the experience in the two markets for the purposes of premium development and to apply a consistent set of rating rules. Carriers doing business in one market would by default be required to participate in both. The PPACA defines small group as employers with up to 100 employees, but it offers the option to use the State's current definition of up to 50 employees for plan years

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

beginning in 2014 and 2015. The first scenario that follows presents the results in the case where separate pools are maintained for the individual and small group markets, and the small group definition remains at 50. We refer to this as our baseline reform scenario.

Baseline Reform Scenario

In the baseline reform scenario separate individual and small group markets are maintained, and the definition of small group remains at 50 until 2016. The table below presents the modeled enrollment and premiums in the individual and small group markets, both inside and outside the Exchange. While premium subsidies are considered in the model, the premiums shown in the following table are prior to reduction for any subsidies and, therefore, reflect total premium dollars flowing to insurers.

It should be noted that a variety of factors and influences will affect how the State's enrollment and premiums develop between 2011 and 2014, and beyond. The results shown here will be different from actual results to the extent that experience emerges differently than the assumptions used. These results should be considered point estimates within a wide range of possible outcomes. In particular, longer projection timeframes introduce greater uncertainty so the projections for later years are even more uncertain than those for the earlier years in the projections.

Baseline Scenario

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2010	0	$0	$0	0	$0	$0	0	$0	$0
2014	41,050	$5,500	$225,972,000	187,100	$4,650	$872,294,000	228,150	$4,800	$1,098,266,000
2015	40,300	$5,700	$222,036,000	193,200	$5,000	$970,296,000	233,500	$5,100	$1,192,332,000
2016	44,600	$5,900	$262,720,000	198,450	$5,350	$1,065,615,000	243,050	$5,450	$1,328,335,000
2017	44,150	$6,200	$273,991,000	198,800	$5,850	$1,167,051,000	242,950	$5,950	$1,441,042,000
2018	44,000	$6,500	$286,726,000	200,500	$6,200	$1,241,579,000	244,500	$6,250	$1,528,305,000

	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2010	263,150	$5,000	$1,320,041,000	117,050	$3,350	$392,319,000	380,200	$4,500	$1,712,360,000
2014	173,200	$5,550	$962,169,000	142,750	$5,000	$710,663,000	315,950	$5,300	$1,672,832,000
2015	167,400	$5,650	$945,205,000	148,450	$5,300	$785,643,000	315,850	$5,500	$1,730,848,000
2016	259,450	$6,150	$1,591,252,000	157,350	$5,650	$890,159,000	416,800	$5,950	$2,481,411,000
2017	257,600	$6,450	$1,664,275,000	161,850	$6,150	$999,377,000	419,450	$6,350	$2,663,652,000
2018	256,700	$6,800	$1,744,495,000	163,850	$6,550	$1,075,171,000	420,550	$6,700	$2,819,666,000

	Connecticut Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2010	263,150	$5,000	$1,320,041,000	117,050	$3,350	$392,319,000	380,200	$4,500	$1,712,360,000
2014	214,250	$5,550	$1,188,141,000	329,850	$4,800	$1,582,957,000	544,100	$5,100	$2,771,098,000
2015	207,700	$5,600	$1,167,241,000	341,650	$5,150	$1,755,939,000	549,350	$5,300	$2,923,180,000
2016	304,050	$6,100	$1,853,972,000	355,800	$5,500	$1,955,774,000	659,850	$5,750	$3,809,746,000
2017	301,750	$6,400	$1,938,266,000	360,650	$6,000	$2,166,428,000	662,400	$6,200	$4,104,694,000
2018	300,700	$6,750	$2,031,221,000	364,350	$6,350	$2,316,750,000	665,050	$6,550	$4,347,971,000

Covered lives are rounded to the nearest 50; annual average premium are rounded to the nearest $100; Total premium are rounded to the nearest $1,000

Key observations for calendar year 2014 when employing the assumptions previously described include:

- Enrollment in the State's individual market is projected to increase by a factor of 2.82 between 2010 and 2014, with 60% of covered individuals enrolled in the individual Exchange, and 75% of those in the individual Exchange receiving subsidies.

- Enrollment in the State's small group market is projected to decline by approximately 18% between 2010 and 2014, to 214,250 members, with roughly 19% of covered individuals enrolled in the SHOP Exchange. More than half of the members projected to enroll in the

SHOP Exchange are employed by small employers eligible for the temporary small business tax credit.

- The small group market will increase by almost 100,000 members in 2016 when the definition of small group is increased to 100; however, the enrollment in the SHOP Exchange will only increase by roughly 4,000 members.

- The uninsured population in 2014 is projected to be roughly 40% of the 2010 level, decreasing to roughly 149,000 individuals.

Premiums are projected to change in 2014 for several reasons. In addition to increases for medical trend, required increases in benefits and new taxes and assessment, premiums for each market will adjust based on the individuals that enroll in the market. As members change markets, their claims morbidity moves with them and impacts premiums in the market to which they migrate.

- Average premiums on a per capita basis in the small group market are projected to increase by 11% from $5,000 in 2010 to $5,550 in 2014. Increases due to medical trend, required increases in benefits covered, and new taxes and assessments combine to increase premiums by 29%. Changes in demographics, the average morbidity of those enrolled and benefit buy-downs made by employers lead to a decrease in premiums of roughly 14%. The result is an overall change of 11%.

- Average premium on a per capita basis in the individual market prior to application of premium subsidies are projected to increase by 43% from 2010 to 2014, from $3,350 to $4,800. In addition to increases due to medical trend, additional covered benefits as a result of the EHB package and new taxes and assessments, this change reflects changes in demographics, benefit plan changes and changes in the average morbidity of those enrolled. Required increases due to the EHB package (i.e., primarily the required increase to an actuarial value of at least 0.60) account for roughly 30% of the increase in premiums, or 13%. The average morbidity of the individual pool is projected to increase by roughly 12% in 2014 primarily due to the influx of individuals who were previously uninsured. The remaining difference is due to medical trend (a 25% increase). The remaining changes (a 10% decrease) come from changes in demographics and the fact that individuals receiving subsidies in the Individual Exchange are modeled to enroll in a Silver plan, which is a higher average benefit than is found in the individual market today.

Enrollment Projection Variation

The enrollment used for Task 7 dealing with financing the Exchange assumes a more gradual ramp-up than has been assumed in addressing the issues here in Task 4. This was done for conservatism. The enrollment projections used in Task 7 reach the levels projected in Task 4 by 2016. We show this in the following table:

Exchange Enrollment Projections

Year	Task 4 enrollment	Task 7 enrollment
2014	228,150	124,755
2015	233,500	192,000
2106	243,050	243,000

TASK 4a – To Integrate High Risk Pools in the Non-group Market or Maintain High Risk Pools Separately

Background

The State's HRA, the State's high risk pool, is among the oldest high risk pools in the country. Eligibility for the HRA generally requires the individual to have been without health insurance coverage for 150 days or to have lost employer coverage.[1] The HRA makes available a plan for low-income individuals where providers are paid at 75% of Medicare reimbursement.

The HRA is funded through a combination of premiums, assessments and federal grants. By statute, premiums under the HRA are set to be equal to no less than "125% nor more than 150% of the average group rate charged for that classification or group with similar characteristics under a policy covering 10 lives."[2] In 2010, premiums were set at the top end of the range.[3] Assessments are made against HRA member companies (commercial carriers and stop-loss carriers). The HRA also includes an option for low-income insureds, the Special Health Care Plan, which pays providers 75% of Medicare reimbursement to keep premiums affordable. At calendar year-end 2010, roughly 20% of the HRA insureds were enrolled in the Special Health Care Plan.[4]

At the end of 2010, the HRA had 1,870 active covered lives. The State is also operating a Temporary High Risk Insurance Pool Program. The program was effective on July 1, 2010. At year-end 2010, the program covered 72 lives.[5] For the purpose of this analysis, we are ignoring this program due to its small size. In addition, the Temporary High Risk Insurance Pool Program will expire December 31, 2013.[6]

In Table 4a-1, we provide information from HRA's 2010 audited financial statements. These data show that in 2010, premiums accounted for 65% of total funding, member assessments accounted for 33% of funding and federal grants and awards contributed 3% towards total funding. Premiums were $21.7 million, and claims were $31.2 million.

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[1] http://www.hract.org/hra/Brochures/brochures.htm.

[2] Connecticut General Statute Chapter 700c, 38a-556c.

[3] Private communications with Pool Administrators, Inc., the organization administering the HRA

[4] Ibid.

[5] Ibid.

[6] PPACA Sec. 1001(a).

Table 4a-1

Health Reinsurance Association
2010 Statutory Financial Statements
Change in Members' Accountability

			Relative to Revenue	Relative to Premium
Premiums and Other Revenues	$	21,667,596	0.646	1.000
Federal Grants and Awards		913,605	0.027	0.042
Member Assessments		10,956,402	0.327	0.506
Total Income	$	33,537,603	1.000	1.548
Health Benefits	$	31,171,224		1.439
Administrative Expenses		2,128,236		0.098
Total Expenses	$	33,299,460		1.537
Change in Members' Accountability	$	238,143		

Source: 2010 Statutory Statement of Operations

The loss ratio shown in the table above is 1.439. If premiums were adjusted to 100% of the standard rate by dividing by 150% and claims were increased to 100% of commercial claims by increasing claims by 20% to account for the low provider reimbursement under the Special Health Care Plan, the loss ratio would increase to 2.588.[7]

In 2010, total premiums in the individual market were $362.5 million, and incurred claims were $251.3 million.[8]

Modeling Results

To model the effects of rolling the HRA membership into the individual market, we started with the experience in the individual market, and we adjusted this experience for the expected growth in the individual market and the expected increase in morbidity in the individual market that we describe in Task 4d. We then include the experience of the HRA adjusted to commercial premiums and reimbursement.

[7] 2.588 = $31.2 million claims x 1.20 / ($21.7 million premium / 1.50).

[8] Oliver Wyman summaries of the 2010 statutory Supplemental Health Care Exhibits.

We show the results of this exercise in Table 4a-2.

Table 4a-2

Impact of Enrolling High-Risk Pool Members into the Individual Market in 2014
($1,000,000s)

	Premium	Claims	Loss Ratio
Current Individual Market	$ 362.5	$ 251.3	0.693
Individual Market Expansion 2014	2.8	2.8	
Morbidity Adjustment	NA	1.12	
Current Market Projected to 2014	$ 1,015.0	$ 788.1	0.776
High Risk Pool at Standard Risk Rates and Reimbursement	14.5	37.4	2.588
Combined Market	$ 1,029.5	$ 825.5	0.802
Premium Increase	0.2%		
Combined Market After Premium Increase	$ 1,031.9	$ 825.5	0.800
HRA Assessment	$ (11.0)		
Premium After Assessment	$ 1,020.9		
Premium Increase including Assessments	-1%		

The loss ratio in the individual market was 0.693 in 2010.[9] We grow the market by a factor consistent with our modeling results and our expectation that the number of individuals insured in the individual market will increase significantly in response to the mandate for coverage and the penalty. In particular, we expect the number of individuals insured in the individual market to increase in response to the subsidies that will be available in the individual market. We also increase claims by a factor of 1.12, reflecting the fact that those new enrollees will have higher morbidity. This results in premium of roughly $1 billion and a loss ratio of 0.802. This represents the expected size and morbidity of the individual market in 2014, but at 2010 price levels.

We then add the 2010 HRA experience to the expected individual experience, after the HRA experience has been adjusted to commercial premiums and commercial provider reimbursement. This assumes the size of the HRA will remain constant between 2010 and 2014. We note that, for the purposes of this analysis, this is a conservative assumption as the HRA

[9] This is using the traditional definition of loss ratio – incurred claims over premium. Elsewhere in this report, we use the definition of loss ratio required under the Patient Protection and Affordable Care Act which allows certain taxes and fees to be excluded from premium, and it allows expenses related to quality improvement to be included in claims.

enrollment has been declining over time.[10] The result is a loss ratio of 0.802, an increase of 2.6 percentage points.

Finally, we show the $11 million HRA assessment. If this assessment were continued, premiums in the individual market could be reduced by 1%.

Considerations

It is likely that the HRA enrollees will migrate to the individual market in 2014. Premiums will be lower in the individual market than in the HRA, and these enrollees will have guaranteed access to coverage. In addition, they may be eligible for premium and cost sharing subsidies based on income.

The HRA enrolled population is very small relative to the expected individual market in 2014, and it would likely contribute less than 2% of premium. So, while claims are considerably higher than premium, adding these enrollees to the individual market would increase the loss ratio by 2.6 percentage points.

The PPACA includes a transitional reinsurance program that is meant to stabilize premiums in the individual market.[11] This program will make payments to health insurers insuring high risk individuals in the individual market. It will be financed through a broad-based assessment on insurers and self-insured plans, and it will bring $10 billion into the individual market nationwide. This program will serve a purpose similar to the one the HRA currently serves, in that this program will bring funds in from market participants in 2014 through 2016 to support the high health care costs of individuals who may have been considered uninsurable in the current environment.

The State does have the option of continuing the HRA assessment. However, it may be difficult to have the assessments follow the high risk member given privacy and other concerns. Even so, it may be possible for the state to use the assessment to supplement the payments from the transitional reinsurance program with lower stop-loss limits or higher coinsurance amounts for people who were previously insured in the HRA. The State would have to devise an alternative means of calculating the assessment in 2014 and beyond.

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[10] Comprehensive Health Insurance for High Risk Individuals: A State-by-State Analysis: 2010/2011, National Association of State Comprehensive Health Insurance Plans.

[11] PPACA Sec. 1341.

TASK 4b – Advantages and Disadvantages of Expanding the Definition of Small Group from 50 to 100 Employees Prior to 2016

Background

Connecticut defines small groups as those with 1 to 50 employees.[1] The PPACA defines small employers as those with up to 100 employees, but gives states the option to define small employers as those with up to 50 employees until January 1, 2016.[2]

In Table 4b-1, we show the number of employers with employees working in Connecticut, the number of individuals employed nationwide by these employers, and the number of employees working in Connecticut. There are 1,901 mid-sized firms with employees in Connecticut compared to 239,680 small firms, and there are 116,000 employees in Connecticut employed by mid-sized firms compared to 820,439 employed by small firms.

Table 4b-1

Employers with Employees in Connecticut by Group Size

Firm Size	Number of Firms	Nationwide Employees	Connecticut Employees
1 - 1	86,816	86,816	86,777
2 - 4	114,737	274,857	274,408
5 - 9	20,582	128,357	127,120
10 - 19	10,353	131,679	127,967
20 - 50	7,192	217,455	204,167
Subtotal 1-50	239,680	839,164	820,439
51 - 74	1,006	61,910	50,367
75 - 100	895	78,915	65,635
Subtotal 51-100	1,901	140,825	116,002
Total	241,581	979,989	936,441

Source: Oliver Wyman calculations using Dunn & Bradstreet data

Premium rates in the small group market are calculated on the basis of modified community rating, and they can only vary based on a given group's demographic makeup. Allowable factors include such things as age, gender and family size. Using claims experience or the presence of

[1] Connecticut Statutes, Chapter 700c, Sec. 38a-564.

[2] PPACA Sec. 1304(b)(2).

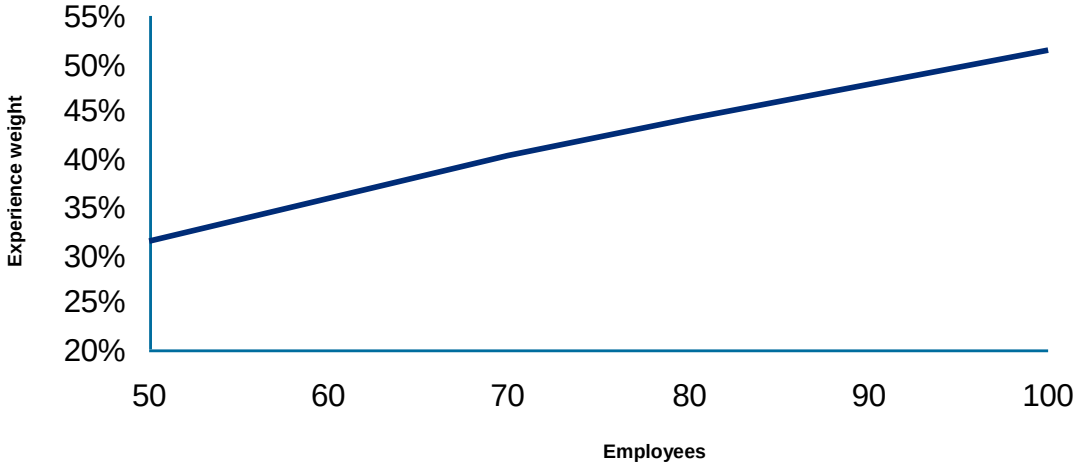
Please reference Section 2 of this report, *Health Care Reform Disclosures.*

chronic conditions in developing premiums for small groups is not allowed. In addition, in the small group market coverage is guarantee issued. That is, if employers meet the requisite criteria and request coverage from a carrier, they must be offered coverage. Finally, coverage in the small group market is guaranteed renewable.[3]

In contrast to the small group market, premiums in the mid-group market are based on the employer's experience. In the following Chart 4b-1, we show the percentage of weight that one carrier in Connecticut places on the group's own experience in developing premiums.[4]

Chart 4b-1

Own experience weight by group size
Connecticut carrier example



At 51 employees, the group's own experience receives roughly 30% of the weight. At 100 employees, the group's own experience receives roughly 50% of the weight. The rest of the weight is assigned to a "manual rate". The manual rate is specific to a given employer and typically based on the carrier's entire book of business, adjusted to reflect factors such as the age, gender, industry and geography of the employees covered under the employer's plan.

The PPACA will introduce additional incentives for groups to self-insure their health benefits, beyond those which currently exist. The PPACA includes an annual tax on health insurance providers that begins in 2014 at $8 billion and increases thereafter.[5] These fees are estimated to increase premiums by roughly 2%.[6] More significantly, a move to modified community rating

[3] Connecticut Statutes, Chapter 700c, Sec. 38a-567.

[4] Rate filings available at http://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx.

[5] PPACA Sec. 9010.

[6] Carlson, Chris, "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans," October 31, 2011. http://www.ahipcoverage.com/2011/11/02/new-technical-analysis-of-impact-of-premium-tax/.

would likely push some of the healthiest mid-sized groups to self-insure to avoid subsidizing the claims of less healthy groups.

In addition, we note that self-insuring in Connecticut is allowed at relatively low attachment points, meaning that groups that choose to self-insure their medical programs do not necessarily need to assume significant risk.[7] Further, under the proposed federal regulations, the SHOP Exchange must "permit a qualified employer to purchase coverage for its small group at any point during the year."[8] This could result in a situation where employers with relatively young, healthy workers self-insure their medical programs when it is financially advantageous for them to do so, and then, purchase coverage in the SHOP Exchange if and when their claims experience deteriorated and self-insurance no longer represented the lowest cost option. This adverse selection would not be an issue only for the SHOP Exchange, but would be an issue for the small employer market as a whole, as carriers have to base premium on the pooled experience from inside and outside of the Health Insurance Exchange (Exchange).

Modeling Results

We used our HRM model to evaluate the expansion of the small group market on the SHOP enrollment. We show the results in Chart 4b-2 below.

Chart 4b-2

SHOP Exchange enrollment

With and without groups to 100

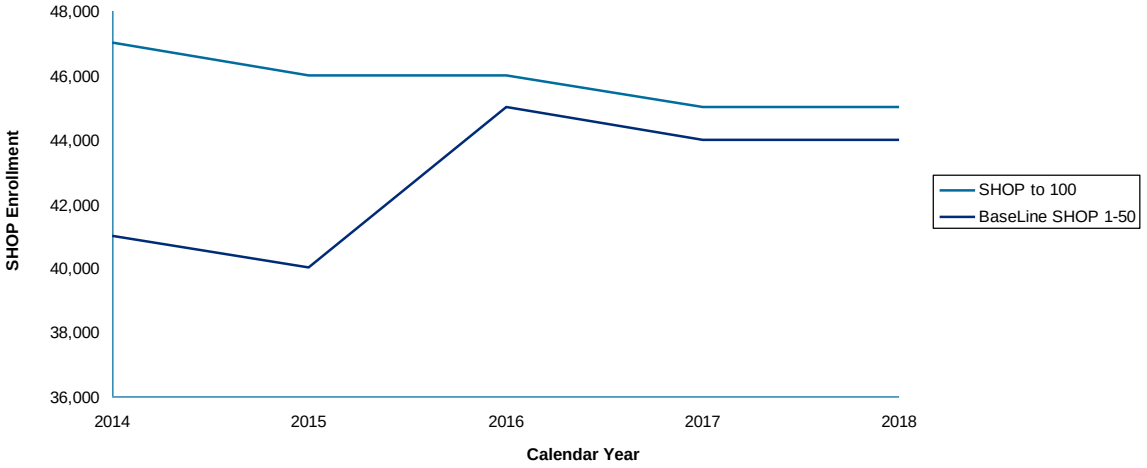


Chart 4b-2 shows that roughly 6,000 more insureds would be covered under the SHOP Exchange if Connecticut were to open the SHOP Exchange to mid-sized groups before it is required in 2016.

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[7] Connecticut Insurance Department Bulletin Number PC-11 & HC44 requires that the employer's retention must be "at least $6,500 per individual or family."

[8] 45 CFP §155.725.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Considerations

The advantages of opening the SHOP to mid-sized employers before 2016 would include the following:

- A moderate increase in the number of enrollees in the SHOP Exchange over which to spread fixed costs
- Potential access to lower cost insurance for mid-sized groups with high morbidity
- Potentially greater interest in participating in the SHOP.

Disadvantages of opening the SHOP Exchange to mid-sized employers prior to 2016 would include the following:

- It would require the state to accept the PPACA's definition of small employer for the operation of its insurance markets outside of the SHOP Exchange. This would subject all mid-sized employers to the PPACA's modified community rating laws in 2014 which would, in turn, introduce significant premium rate disruption relative to the current market. Keep in mind, small group law currently requires premiums based on modified community rating; premiums in the mid-sized employer market are based, at least in part, on a group's own experience.
- There would also be the potential for deterioration in the morbidity of the fully-insured small employer pool as mid-sized employers with relatively healthy work forces could self-insure until their experience deteriorated and it became financially advantageous to enroll in the SHOP Exchange.

TASK 4c – Impact of an Exchange on Employer-provided Insurance and, Specifically, the Impact of Employer Penalties and Tax Credits by the Different Scenarios

Background

The Patient Protection and Affordable Care Act (PPACA) includes both tax credits for small employers with low-wage workers[1] and tax penalties for large employers.[2]

Small Employers

If an employer has fewer than 50 full-time equivalent employees, penalties do not apply for not providing coverage, but there is a tax credit to incentivize small employers with lower wage workers to provide health insurance. The tax credit is a portion of the premiums paid by the employer, subject to the limitation that premiums can be no more than the state average.

This tax credit is already in operation. For the 2010 and 2011 tax years, the average annual premium for the Connecticut small group market was $5,419 for 2010 and $5.640 for 2011 for single coverage; $13,484 for 2010 and $14,096 for 2011 for family coverage.[3] The maximum tax credit for tax years 2010 and 2011 is 25% of the premium (limited to the state average) for tax exempt employers and 35% for other (taxable) employers. For 2014, the first year of Health Insurance Exchange (Exchange) operation, these percentages increase to 35% for tax-exempt organizations and 50% for other (taxable) employers. For those employers that elect it for tax year 2014, the tax credit continues for 2015 at the 2014 level, but then it expires so that there is no tax credit for tax year 2016.

The tax credit in all years is affected by the size of the employer and the average wage paid. Employers with ten or fewer full-time equivalent employees have no size-based reduction. For each additional employee over ten, there is a reduction of one-fifteenth, until the tax credit is eliminated for an employer of 25 full-time equivalent employees. There is also a reduction based on average wage. If the average annual wage is $25,000 or less, there is no reduction. The tax credit is reduced as the average wage increases, reaching zero at $50,000. See the graph and numerical chart below for how the reductions are combined. As an example, an employer with 13 full-time equivalent employees has a tax credit that is 80% of the maximum (for employers of

[1] PPACA Sec. 1421

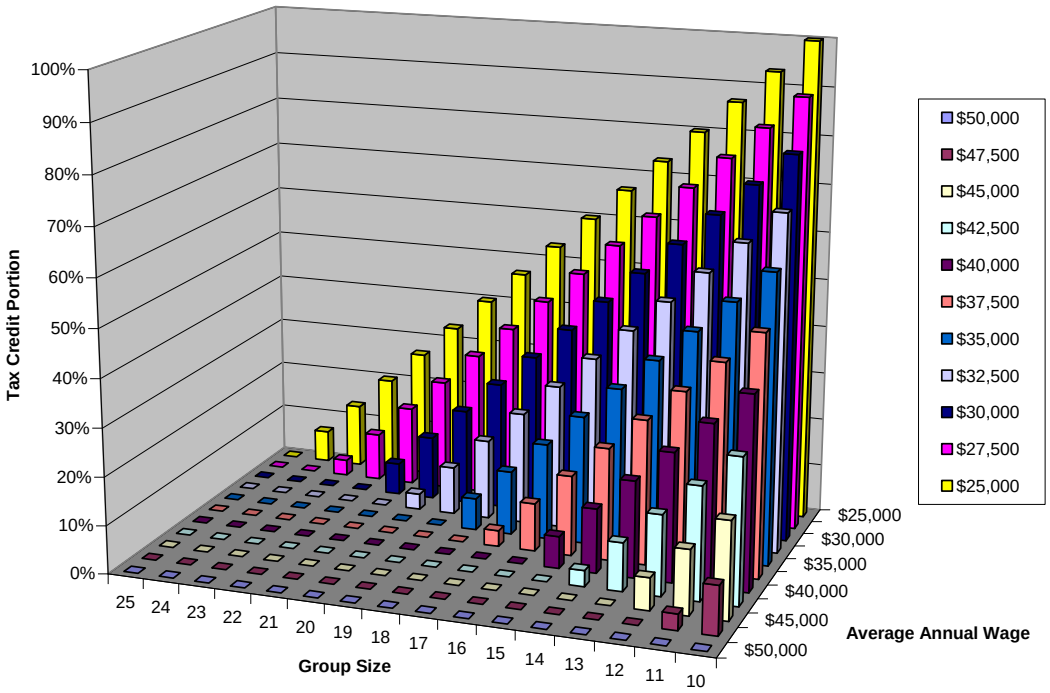
[2] PPACA Sec. 1513

[3] IRS Code, Part 1, Section 45R, available at www.irs.gov/pub/irs-drop/rr-10-13.pdf

ten or fewer) if the average annual wage is $25,000 but is reduced to $0 if the average annual wage is $45,000 or more.

Chart 4c-1

Federal Income Tax Credit for Small Employer Health Premiums



	Number of Full-time Equivalent Employees					
Average Annual Wage	**10**	**13**	**16**	**19**	**22**	**25**
$25,000	100%	80%	60%	40%	20%	0%
$27,500	90%	70%	50%	30%	10%	0%
$30,000	80%	60%	40%	20%	0%	0%
$32,500	70%	50%	30%	10%	0%	0%
$35,000	60%	40%	20%	0%	0%	0%
$37,500	50%	30%	10%	0%	0%	0%
$40,000	40%	20%	0%	0%	0%	0%
$42,500	30%	10%	0%	0%	0%	0%
$45,000	20%	0%	0%	0%	0%	0%
$47,500	10%	0%	0%	0%	0%	0%
$50,000	0%	0%	0%	0%	0%	0%

Scenarios 1 and 2 shown on the next page are for small employers who have the size and average wage that would make them eligible for the small employer tax credit for health insurance premiums. Each scenario shows the financial effect of providing health insurance, including the effect of the tax credit, as compared to not providing health insurance. The employer in Scenario 1 has 13 full-time employees and receives a larger percentage of premium tax credit than the Scenario 2 employer with 22 employees and a lower average annual wage.

Scenarios for Small Employer Tax Credits

		Scenario 1: Tax Year 2014		Scenario 2: Tax Year 2014	
A	Coverage offered?	Yes	No	Yes	No
B	Full-time equivalent employees	13	13	22	22
C	Average annual wage	$ 35,000	$ 35,000	$ 27,500	$ 27,500
D=BxC	Total annual wages	$ 455,000	$ 455,000	$ 605,000	$ 605,000
E	Single coverage annual premium	$ 6,000		$ 6,000	
F	Family coverage annual premium	$ 15,000		$ 15,000	
G	Single coverage employer dollars and % of premium	$ 4,500 75%		$ 4,500 75%	
H	Family coverage employer dollars and % of premium	$ 9,000 60%		$ 9,000 60%	
I	Single coverage employees	7		12	
J	Family coverage employees	6		10	
	Employee contribution and % of average wage				
K=E−G	Single coverage = K/C	$ 1,500 4.3%		$ 1,500 5.5%	
L=F−H	Family coverage = L/C	$ 6,000 17.1%		$ 6,000 21.8%	
M=IxG+JxH	Employer premium dollars paid	$ 85,500	$ 0	$ 144,000	$ 0
N=M/B	Average employer dollars per employee	$ 6,577	$ 0	$ 6,545	$ 0
	Tax credit for taxable employers				
O	Maximum percentage irrespective of size or wages	50%		50%	
P=MxO	Maximum dollar amount	$ 42,750	$ 0	$ 72,000	$ 0
Q	Portion payable due to size and average annual wage	40%		10%	
R=PxQ	Calculated tax credit	$ 17,100		$ 7,200	
S=M−R	Employer premium paid net of tax credit	$ 68,400	$ 0	$ 136,800	$ 0

The tax credit for small employers will have a limited effect in maintaining levels of employer-provided insurance. Its main benefit goes to employers who pay low wages and are small (ten or fewer full-time employees or close to ten employees). Also, the tax credit may only be taken for two consecutive years after tax year 2013.

Large Employer

The PPACA provides for penalties on employers with 50 or more full-time equivalent employees. A full-time employee is one who, with respect to any month, is employed an average of at least 30 hours per week. These employer shared responsibility penalties are not tax deductible as a business expense. The penalties for 2014 apply to any one of the following situations:

- An employer that does not offer coverage to its employees
- An employer that offers coverage, but the coverage is not Bronze level or better (paying for 60% or more of covered medical expenses for a typical employee and dependent group)
- An employer that offers Bronze level coverage or better, but requires employees to contribute more than 9.5% of their wages to be enrolled in single coverage

Large Employer with no Coverage Offered

If an employer does not offer coverage of any level, there is a penalty if at least one employee receives a premium tax credit or cost sharing subsidy in the Exchange. The 2014 penalty is $2,000 for each full-time employee after the first 30, for which there is no penalty. Each year the penalty per employee increases as insurance premiums grow. For 2014, the average cost of single coverage in Connecticut will be in the neighborhood of $6,000 per year (the average premium in 2011 for small group coverage is $5,640[4]). Employers typically pay 50% or more of the cost of coverage. The $2,000 penalty is well under 50% of the cost of single coverage and much less than the cost of family coverage (around $15,000 or 250% of the cost of single coverage.)

Scenarios 3 and 4 shown on the following page are for employers with 50 and 80 full-time employees, respectively. The scenarios show the effect of providing health insurance compared to not providing it (and being subject to the shared responsibility penalty). Each scenario shows the financial effect of providing health insurance, including the effect of the state and federal income tax, with state income tax being deductible for federal income tax purposes. While health insurance premiums are deductible for computing taxable income, the shared responsibility penalties are not deductible, so the scenarios show the premium payments reduced to their after-tax effect for comparison to the non-deductible penalties.

[4] Per IRS calculations

Scenarios for Large Employer No Coverage Offered

		Scenario 3: Tax Year 2014		Scenario 4: Tax Year 2014	
A	Coverage offered?	Yes	No	Yes	No
B	Full-time equivalent employees	50	50	80	80
C	Average annual wage	$ 35,000	$ 35,000	$ 40,000	$ 40,000
D=BxC	Total annual wages	$ 1,750,000	$ 1,750,000	$ 3,200,000	$ 3,200,000
E	Single coverage annual premium	$ 6,000		$ 6,000	
F	Family coverage annual premium	$ 15,000		$ 15,000	
G	Single coverage employer dollars and % of premium	$ 4,500 75%		$ 4,500 75%	
H	Family coverage employer dollars and % of premium	$ 9,000 60%		$ 9,000 60%	
I	Single coverage employees	28		44	
J	Family coverage employees	22		36	
	Employee contribution and % of average wage				
K=E−G	Single coverage = K/C	$ 1,500 4.3%		$ 1,500 3.8%	
L=F−H	Family coverage = L/C	$ 6,000 17.1%		$ 6,000 15%	
M=IxG+JxH	Employer premium dollars paid	$ 324,000	$ 0	$ 522,000	$ 0
	Penalty for not providing any medical coverage				
N	Amount per employee		$ 2,000		$ 2,000
O=B−30	Number of employees for which penalty applies		20		50
P=NxO	Total penalty dollars		$ 40,000		$ 100,000
Q=M/B	Average employer premium dollars per employee	$ 6,480	$ 0	$ 6,525	$ 0
R=Mx0.6013	Employer premium dollars paid, reduced by:	$ 194,805		$ 313,853	
	7.5% marginal rate for state income tax, and				
	35.0% marginal rate for federal income tax				
S=R/B	Average after tax employer premium per employee	$ 3,896	$ 0	$ 3,923	$ 0
T=P/B	Average penalty dollars per employee (all employees)	$ 0	$ 800	$ 0	$ 1,250
U=S/T	After tax employer premium paid plus penalty	$ 3,896	$ 800	$ 3,923	$ 1,250

The presence of the penalty does not provide sufficient incentive for employers to provide coverage. Any employers who were not providing coverage prior to the implementation of the penalty would likely continue to refrain from providing coverage and pay the penalty. The average penalty per person is less for smaller employers (near 50 employees) because the penalty does not apply to the first 30 employees. For example, an employer with 80 employees would have a penalty of $2,000 times 50, or $100,000 – only $1,250 per employee, on average, for the 80 employees.

Large Employer Who Offers Coverage Below Bronze Level

If an employer does offer coverage but that coverage has an actuarial value less than 60% of the total allowed benefit costs (the allowed amount being the amount before deductibles, coinsurance and copays are applied), then there is a penalty. The 2014 penalty is $3,000 for each full-time employee receiving a tax credit (which varies by their income) to purchase coverage in the Exchange. There is also a limit on this penalty of $2,000 per full-time employee after the first 30, the same penalty as for not offering coverage at all. Each year the penalty per employee increases as insurance premiums grow.

Scenarios 5 and 6 shown below are for employers with 50 and 80 full-time employees, respectively, the same as Scenarios 3 and 4. Scenarios 5 and 6 show the effect of providing health insurance of Bronze level compared to not providing coverage with a benefit value below Bronze level (and being subject to the shared responsibility penalty). Each scenario shows the financial effect of providing health insurance, including the effect of the state and federal income tax, with state income tax being deductible for federal income tax purposes. While health insurance premiums are deductible for computing taxable income, the shared responsibility penalties are not deductible, so the scenarios show the premium payments reduced to their after-tax effect for comparison to the non-deductible penalties.

Scenarios for Large Employer, Coverage Offered but Below Bronze Level

		Scenario 5: Tax Year 2014				Scenario 6: Tax Year 2014			
A	Bronze or better coverage offered?	Yes		No		Yes		No	
B	Full-time equivalent employees	50		50		80		80	
C	Average annual wage of full-time employees	$ 35,000		$ 35,000		$ 40,000		$ 40,000	
D=BxC	Total annual wages	$ 1,750,000		$ 1,750,000		$ 3,200,000		$ 3,200,000	
E	Single coverage annual premium	$ 6,000		$ 4,800		$ 6,000		$ 4,800	
F	Family coverage annual premium	$ 15,000		$ 12,000		$ 15,000		$ 12,000	
G	Single coverage employer dollars and % of premium	$ 4,500	75%	$ 3,600	75%	$ 4,500	75%	$ 3,600	75%
H	Family coverage employer dollars and % of premium	$ 9,000	60%	$ 7,200	60%	$ 9,000	60%	$ 7,200	60%
I	Single coverage employees	28		20		44		33	
J	Family coverage employees	22		15		36		27	
	Employee contribution and % of average wage								
K=E−G	Single coverage = K/C	$ 1,500	4.3%	$ 1,200	3.4%	$ 1,500	3.8%	$ 1,200	3.0%
L=F−H	Family coverage = L/C	$ 6,000	17.1%	$ 4,800	13.7%	$ 6,000	15.0%	$ 4,800	12.0%
M=IxG+JxH	Employer premium dollars paid	$ 324,000		$ 180,000		$ 522,000		$ 313,200	
	Penalty for not providing Bronze level or better coverage								
N	Penalty amount per employee			$ 3,000				$ 3,000	
O=B−I−J	Number of employees for which penalty applies			15				20	
P=NxO	Total penalty dollars before limit			$ 45,000				$ 60,000	
P1=P in sc 3,4	Amount of penalty for not offering any coverage			$ 40,000				$ 100,000	
P2=min(P,P1)	Total penalty dollars after application of limit			$ 40,000				$ 60,000	
Q=M/B	Average employer premium dollars per employee	$ 6,480		$ 3,600		$ 6,525		$ 3,915	
R=Mx0.6013	Employer premium dollars paid, reduced by:	$ 194,805		$ 108,225		$ 313,853		$ 188,312	
	7.5% marginal rate for state income tax, and								
	35.0% marginal rate for federal income tax								
S=R/B	Average after tax employer premium per employee	$ 3,896		$ 2,165		$ 3,923		$ 2,354	
T=P2/B	Average penalty dollars per employee (all employees)	$ 0		$ 800		$ 0		$ 750	
U=S/T	After tax employer premium paid plus penalty	$ 3,896		$ 2,965		$ 3,923		$ 3,104	

Larger (50+ full-time equivalent employees) that offer coverage that is less than Bronze level are expected to be so few in number that the Congressional Budget Office did not, in its March 20, 2010 estimate of the effect of the then-proposed PPACA, publish an estimate of the number of persons expected to obtain credits because their employer sponsored benefit plan did not provide minimum value coverage. For any employers that offer coverage that is less than the minimum value requirement, the presence of the penalty does not provide sufficient incentive for employers to offer coverage that complies with the minimum value requirement, unless the employer could increase its benefit plan to Bronze value for less than the amount of the penalty. In the Scenarios 5 and 6 shown above, the penalty dollars add to the employer cost of not providing Bronze coverage, but that addition is less than the insurance premium that the employer avoids because those employees go to the Exchange rather than get coverage through the employer-sponsored benefit plan. Any employers who were not providing coverage at a 60% value or better would likely refrain from enhancing their coverage and pay the penalty, except for those for which the penalty would exceed the cost of moving their benefit plan up to Bronze coverage. Employers who did not want to bring their coverage up to Bronze level could elect to offset the cost of the penalty by further reducing their coverage's value.

Large Employer Who Offers Coverage That Is Not Affordable

If an employer does offer coverage to its full-time employees (for both the employees and their dependents) that pays at least 60% of the total allowed benefit costs, but the employee contribution to participate in the coverage is not affordable, then there is a penalty. The affordability test in PPACA is that the employee contribution cannot exceed 9.5% of the employee's modified adjusted gross income, which is the adjusted gross income *increased* by the following amounts:

- Any amount excluded from gross income as a citizen or resident living abroad
- Any tax-exempt interest received or accrued during the tax year
- Any amount of nontaxable Social Security benefits (per Title IV of PL 112-56, which was enacted November 21, 2011)

However, in the September 13, 2011 Notice 2011-73 the Internal Revenue Service proposed a safe harbor rule for penalties on employers based on the W-2 wages of employees. This proposed safe harbor recognizes that employers do not know their employees' household income, which can include the income of a spouse, investment income, income from other businesses, and adjustments such as alimony paid or received. The safe harbor would apply only for the employer shared responsibility provision; it would not affect the eligibility of the employee for health insurance premium tax credits. The comment period for the proposed rule was scheduled to end on December 13, 2011; the final rule is yet to be published.

The affordability test under the proposed rule is that the employee contribution for single (self-only) coverage cannot exceed 9.5% of the employee's W-2 wages. The 2014 penalty is $3,000 for each full-time employee receiving a tax credit (which varies by the employee's

income) to purchase coverage in the Exchange. There is also a limit on this penalty of $2,000 per full-time employee after the first 30, for which there is no penalty, the same penalty as for not offering coverage at all. Each year the penalty per employee increases as insurance premiums grow.

Scenarios 7 and 8 shown on the following page are for employers with 50 and 80 full-time employees, respectively, the same as Scenarios 3 and 4 and Scenarios 5 and 6. Scenarios 7 and 8 show the effect of providing health insurance of Bronze level or better but with employee contribution that are of a level that either (a) all full-time employees have wages high enough that the employee contribution is affordable or (b) some full-time employees have wages low enough that the contribution is not affordable. The affordability test used in Scenarios 7 and 8 is based on the single coverage contribution and 9.5% of the employee's W-2 wages. (For the low-wage employees, the family coverage contribution is much higher than 9.5% of wages.) Each scenario shows the financial effect of providing health insurance, including the effect of the state and federal income tax, with state income tax being deductible for federal income tax purposes. While health insurance premiums are deductible for computing taxable income, the shared responsibility penalties are not deductible, so the scenarios show the premium payments reduced to their after-tax effect for comparison to the non-deductible penalties.

Scenarios for Large Employer Coverage Offered That Is Bronze Level or Better but Does Not Meet Affordability Threshold

		Scenario 7: Tax year 2014				Scenario 8: Tax year 2014			
A	Meets affordability? (single contribution as % of wages)	Yes		No		Yes		No	
B	Full-time equivalent employees	50		50		80		80	
B1	Full-time employees with low wage so that single	6		6		10		10	
	coverage contribution exceeds 9.5% of wages								
C	Low annual wage B1	$ 20,000		$ 20,000		$ 20,000		$ 20,000	
D	Total wages (unchanged from scenarios 3/4 and 5/6)	$ 1,750,000		$ 1,750,000		$ 3,200,000		$ 3,200,000	
E	Single coverage annual premium	$ 6,000		$ 6,000		$ 6,000		$ 6,000	
F	Family coverage annual premium	$ 15,000		$ 15,000		$ 15,000		$ 15,000	
G	Single coverage employer dollars and % of premium	$ 4,500	75%	$ 3,900	65%	$ 4,500	75%	$ 3,900	65%
H	Family coverage employer dollars and % of premium	$ 9,000	60%	$ 8,400	56%	$ 9,000	60%	$ 8,400	56%
I	Single coverage employees	28		22		44		34	
J	Family coverage employees	22		22		36		36	
	Employee contribution and % of lowest average wage								
K=E−G	Single coverage = K/C	$ 1,500	7.5%	$ 2,100	10.5%	$ 1,500		$ 2,100	10.5%
L=F−H	Family coverage = L/C	$ 6,000	30%	$ 6,600	33%	$ 6,000		$ 6,600	33%
M=IxG+JxH	Employer premium dollars paid	$ 324,000		$ 270,600		$ 522,000		$ 435,000	
	Penalty for not providing affordable coverage								
N	Penalty amount per employee			$ 3,000				$ 3,000	
O=B−I−J	Number of employees for which penalty applies			6				10	
P=NxO	Total penalty dollars before limit			$ 18,000				$ 30,000	
P1=P in sc 3/4	Amount of penalty for not offering any coverage			$ 40,000				$ 100,000	
P2=min (P,P1)	Total penalty dollars after application of limit			$ 18,000				$ 30,000	
Q=M/B	Average employer premium dollars per employee	$ 6,480		$ 5,412		$ 6,525		$ 5,438	
R=Mx0.6013	Employer premium dollars paid, reduced by	$ 194,805		$ 162,698		$ 313,923		$ 261,544	
	7.5% marginal rate for state income tax and								
	35.0% marginal rate for federal income tax								
S=R/B	Average after tax employer premium per employee	$ 3,896		$ 3,254		$ 3,923		$ 3,269	
T=P2/B	Average penalty dollars per employee (all employees)	$ 0		$ 360		$ 0		$ 375	
U=S+T	After tax employer premium paid plus penalty	$ 3,896		$ 3,614		$ 3,923		$ 3,644	

In the Scenarios 7 and 8 shown above, the penalty dollars add to the employer cost of not providing affordable coverage to all full-time employees, but that addition is less than the insurance premium that the employer avoids because those employees go to the Exchange rather than get coverage through the employer-sponsored benefit plan. The presence of the penalty does not provide sufficient incentive for employers to provide coverage that complies with the affordability requirement, unless the employer could meet the affordability threshold for less than the cost of the penalty. This could be accomplished by several different means – reducing employee contributions as a percentage of premium for the same plan, providing a leaner plan (but still Bronze level or higher), so that the employees' percentage contribution is on a lower premium, increasing the wages on some lower-wage employees, or instituting employee contributions that vary by employee wages. Any employers who were not providing affordable coverage would likely maintain their current coverage and just pay the penalty, except for those for which the penalty would exceed the cost of meeting the affordability requirement. Employers who did not want to make their coverage affordable to all employees could elect to offset the cost of the penalty by further reducing their coverage's value.

TASK 4d – Implications of Merging the Markets for Pricing in the Small Group and the Non-group Markets

Background

The PPACA gives states the option to merge their small group and individual markets.[1] A state may make this election at any point in time.

In Connecticut, individual and small group markets function differently in that coverage in the small group market is provided on a guarantee issues basis, and premiums in the small group market are based on a modified community rating technique – a group's claims experience or morbidity cannot be taken into account in the rating process.[2] In the individual market, carriers are allowed to reflect an individual's expected claims in determining premiums, or the carrier may choose not to issue coverage to an applicant based on the applicant's health status. Note that in 2014, the rules for developing premium rates in these two markets will be largely harmonized.

We estimate that morbidity in the current small group market in Connecticut is 5% higher than morbidity in the individual market.

Modeling Results

In 2014, with the influx of the previously uninsured subsidy-eligible population, we estimate that morbidity in the individual market will increase by 12% relative to the current individual market. In our modeling, the morbidity in the small group market does not change significantly between 2010 and 2014. We illustrate this in Chart 4d-1 on the following page, where a value of 1.00 represents the individual market in 2010.

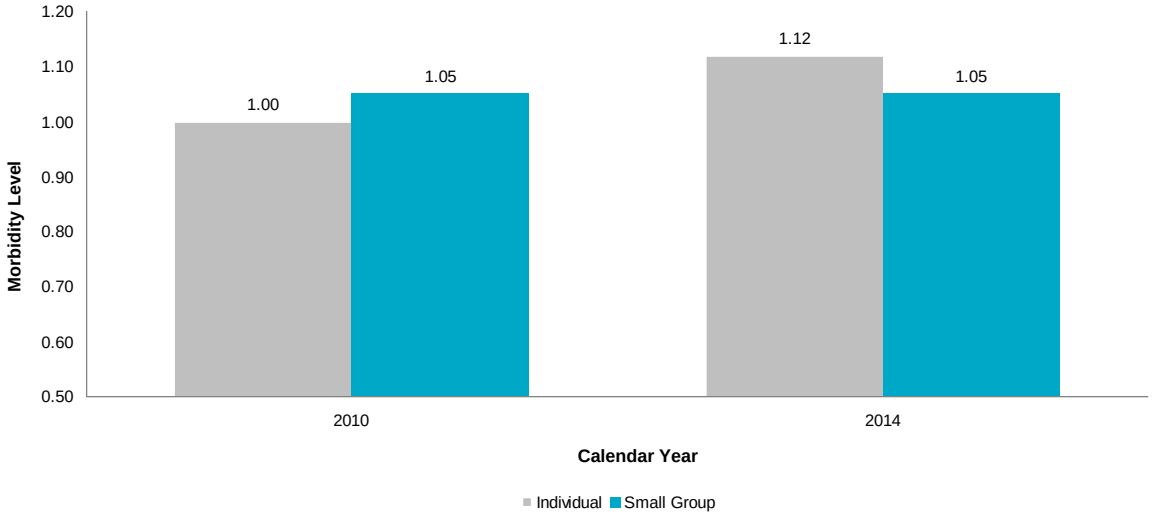
[1] PPACA Sec. 1311

[2] Connecticut Statutes, Chapter 700c, Sec. 38a-564

Chart 4d-1

Morbidity by market – baseline assumptions

1.00 = individual in 2010



Further, our modeling shows that the individual market will grow significantly as a result of the availability of premium and cost sharing subsidies, and it will grow as a result of the individual mandate. Our modeling also shows that the small employer market shrinks as small employers first buy down benefits in response to premiums increasing faster than wages and then lapse coverage when they can no longer provide Bronze level coverage. We note our modeling of small employers buying down coverage in response to rising premiums is consistent with the experience in Massachusetts. In the first quarter of 2007, the average actuarial value of benefit plans in the small group market in Massachusetts was 0.85, and only 5% of groups had actuarial values less than 0.70. By the fourth quarter of 2009, the average actuarial value had declined to 0.73, and 50% of groups had coverage with an actuarial value less than 0.70.[3] We illustrate our estimated change in the size of Connecticut's small group and individual markets in Chart 4d-2 on the following page, where again a value of 1.00 represents the individual market in 2010.

[3] Massachusetts Health Care Cost Trends: Premium Levels and Trends in Private Health Plans: 2007–2009, Division of Health Care Finance and Policy. Available at http://www.mass.gov/eohhs/researcher/physical-health/health-care-delivery/dhcfp-publications.html#costs

Chart 4d-2

Size of respective markets – baseline assumptions

1.00 = individual in 2010

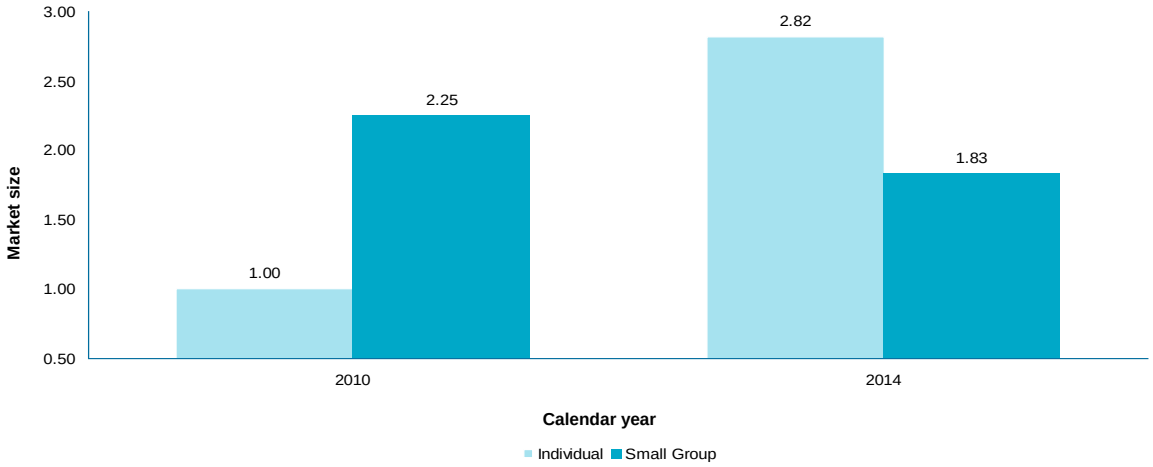


Chart 4d-2 shows, for example, that in 2010, the small group market was 2.25 times the size of the individual market. We estimate that in 2014, the small group market will decrease to being 1.83 times the size of the current individual market, and the individual market will grow by a factor of 2.82 in 2014.

If the small group and individual markets were merged in 2014, the pools would be merged for the purposes of calculating premiums. We illustrate the effect of merging the two markets in Table 4d-3 below.

Table 4d-3

Impact of Merging the Small Group and Individual Markets

	Values Relative to Individual Individual Market in 2010 = 1.00			
Market	Size of Market	Morbidity with Separate Markets	Morbidity if Markets are Merged	Change in Premiums from Merging the Market
Individual	2.82	1.12	1.09	-2%
Small Group	1.83	1.05	1.09	4%
Total	4.65	1.09	1.09	0%

Across both markets, the relative morbidity is 1.09. If the markets were merged, they would both be priced to a relative morbidity of 1.09. This would represent a 2% decrease for those in the individual market and a 4% increase for those insured in the small group market.

In the following table, we show the results of our modeling. If the markets were merged, we would expect a shift in coverage away from small group towards individual coverage, primarily as a result of small employers dropping coverage in response to the increased premium. Across both markets, there would be no material change in the number of enrollees.

Table 4d-4

Impact of Merging the Small Group and Individual Markets in 2014

Market	Enrollment 2014 Markets Separate	Premiums 2014 Markets Separate	Enrollment 2014 Merged Market	Premiums 2014 Merged Market	Premium Rate Change
Individual	329,850	$ 4,800	345,450	$ 4,711	-2%
Small Group	214,250	5,550	199,300	$ 5,762	4%
Total/Merged	544,100	$ 5,095	544,750	$ 5,095	0%

Considerations

Merging the markets would result in a larger pool of insured which could provide more rate stability, though we expect that each market will be large enough in 2014 to produce a stable pool of insured. Merging the markets could simplify the administrative functions that carriers participating in the Exchange would need to perform. As an example, carriers would only need to maintain one product portfolio. We suspect that if the markets are separate, carriers will need to maintain separate product portfolios for competitive purposes.

Merging the markets would allow employees losing group coverage to maintain their policies, provided their employers offered coverage that was available on the Exchange or otherwise offered coverage that was available through the Exchange, and it may encourage greater carrier participation, as carriers who would have otherwise only participated in the SHOP or the individual Exchanges would be forced to participate in both markets. Finally, we note that the SHOP Exchange must allow employee choice among all carriers within a metallic level.[4] Allowing employees the choice among carriers within a given metallic level is similar to the choices that will be available in the individual Exchange if the markets were to remain separate, though individuals may select among metallic levels as well as among carriers.

[4] 45CFR §155.705

As we illustrated in Table 4d-1, if the markets were merged, premiums in the individual market would decline, and premiums in the small group market would increase. This additional rate increase for small employers would provide incentive for small employers to stop offering coverage or to self-insure. We would also note that for subsidy-eligible individuals, the premiums they are expected to pay generally equate to a fixed percentage of income. Decreasing premiums generally serves to decrease subsidies for those who are subsidy eligible, but would have a positive effect on those who are not eligible for subsidies.

Merging the markets may encourage more employers to drop coverage as their employees would obtain coverage from the same source as those with individual coverage. Further, merging the markets could discourage carriers with specialized expertise in one market from offering coverage in the state.

Merging the markets may make it more difficult to meet the needs of the respective markets, and it may complicate the operation of the Exchange. As an example, the SHOP Exchange must offer a rolling open enrollment to employers, but individuals will only be allowed to enroll during an annual open enrollment period.[5] It would likely be more complicated for a single Exchange to enforce both open enrollment periods, depending on the type of enrollee than it would be for separate Exchanges to enforce open enrollment periods specific to the markets they serve.

Finally, we note that if the markets are not merged, individuals would likely find different prices for similar products in the different markets.

[5] 45CFR §155.410

TASK 4e – Impact of the Individual Mandate to Purchase Health Insurance and its Influence on the Markets and the Assumptions Made with Respect to the Models

Background

The Patient Protection and Affordable Care Act (PPACA) imposes an individual mandate to encourage healthy populations to stay in the market and balance the risk pool. If the individual mandate is successful in achieving its goal, the impact of the new rating and issue rules will be to further cross-subsidize risk between lower cost and higher cost populations. Beginning in 2014, all non-incarcerated US citizens must maintain minimum essential coverage.[1] Minimum essential coverage is defined as coverage that meets one of the following:

- Coverage under a government-sponsored program (e.g., Medicaid, Medicare)
- Coverage under an employer-subsidized insurance plan offered in the small or large group market
- Coverage under a plan offered in the individual market
- Coverage under a grandfathered plan
- Coverage under a state risk pool as recognized by Health and Human Services

The PPACA imposes a penalty for those individuals who do not maintain minimum essential coverage. The mandate is not universal and provides a penalty exemption for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income), individuals with a tribal affiliation or exemption due to religious beliefs. Among those who are not exempt, individuals not maintaining coverage will be subject to the following penalties, as outlined in the PPACA:

Year	Flat Annual Penalty	Percent of Income Penalty
2014	$ 95	1.0%
2015	$325	2.0%
2016	$695	2.5%

The penalty is the larger of the flat annual penalty or the percent of income penalty shown in the table above. Children are assessed one half of the annual penalty shown in the table, and the flat annual penalty for a family is capped at 300% of the amount shown in the table.

[1] PPACA Sec. 1501

The presence of the mandate is expected to bring more individuals into the market, particularly young, healthy individuals who have not found great economic utility in purchasing health insurance coverage up to this point. The addition of healthier individuals to the risk pool would have a favorable effect on rates and reduce adverse selection. The individual mandate penalty is low in 2014 and will increase until fully implemented in 2016. This may cause take-up rates to be lower during the first few years after 2014.

Modeling Results

As we describe in the Technical Appendix, we model individual decision-making using a utility function. For each individual in our model, we test the various options available to that individual, e.g., purchase an individual policy, take the coverage offered by the employer, if available, or go uninsured. For each option, we calculate an expected utility. We have assumed that each individual's utility decision is based on four considerations – the expected out-of-pocket cost for the various options (e.g., deductibles and coinsurance in the case of being insured), the net premium after taxes, subsidies and penalties have been considered, a term to reflect risk aversion and, finally, the value that comes from consuming health care services.

We used our model to test the effects of the penalty for not maintaining coverage. We show the results in Chart 4e-1 below:

Chart 4e-1

Impact of penalty and mandate on the number of uninsured in 2014

Under the assumptions we have employed in our modeling, the baseline reduction in the number of uninsured is 194,000, from 343,000 in 2010 to 149,000 in 2014 with the penalty and the mandate in place. Removing the penalty would increase the number of uninsured by roughly 5,000 lives in 2014 – from 149,000 to 154,000 – in both cases, an uninsured rate of roughly 4%.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

In addition to testing the effects of the penalty, we tested the effects of the mandate. As we discuss in the Technical Appendix, in calibrating our migration model in 2010, we assumed that individuals without current health insurance do not seek medical services at the same level as those with insurance. The CBO estimates that the uninsured currently use about 60% as much medical care as insured individuals, after taking into consideration differences in age and morbidity.[2] In 2014 and beyond, we used 100% of expected claims as the cost of being uninsured. We did this to reflect the effects of the mandate and the idea that there will be an expectation in 2014 that individuals will maintain health insurance. Making this assumption produced an uninsured rate of roughly 4%. We note that the uninsured rate in Massachusetts is 1.9% in 2010 but that Massachusetts' reforms included more generous subsidies and stronger individual and employer penalties.[3][4]

If we remove the assumed effect of the mandate and continue the penalty, the number of uninsured increases to 239,000, an uninsured rate of roughly 6%. Premiums in the small group market do not change materially. Premiums in the individual market increase by roughly 5%.

Key Considerations

Our approach to modeling the effects of the penalty and the mandate is based on the assumption that there is increased social or psychic utility that comes simply from complying with the mandate and that there will likely be additional negative utility associated with receiving free care in 2014.

However, there are factors that could make the mandate less effective than our modeling shows. The public perception of the mandate is generally negative,[5] so outreach and education will be important. In addition, the penalty is the only consequence of not complying. This is unlike a number of other mandates, such as the requirement to pay taxes or minimum wage laws, where the consequences of non-compliance can be large fines or incarceration.

There are a number of factors that work to stabilize premiums in the individual market to prevent a rate spiral. The premium subsidies work to stabilize the market in two ways. First, they provide strong incentives for individuals to enroll in coverage. Second, because the individual or family contributes a fixed percentage of income, regardless of the level of the premium (provided the premium exceeds the fixed percentage of income), the subsidies shield the subsidy-eligible individuals from premium increases. While we have not modeled the annual open enrollment

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[2] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-premiums.pdf

[3] Health Reform Facts and Figures: Winter 2011/2012. Available at: https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf

[4] Health Care in Massachusetts: Key Indicators, May 2011 Edition. Massachusetts Division of Health Care Finance and Policy.

[5] http://healthreform.kff.org/public-opinion.aspx

period explicitly, we believe it will serve to limit the sort of adverse selection that can lead to a rate spiral.

TASK 4f – Feasibility of a Basic Health Program (BHP)

Background

As pat of the overall report, the financial feasibility of the BHP in Connecticut, as defined in Section 1331 of the Patient Protection and Affordable Care Act (PPACA), was assessed. The feasibility determination is based on whether the BHP option can be implemented in the State of Connecticut (State) at existing Medicaid provider payment rates at little or no cost to the State (i.e., entirely funded by federal subsidies). Medicaid was selected as the benchmark because this program's provider reimbursement rates are typically lower than commercial health plans available in the Exchange, and building a BHP on a state's Medicaid infrastructure would allow states to cover low-income parents and children together in the same or similar plans and by the same provider networks.

Under the PPACA, Medicaid eligibility will be increased to 133% of the federal poverty level (FPL) in 2014 (138% FPL, including the 5% income disregard). The PPACA defines health care premium and cost-sharing subsidies for individuals below 400% FPL for purchasing mandatory health care through products offered in the State's Exchange. The BHP option creates a separate state run health program to cover individuals up to 200% FPL who are not eligible for other government programs. If the BHP option is elected by a state, BHP-eligible individuals would not be eligible to purchase coverage for plans offered in the state Exchange.

Individuals eligible for coverage under the BHP must meet the following criteria:

- Income up to 200% of the FPL
- US citizen or lawfully present immigrant
- Under age 65
- Not eligible for coverage under Medicaid, Medicare, Children's Health Insurance Program (CHIP) or Military/CHAMPUS–TRICARE
- Not have access to employer-sponsored insurance (ESI) that meets certain PPACA standards (comprehensive and affordable)

Therefore, the two groups of individuals that would be covered by a BHP are:

- Adults with modified adjusted gross income (MAGI) between 138% and 200% of FPL
- Lawfully present individuals with incomes below 138% FPL, not eligible for Medicaid because of immigration status

Most aspects of the design of the BHP are left to the discretion of the states, subject to the following PPACA requirements:

- Cover the minimum (not yet fully defined) Essential Health Benefits (EHB)
- Member premiums must not *exceed* premiums charged for the second lowest cost Silver Level plan offered through the Exchange
- For individuals up to 150% FPL, defined as the "lower BHP FPL band," cost sharing cannot *exceed* Platinum Level (10%)
- For individuals 150% to 200% FPL, defined as the "upper BHP FPL band," cost sharing cannot *exceed* Gold Level (20%)
- BHP is either a managed care system, or offers similar benefits of care management [e.g., fee-for-service (FFS) + enhanced primary care case management (EPCCM) may work]
- To the extent feasible, the consumer is offered a choice of options
- Plan medical loss ratio can be no less than 85%
- Plan selection through a competitive process

Section 1331 of the PPACA provides for financing of BHPs in two ways. The federal government will pay states a premium subsidy of 95% of what it would have paid for the BHP members (premium credit) under the Exchange if the individual enrolled in the second lowest cost Silver Level plan. In addition, the federal government will pay states a cost-sharing subsidy, based on the cost-sharing subsidy available under the Exchange. These subsidies vary by the member's income as defined by the PPACA in relation to the FPL.

Assuming the BHP will be operated by a state's Medicaid managed care organizations (MCO) or through its Medicaid infrastructure, the feasibility of a BHP is primarily determined by the differential between its Medicaid provider reimbursement rates in the BHP and its commercial provider reimbursement rates that would apply if this population was covered in the Exchange. The larger this provider reimbursement rate differential is, the greater the likelihood that a BHP will be feasible from a state's financial perspective.
Connecticut Medicaid will move from its current competing MCO arrangement to an administrative services only (ASO) model beginning January 1, 2012. A Medicaid ASO model could be used to offer a BHP. The PPACA requirements for a state operating a BHP are:

- Contract with one or more plans
- Selected through a competitive process, including negotiation of premiums, cost sharing, care management, and additional benefits
- Offer managed care attributes and systems where feasible in the local market
- Offer a choice of plans where feasible

- Coordinate administration with Medicaid and CHIP

If a state is able to operate its BHP for less than the amount of federal premium and cost-sharing subsides, Section 1331 of the PPACA specifies that states are restricted to the following options as to how to allocate the excess funding, which must be maintained in a separate trust fund account:

- Reduce monthly member premiums
- Reduce member cost sharing
- Increase the plan of benefits
- Increase provider reimbursements

Methodology

The task of assessing the feasibility of the BHP option in the State of Connecticut is broken down into the following steps:

- Estimate the size and demographic characteristics of the population eligible for the Exchange, and the subsets likely to enroll in the BHP and Exchange
- Estimate the Silver Level benefits and premiums (second lowest price) likely to be offered in the Exchange
- Calculate the resulting federal premium and cost-sharing subsidies that would be made available to fund the state BHP based on the estimated Silver Level benefits offered in the Exchange
- Estimate the premiums that would be required to fund health care benefits to the BHP population up to 200% FPL at existing Medicaid provider payment rates
- Calculate the resulting difference between the estimated federal BHP subsidies available and the estimated BHP premiums, and identify the risk factors that could significantly alter the results and the conclusion about financial feasibility

Each of these steps is discussed in more detail, along with results, in the following section (Key Findings) of this task report. It is important to note that the analyses performed included the assumption that there would not be modifications to existing program eligibility requirements, other than those required by law. Therefore, the assumption used was that eligibility and coverage for Medicaid would remain at the current level, in addition to the new coverage requirements of PPACA.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

As illustrated in the Task 10 report, reducing the State's Medicaid eligibility to 133% FPL would increase the BHP-eligible population of 74,000 by an estimated 19,350 individuals, or about 26%. These Medicaid populations above 133% FPL are comprised of Husky A parents, pregnant women, working disabled, and those with breast and cervical cancer, some of which have higher average morbidity and would increase the projected BHP PMPM costs quoted in this report. Consequently, reducing Medicaid eligibility to 133% FPL, and moving these populations to the BHP would soak-up a portion of the surplus in federal BHP subsidies that might exist. However, these additional costs would be more than offset by the savings of the state share of Medicaid funds now being expended for these populations.

Key Findings

Demographic Characteristics of the BHP Population

The primary data sources used by Mercer for estimating the size and demographic characteristics of the population eligible for the Exchange were the Census Bureau annual Current Population Survey (CPS) dataset which breaks down the population of all 50 states. Connecticut-specific CPS data for 2007–2009 were used as the starting point of the demographic analysis. The CPS demographic data were then adjusted to align with the results of the Task 1 report.

In estimating the size of the BHP Exchange eligible and enrolling population, Mercer assumed the BHP risk pool will consist entirely of adults, ages 19 through 64, with incomes up to 200% FPL. There would not be any children below 200% of FPL due to maintenance of effort requirements for CHIP.

Using this definition, Mercer estimates the total BHP *eligible* population to be approximately 74,000, with actual *enrollment* of about 51,000, reflecting an assumed 70% take-up rate for this population, which is similar to the CSS analysis estimate for the New York BHP. As a point of reference, the Kaiser Family Foundation estimates that approximately *9% of Connecticut's members who are eligible for Medicaid or CHIP have not enrolled*. These programs have little to no premiums required of their members. Therefore, it is reasonable to assume an even higher percentage of eligible members would not enroll in a BHP option and Exchange, which will both have some premium requirements.

The demographic profile of the uninsured BHP eligible population expected to enroll and pay premiums is included in Table 4f-1 below.

Table 4f-1 – Estimated Demographic Profile of BHP Enrollees

	< 150% FPL		150%–200% FPL		
	Females	**Males**	**Females**	**Males**	**Total**
Average Age	37	38	45	42	42
19–24	900	800	1,700	1,800	5,200
25–34	1,300	1,400	4,300	4,000	11,000
35–44	600	1,300	3,100	7,400	12,400

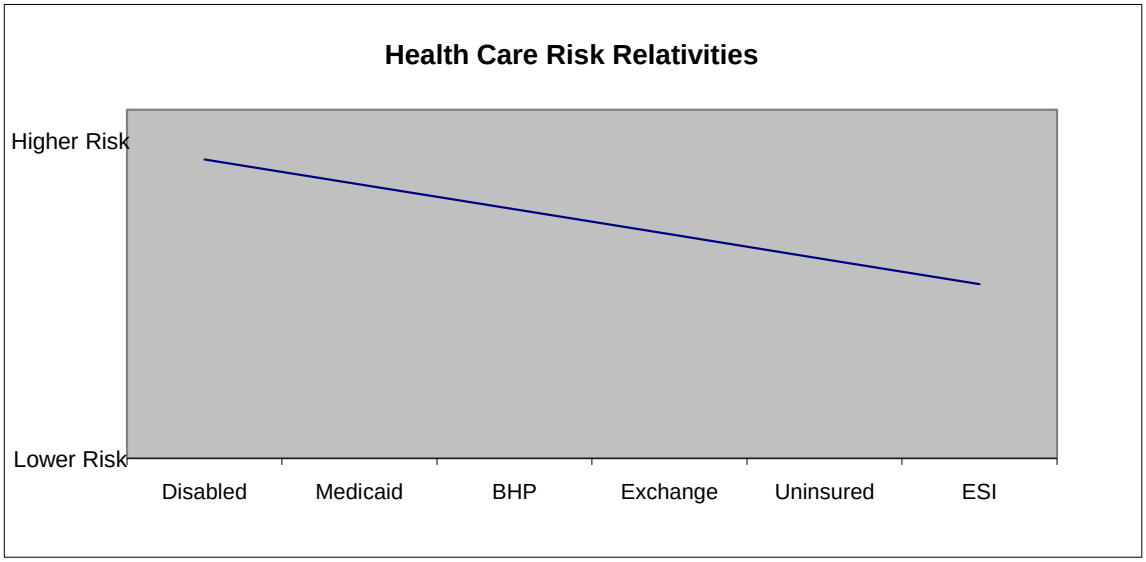
	< 150% FPL		150%–200% FPL		
45–54	900	800	5,500	5,500	12,700
55–64	400	400	5,900	3,000	9,700
Total	4,100	4,700	20,500	21,700	51,000

Relative Health Status of Populations

Generally, health status improves as income increases, resulting in decreasing average health care costs. Conversely, health status declines as income decreases, resulting in increasing health care costs. Relative health status also improves for those who are employed, both because employed individuals have higher incomes than the unemployed and because they are healthy enough to work.

Since Medicaid represents the lowest income population, this population group is assumed to have the highest health care risk and utilization levels. The uninsured population represents a mix of relatively healthier individuals who view purchasing coverage as uneconomical, and those with existing health conditions representing additional risks that can result in the member being denied coverage or resulting in unaffordable premiums. This mix has been shown to reflect an overall average health status that is better than the Medicaid population – with lower average health care risk and utilization – but is somewhat worse than the ESI-covered population. These assumed health care cost relativities, as illustrated in Exhibit 4f-1 below, are consistent with the self-reported health status scores collected with the CPS dataset. While these self-reported scores are subjective and do not easily convert to a numerical rating scale, they confirm the generally held actuarial assumptions and support developing projected health care costs under the PPACA from these income relativities.

Exhibit 4f-1 – Health Care Risk Relativities



Silver Level Benefits and Premiums Offered in the Exchange

Section 1331 of the PPACA authorizes the BHP and defines the premium and cost-sharing subsides based on the EHB, yet to be fully defined by the Secretary of Health and Human Services (HHS). Since the estimated 2014 Silver Level premiums were generated from our micro-simulation model, Mercer aligned its definition of the BHP benefits with this model to put the federal Exchange subsidies and BHP costs on the same basis as the benefits modeled in the Exchange.

The Silver Level of cost sharing is defined by the PPACA as having an actuarial value of 70%, meaning that 70% of the total health benefit costs (excluding plan administration, risk and profit charges) are paid by the plan, with the remaining 30% paid by the member through per service cost sharing in the form of deductibles, coinsurance and copayments. Mercer defined the level of member cost sharing and estimated the premium using its micro-simulation model, adjusted for the Connecticut health care market.

The resulting weighted average Silver Level premiums for the year 2014, priced for the demographics above, as calculated by the micro-simulation model, are $395 PMPM for the BHP population in the 138%–150% FPL income band, and $460 PMPM for the BHP population in the 150%–200% FPL income band, with a combined weighted average of $450 PMPM. The 150%–200% FPL weighted average premium is higher because the average age of its estimated population is about six years older than the 138%–150% FPL band.

Federal BHP Premium and Cost-Sharing Subsidy Calculations

The BHP federal premium and cost-sharing subsidy formula is not clearly defined. Section 1331(d)(3)(A)(i) of the PPACA defines it as, "*… equal to 95 percent of the premium tax credits …, and the cost-sharing reductions under section 1402 …"* which can be interpreted as either:

- 95% x [Premium Subsidy + Cost-Sharing Subsidy]
- 95% x Premium Subsidy + 100% x Cost-Sharing Subsidy

The Premium Tax Credit is defined mathematically as:

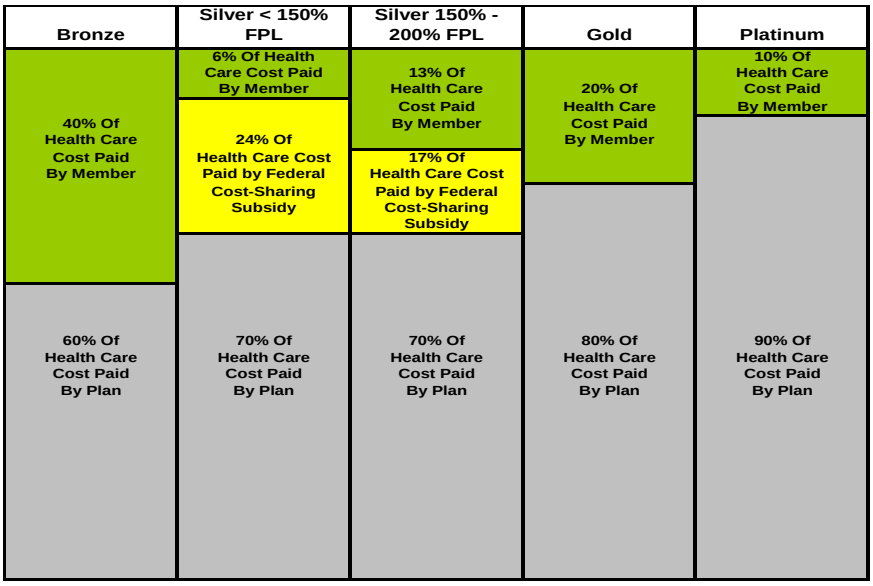
The Premium (for the second lowest Silver Level benefit plan) –The member share of premium, as determined by the applicable premium offset percentage (based on income as defined in Section 1401(b)(3)(A)(i) and as specified in Table 4f-2 below).

Table 4f-2– Premium Offset Percentages (Of Income)

	Low-end Premium Offset %	High-end Premium O%	Cost Sharing (Actuarial Value)
100%–133% FPL	2.00%	3.00%	94%
133%–150% FPL	3.00%	4.00%	94%
150%–200% FPL	4.00%	6.30%	87%
200%–250% FPL	6.30%	8.05%	73%
250%–300% FPL	8.05%	9.50%	No subsidy
300%–400% FPL	9.50%	9.50%	No subsidy

Section 1402(c)(2) defines the additional cost-sharing subsidy as, "*… the issuer of a qualified health plan … shall further reduce cost-sharing under the plan in a manner sufficient to — (A) in the case of an eligible insured whose household income is … not more than 150% of the poverty line … increase the plan's share of the total allowed costs of benefits provided under the plan to 94% of such costs; … in the case of an eligible insured whose household income is more than 150% but not more than 200% of the poverty … increase the plan's share of the total allowed costs of benefits provided under the plan to 87% of such costs."* Mercer interprets this language to mean that those between 100% and 150% FPL have plans with an effective actuarial value of 94% (paying an average of 6% cost sharing) and those between 150% and 200% FPL have plans with an effective actuarial value of 87% (paying an average of 13% cost sharing). See Exhibit 4f-2 below for cost-sharing percentages by benefit level.

Exhibit 4f-2 – Cost-Sharing Percentages by Benefit Level



Mercer estimates the 2014 FPL for a single adult will be $12,200, which would generate the Exchange premium offset amounts shown in Table 4f-3 below.

Table 4f-3 – Estimated Exchange Premium Offset Calculation

One Adult	$ Income	Premium Offset %	Annual	Monthly
100% FPL	$12,200	2.00%	$245	$20
138% FPL	$16,800	3.29%	$555	$45
144% FPL	$17,600	3.65%	$640	$55
150% FPL	$18,300	4.00%	$730	$60
175% FPL	$21,300	5.15%	$1,100	$90
200% FPL	$24,400	6.30%	$1,535	$130

Figures in the table are rounded.

The 138% level is used in this table since FPL levels below this will be coved by Medicaid (133% FPL + 5% income disregard). The number of people estimated below this income level (legal immigrants not currently eligible for Medicaid) is very small. Since 144% FPL is midway between the lower BHP population income segment of 138%–150% FPL, and 175% FPL is midway between the upper BHP population income segment of 150%–200% FPL Mercer used the 144% (lower BHP FPL band) and 175% (upper BHP FPL band) midpoints to represent the average of each population segment for pricing purposes.

Using the Exchange premiums developed in our modeling, the combined weighted net federal BHP premium and cost-sharing subsidy is about $435. Simplified rounded calculations are shown in Table 4f-4 below.

Table 4f-4 – Calculation of the Estimated BHP Subsidy

	< 150% FPL	150%–200% FPL	Combined
Total projected health care cost	$450	$525	$515
– 30% member cost-sharing	$135	$160	$155
= 70% plan covered health care cost	$315	$365	$360
+ 20% administrative loading	$80	$95	$90
= Silver level premium PMPM	$395	$460	$450
- BHP premium offset	$55	$90	$85
= gross premium subsidy	$340	$370	$365
x 95% = net premium subsidy	$325	$350	$345
Gross cost-sharing subsidy	$110	$90	$95
x 95% = net cost-sharing subsidy	$105	$85	$90
Total BHP net subsidy PMPM	$430	$435	$435

Six-year age difference accounts for higher 150%–200% FPL band premium.

In the absence of a BHP, the monthly member cash out-of-pocket costs in the Exchange are shown in Table 4f-5 below:

Table 4f-5 – Exchange Premium and Cost-sharing by Income Threshold

		Lower BHP FPL Band		Upper BHP FPL Band		Exchange FPL Band	
FPL band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$45	$60	$60	$130	$130	$385
Cost share	$0	$30	$30	$70	$70	$140	$155
Total	$0	$75	$90	$130	$200	$270	$540

Estimated 2014 BHP Premiums

A demographic profile is defined as the relative distribution of a population by age and gender. Mercer adjusted the demographic profile of the BHP enrolling population slightly by assuming that younger people, who are less likely to have ongoing health care needs, will be less likely to comply with the federal mandate to purchase coverage, while older people, conversely, are more likely to have ongoing health care needs and be more likely to comply with the federal mandate to purchase coverage. The penalties that apply to this population for failing to purchase minimum essential coverage are $95 in 2014, $325 in 2015 and $695 in 2016.

While we assume an average of 70% of the BHP-eligible population will enroll, we assume that only 50% of the youngest age brackets will enroll, while 90% of the oldest age brackets will enroll. This adjustment increased the average age of the estimated enrolled BHP population by about two years.

The demographic profile of the uninsured BHP-eligible population expected to enroll and pay premiums is 52% male with an average age of 42 and estimated to be 51,000.

Our estimate of the enrollment of the 138%–200% FPL income band (in the BHP) is greater than what we would estimate if a BHP was not offered. This is because we would assume a smaller percentage of individuals up to 200% FPL would actually enroll in the Exchange as compared to a BHP due to the higher premiums and cost-sharing requirements.

To estimate the BHP expenses in 2014 for this population, Mercer used the following assumptions in its modeling:

- Provider reimbursements based on Connecticut Medicaid levels were reduced relative to commercial rates as follows:
  - Physician reimbursements at 47% of commercial levels
  - Inpatient and outpatient facility reimbursements at 63% of commercial levels
  - Pharmacy reimbursements at 10% above commercial levels

- Combined (cost and utilization) annual Medicaid PMPM trends of 4%
- Administrative loading of 15% (including profit, risk, contingency loading)
- As noted above, health status decreases with income. Since the BHP-eligible population sits just below the Exchange population on the income scale, the BHP health care risk should be slightly worse. Thus, as a margin of conservatism, Exchange morbidity was increased:
  - 5% for the 150%–200% FPL income band
  - 8% for the 138%–150% FPL income band

The provider reimbursement relativity assumptions are based on Mercer's analysis of Medicaid physician reimbursements from MCO encounter data from April 2010 to March 2011 for the most commonly submitted CPT codes, the annual Department of Public Health reports of Connecticut acute care hospital reimbursements, supplemented by information supplied by Connecticut commercial carriers and publicly available reports. We have adjusted the reported provider reimbursement relativities upwards slightly as a margin of conservatism, as these calculations are subject to variability.

The following benefit and cost-sharing assumptions were used for the BHP cost scenario:

- Mercer priced a $10 monthly premium for the less than 150% FPL income group and a $20 premium for the 150%–200% FPL income group
- The plan of benefits was aligned with that priced in the micro-simulation model. This benefit package does not include some Connecticut State mandates, which could be added if there are sufficient excess federal BHP subsidies to fund them
- Plan cost sharing by BHP income band as follows:
  - The 138%–150% FPL income band was priced with mostly $10 inpatient and $5 ambulatory copays, generating a plan actuarial value of 97%
  - The 150%–200% FPL income band was priced with mostly $20 inpatient and $10 ambulatory copays, generating a plan actuarial value of 94%

To project future health care costs from the base data, Mercer applied consistent adjustments in our modeling to convert the historical cost and utilization data into estimated 2014 premium rates to meet the PPACA requirements.

Using the member premiums and cost sharing noted above, the resulting monthly net BHP premiums (net cost to the State) for this plan of benefits are estimated to be $330 for the $138%–150% FPL band and $360 for the 150%–200% FPL income, for a combined net BHP

premium of $355 as shown in Table 4f-6 below. This combined $355 PMPM net BHP cost to the State is $80 less than the estimated combined federal BHP subsidy of $435 PMPM. This represents approximately 22% of the $355 BHP cost, and could provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional State funding from a purely financial perspective based on provider reimbursement differentials.

Table 4f-6 – Estimated BHP Premiums

	< 150% FPL	150%– 200% FPL	Combined
Total projected health care cost	$300	$345	$335
- 3%/6% member cost sharing	$10	$20	$20
= Plan covered health care cost	$290	$325	$315
+ 15% administrative loading	$50	$55	$55
= BHP premium PMPM	$340	$380	$375
- BHP member premium	$10	$20	$20
= State net BHP premium	$330	$360	$355
- BHP premium subsidy	$430	$435	$435
= Net state BHP cost/(surplus)	($100)	($75)	($80)

In contrast to Table 4f-5 above, using these member premiums and cost sharing, the monthly member cash out-of-pocket costs in the Exchange with a BHP are shown in Table 4f-7:

Table 4f-7 – BHP and Exchange Premium and Cost Sharing by Income Threshold

		Lower BHP FPL Band		Upper BHP FPL Band		Exchange FPL Band	
FPL band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$10	$10	$20	$20	$130	$385
Cost share	$0	$10	$10	$20	$20	$140	$155
Total	$0	$20	$20	$40	$40	$270	$540

In this low cost BHP scenario, the out-of-pocket cost for a BHP member at 138% FPL drops from $75 to $20, or 73%, and the out-of-pocket cost for a BHP member at 200% FPL drops from $220 to $40, or 82%. While the BHP can make heath coverage more accessible and affordable for the lower income band that sits just above the Medicaid eligibility threshold, it also dramatically increases the out-of-pocket cost gap for someone at the 200% FPL cusp. At 199.9% FPL, this person would pay only $40 per month for health benefits, but at 200.1% FPL (a mere $44 increase in annual income, about $4 a month or 2 cents of an hourly wage) this person would be required to pay $270 a month for the same health care. This represents an increase of $230 a month or $2,760 a year.

To address this potential concern, we modeled an alternative scenario with somewhat higher member premiums and cost sharing to smooth the slope of the out-of-pocket cost curve along

the income scale. The following benefit and cost-sharing assumptions were used for the alternative BHP cost scenario:

- Mercer priced a $20 monthly premium for the less than 150% FPL income group and a $60 premium for the 150%–200% FPL income group
- Plan cost sharing by BHP income band as follows:
  - The 138%–150% FPL income band was priced with mostly $20 inpatient and $5 ambulatory copays, and a $10 brand drug copay, generating an actuarial value of 95%
  - The 150%–200% FPL income band was priced with mostly $40 inpatient and $20 ambulatory copays, and a $20 brand drug copay, generating an actuarial value of 88%

The resulting monthly net BHP premiums for this plan design are estimated to be $310 for the 138%–150% FPL band, $285 for the 150%–200% FPL income, for a combined net BHP premium of $290. This $290 PMPM net BHP cost to the State is $145 less than the estimated federal BHP subsidy of $435 PMPM. This represents 50% of the $290 BHP cost, and could provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional State funding from a purely financial perspective based on provider reimbursement differentials.

This alternate scenario provides the advantages of a larger BHP subsidy margin for the State and a more reasonable member out-of-pocket cost curve along the income scale. However, it does increase member costs for this low-income group and could potentially adversely affect the enrolling BHP risk pool as healthier members decide to opt-out.

The resulting monthly member cash out-of-pocket costs in the Exchange with a BHP are shown in Table 4f-8 below:

Table 4f-8 – BHP and Exchange Premium and Cost sharing by Income Threshold

		Lower BHP FPL Band		**Upper BHP FPL Band**		**Exchange FPL Band**	
FPL band	**Medicaid**	**138%**	**150%**	**150%**	**200%**	**200%**	**400%**
Premium	$0	$20	$20	$60	$60	$130	$385
Cost share	$0	$15	$15	$40	$40	$140	$155
Total	$0	$35	$35	$100	$100	$270	$540

Surplus/(Deficit) of Estimated Federal BHP Subsidies Over BHP Premiums

In calculating the calendar year (CY) 2014 BHP premium subsidy and BHP cost estimates, Mercer employed conservative assumptions where possible.

The $80 PMPM gap between the estimated premium subsidy and BHP costs for the most conservative scenario represents about 22% of the $355 net BHP costs, which allows for a significant margin of error in these estimates and assumptions. The size of this gap should not be affected by the actual number with incomes less than the 200% FPL and eligible for the BHP, assuming a sufficient number enroll to make the BHP sustainable. However, it will be affected by the relative risk profile of the percentage that decides to enroll.

As noted above, the federal BHP subsidies do not include state-mandated benefits which must be funded entirely by the states. Given that Connecticut has one of the larger sets of state-mandated benefits, an expansion above the level of EHB from which the federal subsidies are calculated is one option for the State to consider when allocating this excess funding.

To assess the boundaries of the feasibility of the BHP option, we tested the scenario where the BHP has zero premiums and no member cost sharing to match Medicaid. The resulting monthly BHP premiums for this Medicaid plan design are estimated to be $355 for the $138%–150% FPL band and $420 for the 150%–200% FPL income, for a combined net BHP premium of $405. This $405 PMPM net BHP cost to the State is $30 less than the estimated federal BHP subsidy of $435 PMPM. This represents approximately 7% of the $405 BHP cost, and could conceivably provide sufficient margin (assuming all other assumptions hold) to operate a BHP without additional state funding from a purely financial perspective based on provider reimbursement differentials.

This Medicaid scenario provides the best advantage to this low-income population, which would also have the best chance of maximizing enrollment. This scenario would both cover the greatest number of eligible adults and result in the lowest morbidity level of the risk pool. However, the disadvantages to the State are that the surplus margin could result in a deficit if all of the assumptions do not hold, and would limit the State's ability to add mandated benefits or increase provider reimbursements. The results of the three scenarios are summarized in Table 4f-9 below.

Table 4f-9 – BHP Scenario Results

PMPM Estimates	$10/$20 Premiums 3%/6% Cost Sharing	$20/$60 Premiums 5%/12% Cost sharing	Zero Premiums No Cost Sharing
Federal subsidy	$435	$435	$435
Net State BHP cost	$355	$290	$405
Excess/(Deficit)	$80	$145	$30

The choice among these scenarios is not as obvious as it appears. The alternative scenario with the $145 PMPM subsidy surplus might appear to offer the best protection to the State's budget. However, this scenario also has the highest premiums and cost sharing, which will have the effect of generating the lowest enrollment (of the above three scenarios) and the highest level of morbidity in the risk pool. Conversely, the no cost Medicaid scenario might appear to present the greatest risk to the State's budget. However this scenario will have the effect of generating the highest enrollment and the lowest level of morbidity in the risk pool, decreasing the likelihood that these unknown variables might deviate too far from the assumptions.

Conclusions on Financial Feasibility

Provided all of the assumptions listed above hold, under any scenario based on the estimated subsidy and costs modeled in this analysis, the result is that it would be financially feasible for Connecticut to offer a BHP option at Medicaid provider reimbursement levels with no costs to the State. These results are driven by the estimated differential in Medicaid versus commercial provider rates of reimbursement. These estimates are speculative at this early stage with so many provisions of the PPACA undefined and specifics of the BHP undetermined. However, the gap between the estimated premium subsidy and projected health care cost to cover the BHP population is consistent with findings from other studies on this topic (e.g., the January 2011 Sustinet report, the Urban Institute's 50 state BHP analysis, and the CSS New York state report).

In Connecticut, the excess of the federal subsidies over the resulting costs of a BHP could be used to increase provider reimbursement rates, reduce member premiums and cost sharing, expand benefits and extend outreach to enroll a greater share of this low-income population.

As with Medicaid, MCOs operating a BHP bear the risk that the capitated premiums paid by the state are sufficient to cover the cost of providing the benefits. However, states operating a BHP, such as under the new Connecticut ASO Medicaid model, will bear this risk. Thus Connecticut needs to consider the BHP delivery system when assessing the overall risk to the state of implementing a BHP.

Perhaps the most significant caveat to the BHP modeling, calculations and conclusions contained in this report is the key unknown of the variation of the Silver Level premiums offered in the Exchange. These calculations and conclusions are based on the $450 PMPM weighted average estimate of Silver Level premiums from our micro-simulation modeling. Implicit in the use of this $450 PMPM premium estimate is that this will represent the second lowest Silver Level plan offered in the Exchange, or that the Silver Level premiums offered in the Exchange will be tightly clustered around this value.

However, should there be a wide variation in Silver Level premiums offered in the Exchange – e.g., if they range from a low of $350 to a high of $550 PMPM – the BHP subsidies will be based on a much lower weighted average premium of perhaps $360 PMPM. This would result in an almost 25% reduction in the weighted average BHP subsidy from $435 to $330 PMPM.

If this were to occur, both the low cost and no cost Medicaid scenarios could not be implemented without additional State funding. However, plans that under-price the market in 2014 (the first year of the Exchange) may very quickly increase their premiums in subsequent years (assuming the increases would be approved), and this BHP subsidy deficit may not last for more than a couple of plan years.

In contrast, the results in this analysis are largely immunized from the unknown assumption of the definition of EHB. If the EHB are greater or less than those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies, would increase more or less at the same rate as the resulting BHP costs, with the resulting BHP subsidy excess or deficit relatively unaffected.

Similarly, the results in this analysis are largely immunized from the unknown assumption of the medical inflation and utilization trends from now until 2014. If the medical trends are greater or less than those priced in this analysis, then the Exchange Silver Level premiums, along with the federal BHP subsidies, would increase more or less at the same rate as the resulting BHP costs, with the resulting BHP subsidy excess or deficit relatively unaffected.

Mercer is not advocating for or against the BHP option. The results of this study indicate this may be a viable option for the State to consider as it decides how best to implement the many provisions of the PPACA. While the results of the analysis do show this to be financially feasible, clearly implementation of a BHP would not be without some element of risk to the State.

Medicaid and BHP Provider Availability and Access

The PPACA effectively expands Medicaid to 138% FPL, which is estimated to increase Medicaid/CHIP enrollment by almost 100,000 in 2014. This enrollment expansion could place additional strain on the Connecticut Medicaid provider networks, increase cost-shifting to commercial carriers, and reduce the access and availability to providers for Medicaid patients. Implementing a BHP would increase the Medicaid patient base by another 51,000, further exacerbating this impact in 2014.

Accrediting agencies such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) do not establish network adequacy standards, leaving these to be defined by the plans. Likewise, CMS does not establish network adequacy standards for Medicaid, leaving most managed care plans and State health care purchasers to develop them based on the unique circumstances, membership and geography. For instance, there are often different standards for rural versus urban areas, or in the ratio of providers to enrollees for primary care versus specialty care services.

In 2006, Massachusetts sought to achieve near universal coverage for state residents, and in 2007 implemented the “individual mandate”, similar to that called for under the PPACA. Thus, the experience in Massachusetts provides a strong indication of the impact other states may need to plan for in the implementation of their Exchange programs. According to a paper

published by The Kaiser Commission on Medicaid and the Uninsured, there were three key lessons:

- Insurance expansions can lead to a surge in the demand for primary health care, especially in medically underserved low-income communities
- In addition to expanding insurance coverage, investments to expand the capacity of the primary care system that will care for the newly insured, as well as for those who remain uninsured will be important
- Even post-reform, there will be a continuing need for sources of care for the uninsured

Prior to reform, community health centers had already been providing care to one out of every 13 Massachusetts residents, and one out of every four low-income residents, highlighting the importance of these safety net providers within the Massachusetts delivery system. When compared to private physicians, these health centers saw a larger share of low-income and uninsured patients, further indicating that private physicians are unwilling to treat low-income and uninsured patients.

Post reform, health centers found an overall organic increase in patient growth representing both insured and uninsured individuals, mainly in the adult age bands. However, what was unexpected is that many of the newly insured patients remained at the health centers, thus effectively changing the payer mix but not the clientele served. This is important to understand, as financing for most health insurance expansion is covered, in part, by the assumption that less money is needed for safety net providers assuming that expanded coverage is more plentiful through private physician offices and therefore less reliant on the safety net.

The Massachusetts Medical Society also conducted a Physician Workforce Study that indicated serious shortages of internists, family practitioners and some specialists. In general, physician workforce shortages are well chronicled nationally, and Massachusetts' shortages are consistent with national trends. These shortages, in general, already decreased the primary care capacity within the Commonwealth, but did not appear to offer greater disparity between commercial capacity and their State insurance counterpart.

The status of Connecticut's physician workforce is not dissimilar. A 2009 study by Aseltine, Katz and Geragosian surveyed the primary care physician (PCP) satisfaction, supply and patient access to medical care, which indicated that nearly one-quarter of PCPs were no longer accepting new patients. The average time to obtain a new appointment was 18 days for a new patient, and just over 13 days for existing patients. Considering that 40% of Connecticut's physicians are over the age of 50 (a time when physicians typically consider reducing patient hours), and that recruitment of new physicians is difficult (averaging about 13 months to recruit a new PCP), Connecticut is already facing significant PCP shortages.

A thorough analysis of the Connecticut Medicaid provider infrastructure should be undertaken to assess the impact of expanding the Medicaid eligible population as required by the PPACA, as well as the additional impact of potentially adding the BHP population to this patient base.

BHP Impact on the Exchange

This section of the report addresses some of the potential impacts adopting a BHP option could have on the Exchange in Connecticut. Specifically, the following potential areas of impacts are discussed:

- Impact on Exchange risk
- Impact on Exchange self-sustainability

Finally, we close with a host of “other considerations” related to the analyses performed and included in this report.

Impact on Exchange Risk

As illustrated by the Health Care Cost Relativities graph in the previous section, the BHP population less than 200% FPL should represent a less healthy (and more costly) risk profile than the remaining Exchange population above 200% FPL. In addition, the level of premiums and cost sharing in a BHP and in an Exchange population (with or without a BHP option) will have a direct impact on the risk of the population that enrolls. Specifically, higher premium and cost-sharing levels increase the level of adverse risk and lead to higher enrolled population risk. With the assumption that a BHP option would only be implemented with reduced premiums and cost sharing (as compared to what would be available under the Exchange for the same BHP-eligible subgroup), it is reasonable to conclude that the risk of the enrolling population up to 200% FPL would be better under a BHP than the risk of the same population subgroup that would enroll under an Exchange.

It is impossible to be sure how the risk of the remaining Exchange population above 200% FPL would compare to the less than 200% FPL group under an Exchange. However, one could argue that with less disposable income at the lower income levels, the impact of adverse risk would be greater at the lower income levels. If that holds true, Exchange risk may actually improve with the implementation of a BHP.

On the other hand, at higher income levels the subsidy is considerably lower than at lower income levels. Therefore the motivation to participate within the Exchange versus the outside market is much lower for the healthiest segment of the Exchange population. Plan participation, consumer choice and risk dynamics for the Exchange population are complicated and beyond the scope of this analysis.

Impact on Exchange Self-sustainability

All Exchanges must be self-sustaining by January 1, 2015. There will be no federal funds available for states to use for the ongoing operations of the Exchanges after this date. Therefore, it is reasonable to be concerned about removing some Exchange-eligible members from the pool of members from which the Exchange may be funded.

We assume that 51,000, or 70%, would enroll in a BHP, enticed by the additional incentives of reduced premiums and cost sharing. However, without these additional incentives in the Exchange, we assume that only 37,000, or 50% of those in the low income band would enroll in the Exchange, comprising about 15% of the total Exchange enrollment. Implementing a BHP would remove these 37,000 from the Exchange, and would increase the Exchange premium assessment from 2.8% to 3.0% of premium based on the Task 7 Exchange sensitivity analysis.

Note that implementing a BHP would not create a complete duplication of efforts, because those in the BHP would still enroll through the Exchange front-end portal and be directed to the BHP via the “no wrong door” approach. This would either reduce the cost of implementing a BHP, or some of the BHP operational revenue could be funneled to the Exchange to compensate for the use of the enrollment function.

Additional Risks of Variation in Federal BHP Subsidies

Two additional identifiable categories of BHP risks that cannot be quantified at this stage deal with retrospective adjustments to the federal subsidies provided to fund the BHP. Section 1331(d)(3)(A)(ii) specifies that the Secretary of HHS will make retrospective adjustments to the amounts of federal BHP premium and cost sharing subsidies to the states to account for the actual income and health status of each individual enrollee.

The retrospective income adjustment presumably would increase the BHP subsidies if an enrollee’s actual income was less than the income determined at enrollment (e.g. if actual income was 140% FPL instead of 180%), and would decrease the BHP subsidies in an enrollee’s actual income was greater than the income determined at enrollment (e.g. if actual income was 180% FPL instead of 140%). In the Exchange, each enrollee bears the risk of this variation in the retrospective premium and cost sharing, while in a BHP, the state bears this risk.

In addition to the fact that the process for this adjustment remains undetermined at this stage, is the inevitability of the further complications presented in cases of those BHP enrollees whose incomes drops below the 138% Medicaid eligibility threshold, as well as those BHP enrollees whose incomes rise above the 200% FPL threshold. The final HHS rules and process for this adjustment may have a significant impact on the financial feasibility of the BHP option.

The retrospective risk sharing adjustment presumably would increase the BHP subsidies if an enrollee’s health status was calculated as higher than the average Exchange risk, and would decrease the BHP subsidies in an enrollee’s health status was calculated as lower than the average Exchange risk. Assuming the final HHS rules and process for this adjustment follow this logic, the BHP retrospective risk adjustment would reduce the unknown risk a state would be

taking by implementing a BHP, and would not have a significant impact on the financial feasibility of the BHP option.

Other Key Considerations

As illustrated in Table 3 in the previous section, the income band spanning 138% and 200% FPL is a rather narrow range of only $7,600 annually. Sommers and Rosenbaum, in the February 2011 issue of *Health Affairs*, published a study which showed that over the course of a year, approximately 50% of the people at this income level will experience earnings fluctuations which will move them above or below the 138% FPL BHP eligibility threshold, rendering them ineligible for the specific coverage they have and requiring them to re-enroll in the coverage for the income category they move to.

A September 2011 Institute for Health Policy Studies report projects that the total number of individuals eligible for the BHP in a given year will be four times greater than the number eligible at the start of the year due to income fluctuations among this segment of the population. Regardless of the actual percentage, which will vary with changing economic conditions, this churning of coverage will also likely exist above or below the 200% BHP upper income eligibility threshold, requiring them to dis-enroll in the BHP and enroll in the Exchange (or vice versa). We did not attempt to model this phenomenon and have not made any adjustment to our analysis to account for this.

Section 1411(b)(4) of the PPACA places the responsibility for income redeterminations on the individual enrollees. It states "*If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer*."

The expected result is that individuals will be less likely to report increases in their income, reducing or eliminating their premium and cost sharing subsidies, whereas they will be more likely to report decreases in their income, increasing their premium and cost sharing subsidies, or even moving them from the Exchange to the BHP, or from the BHP to Medicaid. This means that more of the increases in federal subsidies will be reported earlier, leaving the decreases in federal subsidies to be accounted for after the year has ended in the retrospective reconciliation process.

We have not modeled the increased reimbursements for primary care providers (PCPs) to the Medicare levels mandated by the PPACA for CY 2013 and CY 2014. As the law currently stands, these PCP reimbursement rates will revert to their current levels starting in 2015; however, some states are contemplating leaving the PCP reimbursement rates intact after 2014.

The PPACA currently requires Exchange participating health plans to offer Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) as part of their provider networks. In addition, payment for these FQHCs and RHCs is to be at the prospective payment rates used by the states' Medicaid programs. In Connecticut, these payment rates tend to be significantly

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

higher than regular physician Medicaid and even commercial payment levels. As the PPACA stands today (before regulations are published), these requirements do not exist for a BHP option. Mercer did not make any adjustment to the estimated BHP or Exchange health care costs to account for this requirement. If material changes to this assumption are anticipated, this analysis should be further refined to reflect the assumed delivery system for the BHP.

While there are monetary penalties (which increase with income) for failing to pay premiums and continue coverage once an immediate health need passes, the PPACA allows for a generous 90-day grace period of continued coverage once a member ceases to pay monthly premiums, and there is no waiting period or underwriting when re-enrolling after a gap in coverage. The result will be that healthier lives will tend to lapse, while those with acute and chronic health care needs will tend to remain covered, driving up the average per capita cost.

The State of Washington BHP started in 1989 and has more than two decades of experience. While it covers a similar population as the PPACA BHP, those earning less than 200% FPL, it also covers those below 138% FPL, down to the State's Medicaid income limits of 74% for parents and 0% for childless adults. The current monthly premiums for a 42 year-old in the plan range from $100.00 for those earning 140% FPL, and $180.00 for those earning 180% FPL, which are higher than the projected member premiums in the Exchange.

In 2008 and the first part of 2009, approximately 4% of the Washington BHP membership lapsed each month. Once an enrollment cap was enforced in 2009 and a waiting list was created for those who wanted to enroll but could not, the monthly lapse rate dropped to about 3% in 2010. This decrease in the lapse rate is consistent with the adverse selection assumption which holds that the remaining population will be less healthy and more diligent in paying their monthly premiums to avoid losing their valued coverage for any period of time.

While some of the Washington BHP lapses are due to (a) changes in income, (b) replacement by other coverage – ESI, Medicaid or Medicare, (c) movement out of state and (d) death, the level of adverse selection present is significant and measureable. The adverse selection present among the Connecticut BHP population is assumed to be similar and could have a significant impact on BHP costs in Connecticut.

All estimates in this report are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any estimates or projection must be interpreted as having a likely range of variability from these estimates. Mercer has prepared these projections exclusively for the State of Connecticut. These estimates may not be used or relied upon by any other party or for any other purpose than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. The estimates and projections included in this report are not a guarantee of results which might be achieved.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the PPACA and Health Care Education and Reconciliation Act (HCERA) have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. Accordingly, these estimates are not actuarial

opinions. The State of Connecticut is responsible for all decisions related to the policy direction of the Exchange and a BHP option. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Because of numerous uncertainties about the health care marketplace in 2014, the analyses and findings contained in this report are preliminary and subject to change for many reasons, including, but not limited to:

- Uncertainties regarding the PPACA:
  - Key terms and provisions in the law remain undefined or not yet fully defined more than a year after it was enacted, such as the definition of the “essential health benefits” that will be required for all products offered in the Exchange and which will drive the BHP premium and cost-sharing subsidies
  - Key terms and provisions of the law conflict. For example, Section 1331(a)(2)(A)(ii) defines the BHP cost-sharing subsidies to be a minimum of Platinum Level benefits (90% actuarial value) for individuals between 100%–150% FPL and Gold Level benefits (80% actuarial value) to individuals between 150%–200% FPL, while Section 1402(c)(2) defines the additional cost-sharing subsidies to be a minimum of 94% actuarial value for individuals between 100%–150% FPL and 87% actuarial value to individuals between 150%–200% FPL
  - Key terms and provisions of the law are unclear, such as the precise definition of “actuarial value” and the formula for the BHP cost-sharing subsidy (100% or 95%)
- Decisions about how the State would structure a BHP, such as the premiums and cost-sharing levels which will impact the risk profile of those who enroll, and how the State decides to legislate and regulate the health care marketplace under the PPACA
- Uncertainties regarding consumer behavior under the PPACA, for example:
  - What will be the level of compliance with the federal insurance mandate?
  - Will those above 400% FPL not eligible for premium subsidies purchase health care in the Exchange or migrate to other products outside it, leaving the Exchange with a potentially lower income and less healthy risk pool?
  - How will the 90-day grace period for non-payment of premiums and the lack of a penalty for re-enrollment affect coverage persistency and premium payments in a BHP and/or in the Exchange?

TASK 4g – The Cost of Connecticut Benefit Mandates That Are Above the Federal Essential Benefits in the Context of a Revised Insurance Market

Background

The Patient Protection and Affordable Care Act (PPACA) provides for major health insurance market reforms and adds consumer protections to health plans offered both inside and outside of the Exchanges. One of the consumer protections contained in the PPACA requires the establishment of a package of essential health benefits (EHB) which will provide a defined set of benefits that serve as the basis for the development of all premiums for non-grandfathered plans offered inside and outside the Exchanges, with some exceptions for self-insured and large groups.

The PPACA also provides states the option to require that benefit packages include benefits in excess of those prescribed in the EHBs, such as state-mandated benefits. However, states will have to assume the costs associated with these additional requirements for Qualified Health Plans (QHP) offered in Exchanges.[1] In addition, federal premium subsidies and tax credits will be based only on the EHBs and not include any credits or subsidies for additional benefits in excess of the EHBs.

Essential Health Benefits

The PPACA provides broad guidance related to what is defined as EHBs. The EHBs shall include at least the following general categories and the items and services covered within the categories:[2]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices

[1] §1311(d)(3)(B) of the PPACA

[2] §1302(b)(1)(A–J) of the PPACA

- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The PPACA also provides additional guidance to be used in helping to further define the EHBs:

- The scope of the EHBs is equal to the scope of benefits provided under a typical employer plan[3]
- The definition of the EHB shall:[4]
  - Reflect an appropriate balance among the categories so that benefits are not unduly weighted toward any category
  - Not discriminate against individuals because of their age, disability or their expected length of life
  - Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities and other groups
  - Provide prescribed coverage for emergency department services
  - Include a process to periodically review the EHBs and provide a report to Congress and the public containing an assessment whether enrollees are facing difficulty accessing needed services for reasons of coverage or cost, and to assess whether the EHBs need to be modified, updated or expanded due to factors such as changes in medical evidence, scientific advancement and balancing costs

Clarification related to the specifics surrounding the final EHBs is still forthcoming. with an anticipated release date of the EHBs no later than May 1, 2012. However, states must begin to determine the potential cost impact of maintaining state-mandated health benefits that are assumed to be in excess of the EHB.

[3] §1302(b)(2)(A) of the PPACA.

[4] §1302(b)(4) of the PPACA.

Institute of Medicine Report

One of the early steps in defining the EHBs was a request from the Secretary of Health and Human Services (HHS) to the Institute of Medicine (IOM) to develop recommendations related to the methods and processes for determining and updating the EHBs. These recommendations were released in a report on October 7, 2011. From this report, it was stated that, *"The charge of the committee specifically was not to decide what is covered in the EHB but rather to propose a set of criteria and methods that should be used in deciding what benefits are most important for coverage."*[5]

The criteria from the IOM frames the considerations recommended to HHS for use in determining the final EHBs. These recommendations, if adopted by HHS, will play a critical role in the final determination of the EHBs, and consequently, the impact of state-mandated benefits in excess of the EHBs.

The IOM developed criteria for three purposes of an EHB: criteria to guide content of the aggregate EHB package; criteria to guide EHB content on specific components; and criteria to guide methods for defining and updating the EHB. A summary of the criteria for each of these is provided below.[6]

Criteria to Guide Content of the Aggregate EHB Package

In the aggregate, the EHB must:

- BE AFFORDABLE for consumers, employers and taxpayers
- MAXIMIZE THE NUMBER OF PEOPLE WITH INSURANCE COVERAGE
- PROTECT THE MOST VULNERABLE by addressing the particular needs of those patients and populations
- ENCOURAGE BETTER CARE PRACTICES by promoting the right care to the right patient in the right setting at the right time
- ADVANCE STEWARDSHIP OF RESOURCES by focusing on high value services and reducing use of low value services. Value is defined as outcomes relative to cost
- ADDRESS THE MEDICAL CONCERNS OF GREATEST IMPORTANCE to enrollees in EHB-related plans, as identified through a public deliberative process

[5] Essential Health Benefits Report Brief, IOM, October 2011.

[6] Essential Health Benefits, Criteria, IOM, October 2011.

- PROTECT AGAINST THE GREATEST FINANCIAL RISKS due to catastrophic events or illnesses

These criteria focus on balancing the comprehensiveness of the EHBs with the affordability of the EHBs. Affordability of the EHBs will impact the number of people purchasing the insurance, which tie into one of the primary objective of the PPACA which is to increase the number of citizens with meaningful and affordable health insurance coverage. Also, focusing on better care practices and high value services will contribute to maintaining the affordability of insurance and maximizing the number of insured citizens.

Criteria to Guide EHB Content on Specific Components

The individual service, device, drug for the EHB must:

- BE SAFE – expected benefits should be greater than expected harms
- BE MEDICALLY EFFECTIVE and supported by a sufficient evidence base, or in the absence of evidence on effectiveness, a credible standard of care is used
- DEMONSTRATE MEANINGFUL IMPROVEMENT in outcomes over current effective services/treatments
- BE A MEDICAL SERVICE, not serving primarily a social or educational function
- BE COST EFFECTIVE so that the health gain for individual and population health is sufficient to justify the additional cost to taxpayers and consumers

Caveats

- Failure to meet any of the criteria should result in exclusion or significant limits on coverage.
- Each component would still be subject to the criteria for assembling the aggregate EHB package.
- Inclusion does not mean that it is appropriate for every person to receive every component.

These criteria and caveats provide a basis for evaluating whether a specific benefit should be part of the EHB package. If adopted, these criteria would help to clarify the specifics of the EHBs and allow for a more refined analysis for state-mandated health benefits in excess of the final EHBs. While these criteria provide context and guidance surrounding the IOM recommendations to consider when developing the EHBs, they also create uncertainty in projecting what services the final EHBs will ultimately comprise. For example, how will the various types of habilitative services be classified as it is one of the ten general categories of services broadly defined in the EHBs, but is it universally accepted as primarily a medical service? Will significant limits on coverage be placed on these services?

Criteria to Guide Methods for Defining and Updating the EHB

Methods for defining, updating and prioritizing must be:

- TRANSPARENT. The rationale for all decisions about benefits, benefit design, and changes is made publicly available.
- PARTICIPATORY. Current and future enrollees have a role in helping define the priorities for coverage.
- EQUITABLE AND CONSISTENT. Enrollees should feel confident that benefits will be developed and administered fairly.
- TOTAL NON-FULLY INSURED. To be accountable to taxpayers and plan members, the covered service must provide a meaningful health benefit.
- RESPONSIVE TO NEW INFORMATION. EHB will change over time as new scientific information becomes available.
- ATTENTIVE TO STEWARDSHIP. For judicious use of pooled resources, budgetary constraints are necessary to keep the EHB affordable.
- ENCOURAGING TO INNOVATION. The EHB should allow for innovation in covered services, service delivery, medical management, and new payment models to improve value.
- DATA-DRIVEN. An evaluation of the care included in the EHB is based on objective clinical evidence and actuarial reviews.

The IOM recommends that these criteria for determining the aggregate EHBs, the specific components of the EHBs, and for defining and updating the EHBs should serve as the foundation for determining the final EHBs.

State-mandated Benefits

The IOM also provided recommendations and guidance related to state-mandated benefits. The IOM's recommendation is that state-mandated benefits should not receive any special treatment when developing the definition of the EHB, and that each state-mandated benefit be subject to the same evaluative method as every other service considered for inclusion in the EHBs.

In coming to this recommendation, the IOM specifically considered several options for addressing benefits currently mandated by specific states for inclusion in the EHBs. These options and the rationale associated with the decision to include these options for consideration in determining the final EHBs or not, are described below.

ANY BENEFIT THAT IS CURRENTLY MANDATED IN A SPECIFIC STATE WOULD CONTINUE TO BE INCLUDED IN THE EHBS FOR THAT STATE: The IOM ultimately rejected this because it would create a situation where there would be material differences in the EHBs among states. However, the IOM also recommends providing states some level of flexibility in determining the EHBs for their state although this is tied to a nationwide cost ceiling. Also, the IOM felt this was inconsistent with the PPACA verbiage that specifically requires states to fund additional costs for mandates that exceed the EHBs.

CONSIDER COVERING THE MANDATES THAT ARE CURRENTLY COVERED BY A "SUPER MAJORITY" OF THE STATES: The advantage of this approach is that the EHBs would be universal across all states. The IOM felt this was still inconsistent with the PPACA verbiage specifically requiring states to fund additional costs for mandated benefits that exceed the EHBs, thereby requiring the Federal government to subsidize state decisions. Also, this would in effect result in the majority of states controlling the benefits for the minority, requiring the minority to adopt benefits that they did not previously have in place. Furthermore, the IOM believed that very few states have a legislative decision-making process that subjects the mandates to the criteria defined by the IOM for inclusion of any benefit.

SUBJECT THE MANDATES TO THE CRITERIA DEVELOPED BY THE IOM FOR EACH OF THE SPECIFIC COMPONENTS: The IOM believed this was the most equitable means of determining which benefits, mandated or not, should be part of any EHB. The IOM conclusion was: *"Because state mandates are not typically subjected to a rigorous evidence-based review or cost analysis, cornerstones of the committee's criteria, the committee does not believe that state-mandated benefits should receive any special treatment in the definition of the EHBs and should be subject to the same evaluative method. This interpretation is consistent with the language in the PPACA regarding state mandates; that is, Congress did not require their inclusion."*[7]

Connecticut is a state that requires an analysis that includes medical efficacy, social impact and financial impact of any proposed mandated benefit. Whether or not this analysis is as rigorous as that being contemplated by the IOM is unknown at this time. The results and analyses developed as an outcome of this requirement in Connecticut to review each proposed state-mandated health benefit are referenced later in this report.

Predefined Cost Target and Covered Services

Two other important recommendations and conclusions as identified in the IOM report relate to incorporating a cost target to be used in helping to define the set of benefits determined to ultimately be included as EHBs and the classification of a benefit as essential versus non-essential.

[7] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 18

The IOM identifies costs as an integral component in determining the final EHBs. The report states that "*Without some constraint on the size of the EHB package, the premium prices faced by individuals seeking to obtain coverage both inside and outside of the exchanges in the individual and small business market may prove unaffordable to the target population and diminish access to health insurance coverage. The committee concludes that the EHB should be defined as a package that will fall under a predefined cost target rather than building a package and then finding out what it would cost.*[8]

This recommendation to incorporate a cost target to aid in prioritizing the types of services to include in the EHBs is significant to address the affordability and sustainability concerns. The IOM is recommending that any EHB have a 2014 small group premium at the Silver level of benefits no greater than the 2014 small group premium that would have been experienced had the PPACA not been passed. If adopted, this is a powerful tool for limiting the scope of benefits to be included in any EHB. Furthermore, future adjustments to the EHB package should be premium neutral, after adjusting for medical inflation. So if the EHB package is to enhance the benefits from those prevalent in the pre-ACA small group market, other benefits of equal value must be removed. In its web conference, the IOM also discussed incorporating annual service limits for some benefits.

The IOM report also concludes that *"the Section 1302 language that says 'the items and services covered within the categories' should not be read to mean that every service that is within one of the 10 categories or is covered by a typical employer plan should automatically be included within the definition of the EHB."*[9]

Many of the state-mandated health benefits in Connecticut can be argued to fit, whether in whole or in part, within one of the 10 categories as identified in the PPACA. However, this conclusion from the IOM in combination with the recommendation to develop a pre-defined cost target and build the EHBs to fit within these constraints creates uncertainty related to projecting what the final EHBs will be. In addition, state mandates that pass the initial criteria and definitions for an essential health benefit may still be excluded from the final EHB package due to premium constraints. This may result in an iterative process in determining the final EHBs. While providing additional guidance related to the recommended processes and considerations to include in the determination of the EHBs, these recommendations also create further uncertainty when projecting which state mandates may be in excess of the EHBs.

[8] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 7

[9] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 6

State Mandates – Resources

The State of Connecticut currently has a wide variety of mandated benefits. The mandates for health insurance contracts can be found in Chapter 700c of the General Statutes of Connecticut[10]. These mandates are categorized into the following general categories – benefit mandates (includes certain population mandates) and provider mandates. For purposes of this review, the focus of this section is on the benefit mandates. As the ten general categories of items and services identified as the EHBs by the PPACA encompass condition-specific care such as maternity and services related to specific populations such as newborns, this review also incorporates mandates that are condition-specific and population specific such as coverage for newborn infants.

Provider mandates are not explicitly identified as a part of the ten general categories of items and services, however, for completeness of this review, a summary of the provider mandates are included in this report. Table 1 lists the state-mandated health benefits reviewed for both the individual and group markets. Table 4 lists the provider mandates included for completeness of the review.

The State currently receives comprehensive reports describing the financial and social impact of the state-mandated health benefits as required by Public Act 09-179[11]. The act requires the commissioner to contract with the UConn Center for Public Health and Health Policy (UConn) to conduct reviews of the state-mandated health benefits and retain additional support as necessary to complete the reviews. As these reports reflect the most recently published reviews of the state mandates in Connecticut, they are referenced within this report. The reports are publicly available and can be accessed on-line.[11]

The UConn reports were not intended to specifically assess the impact of the PPACA, including an estimate of the potential cost to the State for state-mandated health benefits that are assumed to be in excess of the EHB. For purposes of this review, the cost estimates provided in the UConn reports are referenced as reasonable estimates related to the impact of the full cost attributable to each state-mandated health benefit based on paid medical charges.

The reports utilize claims data from six major carriers/managed care organizations domiciled in Connecticut representing 90% of the fully insured population. In addition, proprietary claims information from the reports contracted consultant Ingenix Consulting is utilized to compare against and supplement the carrier data.

While the cost estimates reflected in the report represent point estimates for each mandate, the report provides cost ranges to account for the variability inherent in any projection including actuarial estimation and judgment and data credibility issues. In addition, the cost estimates may

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[10] Chapter 700c – Health Insurance. http://www.cga.ct.gov/2011/pub/chap700c.htm (Accessed July 27, 2011)

[11] http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304

be overstated based on the mandate under review as there may be some overlap in reported claims for mandates that cover similar services. Also, there may be difficulty in isolating the exact impact of a mandate in the claims data which could result in potentially more claims data being pulled by the carrier.

Although results are displayed for both the individual market and the group market, due to the number of covered lives in each market, the results for the individual market analysis are less credible than the results for the group market. For a complete listing of the data limitations, methodology and caveats related to these reports, the reader should review the complete 2010 and 2011 reports including the appendices.

The Council for Affordable Health Insurance also distributes a report related to state mandates nationwide and high level cost estimate ranges associated with each identified mandate[12]. This information provides a state-by-state comparison of how prevalent certain broad types of health care mandates are throughout the nation.

Two additional resources were also reviewed as reasonable benchmarks to consider in estimating the covered services that may eventually be considered a part of the final EHBs. These are the Federal Employee Health Benefits Program and what self-funded groups offer as coverage in Connecticut in relation to the state-mandated health benefits (self-funded groups are not required to provide coverage for state-mandated health benefits). The 2010 UConn report includes a self-reported survey from insurance carriers that identify the percentage of members covered by each state-mandate offered by self-funded insurance.

It is noted that the IOM report recommends that a typical employer plan be initially defined as one that would be typical in the small employer market, while these additional resources reflect benefits observed in larger market segments. However, these additional resources are viewed as reasonable to use in terms of a general comparison to the scope of benefits covered as compared to the EHBs. The IOM report states that "*From what data is available, there exists little difference in the scope of benefits by firm size. However, the major differential in pricing comes from benefit design choices, including the level of deductible, cost sharing and out-of-pocket maximums.*"[13]

Each data source included in the review has its own limitations and data qualifications. These resources, and subsequent analysis, can be utilized and further refined once clarification from HHS is released as it relates to the final EHBs.

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[12] Victoria Craig Bunce and JP Wieske (2010). Health Insurance Mandates in the States 2010. Council for Affordable Health Insurance.

[13] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 14

Conclusions

Over time, the State has enacted many types of patient protections in the form of state-mandated health benefits. With the passing of the PPACA, the State must assume the cost for any state-mandated health benefit determined to be in excess of the EHBs that are offered inside of the health benefits exchange. The EHBs are not yet well-defined by HHS; however the targeted release date for the EHBs is anticipated to be no later than May 1, 2012.

The IOM report has provided some clarity as to the potential criteria and processes to consider in determining the final essential health benefits. However, the report also introduces additional uncertainty in making future estimates as to which state-mandated health benefits may be in excess of the final EHBs.

One significant recommendation made by the IOM incorporates cost as an integral component in the ultimate development of the EHBs. The IOM recommendation states that "*Once a preliminary EHB list is developed…, the package should be adjusted so that the expected national average premium for a silver plan with the EHB package is actuarially equivalent to the average premium that would have been paid by small employers in 2014 for a comparable population with a typical benefit design.*"[14]

This would potentially involve an iterative process designed to narrow the preliminary scope of benefits in order to yield an EHB package at an affordable premium. For example, benefits that could be reasonably argued as an essential health benefit as currently identified by the ten general categories of items and services identified as the EHBs may not ultimately end up in the final EHB package dependant upon the projected premium costs and prioritization of services to be included in the final package.

With this understanding, the conclusions presented in the following sections identify the state-mandated health benefits that are strongly assumed to be an EHB, and the remaining mandates are grouped as "unknown". This classification does not imply that the state-mandated health benefit will not be included in the final EHBs. It simply identifies that based upon the final IOM recommendations and which recommendations are ultimately adopted by HHS, each of the "unknown" state-mandated health benefits could fall into one of the following categories:

- Fully encompassed as an EHB
- Partially captured as an EHB
- Fully excluded as an EHB

The uncertainty driving this classification is driven by many factors including:

[14] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 5, Page 17

- Final detailed EHB guidance expected no later than May 1, 2012
- The IOM recommendation for a pre-defined cost target
- The recommended IOM evaluation criteria is multi-dimensional
- The flexibility provided states in defining covered services
- The allowances for benefit limits
- The allowances for policy exclusions
- The state mandates can be complex and multi-faceted

Rational arguments can be made for many of Connecticut's state-mandated health benefits as to why a specific mandate should be included in the final EHBs. However it is clear that based upon the constraints recommended by the IOM as described in previous sections of this report, some of these mandates will exceed the final EHBs either in whole or in part.

Individual Market Conclusions

Utilizing the cost estimates and the accompanying detailed financial, social and economic analysis as provided in the UConn reports, Table 2 summarizes the 2010 impact of various state-mandated health benefits in terms of a per member per month (PMPM) cost and a percentage of claims for the individual market. Similarly, Table 3 illustrates the same information, but it is specific to the group market. These appendices also include a column to identify whether or not each mandate is assumed to be included as an EHB or are unknown at this time.

In the individual market, thirty-seven state mandates were reviewed that comprise approximately 17.2% of the total projected 2010 medical cost PMPM for the average person covered by an individual policy. Of the individual mandates, nine of the state mandates are assumed to be an EHB based on Mercer's interpretation of the covered populations as defined by the EHBs, benefit reforms that have already been implemented, or benefit reforms that are scheduled to be implemented such as:

Providing preventive services with no cost sharing for:

- Services/items with a rating of "A" or "B" as recommended by US Preventive Services Task Force
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)

- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents

- Additional preventive care and screenings for women's' health as recommended by HRSA (scheduled to be implemented August 2012)

In addition, the comprehensive mandate covering tumors and leukemia, breast reconstruction and wigs reflects almost one-quarter of the total cost for all individual mandates. Because this mandate reflects such a large proportion of the total cost for all the individual mandates, Mercer specifically reviewed this mandate to provide a best estimate for classifying this mandate as an EHB or not. With the exception of the benefit for wigs, this mandate is assumed an EHB due to the near universal coverage of the mandated benefits across the nation, and the assumed importance of having these as covered benefits from the perspective of the general public.

These nine state-mandated benefits reflect almost one quarter of the total number of mandates, but over half of the projected costs of the mandates. Four of the remaining twenty-eight individual mandates reflect 75% of the remaining costs attributable to the individual mandates. Of these four mandates, only the infertility mandate is projected to mostly be excluded from the final EHBs. This identifies that thirteen of the thirty-seven individual mandates reflect over 88% of the total projected costs for the individual mandates. This illustrates one method that the State can utilize to prioritize its review and assessment of each state-mandated health benefit in relation to the final EHBs. A cost prioritization process will allow the State to address a more manageable number of mandates for review that comprise the majority of the projected costs.

A summary of the initial findings for the individual market are presented below:

Classification	Mandate Count	Estimated Percent of Claims – 2010
EHB	9	9.1%
Unknown	28	8.2%
Total	37	17.2%

** Totals may not sum due to rounding*

The 8.2% of claims estimate for the "unknown" classification can be viewed as a worst case scenario for the states exposure to benefits in excess of the EHB in the individual market based on the assumptions described in this report. However, it is much more likely that this value will decrease once the guidance from HHS related to the EHBs is provided as many of the mandates currently classified as "unknown" could be re-classified as an EHB either in whole or in part. The top five mandates classified as "unknown" based on projected costs in the individual market are presented below:

Statute	Summarized Description	Percent of Claims
Sec. 38a-488a	Mental or nervous conditions	2.67%
Sec. 38a-476b	Psychotropic drug availability	1.90%
Sec. 38a-492b	Off-label use of cancer drugs	0.91%
Sec. 38a-509	Infertility diagnosis and treatment	0.66%
Sec. 38a-498	Ambulance services	0.60%

Some of the mandates currently classified as “unknown” in this report have very strong, rational arguments as to why they should be considered an EHB. However, based on the IOM recommendations discussed previously, all of these “unknown” mandates could be at risk of being excluded from the EHBs or being included in the EHBs but not at the levels of coverage provided for in the state-mandates.

It is noted that the classification of these mandates will change, and refinements for the estimated cost impact can be further refined once more prescriptive clarification of the final EHB is provided by HHS targeted for release no later than May 1, 2012.

Group Market Conclusions

In the group market, forty state mandates were reviewed that comprise approximately 21.0 percent of the total projected 2010 medical cost PMPM for the average person covered by a group plan. Of the group mandates, nine of the state mandates are assumed to be an EHB based on similar criteria as detailed in the previous section for the individual mandates.

These nine state-mandated benefits reflect 22.5% of the number of mandates, but half of the projected costs of the mandates. Four of the remaining thirty-one group mandates reflect 69.2% of the remaining costs attributable to the group mandates. Of these four mandates, only the infertility mandate is projected to mostly be excluded from the final EHBs. This identifies that thirteen of the forty group mandates reflect almost 85% of the total projected costs for the group mandates.

The group mandates also includes a “mandatory offer” mandate for comprehensive rehabilitation services that allows groups to choose whether they want a policy with this type of coverage or not. The IOM report explicitly omits these types of mandatory offerings in its discussion of state mandates.[15] For purposes of this report, mandatory offerings are assumed to be treated similarly to other state mandates. If the benefits associated with the mandatory offering are in excess of the EHB, the State would be responsible for these costs for insurance provided through the health benefits exchange. However, as the PPACA moves away from health insurance rating based upon selection criteria towards a more level playing field, it is recommended that the

[15] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 15

State consider either fully enacting this mandatory offer into a more traditional benefit mandate or excluding it entirely to reduce the potential for adverse selection related to this offering.

A summary of the initial findings for the group market are presented below:

Classification	Mandate Count	Estimated Percent of Claims - 2010
EHB	9	10.6%
Unknown	31	10.4%
Total	40	21.0%

Note: Totals may not sum due to rounding

The 10.4% of claims estimate can be viewed as a worst case scenario for the states exposure to benefits in excess of the EHB in the group market based on the assumptions described in this report. However, it is much more likely that this value will decrease once the guidance from HHS related to the EHBs is provided as many of the mandates currently classified as “unknown” could be re-classified as an EHB either in whole or in part. The top five mandates classified as “unknown” based on projected costs in the group market are presented below:

Statute	Summarized Description	Percent of Claims
Sec. 38a-514	Mental or nervous conditions	2.83%
Sec. 38a-476b	Psychotropic drug availability	2.50%
Sec. 38a-518b	Off-label use of cancer drugs	0.95%
Sec. 38a-536	Infertility diagnosis and treatment	0.93%
Sec. 38a-523	Comprehensive Rehabilitation Services*	0.81%

** Mandatory offering*

Some of the mandates currently classified as “unknown” in this report have very strong, rational arguments as to why they should be considered an EHB. However, based on the IOM recommendations discussed previously, all of these “unknown” mandates could be at risk of being excluded from the EHBs or being included in the EHBs but not at the levels of coverage provided for in the state-mandates.

It is noted that the classification of these mandates will change, and refinements for the estimated cost impact can be further refined once more prescriptive clarification of the final EHB is provided by HHS in May 2012.

Provider Mandates

For completeness of this report, Table 4 summarizes six mandates impacting both the individual and group markets. These mandates typically require coverage for services rendered by a specific provider type or facility to the same extent that these services are covered by other providers. Certain benefit reforms may already address these provider mandates such as requiring access to an OB/GYN without a referral.

The projected 2010 cost impact of these six provider mandates reflect 0.65% of the total medical cost of an individual policy and 0.95% of the cost for a group policy. The mandate to provide coverage for licensed chiropractors represents the majority of the costs in both the individual and group markets ~ 90%. The IOM recommendations do not explicitly address coverage for specific provider types, focusing instead on the determination of medically necessary services. It is unknown at this time how these types of provider mandates will be addressed, or not addressed, in the final EHB. The IOM report states *"The PPACA prohibits insurers from discriminating on the basis of type of provider as long as the provider is operating within its scope of practice; however, this is a separate issue from defining specific types of services as being part of the EHB package."*[16]

Key Options and Considerations

The PPACA is a very complex and substantial piece of legislation. There are still many parts that have yet to be fully defined. Similarly, interpretations of the IOM report as well as the numerous regulations issued are still "evolving." There are many unknowns and various interpretations of many components of the legislation at the time this report is written, all of which could materially impact our conclusions. We have developed the following options based upon our knowledge and interpretations, and have endeavored to clearly state this throughout the report.

The final EHBs may not be defined until May 2012. It is almost impossible to predict which existing mandates other than the ones already implemented or are scheduled to be implemented will be included in any EHB. It must be kept in mind as well, that the IOM report is a recommendation to HHS. HHS does not have to accept it. However, given the concerns identified in the IOM report pertaining to accessibility, affordability and sustainability, we expect HHS to seriously consider using the IOM recommendations as the basis for making these difficult decisions.

Key Options

Based on this information, we have identified the following options for the State to consider with regard to state-mandated health benefits and the EHB.

[16] Essential Health Benefits – Balancing Coverage and Cost, IOM, Chapter 4, Page 19

Wait Until the EHB Guidance from HHS Is Fully Defined

This option allows Connecticut to eliminate the guess-work associated with determining which mandates, in whole or in part, will exceed the final EHBs. Resources can be utilized in other areas preparing for the implementation of the exchanges and other aspects of health care reform.

The major drawback to this option is the timing of the release of the guidance from HHS. If the guidance is released closer to May 2012, then policymakers are left with very little time to re-assess the cost impact based on the final HHS guidance and make decisions related to each mandated benefit.

Maintain All Existing Mandates

This option does not require immediate resources to estimate which mandates are included and which are not. The State also retains the authority for determining its mandated benefits.

The primary drawback to this option will be the cost of the state-mandated benefits in excess of the EHBs. The cost to the State will be greatest if it chooses to maintain all the existing mandated benefits currently in place and also continue to introduce new mandates. A cost estimate will eventually need to be completed to determine the level of benefits in excess of the EHB for budgeting purposes.

Define a Prioritization Process to Begin Discussions About How to Deal With the Mandates or Specific Combinations of Mandates

This option leverages the current information available to begin discussions related to maintaining or repealing state-mandated health benefits. This will allow the State to have decisions ready when the EHBs are finalized allowing the State to move quickly in assessing each mandated benefit. This report provides a prioritization process based on projected costs for each mandate. However, decisions to maintain, repeal or scale back any mandate should encompass a much broader discussion related to the medical efficacy and social impact of the mandate in addition to the financial cost of the mandate.

The drawback to this option is the complexity in determining which mandates to review, in what level of detail, and how to engage the public in these discussions. This can be a complicated, time consuming and resource intensive process.

Key Considerations

Maintaining the patient protections afforded by state-mandated health benefits is a highly visible topic that comes with many different perspectives. Because of this, the following list provides some key issues to consider as additional guidance is provided related to the EHBs and more in depth analysis and discussions can be performed related to the state-mandated benefits:

- Discuss the process the State would like to utilize to determine what to do with state benefit mandates that are determined to be in excess of the EHBs. It is our understanding that the Exchange Board does not have the statutory authority to legislate changes to the state benefit mandates. However, the Exchange Board can develop a process to determine which mandates to ultimately change through legislation.

- Incorporate the financial, medical efficacy and social impact perspectives in the determination process.

- Decide how to incorporate public comments related to the discussions about state mandates determined to be in excess of the EHBs.

- Reassess the assumptions presented in this report to determine the mandates that are in excess of the EHB once more prescriptive guidance is provided by HHS targeted for release no later than May 1, 2012.

- Discuss the potential selection bias as a result of having the costs of state benefit mandates defrayed by the state for plans offered inside of the Exchange versus the member paying for the mandates through premiums for plans offered outside of the Exchange. This would result in lower premiums to the consumer for plans offered inside of the Exchange versus similar plans offered outside of the Exchange for each insurance carrier.

- Determine if Connecticut should continue to introduce new legislation related to state-mandated health benefits prior to the release of the final EHBs in 2012.

- Discuss how to address provider mandates, such as the chiropractor mandate. This assessment should take into consideration the medical efficacy, social and financial impact of this action.

- Discuss how to address mandates that are not as costly, but may serve a larger social need, regional need or it provides patient protections to a small segment of the insured population that Connecticut would like to maintain such as Lyme disease treatments.

- Determine how to address the mandatory offer mandate in the group market.

Supplemental Note

After the completion of this report, a proposed bulletin to provide information and solicit comments was released by the Center for Consumer Information and Oversight (CCIIO) on December 16, 2011 related to the definition of the EHBs. This is not a final rule, however it does provide additional guidance for HHS to consider as it relates to the development of the EHBs. Some key items to note:

- Flexibility. Each state would be allowed to define an EHB by a “benchmark plan” to be selected from a pre-determined list of plan designs.

- Flexibility. Health plans would be allowed to develop plan designs that adjust the benefits, provided that the design maintains coverage for all 10 statutory EHB categories and the changes result in an equivalent value of benefits.

- State mandates. Dependant upon the choice of a “benchmark plan”, state benefit mandates may ultimately be encompassed as a part of the state’s EHB during a stated transition period in 2014 and 2015. This could occur if the state chooses a benchmark subject to state mandates. This transition period could provide states with additional time to coordinate their benefit mandates with the EHB. In 2016 HHS may revise the approach in determining the EHB which may exclude some state benefit mandates from the EHB.

- Cost. No significant guidance was provided as it relates to the cost of the EHB.

Table 4g-1

Number	Individual Policy Statute[1]	Group Policy Statute[1]	Summarized Description
1.	Sec. 38a-476b.	Sec. 38a-476b.	Psychotropic drug availability.
2.	Sec. 38a-483c.	Sec. 38a-513b.	Experimental treatments.
3.	Sec. 38a-488a.	Sec. 38a-514.	Mental or nervous conditions.
4.	Sec. 38a-488b.	Sec. 38a-514b.	Autism spectrum disorder therapies.
5.	Sec. 38a-490.	Sec. 38a-516.	Coverage for newborn infants.
6.	Sec. 38a-490a.	Sec. 38a-516a.	Birth to three program.
7.	Sec. 38a-490b.	Sec. 38a-516b.	Hearing aids for children twelve and under.
8.	Sec. 38a-490c.	Sec. 38a-516c.	Craniofacial disorders.
9.	Sec. 38a-490d.		Blood lead screening and risk assessment.
10.	Sec. 38a-491a.	Sec. 38a-517a.	Dental coverage - Inpatient, outpatient, and one-day dental services.
11.	Sec. 38a-492.	Sec. 38a-518.	Accidental ingestion of controlled drug.
12.	Sec. 38a-492a.	Sec. 38a-518a.	Hypodermic needles and syringes.
13.	Sec. 38a-492b.	Sec. 38a-518b.	Off-label use of cancer drugs.
14.	Sec. 38a-492c.	Sec. 38a-518c.	Low protein modified food products, amino acid modified preparations and specialized formulas.
15.	Sec. 38a-492d.	Sec. 38a-518d.	Diabetes testing and treatment.
16.	Sec. 38a-492e.	Sec. 38a-518e.	Diabetic self management training.
17.	Sec. 38a-492f.	Sec. 38a-518f.	Prescription drugs removed from formulary.
18.	Sec. 38a-492g.	Sec. 38a-518g.	Prostate cancer screening.
19.	Sec. 38a-492h.	Sec. 38a-518h.	Lyme disease treatments.
20.	Sec. 38a-492j.	Sec. 38a-518j.	Ostomy-related supplies.
21.	Sec. 38a-492k.	Sec. 38a-518k.	Colorectal cancer screening.
22.	Sec. 38a-492l.	Sec. 38a-516d.	Neurophysical testing for children diagnosed with cancer.
23.	Sec. 38a-492m.	Sec. 38a-518l.	Renewals of prescription eye drops.
24.	Sec. 38a-492n.	Sec. 38a-518m.	Mandatory coverage for certain wound-care supplies.
25.	Sec. 38a-493.	Sec. 38a-520.	Home health care.
26.	Sec. 38a-496.	Sec. 38a-524.	Occupational therapy.
27.	Sec. 38a-498.	Sec. 38a-525.	Ambulance services.
28.	Sec. 38a-498c.	Sec. 38a-525c.	Prohibition on denying coverage for treatment of injury based on consumption or intoxication from alcohol, drugs or both.
29.	Sec. 38a-503.	Sec. 38a-530.	Mammography and breast ultrasound.
30.	Sec. 38a-503c.	Sec. 38a-530c.	Maternity minimum stay.
31.	Sec. 38a-503d.	Sec. 38a-530d.	Mastectomy or lymph node dissection (48 hours).
32.	Sec. 38a-503e.	Sec. 38a-530e.	Prescription contraceptives.
33.	Sec. 38a-504.	Sec. 38a-542.	Tumors and leukemia, wigs, breast reconstruction.
34.	Sec. 38a-504a.	Sec. 38a-542a.	Cancer clinical trials: Coverage for routine patient care costs.
35.	Sec. 38a-509.	Sec. 38a-536.	Infertility diagnosis and treatment.
36.	Sec. 38a-510.	Sec. 38a-544.	Prohibit against requiring an insured to obtain prescription drugs from a mail order pharmacy.
37.	Sec. 38a-511.	Sec. 38a-550.	Co-payments regarding in-network imaging services.
38.		Sec. 38a-523.	Comprehensive rehabilitation services (mandatory offer).
39.		Sec. 38a-533.	Treatment of medical complications of alcoholism.
40.		Sec. 38a-535.	Preventive Pediatric Care and Blood Lead Screening
41.		Sec. 38a-547.	Maternity benefits and pregnancy care following policy termination.

1. *Detailed legislation can be accessed at http://www.cga.ct.gov/2011/pub/chap700c.htm .*

Table 4g-2

Number	Individual Policy Statute[1]	Summarized Description	2010 Estimates Percent of Claims[2]	2010 Estimates Medical PMPM[2]	Assumption: Essential Benefit
1.	Sec. 38a-476b.	Psychotropic drug availability.	1.90%	$ 3.98	Unknown
2.	Sec. 38a-483c.	Experimental treatments.	0.00%	$ -	Unknown
3.	Sec. 38a-488a.	Mental or nervous conditions.	2.67%	$ 5.60	Unknown
4.	Sec. 38a-488b.	Autism spectrum disorder therapies.[3]	0.00%	$ -	Unknown
5.	Sec. 38a-490.	Coverage for newborn infants.	1.89%	$ 3.96	Yes
6.	Sec. 38a-490a.	Birth to three program.	0.12%	$ 0.25	Unknown
7.	Sec. 38a-490b.	Hearing aids for children twelve and under.	0.00%	$ 0.01	Unknown
8.	Sec. 38a-490c.	Craniofacial disorders.	0.01%	$ 0.03	Unknown
9.	Sec. 38a-490d.	Blood lead screening and risk assessment.	0.00%	$ -	Yes
10.	Sec. 38a-491a.	Dental coverage - Inpatient, outpatient, and one-day dental services.	0.09%	$ 0.19	Unknown
11.	Sec. 38a-492.	Accidental ingestion of controlled drug.	0.01%	$ 0.02	Unknown
12.	Sec. 38a-492a.	Hypodermic needles and syringes.	0.00%	$ 0.01	Unknown
13.	Sec. 38a-492b.	Off-label use of cancer drugs.	0.91%	$ 1.91	Unknown
14.	Sec. 38a-492c.	Low protein modified food products, amino acid modified preparations and specialized formulas.	0.04%	$ 0.08	Unknown
15.	Sec. 38a-492d.	Diabetes testing and treatment.	0.27%	$ 0.56	Yes
16.	Sec. 38a-492e.	Diabetic self management training.	0.01%	$ 0.02	Unknown
17.	Sec. 38a-492f.	Prescription drugs removed from formulary.	0.00%	$ -	Unknown
18.	Sec. 38a-492g.	Prostate cancer screening.	0.05%	$ 0.11	Yes
19.	Sec. 38a-492h.	Lyme disease treatments.	0.16%	$ 0.34	Unknown
20.	Sec. 38a-492j.	Ostomy-related supplies.	0.01%	$ 0.02	Unknown
21.	Sec. 38a-492k.	Colorectal cancer screening.	0.80%	$ 1.68	Yes
22.	Sec. 38a-492l.	Neurophysical testing for children diagnosed with cancer.	0.00%	$ -	Unknown
23.	Sec. 38a-492m.	Renewals of prescription eye drops.[4]	0.02%	$ 0.05	Unknown
24.	Sec. 38a-492n.	Mandatory coverage for certain wound-care supplies.[5]	Not Available	Not Available	Unknown
25.	Sec. 38a-493.	Home health care.	0.36%	$ 0.75	Unknown
26.	Sec. 38a-496.	Occupational therapy.	0.20%	$ 0.42	Unknown
27.	Sec. 38a-498.	Ambulance services.	0.60%	$ 1.25	Unknown
28.	Sec. 38a-498c.	Prohibition on denying coverage for treatment of injury based on consumption or intoxication from alcohol, drugs or both.	0.05%	$ 0.10	Unknown
29.	Sec. 38a-503.	Mammography and breast ultrasound.	0.90%	$ 1.88	Yes
30.	Sec. 38a-503c.	Maternity minimum stay.	0.61%	$ 1.28	Yes
31.	Sec. 38a-503d.	Mastectomy or lymph node dissection (48 hours).	0.03%	$ 0.07	Unknown
32.	Sec. 38a-503e.	Prescription contraceptives.	0.45%	$ 0.94	Yes
33.	Sec. 38a-504.	Tumors and leukemia, wigs, breast reconstruction.	4.10%	$ 8.60	Yes
34.	Sec. 38a-504a.	Cancer clinical trials: Coverage for routine patient care costs.	0.00%	$ -	Unknown
35.	Sec. 38a-509.	Infertility diagnosis and treatment.	0.66%	$ 1.39	Unknown
36.	Sec. 38a-510.	Prohibit against requiring an insured to obtain prescription drugs from a mail order pharmacy.	0.00%	$ -	Unknown
37.	Sec. 38a-511.	Co-payments regarding in-network imaging services.	0.33%	$ 0.69	Unknown

1. *Detailed legislation can be accessed at http://www.cga.ct.gov/2011/pub/chap700c.htm .*
2. *2010 Connecticut Mandated Health Insurance Benefits Reviews accessed at http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304.*
3. *Due to a timing issue related to the collection of data and the enactment of more recent legislation, the cost estimate for autism spectrum disorder therapies are understated. In 2010, this mandate was expanded to cover additional behavioral health therapy services such as psychiatric and psychological services. The current estimate only reflects the costs for physical therapy, occupational therapy and speech therapy.*
4. *2011 Connecticut Mandated Health Insurance Benefits Reviews accessed at http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304.*
5. *Recently enacted legislation. No cost estimates avaialble.*

Table 4g-3

Number	Group Policy Statute[1]	Summarized Description	2010 Estimates Percent of Claims[2]	2010 Estimates Medical PMPM[2]	Assumption: Essential Benefit
1.	Sec. 38a-476b.	Psychotropic drug availability.	2.50%	$ 7.50	Unknown
2.	Sec. 38a-513b.	Experimental treatments.	0.00%	$ 0.01	Unknown
3.	Sec. 38a-514.	Mental or nervous conditions.	2.83%	$ 8.50	Unknown
4.	Sec. 38a-514b.	Autism spectrum disorder therapies.[3]	0.01%	$ 0.03	Unknown
5.	Sec. 38a-516.	Coverage for newborn infants.	1.65%	$ 4.96	Yes
6.	Sec. 38a-516a.	Birth to three program.	0.07%	$ 0.22	Unknown
7.	Sec. 38a-516b.	Hearing aids for children twelve and under.	0.00%	$ 0.01	Unknown
8.	Sec. 38a-516c.	Craniofacial disorders.	0.01%	$ 0.02	Unknown
9.	Sec. 38a-517a.	Dental coverage - Inpatient, outpatient, and one-day dental services.	0.02%	$ 0.05	Unknown
10.	Sec. 38a-518.	Accidental ingestion of controlled drug.	0.01%	$ 0.03	Unknown
11.	Sec. 38a-518a.	Hypodermic needles and syringes.	0.02%	$ 0.05	Unknown
12.	Sec. 38a-518b.	Off-label use of cancer drugs.	0.95%	$ 2.86	Unknown
13.	Sec. 38a-518c.	Low protein modified food products, amino acid modified preparations and specialized formulas.	0.08%	$ 0.24	Unknown
14.	Sec. 38a-518d.	Diabetes testing and treatment.	1.53%	$ 4.60	Yes
15.	Sec. 38a-518e.	Diabetic self management training.	0.02%	$ 0.06	Unknown
16.	Sec. 38a-518f.	Prescription drugs removed from formulary.	0.00%	$ -	Unknown
17.	Sec. 38a-518g.	Prostate cancer screening.	0.06%	$ 0.19	Yes
18.	Sec. 38a-518h.	Lyme disease treatments.	0.09%	$ 0.28	Unknown
19.	Sec. 38a-518j.	Ostomy-related supplies.	0.02%	$ 0.06	Unknown
20.	Sec. 38a-518k.	Colorectal cancer screening.	1.13%	$ 3.40	Yes
21.	Sec. 38a-516d.	Neurophysical testing for children diagnosed with cancer.	0.00%	$ -	Unknown
22.	Sec. 38a-518l.	Renewals of prescription eye drops.[4]	0.02%	$ 0.07	Unknown
23.	Sec. 38a-518m.	Mandatory coverage for certain wound-care supplies.[5]	Not Available	Not Available	Unknown
24.	Sec. 38a-520.	Home health care.	0.49%	$ 1.47	Unknown
25.	Sec. 38a-524.	Occupational therapy.	0.29%	$ 0.86	Unknown
26.	Sec. 38a-525.	Ambulance services.	0.76%	$ 2.27	Unknown
27.	Sec. 38a-525c.	Prohibition on denying coverage for treatment of injury based on consumption or intoxication from alcohol, drugs or both.	0.01%	$ 0.03	Unknown
28.	Sec. 38a-530.	Mammography and breast ultrasound.	0.85%	$ 2.54	Yes
29.	Sec. 38a-530c.	Maternity minimum stay.	0.62%	$ 1.85	Yes
30.	Sec. 38a-530d.	Mastectomy or lymph node dissection (48 hours).	0.03%	$ 0.10	Unknown
31.	Sec. 38a-530e.	Prescription contraceptives.	0.40%	$ 1.20	Yes
32.	Sec. 38a-542.	Tumors and leukemia, wigs, breast reconstruction.	3.67%	$ 11.00	Yes
33.	Sec. 38a-542a.	Cancer clinical trials: Coverage for routine patient care costs.	0.00%	$ -	Unknown
34.	Sec. 38a-536.	Infertility diagnosis and treatment.	0.93%	$ 2.80	Unknown
35.	Sec. 38a-544.	Prohibit against requiring an insured to obtain prescription drugs from a mail order pharmacy.	0.00%	$ -	Unknown
36.	Sec. 38a-550.	Co-payments regarding in-network imaging services.	0.33%	$ 1.00	Unknown
37.	Sec. 38a-523.	Comprehensive rehabilitation services (mandatory offer).	0.81%	$ 2.42	Unknown
38.	Sec. 38a-533.	Treatment of medical complications of alcoholism.	0.12%	$ 0.37	Unknown
39.	Sec. 38a-535.	Preventive Pediatric Care and Blood Lead Screening	0.64%	$ 1.91	Yes
40.	Sec. 38a-547.	Maternity benefits and pregnancy care following policy termination.	0.00%	$ -	Unknown

1. *Detailed legislation can be accessed at http://www.cga.ct.gov/2011/pub/chap700c.htm .*
2. *2010 Connecticut Mandated Health Insurance Benefits Reviews accessed at http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304.*
3. *Due to a timing issue related to the collection of data and the enactment of more recent legislation, the cost estimate for autism spectrum disorder therapies are understated. In 2010, this mandate was expanded to cover additional behavioral health therapy services such as psychiatric and psychological services. The current estimate only reflects the costs for physical therapy, occupational therapy and speech therapy.*
4. *2011 Connecticut Mandated Health Insurance Benefits Reviews accessed at http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304.*
5. *Recently enacted legislation. No cost estimates avaialble.*

Table 4g-4

Number	Individual Policy Statute[1]	Group Plan Statute[1]	Summarized Description	2010 Estimate - Individual Percent of Claims[2]		Medical PMPM[2]	2010 Estim Percent of Claims[2]
1.	Sec. 38a-492i.	Sec. 38a-518i.	Mandatory coverage for pain management.	0.00%	$	-	0.00%
2.	Sec. 38a-498b.	Sec. 38a-525b.	Mandatory coverage for mobile field hospital.	0.00%	$	-	0.00%
3.	Sec. 38a-499.	Sec. 38a-526.	Mandatory coverage for services of physician assistants and certain nurses.	0.00%	$	-	0.00%
4.	Sec. 38a-502.	Sec. 38a-529.	Mandatory coverage for services provided by the Veterans' Home.	0.07%	$	0.14	0.11%
5.	Sec. 38a-503b.	Sec. 38a-530b.	Carriers to permit direct access to obstetrician-gynecologist.	0.00%	$	-	0.00%
6.	Sec. 38a-507.	Sec. 38a-534.	Mandatory coverage for chiropractic services.	0.59%	$	1.23	0.84%

1. *Detailed legislation can be accessed at http://www.cga.ct.gov/2011/pub/chap700c.htm .*
2. *2010 Connecticut Mandated Health Insurance Benefits Reviews accessed at http://www.ct.gov/cid/cwp/view.asp?a=1254&q=447304.*

TASK 4h – Impact of the Exchange on Insurer Profitability and Potential Market Exit

Background

The Patient Protection and Affordable Care Act (PPACA) and the Health Insurance Exchanges (Exchanges) either have removed or will remove some of the primary means health insurers have historically used to compete for business. The federal minimum loss ratio requirements have made it very difficult for certain carriers to win business by paying high commissions.[1] Guarantee issue eliminates a company's ability to use sophisticated underwriting systems to avoid enrolling unhealthy individuals, and we expect the Exchanges to bring additional transparency to benefit design, making it more difficult for carriers to use benefit features as a means of competition.

In Table 4h-1 below, we show experience in the individual market from the 2010 Supplemental Health Care Exhibits that carriers file with the Connecticut Insurance Department as part of their annual statutory financial filings.

Table 4h-1

Individual Market in Connecticut -- 2010

Company	Covered Lives	Earned Premium (1,000s)	Loss Ratio	Underwriting Margin	Underwriting Margin at 80% MLR
Aetna	16,117	$ 31,486	0.655	16%	-3%
Assurant Group	2,543	9,952	0.708	-1%	-14%
ConnectiCare	8,649	30,916	0.695	5%	-9%
United	22,025	56,847	0.696	10%	-4%
WellPoint	55,665	193,189	0.801	8%	8%
Other	3,476	14,064	0.753	1%	-5%
Total	108,475	$ 336,453	0.755	8%	2%

Source: 2010 Supplemental Health Care Exhibits except underw riting margin at 80% MLR w hich is an Oliver Wyman tabulation.

The data in Table 4h-1 have been rolled up to the holding company level. As an example, Aetna wrote business in the individual market in Connecticut through two separate legal entities in 2010. In Table 4h-1, we have combined the experience for both of these companies and show the result as Aetna.

[1] "Insurance Brokers and the Medical Loss Ratio," The Kaiser Family Foundation, December 8, 2011.

Note that the loss ratio we show in Table 4h-1 makes use of the federal definition of the minimum loss ratio (MLR), which allows certain administrative expenses related to quality improvement to be added to claims and certain taxes and fees to be subtracted from premium. In 2011 and beyond, the minimum loss ratio is 0.80 for small groups and individual businesses. Carriers that do not meet this minimum must return the excess premium in the form of rebates. In Connecticut's individual market, only WellPoint had an MLR greater than the federal minimum.

Across the entire market, the underwriting margin was 8%. In the last column of Table 4h-1, we show the underwriting margin, where we reduced the premium to produce a 0.80 MLR. The market-wide MLR declines from 8% to 2%. While this is only one year's results, companies with a large negative underwriting margin at the 0.80 MLR could be considered at risk for leaving the market. If the 2010 experience were to be repeated in 2011, these companies would either have to manage expenses more aggressively than they did in 2010 or face underwriting losses.

While the number of individuals insured by carriers at risk for market exit may be relatively small, a market exit by those carriers could make it difficult for their insured to find affordable replacement coverage.

In Table 4h-2 below, we show the same information for the small group market.

Table 4h-2

Small Group Market in Connecticut -- 2010

Company	Covered Lives	Earned Premium (1,000s)	Loss Ratio	Underwriting Margin
Aetna	27,905	$ 108,098	0.812	6%
Cigna	36,943	97,832	0.922	-7%
ConnectiCare	53,603	244,627	0.804	4%
United	94,694	437,044	0.834	9%
WellPoint	82,533	488,072	0.873	9%
Other	2,749	20,819	0.780	5%
Total	298,427	$ 1,396,492	0.846	7%

Source: 2010 Supplemental Health Care Exhibits

In the small group market, all the major carriers had MLRs in excess of the federal MLR.

The profitability of carriers operating both inside and outside the Exchanges or only inside the Exchanges could suffer if the Exchanges experience adverse selection relative to the non-Exchange market, and some carriers are allowed to operate only outside of the Exchanges. Carriers that choose to operate both inside and outside of the Exchange would be required to

develop premiums based on the combined experience of their Exchange and non-Exchange business, and they would be required to charge the same premiums both inside and outside of the Exchange. Competitive pressures would limit premiums so that these carriers would not be able to price for this adverse selection and their profitability would likely suffer.

This adverse selection could come about from a number of different sources. Carriers operating only outside of the Exchanges may use marketing or other tools to attract more favorable risks. There is evidence that individuals with incomes below 200% FPL have higher morbidity than those with higher incomes.[2] Because subsidies are only available to individuals purchasing their coverage through the Exchange, we expect the individual Exchange to attract a disproportionate percentage of low-income individuals with relatively high morbidity. Finally, the small employer tax credits are most attractive to the smallest employers, and these employers tend to have the highest morbidity.[3]

Risk adjustment will help mitigate this problem of adverse selection and carriers operating only outside of the Exchange but is unlikely to completely eliminate it, as risk adjustment systems tend to underpay for high-cost claimants and overpay for low-cost claimants.[4]

Considerations

The pricing and financing mechanisms and the operating cost of the Exchange could have a significant impact on insurers' profitability. To the extent the Exchange charges more for the services it delivers than carriers could provide those services for on their own, carrier profitability could be compromised, particularly if some carriers to stay out of the Exchange completely, as those carriers that choose to stay outside of the Exchange completely could charge lower premiums.

It is likely that participating in the Exchange will increase a carrier's administrative costs. There will be a need for additional information technology capabilities to participate in the Exchange. Carriers operating in the Exchange will have to shepherd their products through the process of obtaining a certification as a qualified health plan which could be in addition to the form and rate approval process the Connecticut Insurance Department currently runs. Carriers participating in the Exchange may also have additional reporting requirements.

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[2] Bueno, D., The Relationship Between Income, Health Status, and Health Expenditures in the United States, M.B.A. Thesis, Sloan School of Management, 2011.

[3] See, for example, Gorman, B., Preliminary Data Analysis, Wisconsin Small Group Market, July 16, 2008, available at www.statecoverage.org/files/Appendix%201.pdf.

[4] Hsu, J., et al. Distributing $800 Billion: An Early Assessment of Medicare Part D Risk Adjustment, Health Affairs, Vol. 28, No. 1, January/February 2009

Allowing carriers to operate only outside of the Exchanges could put downward pressure on the profitability of those carriers who chose to operate inside the Exchanges if there is adverse selection in the Exchanges relative to the non-Exchange markets.

If the Exchange were financed through an assessment on the market as a whole, the misalignment between the Exchange's charges and the carriers' cost of providing services would be eliminated. However, there are other issues associated with implementing a broad-based fee, such as the question of equity, as a broad-based fee would mean that individuals and groups purchasing their coverage outside of the Exchange would be paying for services they were not directly using.

Two other factors will likely put significant pressures on carriers' profitability. First, because the premium subsidies available in the individual market are based on the difference between the second lowest cost Silver level plan and a given percentage of an individual's income, the cost of purchasing a plan more expensive than the second lowest cost Silver level plan is completely borne by the insured. As an example, the federal poverty level (FPL) for a family of four was approximately $22,000 in 2010. At 250% of the FPL, that family would be expected to pay 8.05% of income towards the cost of coverage or roughly $370 per month. Assume the second lowest cost premium in the market was $1,250 per month. The subsidy would be the difference or $880. If this family wanted to buy the next, more expensive, policy that was priced 5% higher, the family's cost would go from $370 per month to about $433 ($433 = $1,250 x 1.05 - $880 subsidy), an increase of $63 per month or roughly $750 per year. Because the subsidized population will have to pay the full difference in price between the second lowest cost Silver level plan and any product more expensive, we expect that there will be considerable pressure on carriers to keep prices low.

The second factor that we believe will put pressure on profitability is the additional transparency that the Exchange will bring to the market.[5] This transparency will result from two changes. First, people will be able to comparison shop with ease. Second, products will be somewhat standardized, as they will have to meet certain actuarial values and cover the Essential Health Benefits package.

We expect the result of these forces will be to favor those insurers that are most effective at managing the care delivered to their members, at managing administrative expenses, and those who are best able to negotiate provider contracts that result in a unit cost advantage relative to the competition or that most successfully engage providers in managing patient care, each of which typically require scale and favor larger carriers.

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[5] See, for example, the Massachusetts HealthConnector website for an example of this transparency at https://www.mahealthconnector.org/portal/site/connector/.

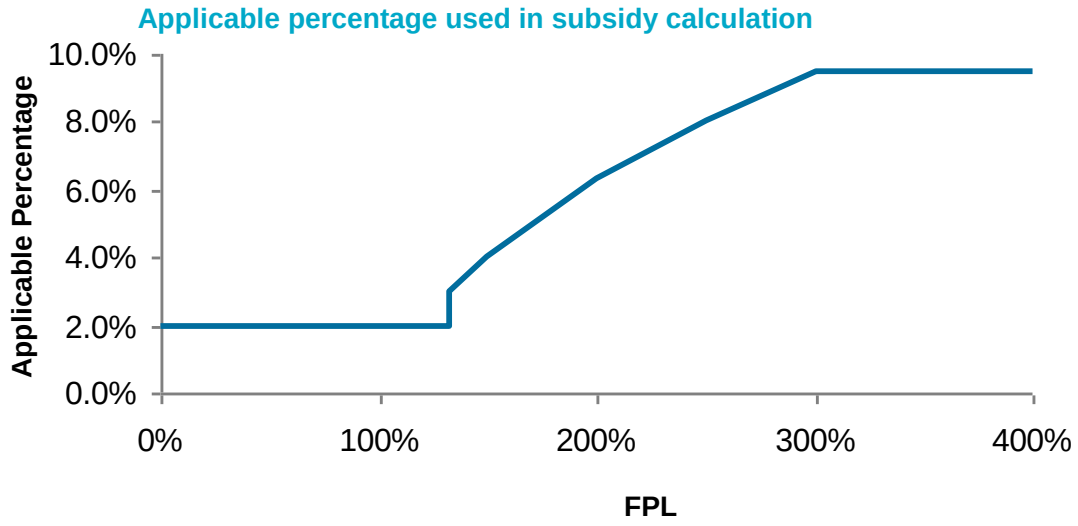
TASK 4i – Impact of the Exchange on Household Budgets

Background

The Patient Protection and Affordable Care Act (PPACA) provides premium tax credits (premium subsidies) for individuals with income up to 400% of the federal poverty level (FPL) and cost sharing subsidies for individuals with incomes up to 250% of the FPL.[1] The premium subsidy is equal to the cost of the second lowest cost Silver Level plan in the market, less the applicable percentage of income. These subsidies are only available to individuals who purchase their coverage through the Health Insurance Exchange (Exchange).

At 150% of the FPL, the applicable percentage of income that individuals or families must pay towards the cost of coverage is 4%. At 250% of the FPL, the applicable percentage is 8.05% of income. We show the applicable percentage in Chart 4i-1 below.

Chart 4i-1



The cost sharing subsidies increase the actuarial value of the insured's benefit plan above the Silver Level so that the individual will be responsible for lower cost sharing amounts. We show this in Table 4i-1 below.

[1] PPACA Sec. 1412.

Table 4i-1[2]

Household Income as a % of FPL	Out-of-pocket Limit Relative to Maximum Permissible	Actuarial Value After Subsidy
138% to 150%	Reduced by two-thirds	0.94
151% to 200%	Reduced by two-thirds	0.87
201% to 250%	Reduced by one-half	0.73
251% to 300%	Reduced by one-half	0.70
301% to 400%	Reduced by one-third	0.70

The maximum permissible out-of-pocket limit is based on the maximum permissible for health services agreement (HSA) qualified high deductible health plans. In 2010, this was $5,950 for single coverage and $11,900 for family coverage.[3] Thus a two-thirds reduction in the out-of-pocket cost would result in a maximum out-of-pocket cost of $2,000 for single coverage and $4,000 for family coverage for households with incomes up through 200% FPL. If needed, additional adjustments would be made to cost sharing amounts such as deductible, copays and coinsurance so that individuals with incomes up through 250% FPL would have their plans adjusted to produce the actuarial values shown in Table 4i-1. As an example, rather than being responsible for 30% of the cost sharing associated with the Silver Level plan, individuals with incomes less than 150% FPL will be responsible for no more than 6% of total plan costs.

Modeling Results

As we discussed previously, our model produces a considerable shift in the distribution of enrollees among the individual market, the small group market and uninsured population. We show this shift in Chart 4i-2 below.

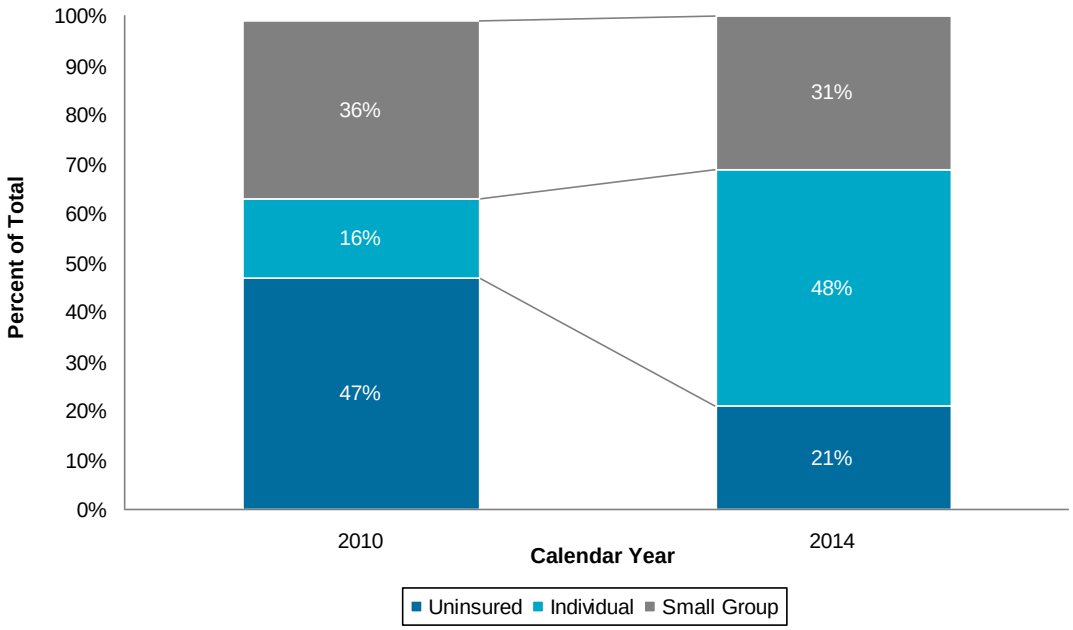
[2] Chaikind, H., et al., Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA), Congressional Research Services, May 4, 2010.

[3] http://www.irs.gov/irb/2009-22_IRB/ar09.html

Chart 4i-2

Change in the make-up of the market

Individual, uninsured and small group combined



Considering the total universe to be those who are uninsured and those with individual or small group coverage, we are expecting the percentage of the market represented by the uninsured to decline between 2010 and 2014 from roughly 48% (343,000) to 21% (149,000). The individual market will grow during that time from 16% (117,000) to 48% (330,000), and the small group market will decline from 36% (263,000) to 31% (214,000). The movement of the population to the individual market is driven largely by the availability of subsides which primarily draw those who were previously uninsured. Note that this universe does not consider those covered by mid-sized and large employers or government programs like Medicaid.

This shift has important implications for household expenditures on health care services. Even for those eligible for subsidies, the cost of paying the premium net of subsidies and the associated cost sharing will consume a material portion of their household income. Consider, for example, a family of four with income at 251% of the FPL. At this level of income, the applicable percentage of income would be 8.05% and they would not be eligible for cost sharing subsidies. Using 2010 dollars, at this level of the FPL, their income would be roughly $55,000, so they would be expected to contribute 8.05% of their income or $4,428 towards the cost of a premium. (For this example, we assume a premium for this coverage of $14,000.) Out-of-pocket cost sharing at the Silver Level would be roughly $4,800.[4] These two amounts taken together total

[4] Calculated as 30% cost sharing x $14,000 premium x 0.80 loss ratio / 0.70 actuarial value for Silver Level plan.

$9,228 or roughly 18% of income. While this represents a material portion of income, the presence of health insurance provides important benefits, including limits on out-of-pockets costs, access to provider discounts and improved access to medical care. In addition, the plans that will be offered in 2014 will generally be more comprehensive than many plans currently available in the market.

A second important consequence of the change in the make-up of the market illustrated above is the shift away from employer coverage. In the small group market in Connecticut, employers pay roughly 75% of the cost of premiums and employees are asked to pay roughly 25% of the cost; this 25% is tax-advantaged.[5] In the individual market in 2014, we are estimating that roughly 75% of individuals in the Exchange will receive subsidies and about 60% of the individual market will be covered through the Exchange. So, for the entire individual market we estimate that roughly 45% of individuals will receive subsidies and 55% will not. For those receiving subsides, we expect the subsidies to cover roughly 60% of the cost of premiums and the enrollees will be responsible for roughly 40% of the cost. Even for many of those who will be subsidy eligible, the cost of premiums will be generally higher in the individual market than in the small group market.

In Table 4i-2 below, we have grouped health insurance units (HIU) into one of three buckets: low, medium and high, depending on their expected spending on health care services. Expected costs could be high for a number of reasons: the family members could be old, the family could be large or there could be family members with high morbidity. We have also grouped these HIUs by their income relative to the FPL. The estimates in the table are the out-of-pocket spending net of the cost sharing subsidies, plus the cost of premiums after premium subsidies and employer contributions, all divided by family income to show the spending on health care as a percentage of income in 2010 and 2014. Note that we have valued expected claims among the uninsured at 10% of the modeled cost to reflect bad debt and charity care.

[5] MEPS 2010, Table II, available at
http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=6&year=2010

Table 4i-2

Out-of-Pocket Spending for Health Care by FPL and Health Burden
Uninsured, Individual, and Small Group Markets Combined

Health Burden	139-200%	201-300%	301-400%	Over 400%
		2010		
Low	4%	5%	4%	4%
Medium	8%	9%	6%	8%
High	18%	16%	10%	10%
Total	8%	9%	6%	7%
		2014		
Low	8%	14%	4%	5%
Medium	11%	19%	12%	10%
High	13%	17%	13%	12%
Total	11%	17%	11%	10%

As would be expected, the percentage of income spent on health care increases with the health burden. This is primarily a function of the out-of-pocket costs and the propensity of those with a higher health burden to purchase health insurance. In addition, the percentage of income spent on health care tends to decline with increasing income. The exception to this tendency is shown for incomes between the 138% to 200% of FPL income range and the 201% to 300% range. This is because the percentage of income that goes towards paying premiums increases from roughly 5% between 138% and 200% of the FPL to roughly 8% in the 200% to 300% range, and the cost sharing subsides are also relatively lower in the higher income range.

Discussion

There are several factors, other than the premium and cost sharing subsidies, which will likely impact household budgets. The mandate to maintain coverage and the penalty associated with not doing so would be among the other factors. We have not reflected these factors in Table 4i-2. In addition, it is likely that employers dropping coverage would increase their employees' wages by some amount to compensate for the loss of health care coverage. This effect is also not included in Table 4i-2.

There are other aspects that we not have taken into account in Table 4i-2, but which are important. The presence of premium and cost sharing subsidies through the Exchange will

significantly reduce the cost of obtaining health insurance coverage for low income individuals and families which make up a disproportionate percentage of the uninsured. This, coupled with the mandate that individuals purchase coverage, is the primary reason that we are projecting a significant decrease in the number of uninsured in 2014. The market reform provisions in the PPACA will provide a large portion of insureds with guaranteed access to more generous coverage than they likely would have been able to purchase in the absence of health care reform. This includes lower out-of-pocket cost sharing, more generous coverage of preventive benefits and increased actuarial values.

TASK 5 – The Effect if the Large Employer Market (>100 Employees) Seeks Participation in the Exchange After 2017

Background

Under the Patient Protection and Affordable Care Act (PPACA), states have the option to allow health insurers to offer large employers, those with more than 100 employees, qualified health plans (QHPs) through the Health Insurance Exchange (Exchange) beginning in 2017.[1] The large employer pool and its products and pricing can remain separate from the individual and small group pools.

While the products and pools can remain separate, all plans offered through the Exchange must be QHPs requiring, among other things: that the essential health benefits package be covered; that products fall in the "metallic" tiers of Bronze, Silver, etc.; that certain network standards be met; and that products sold inside the Exchange be sold at the same price as those sold outside of the Exchange.[2]

In Table 5-1 below, we show the percentage of private sector firms in Connecticut and nationwide that offer health insurance and that also self-insure (based on Medical Expenditure Panel Survey (MEPS) data from 2009).[3]

Table 5-1

Percent of Private-Sector Establishments that Offer Health Insurance that Self-Insure at Least One Plan by Firm Size

Number of Employees	Connecticut	Nationwide
<100	12.9%	13.5%
100-499	27.1%	25.7%
500+	82.4%	82.1%
Total	31.9%	35.1%

Source: 2009 MEPS

[1] Ibid.

[2] PPACA Sec. 1301.

[3] While 2010 MEPS data are available, the standard errors associated with the 2010 estimates in Connecticut are large, so we are reporting 2009 data here which has a much lower standard error.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Even premiums for those employers with more than 100 employees who are fully insured will reflect the group's own experience to some degree, as carriers blend the group's experience with a manual rate depending on the group's size.

Large employers in Connecticut, and nationwide, choose to self-insure their medical plans for a number of reasons. Among these reasons are improved cash flow, the avoidance of some carriers' non-benefit costs (e.g., premium taxes, profit and risk charges), the ability to customize benefits and avoid State mandates, and increased control over the operation of the plan. These incentives will remain in 2014 when the PPACA becomes fully effective, but the insurer tax that we discussed at the beginning of this section will add an additional 2% to 3% to the cost of purchasing insurance relative to self-funding.

In Table 5-2 below, we show distributions of employers with employees in Connecticut.

Table 5-2

Employers with Employees in Connecticut by Group Size

Firm Size	Number of Firms	Nationwide Employees	Connecticut Employees	Percentage of Connecticut Employees
1 - 50	239,680	839,164	820,439	40%
51 - 100	1,901	140,825	116,002	6%
Subotal	241,581	979,989	936,441	46%
101 - 250	1,262	201,816	124,207	6%
251 - 500	604	217,283	85,487	4%
501 - 1,000	475	342,623	88,777	4%
1,001 - 2,500	558	907,680	115,217	6%
2,501 - 5,000	405	1,455,153	103,471	5%
5,001 - 10,000	340	2,403,822	92,821	5%
10,001 - 25,000	287	4,580,015	119,403	6%
25,001 +	221	19,743,424	362,567	18%
Subtotal	4,152	29,851,816	1,091,950	54%
Total	245,733	30,831,805	2,028,391	100%

Source: Oliver Wyman calculations using Dunn & Bradstreet data

Forty-six percent of employees in Connecticut work for employers with 100 or fewer employees, and these employers will be considered small employers for the purposes of the PPACA market reforms by January 1, 2016 at the latest.[4] For employers with more than 100 employees, only employers with 101 to 250 employees have the majority of their employees in Connecticut, and these firms employ only 6% of employees working in Connecticut. The Mercer team believes

[4] PPACA Sec. 1304.

employers in the 101 to 500 size range are the most likely to purchase coverage through the Exchange if coverage through the Exchange were made available to large employers. Groups in this size range represent a relatively small portion of employees in Connecticut, and opening the Exchange to large groups would subject the Exchange to a significant risk of adverse selection as explained below.

Considerations

The requirement that all plans sold through the Exchange be qualified means, among other things, that carriers participating in this market would be required to use some form of community rating in offering products to large employers. It would also mean that the plans provide the essential health benefit package, and that the plans be offered at the same price without regard to whether the plan is offered through an Exchange, directly by the issuer or through a broker. [5]

Large employers are relatively sophisticated purchasers, able to weigh various options regarding the provision of health benefits to their employees. In addition, large employers are generally able to self-insure. If large employers are given the choice of a modified community-rated product in the Exchange and self-funding or an experience-rated product outside of the Exchange, they will likely choose the lowest cost option. This means that the only large employer groups that are likely to purchase their coverage through the Exchange are those groups with relatively high morbidity. This adverse selection will lead to needed premium increases that exceed market-wide premium increases which could, in turn, lead an untenable premium rate spiral and the death of the pool.

Opening the Exchange to large employers would allow for the spread of the Exchange's fixed costs over a broader base and may lower the per-person cost of operating the Exchange. However, large employers' needs are very different from those of a small employer, and trying to service both markets could complicate the operation of the Exchange. As an example, large employers may want reporting from the Exchange that is not offered to small groups. Large employers typically have a human resources function that provides some of the services that small employers will expect the Exchange to provide.

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[5] PPACA Sec. 1301. Regulations have not been issued implementing this section of the law relating to large employers being offered coverage in the Exchanges; so there is considerable uncertainty in how this will be accomplished.

TASK 6 – The Impact of the Exchange in Regards to the Interaction with Health Coverage Initiatives in Connecticut

Background

Careful analysis of the health coverage initiatives in the context of the new Health Insurance Exchange (Exchange) is essential to ensure each system is taken into consideration appropriately and in accordance with its unique characteristics. Ultimately, the analysis of the health coverage initiatives coinciding with the Exchange implementation enables Connecticut to prevent duplication of service delivery, reduce administrative costs and provide improved customer service for Connecticut's citizens.

Connecticut began early to plan for health care reform with the creation of the multi-stakeholder Health Care Reform Advisory Board by the Governor in July 2009. The Board's Final Report, presented to Governor Rell and the General Assembly on June 30, 2010, emphasized the role of the Exchange as the mechanism to provide consumers with the information they need to make informed health care choices. The report also highlighted Patient Protection and Affordable Care Act's (PPACA's) requirement that the Exchange allow consumers eligible for Medicaid and CHIP to enroll through its web portal.

The Exchange will function as the hub of access to public and private health insurance products – providing comparative information about all health plans available to Connecticut's residents in the Exchange, offering a choice of enrollment in Exchange-sponsored health plans and establishing common guidelines for insurance offerings and pricing. It is important that the Exchange does not operate in isolation; it cannot be effective without information and appropriate levels of interaction with other health systems in Connecticut. These health coverage initiatives are varied – they may be major government programs like Medicaid and CHIP or newly planned initiatives for certain segments of the population, like Partnership Plans or service delivery initiatives that improve the quality of care.

Health Coverage Initiatives

The analysis under this task considered a wide range of health coverage systems expected to exist in the marketplace at the time of the Exchange. Some of these systems have been around for years and others are just now being planned. Some are administered by government entities and others are privately administered. Some are statewide, affecting large numbers of individuals, and others affect only certain limited populations. The table in Appendix 6B lays out these different variables of the health coverage initiatives.

Methodology

The Mercer/HMA team worked with the Office of Policy and Management (OPM) to identify the health coverage initiatives to be included in the analysis to ensure the outcomes of our efforts provide the information that is needed to assist the Exchange Board with designing, developing and implementing a sustainable Exchange for Connecticut. Several larger public programs'

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

interaction, like Medicaid and CHIP, with the Exchange will be discussed in greater detail in Task 10 (impact study of the Medicaid program [including CHIP] on the Exchange.)

For each health coverage initiative examined, the Mercer/HMA team gathered and documented the unique characteristics of the initiative by conducting research and interviews with State staff. The team also reviewed existing enabling legislation for coverage initiatives, developed a list of coverage initiatives with likely interaction with the Exchange, reviewed the list of initiatives with OPM, reviewed existing background information available from various sources, itemized characteristics of identified coverage initiatives and assessed the appropriate interface with the Exchange and the impact of the Exchange with each program.

The following source information was reviewed in the analysis of this task:

- Legislation:
  - Public Act 11-58
- Discussions with State staff
- Websites:
  - Connecticut Business and Industry Association CBIA – www.cbia.com
  - Department of Social Services
  - Connecticut's pre-existing condition insurance plan – http://www.ct.gov/dss/cwp/view.asp?a=2345&q=463668
  - HUSKY B
  - CADAP

Analysis

For each health coverage initiative examined, the Mercer/HMA team gathered and documented the unique characteristics of each initiative. For comparison purposes, this was documented in a matrix (see Appendix 6B) containing a list of possible factors and displaying the description of each factor by initiative. In addition, a list of viable options for interaction between the Exchange and the other health coverage initiatives was developed and added to the matrix. For example, it may be appropriate to provide direct access through the Exchange to one health system, but only provide information about another. The list includes the following options:

- Provide access and information only through the Exchange

- Actively refer using the Navigator
- Incorporate into the Exchange

With the matrix and the list of possible options for interaction with the Exchange, the Mercer/HMA team also developed the pros and cons for each initiative with respect to each option for the Exchange Board to consider as part of the Exchange planning.

Results

Using the analysis of each initiative with respect to each possible option for interaction with the Exchange will provide the Exchange Board with the information needed to make well-founded and reasonable decisions regarding the best way for the Exchange to interact with the health systems with which it will coexist. The Board can also decide, in another phase of the Exchange planning, to consider the total costs (and State costs) of the coverage initiative as another factor in their decision making. The result will be a plan which is efficient, cost effective and customer-focused.

Partnership Plans Program

In June 2011, the State of Connecticut passed two pieces of legislation to address insurance market reforms that ensures Connecticut's compliance with the provisions described in the PPACA. Public Act 11-58 (the Act), *An Act Establishing the Connecticut Healthcare Partnership (Act)*, changes various health insurance statutes to conform to the PPACA and under Section 2 of the Act, creates a "Partnership plan". This "Partnership plan" requires the Comptroller for the State of Connecticut to offer a health care benefit plan to non-State public employers or nonprofit employers and their retirees. The Comptroller has been given the discretion to offer a fully-insured or risk-pooled option. The Act also establishes a non-State Public Health Care Advisory Committee whose charge is to make recommendations to the Health Care Cost Containment Committee concerning health care coverage for non-State public employees. The advisory committee membership is to consist of non-State public employers and employees participating in a Partnership Plan. The members are to be appointed by the Comptroller.

This provision within the Act was effective July 1, 2011 and requires the Comptroller to adhere to the following rolling implementation dates[1]:

- Non-State public employees, effective 1/1/2012
- Non-profit employers, effective 1/1/2013

[1] Implementation dates may be delayed. Office of Policy and Management Secretary Ben Barnes' letter to Comptroller Kevin Lembo requesting a delay to the implementation of this program until further analysis of the state's risk can be reviewed, December 12, 2011.

- Small employers, effective 1/1/2014

The Comptroller's Office is in the initial planning stages for creating this program and the particular policies and procedures of the program as established by the Act. Since the details of the program, including enrollment projections, are still being created, the analysis of the interaction of the Partnership Plan with the Exchange is based on how the program is described in the Act. The final implementation date, as established by Public Act 11-58, coincides with the implementation date of the Exchange of January 1, 2014.

The following are options for the State of Connecticut to consider for the interaction of the Partnership Plan with the Exchange:

Provide Access or Information Only Through the Exchange

The Exchange will serve as the single point of entry for potential enrollees seeking health care coverage and will also enroll qualified individuals into the Exchange or other State-sponsored programs like Medicaid and CHIP. The Comptroller's Office can consider utilizing the Exchange to serve as the entry point for the Partnership Plan program once the Exchange is certified by the US Department of Health and Human Services (HHS) as required by the PPACA. The Partnership Plan will be an option available within the State of Connecticut for those seeking health care coverage.

The Exchange is required to provide information on all health care coverage options available in the Exchange and other State health programs through required consumer assistance, including a consumer-friendly website, a call center and the Navigator program. The Exchange can also serve this function for the Partnership Plan by having consumer assistance include the Partnership Plan as an option for obtaining health care coverage for non-State public employers and non-profit employers and their retirees. Again, this could be a shared function with the Exchange and reduce administrative costs for the State of Connecticut by not having to operate a separate referral/information function for the Partnership Plan.

Actively Refer Using the Navigator

As mentioned previously, the PPACA requires Exchanges to establish several new functions to ensure information on health care coverage options is developed within a State's Exchange, including the Navigator program. As established by Section 1311(i) of the PPACA, the Navigator program has been established to require an entity (defined in Section 1311(i)(2)(B)) to conduct a variety of consumer functions. Furthermore, draft regulations issued in July 2011 further define the role of Navigators by proposing their consumer functions include: (1) conducting public education activities to raise awareness about the Exchange; (2) maintaining expertise in eligibility, enrollment and program specifications; (3) facilitating enrollment into qualified health plans within the Exchange; and (4) providing Exchange information and services in a fair, accurate and impartial manner and must acknowledge other health programs.

As the Navigator's role currently exists in draft regulations, the Exchange can require the Navigators to actively refer the Partnership Plan program as an option for non-State public and non-profit employers. It is recommended that the Exchange monitor the functions of the Navigator program as the regulation gets codified and their role is further defined.

Incorporate Into the Exchange

The Partnership Plan program provides a health care benefit to non-State public and non-profit employers and their respective retirees beginning January 1, 2012[2] for non-State public employers and January 1, 2013 for non-profit employers. This implementation timeframe does not coincide with the implementation timeframe for the Exchange. As it is proposed, the Partnership Plan coverage option will be up and running when the Exchange is certified and begins offering coverage itself, beginning January 1, 2014, unless there was a change in State legislation.

The Comptroller's Office should begin discussions with the Exchange Board regarding whether it makes sense for the State of Connecticut to consider incorporating the Partnership Plan program into the Exchange or maintaining it as a separate program after January 1, 2014. Several aspects of the Partnership Plan program, as it becomes established, may be similar to what will be offered under the Exchange. In addition, those who seek coverage under the Partnership Plan can be incorporated into the Exchange to leverage the purchasing power of the Exchange, which could ultimately benefit this State program by pooling resources.

A risk of incorporating the program into the Exchange is that it may dilute the identity of the Parternship Plans and the intent of the State law. As the program becomes established and additional details are determined by the Comptroller's Office and State regulations, factors such as incorporating it into the Exchange will need to be considered to ensure compliance with the rules set forth for the Exchange to avoid duplication of services and to ensure State efficiencies.

[2] Implementation dates may be delayed. Office of Policy and Management Secretary Ben Barnes' letter to Comptroller Kevin Lembo requesting a delay to the implementation of this program until further analysis of the state's risk can be reviewed, December 12, 2011.

Health Connections

The Connecticut Business and Industry Association (CBIA) represents businesses in the State of Connecticut. According to their website CBIA's mission is to serve as an advocate for the general business and industry community in Connecticut, promote a State business climate that is globally competitive, encourage communication and cooperation among businesses, government, the private sector and the general public on economic and social issues, and to provide a wide range of products and services that benefit their members. Members pay an annual membership fee based on the employer's payroll size. The fees have ranged from approximately $250 per year for a company with a payroll of $0 to $99,000 to a maximum fee of $27,000 per year for a company with a payroll in excess of $1,000,000.[3]

One of the products/services CBIA offers its members is a private sector health Exchange known as Health Connections. Since 1995, Health Connections offers companies with three to100 employees the opportunity to purchase health insurance at a competitive premium rate and allows for the choice of plans. It also serves as a central source of information about health benefits for small employers for the plans that it offers. Currently, Health Connections' enrolls approximately 6,000 small employers[4] in Connecticut, with roughly 87,000 members covered.

In 2011, CBIA provides employers with a choice of two health insurers, ConnectiCare and Oxford Health Plans, with12 plan options. Prior to 2011, CBIA had offered the choice of four insurers, but with the changing market in Connecticut, two insurers, Health Net and Cigna, stopped offering coverage in 2010. CBIA also works closely with brokers to retain and recruit employer groups.

CBIA considers Health Connections an employee choice model and requires standardized benefits amongst their participating insurers where employees can choose the insurer, price, network and formularies. CBIA is known for providing employees with easily understandable plan choices that are either HMO or point-of-service plans.

CBIA has been able to successfully compete with the outside market since it operates under the same underwriting and eligibility rules and rating standards as imposed by Connecticut's Insurance Department. Their success running a private Exchange can be attributed to working closely with carriers to manage risk and adverse selection, their multiple plan offerings and employee choice, handling billing and administrative issues for their customers, standardized benefit packages across participating plans, maintaining close ties with brokers and restricting itself primarily to the small group market. These help focus their product and enables them to remain competitive.

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[3] Connecticut Business & Industry Association Membership Application and Report Card.

[4] Families USA, "Implementing Exchanges." February 2011

CBIA also provides their members additional products, such as dental, life and disability insurance, COBRA administration, Health Reimbursement Arrangements (HRAs), wellness programs, HR consulting, discount programs (such as home and auto insurance) and additional business services[5]. The administration for all of these services is handled by CBIA rather than the small employer.

In addition to establishing the individual Exchange, the PPACA also establishes a small business Exchange. This Exchange, known as the Small Business Health Options Program (SHOP), gives small businesses and their employees a one-stop shopping place for health coverage, allowing individuals and business owners to shop for different plan offers at different cost thresholds and make health care coverage more affordable. States also have flexibility in the design of their SHOP, similar to the individual Exchange. Participation in the SHOP is optional for small businesses and will initially be limited to employers with fewer than 50 employees until 2016, when small group is defined as 100 or fewer employees. In addition, small employers that offer health coverage may qualify for a small business tax credit (up to 50% in 2014 for private employers and up to 35% for non-profits). The tax credit is designed to both support those small businesses that provide coverage today, as well as those that newly offer coverage.

The following are options for the State of Connecticut to consider for the interaction of Health Connections with the Exchange:

Provide Access or Information Only Through the Exchange

The small business Exchange is to provide access to affordable health care coverage for small employers and their employees. Participation in this program is voluntary and employers can still purchase coverage outside the Exchange. Health Connections, as offered by CBIA, is a private program whereby providing access to this program through the Exchange is not an option as established by the PPACA or proposed regulations.

The small business Exchange will be another option to Health Connections for small businesses to consider for coverage of their employees. As a separate private program, Health Connections would be competing for the same small employer members that the Exchange would be targeting.

Actively Refer Using the Navigator

The Navigator program that is established in Connecticut's Exchange will be required to provide consumer assistance to individuals and small businesses seeking health insurance coverage options within the Exchange. It is expected for the Navigator to receive a high volume of inquiries, and it will be their responsibility to explain the coverage options and facilitate

[5]Connecticut Business and Industry Association website – www.cbia.com

enrollment in the Exchange, as well as other State programs (e.g., Medicaid and CHIP) for which the individual may qualify.

As the proposed rules exist today, it is not a responsibility of the Navigators to refer or describe private programs as options for coverage. Therefore, using the Navigators to actively refer to Health Connections is not an option for the Exchange Board to consider.

Incorporate Into the Exchange

Health Connections is considered one of the oldest and most successful private Exchanges in the country. In addition, CBIA has made it their mission as an organization to ensure their members are provided with products that benefit their members, including offering affordable health care coverage for small employers within the State. CBIA has shown a commitment to the small group market and has a wealth of knowledge from their experience operating a private Exchange.

An alternative to Connecticut creating its own SHOP Exchange would be for Connecticut to seek ways to collaborate with CBIA to establish Connecticut's small group Exchange through a sub-contractual arrangement. An arrangement between the Connecticut Exchange and Health Connections could leverage the years of experience and best practices of Health Connections for the State's SHOP Exchange. It also puts Connecticut one step closer to implementing the small business Exchange as required by PPACA by partnering with an entity that has established relationships with insurers serving the small group market and has experience with the administrative functions of operating an Exchange. The State will need to carefully consider the requirements of the PPACA and make necessary adjustments to the Health Connections program to ensure compliance with certain benefits and cost standards as established by the PPACA.

Pre-existing Condition Insurance Plan

To satisfy the immediate concerns of those with pre-existing conditions that are not able to obtain health care coverage, the PPACA included immediate access to a temporary high-risk insurance pool program to provide health insurance coverage for eligible individuals within 90 days of enactment of the PPACA through December 31, 2013. The PPACA authorized funding for states to administer their own program, known as the Pre-Existing Condition Insurance Plan (PCIP). According to a General Accounting Office Report[6], 27 states chose to administer their own PCIPs in calendar years 2010 and 2011. Connecticut is one of those states that chose to administer their own program and contracted with the Health Reinsurance Association (HRA), under contract with the Department of Social Services (DSS), to operate the program.

[6] General Accounting Office Report, *"Pre-Existing Condition Insurance Plans: Program Features, Early Enrollment and Spending Trends, and Federal Oversight Activities."* GAO-11-662. July 2011.

Connecticut's PCIP enrollment, as of October 31, 2011, stood at 103[7] enrollees receiving coverage under the State's temporary program.

In addition to the PCIP, Connecticut's Health Reinsurance Association operates the state's high-risk pool, which is among the oldest high-risk pools in the country. Eligibility for the HRA generally requires the individual to have been without health insurance coverage for 150 days or to have lost employer coverage.[8] The HRA makes available a plan for low-income individuals where providers are paid at 75% of Medicare reimbursement. The HRA is funded through a combination of premiums, assessments and federal grants. At the end of 2010, the HRA had 1,870 active covered lives. The State also operates a Temporary High Risk Insurance Pool Program. For the purposes of this task, Mercer analyzes the interaction of this temporary high risk insurance pool program with the Exchange. The HRA is analyzed in greater detail in Task 4a (refer to separate Task 4a report).

Connecticut's PCIP program allows residents in the State that have been uninsured for at least six months with a pre-existing qualified medical condition to receive comprehensive health care coverage. The program has been implemented and will continue offering coverage through December 31, 2013.

The following are options for the State of Connecticut to consider for the interaction of the PCIP with the Exchange:

Provide Access or Information Only Through the Exchange and Actively Refer Using the Navigator

Connecticut's PCIP will cease operations by December 31, 2013, with all of its existing Medicaid ineligible enrollees transitioned into Connecticut's Exchange. There will be no need at this point to provide access or information through the Exchange or actively refer using the Navigator program, other than to provide information on the program. Details will need to be worked out on how to transition these enrollees into the Exchange in a seamless and non-disruptive manner. Guidance for states on the transition of current enrollees will be developed by the US Department of HHS.

Incorporate Into the Exchange

The PPACA requires that the enrollees in the PCIP programs, in either the federally-operated PCIP program or state-operated programs, be transitioned into the Exchange and begin receiving coverage through the Exchange as of January 1, 2014. As of October 2011, 103 active enrollees[9] are participating in Connecticut's PCIP. These enrollees, and those that join between

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[7] Enrollment data was provided by the Health Reinsurance Association.

[8] http://www.hract.org/hra/Brochures/brochures.htm

[9] Enrollment data provided by the Health Reinsurance Association.

now and December 31, 2013, will be transitioned into Connecticut's Exchange and seek coverage from one of the qualified health plans participating in the Exchange.

The DSS should share their experiences of running this program with the Exchange Board as they work to smoothly transition these enrollees into the Exchange, even though the experience has been limited due to the lower number of enrollees.

Charter Oak Health Plan

The Charter Oak Health Plan (COHP) is a State-subsidized program that provides Connecticut residents with access to a standard health benefit plan on a guaranteed basis with no-pre-existing condition exclusion periods. To be eligible, individuals must be between the ages of 19–64, uninsured for at least six months (exceptions apply) and ineligible for Medicare, Medicaid, CHIP or other publicly-funded health insurance. There is an annual benefit maximum of $100,000 and premium assistance has historically been available to low-income individuals; however, legislation passed in 2010 prohibits the State from subsidizing the cost of the program for anyone who joined after May 31, 2010. COHP is not eligible for federal financial participation.

As of October 2011, 8,000 individuals were enrolled in the program, a 17.6% decline from August 2011 due to an increase in monthly premiums from $307 to $446 on September 1, 2011.[10] COHP enrollment by income band as of October 2011 is as follows:

Band	Income by FPL	Oct 2011 Enrollment
Band 1	Under 150%	2,248
Band 2	150% to 185%	896
Band 3	185% to 235%	1,476
Band 4	235% to 300%	1,456
Band 5	Over 300%	1,924
Total		8,000

Individuals enrolled in COHP with modified adjusted gross incomes below 133% FPL and who meet citizenship and residency requirements will qualify for Medicaid, effective January 1, 2014, under the Medicaid eligibility expansion (see Task 10 for further details).

For the balance of COHP enrollees, the following are options for the State of Connecticut to consider for the interaction of the Charter Oak Health Plan with the Exchange:

[10] A. Levin Becker (September 9, 2011). "Charter Oak health plan enrollment falls as premiums rise", The Connecticut Mirror.

Provide Access or Information Only Through the Exchange

The Exchange could serve as only an access point or referral resource for the existing COHP; however, enrollees would not be eligible for federal premium and cost-sharing subsidies which are only availble under qualified health plans sold on the Exchange.

Actively Refer Using the Navigator

The Navigator's role of informing individuals and small employers about the availability of qualified health plans within the Exchange and facilitating enrollment into these plans could also involve informing COHP enrollees of their options under the Exchange.

Incorporate Into the Exchange

Connecticut could discontinue the Charter Oak Health Plan and transition COHP enrollees who are not eligible for Medicaid into an Exchange health plan. Only enrollees with incomes less than 400% FPL will qualify for premium and cost-sharing subsidies. Discontinuation of the COHP could have an impact of reducing the administrative burden for the State by having this function fall within the Exchange's purview. Furthermore, Connecticut would realize budget savings by discontinuing COHP, which is not eligible for federal financial participation. COHP enrollees, particularly those who enrolled after May 31, 2010, may be eligible for higher federal premium and cost-sharing subsidies than under the current program.

Connecticut AIDS Drug Assistance Program

The Connecticut AIDS Drug Assistance Program is a statewide program for Connecticut residents with Human Immune-deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), with incomes below 400% FPL, that are not enrolled in Medicaid. The program pays for HIV/AIDS medications and other pharmaceuticals. CADAP also pays health insurance premiums for anyone who is already covered by a health plan and is eligible for the CADAP program. The state receives federal funding for the program under Ryan White Title II grants that are awarded to the Department of Public Health. CADAP served approximately 1,600 clients as of June 2010. In September 2011, HHS awarded Connecticut with $14.8 million in Ryan White program funding for CADAP in fiscal year (FY) 2011.

The following are options for the State of Connecticut to consider for the interaction of the CADAP with the Exchange:

Provide Access or Information Only Through the Exchange

Individuals with incomes less than 400% FPL will be eligible for federal premium and cost-sharing subsidies for health plans sold on the Exchange. CADAP could provide additional premium assistance and cost sharing to individuals with HIV/AIDS who are enrolled in an Exchange plan as a way to wrap some or all costs that would otherwise be borne by the individual. Additionally, CADAP could wrap prescription drug coverage for HIV/AIDS medications that are not covered by an Exchange plan.

Actively Refer Using the Navigator

The Navigator's role of informing individuals and small employers about the availability of qualified health plans within the Exchange and facilitating enrollment into these plans could also involve informing enrollees of their options under CADAP.

Incorporate Into the Exchange

Connecticut could mandate that plans sold within the Exchange cover the CADAP drug formulary; however, there are important implications regarding the state's ultimate selection of an Essential Health Benefits (EHB) benchmark plan.

Health plans offered through a state Exchange, as well as new individual and small-group health plans sold outside of an Exchange, will be required to meet the EHB standard. Originally, the Secretary of Health and Human Services was expected to define EHB through regulation based on ten PPACA-mandated categories of benefits; however, the Obama administration announced on December 16, 2011 that it plans to give states the discretion to select an existing health plan to set the "benchmark" for the items and services included in the EHB package. States may choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state
- One of the three largest state employee health plans
- One of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

To the extent that Connecticut mandates that plans sold on the Exchange cover specific CADAP formulary benefits beyond those included in the state's EHB benchmark plan, Connecticut may be required to assume those costs (as discussed in Task 4g).

HUSKY B > 300% of the FPL

HUSKY B covers children in families with incomes between 186% and 300% of the FPL. Children in households with income between 186%–235% of FPL qualify for HUSKY B–Tier 1 and pay no premium and some copays for health care. Children with household income between 236%–300% of FPL qualify for HUSKY B–Tier 2 and pay limited premiums and some copays. Families with incomes above 300% of the FPL may "buy into" HUSKY B by paying the full cost of premiums plus copays (and are not CHIP-eligible for the purposes of federal reimbursement). State spending on health care costs for HUSKY B tiers 1 and 2 is eligible for the enhanced federal financial participation rate of 65% (scheduled to increase to 88% from FY16–FY19).

Within HUSKY B, children living in households with income between 186%–200% FPL would be eligible to enroll in an Exchange plan or a BHP alternative beginning October 1, 2019[11]. Children in households with income between 201%–400% FPL would only be eligible for premium and cost-sharing subsidies in an Exchange plan.

As of October 2011, 15,155 individuals were enrolled in the program and enrolled in the following tiers:

Tier	Income by FPL	October 2011 Enrollment
Tier 1	186% to 235%	7,714
Tier 2	236% to 300%	5,711
Tier 3	Above 300%	1,730
Total		15,155

The following are options for the State of Connecticut to consider for the interaction of HUSKY B with the Exchange:

Provide Access or Information Only Through the Exchange

The Exchange will serve as a point of entry for potential enrollees seeking health care coverage and will also enroll qualified individuals into the Exchange or other State-sponsored programs like Medicaid and CHIP or BHP. Those who are determined to be eligible for HUSKY B will be identified through that process and, if eligible, enrolled in the appropriate program.

Actively Refer Using the Navigator

The Navigator's role of informing individuals and small employers about the availability of qualified health plans within the Exchange and facilitating enrollment into these plans involves informing potential enrollees of their options under Connecticut's Medicaid and CHIP programs, including HUSKY B.

Incorporate Into the Exchange

Connecticut could decide to incorporate all or parts of the HUSKY B program into the Exchange. HUSKY B–Tier 3 is not currently a federally reimbursed program under Medicaid or CHIP and, therefore, not subject to the PPACA's maintenance of effort (MOE) requirement (discussed in Task 10) for children's Medicaid and CHIP eligibility. As soon as the Exchange becomes certified in 2014, Connecticut may wish to transition HUSKY B–Tier 3 enrollees into the Exchange in order for enrollees to qualify for federal subsidies instead of buying into the program at full cost. HUSKY B tiers 1 and 2 are subject to the PPACA's MOE requirements. For

[11] PPACA requires States to maintain CHIP income eligibility standards for children through September 30, 2019 as a condition of receiving Medicaid federal financial participation. Therefore, October 1, 2019 is the first opportunity for children under the CHIP program to be eligible for the Exchange or BHP.

any Medicaid-eligible child who is under age 19 (or such higher age as the State may have elected), the MOE requirement continues through September 30, 2019. States are also required to maintain CHIP income eligibility standards for children through September 30, 2019 as a condition of receiving Medicaid federal financial participation. After this point, Connecticut could consider transitioning tiers 1 and 2 into the Exchange.

Key Considerations

The Connecticut Exchange Board will need to carefully consider the requirements of the Exchange as established by the PPACA and the mandated requirements of State-run programs or those relationships with privately run programs. There are sensitivities, both politically and programmatically, that the Exchange Board will need to consider in their final decisions. The analysis in this report outlines programmatic and administrative efficiencies that can be gained by incorporating the health coverage initiative into the Exchange. It also outlines where the interaction with the Exchange is hindered by existing rules and regulations.

Mercer/HMA has determined through this analysis that the Exchange is expected to impact several of these existing programs that were reviewed as part of this task in varying degrees. Impacts can be summarized in the following areas:

- Overlap of eligible enrollees:
  - Current populations covered by Health Connections, PCIP, Charter Oak, CADAP, HUSKY B and, potentially, the Partnership Plans would be also eligible for coverage under the individual and small business Exchange and qualify for subsidies or tax incentives
- Competition of products/services:
  - Products and services currently being offered through Health Connections, PCIP, Charter Oak, CADAP, HUSKY B and, potentially, the Partnership Plans would also be offered under the individual and small business Exchange
  - The Exchange can consider incorporating some or all these initiatives into their program to eliminate competition and/or streamline offerings of products for potential enrollees
- Duplicate administrative functions:
  - Connecticut could potentially achieve some administrative budget savings by incorporating the coverage initiatives into the Exchange and streamlining consumer assistance, marketing, enrollment and eligibility functions

It is recommended that the Exchange Board carefully weigh each option and determine what is best for the State, the Exchange, the individual and small employers and the established

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

coverage initiative. In addition, the Board may also want to consider further analyzing the total costs (and state costs) of the coverage initiative as another factor in their decision making. While there are other State programs whose impacts were analyzed in Task 10 of this report, there may be other State programs the Exchange Board would like to further analyze utilizing a similar approach. This analysis will assist the Exchange Board in their role in providing accessible and affordable health care coverage to the residents and small employers in Connecticut.

Appendix 6A

Health Coverage Initiative Chart

Health Coverage Initiative	Description and Eligibility	Type of Health Coverage		Length of Operation		Governing Source		Service Area		Current Enrollment
		Partial	Full	Less than 5 years	More than 5 years	Public	Private	Statewide	Regional	
Exchange	State-based competitive marketplace for individuals and small businesses to purchase private health insurance		✓	✓		✓	✓	✓	✓	Unknown[12]
Partnership Plans	Health care benefit plan offered to non-state public employers or nonprofit employers and their retirees		✓	✓		✓		✓	✓	Unknown[13]
Health Connections	Exchange for small employers with 3 to 100 employees to purchase health insurance at competitive pricing		✓		✓		✓	✓	✓	87,000
PCIP	Health benefit package for those with a pre-existing qualified, diagnosed medical condition and uninsured for six months		✓	✓		✓		✓	✓	103
COHP	State subsidized health benefit plan on a guaranteed basis with no pre-existing condition exclusion periods		✓	✓		✓		✓	✓	8,000
CADAP	Medication program for enrollees HIV/AIDS and with incomes below 400% FPL	✓			✓	✓		✓	✓	1,600
HUSKY B >300% FPL	Connecticut's health insurance program for children in families with incomes over 185% FPL. Those over 300% FPL may "buy into" HUSKY B		✓		✓	✓		✓	✓	1,730

[12] Implementation to occur in January 2014.

[13] Implementation to occur in January 2012 but may be delayed due to concerns raised by Office of Policy and Management Secretary Barnes.

Appendix 6B

Exchange Interaction Options

There currently exists in the State of Connecticut a wide range of health coverage initiatives that will exist in the marketplace at the time of the Exchange. Some of the systems have been around for years, and others are just now being planned. Some are administered by government entities, and others are privately administered. Some are statewide – affecting large numbers of individuals, and others affect only certain limited populations. For each type of health coverage initiative examined beyond Medicaid and the CHIP, Mercer has gathered and documented the unique characteristics of each initiative in the tables below.

Partnership Plans	
Program description	Health care benefit plan to be offered to non-State public employers, non-profit employers, and both their retirees and small employers, to join the State employee health plan Creates a partnership plan for these employees Eligible employers submit an application to the Comptroller for coverage under such plan or plans A Partnership premium account will be established for all premiums paid by employers and their respective employees
Governing source	Connecticut Comptroller's Office There is an established non-State Public Health Care Advisory Committee whose charge is to make recommendations to the Health Care Cost Containment Committee concerning health care coverage for non-State public employees. The Advisory Committee membership consists of non-State public employers and employees participating in a Partnership Plan. The members are appointed by the Comptroller
Population covered	Non-State public employers and employees Non-profit employers and employees Non-State public employers whose applications for coverage for their employees under a Partnership Plan has been accepted may seek coverage for their retired employees

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Partnership Plans	
Type of initiative	Plans may be offered on a fully insured or risk–pooled basis at the discretion of the Comptroller
Implementation timeframe	Effective July 1, 2011 with varying implementation dates[14]: Non-State public employers, effective January 1, 2012 Non-profit employers, effective January 1, 2013 Small employers, effective January 1, 2014
Exchange interaction options and implications	Provide access and information to Partnership Plans through Exchange: Exchange would serve as single point of entry for potential enrollees – similar to how the eligibility Exchange will do for other State-based programs (Medicaid/CHIP) Would reduce administrative burden by having Exchange provide access to program Maintains separate identity from the Exchange, but also competes with Exchange's purchasing power Actively refer to Partnership Plans using the Navigator: Leverages Navigator's understanding of the different programs within the State, as well as the high volume of inquiries/referrals most likely coming through the Navigator program Could dilute Navigator's main function, which is to refer to the options within an Exchange Incorporate Partnership Plans into Exchange: Partnership Plans are new and could more easily be incorporated into Exchange planning Avoids duplication of efforts for similar programs Garners purchasing power from Exchange volume to share with the Partnership Plans May dilute "identity" of Partnership Plans and intent of State law

[14] Implementation dates may be delayed. Office of Policy and Management Secretary Ben Barnes' letter to Comptroller Kevin Lembo requesting a delay to the implementation of this program until further analysis of the state's risk can be reviewed, December 12, 2011.

Health Connections	
Program description	Statewide business organization developed for companies with 3 to 100 employees in order to purchase health insurance at a competitive premium rate and allow a choice of plans Operates as an Exchange, providing employers with a central source of information about health benefits Enrolls approximately one-fifth of the small employer market in Connecticut
Governing source	Connecticut Business and Industry Association
Population covered	Employers ranging in size from 3 to 100 employees
Type of initiative	Comprehensive health care coverage
Implementation timeframe	Implemented
Exchange interaction options and implications	Provide access and information only to Health Connections through Exchange: Health Connections is a private program whereby access through the Exchange is not an option, and it maintains independence as a separate program by remaining outside the Exchange Actively refer to Health Connections using the Navigator: There will be a high volume of inquiries/referrals most likely coming through the Navigator program with their main function being to refer to the options within an Exchange or other State programs (e.g., Medicaid and CHIP); not private programs Incorporate Health Connections into Exchange: Operate as a subcontractor to operate small group Exchange Brings years of experience to the Exchange, including best practices Loss of the unique identity of a private Exchange

Pre-Existing Condition Insurance Plan (PCIP)	
Program description	– A temporary comprehensive health benefits package open to Connecticut residents who have a pre-existing, qualified, diagnosed medical condition and have been uninsured for six months
Governing source	– Established and funded under Section 1101 of the PPACA – Operated by the Health Reinsurance Association under contract with the DSS, the administering State agency
Population covered	– Residents of Connecticut who have been uninsured for at least six months with a pre-exiting qualified medical condition
Type of initiative	– Comprehensive health care coverage
Implementation timeframe	– Implemented

Exchange interaction options and implications	– Provide access and information only to pre-existing condition insurance plan through Exchange:
	  – The program will cease operations by December 31, 2013, with all existing members transitioned into the Exchange, so no opportunity to provide access through the Exchange
	– Actively refer to pre-existing condition insurance plan using the Navigator:
	  – The program will cease operations by December 31, 2013, with all existing members transitioned into the Exchange, so no opportunity to actively refer using the Navigator
	– Incorporate pre-existing condition insurance plan into Exchange:
	  – The enrollees of this program will be allowed coverage under the Exchange, and this ensures continuity of coverage for current enrollees
	  – There is an existing health plan relationship already established under this program
	  – The DSS can share experiences of running this program with the Exchange Board
	  – Unfortunately, there has been a limited number of enrollees and experience to associate similar experience under the Exchange

Charter Oak	
Program description	State-subsidized program that provides Connecticut residents with access to a standard health benefit plan on a guaranteed basis, with no-pre-existing condition exclusion periods. There is an annual benefit maximum of $100,000 and premium assistance has historically been available to low-income individuals; however, legislation passed in 2010 prohibits the State from subsidizing the cost of the program for anyone who joined after May 31, 2010
Governing source	Connecticut DSS
Population covered	Individuals between the ages of 19–64 uninsured for at least six months (exceptions apply) and ineligible for Medicare, Medicaid, CHIP or other publicly-funded health insurance
Type of initiative	Comprehensive health care coverage
Implementation timeframe	Implemented
Exchange interaction options and implications	Provide access or information only to COHP through Exchange: The Exchange could serve as only an access point or referral resource for the existing COHP; however, enrollees would not be eligible for federal premium and cost sharing subsidies, which are only available under qualified health plans sold on the Exchange Actively refer COHP using the Navigator: The Exchange can inform potential enrollees of their options under Medicaid and CHIP, including COHP enrollees of their options under the Exchange Incorporate COHP into Exchange: Connecticut could discontinue the COHP and transition COHP enrollees who are not eligible for Medicaid into an Exchange health plan. Only enrollees with incomes less than 400% of the FPL will qualify for premium and cost-sharing subsidies Connecticut would realize budget savings by discontinuing COHP

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Connecticut AIDS Drug Assistance Program (CADAP)	
Program description	• Statewide program for Connecticut residents with HIV or AIDS with incomes below 400% FPL that are not enrolled in Medicaid. The program pays for HIV/AIDS medications and other pharmaceuticals
Governing source	• Connecticut DSS
Population covered	• Connecticut residents, including immigrants without green cards who have HIV or AIDS
Type of initiative	• Pharmaceutical program; program also pays health insurance premiums for anyone who is already covered by a health plan and is eligible for the CADAP program
Implementation timeframe	• Implemented
Exchange interaction options and implications	• Provide access and information only to CADAP through Exchange: – Individuals with incomes less than 400% FPL will be eligible for federal premium and cost-sharing subsidies for health plans sold on the Exchange. CADAP could provide additional premium assistance and cost sharing to individuals with HIV/AIDS who are enrolled in an Exchange plan, as a way to wrap some or all costs that would otherwise be borne by the individual – Additionally, CADAP could wrap prescription drug coverage for HIV/AIDS medications that are not covered by an Exchange plan (for example, off-label medications) • Actively refer to CADAP using the Navigator: – The Exchange can inform potential enrollees of their options under CADAP • Incorporate CADAP into Exchange: – Connecticut could mandate that plans sold within the Exchange cover the CADAP drug formulary – To the extent that Connecticut mandates that plans sold on the Exchange cover specific CADAP formulary benefits beyond those included in the state's EHB benchmark plan, Connecticut may be required to assume those costs

Healthcare for Uninsured Kids and Youth (HUSKY) B > 300% FPL	
Program description	HUSKY B is a federal- and state-managed health insurance program only for uninsured children ages 18 and under, who are US citizens or legal permanent residents, with family incomes over 185% of FPL The benefit package is similar to that of HUSKY A, but with copayments Those children with incomes over 300% FPL may "buy into" HUSKY B by paying the full cost of premiums plus copays
Governing source	Connecticut DSS
Population covered	HUSKY Part B–Tier 1 – Health services for families with incomes between 185% and 235% FPL HUSKY Part B–Tier 2 – Health services for children in households with income between 236% and 300% of FPL HUSKY Part B–Tier 3 – Health services for children in households with income above 300% of FPL
Type of initiative	Comprehensive health care coverage
Implementation timeline	Implemented
Exchange interaction options and implications	Provide access and information only to HUSKY B through Exchange: The Exchange will serve as a point of entry for potential enrollees seeking health care coverage and will also enroll qualified individuals into the Exchange or other State-sponsored programs, like Medicaid and CHIP. Those who are determined to be eligible for HUSKY B will be identified through that process Actively refer to HUSKY B using the Navigator: The Exchange can inform potential enrollees of their options under Medicaid and CHIP, including HUSKY B Incorporate HUSKY B into Exchange: Connecticut could decide to incorporate all, or parts of, the HUSKY B program into the Exchange As soon as the Exchange becomes certified in 2014, Connecticut may wish to transition HUSKY B–Tier 3 enrollees into the Exchange in order for enrollees to qualify for federal subsidies, instead of buying into the program at full cost HUSKY B, tiers 1 and 2 are subject to the PPACA's children's eligibility maintenance of effort requirements through September 30, 2019

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

TASK 7 – Assessment of Technical Requirements and Development of Specifications for Accounting and Financial System Functions for the Exchange

Background

The process for planning and implementing Connecticut's Health Insurance Exchange (Exchange) will require accurate projections of the likely costs associated with creating and operating the Exchange as well as revenues generated through Exchange activity. Provided below are estimates of the financial resources that will be necessary to operate Connecticut's Exchange and estimated revenues available to the Exchange through a number of financing methods.

Financial Model Results

Provided below in Tables 7-1 to 7-3 are comprehensive estimates of Exchange costs and revenues between 2012 and 2016; these tables present a consolidated view of the likely financial condition of Connecticut's Exchange using the estimates generated in the cost model and the assumed revenues outlined in this paper. The Mercer/HMA budget model was constructed to generate a "high" and "low" budget estimate to appropriately account for the range of impact that unknown inputs will have upon final budget numbers. The projections outlined below have assumed costs equivalent to the "high" estimates generated through our budget model. The use of the higher bound of our budget estimate was viewed as a more conservative approach to projecting the financial condition of Connecticut's Exchange.

Recommendation

The Mercer/HMA team reviewed a number of financing mechanisms for supporting Connecticut's Exchange. After reviewing each of these financing mechanisms, we recommend that Connecticut support Exchange operations through the pairing of the following two revenue generating strategies:

1. The creation of a premium assessment, calculated as a percentage of health premium cost that would be imposed upon all health coverage purchased through Connecticut's Exchange. (The Exchange could specify that the premium assessment be charged to health insurance carriers, based on the number of covered lives they serve in the Exchange, or it could be charged to Exchange consumers as a portion of their health coverage premium. The Exchange would generate the same amount of revenue whether the assessment is charged to carriers or enrollees)

2. Implementing an assessment upon health carriers who do not participate in Connecticut's Exchange

The details of the primary financing mechanisms that the team reviewed are described below, and include calculations of the amounts required to achieve a financially self-sustaining Exchange given the projections made in the Mercer/HMA budget model.

1. Exchange Premium Assessment

Table 7-1 outlines the revenues available to Connecticut's Exchange if the Exchange implemented a premium assessment upon all coverage purchased through the Exchange and an additional assumed $1.0 million in revenue generated through both the carrier non-participation assessment and advertising revenue. Using the Mercer/HMA budget model, the premium assessment necessary for a financially self-sustaining Exchange (one that generates sufficient revenue for their operating costs) is 2.8%[1]. Specifically, this projection is dependent upon the membership estimates, cost projections and assumed revenue base discussed in this section. The table assumes Exchange costs equivalent to the "high" cost estimate outlined in this paper.

[1] The 2.8% premium assessment was derived by comparing assumed Exchange operating costs in 2015 and 2016 against the product of assumed Exchange membership referenced in Appendix 7B and the assumed average premiums for Exchange coverage calculated by Mercer for this report.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Table 7-1: Five Year Budget Projection: 2.8% Premium Assessment on Exchange Coverage and Health Insurance Carrier Non-Participation Assessment

	2012	2013	2014	2015	2016
CASELOAD					
INDIVIDUAL MARKET CONTRACTS	0	56,000	72,118	110,793	138,600
SHOP CONTRACTS	0	5,500	11,963	18,549	24,750
MEMBERS	0	90,000	124,775	192,000	243,000
MEMBER MONTHS	0	270,000	1,497,300	2,304,000	2,916,000
EXCHANGE PREMIUMS	$0	$0	$603,842,500	$980,235,000	$1,330,200,000
OPERATING REVENUE					
FEDERAL EXCHANGE GRANTS	$19,761,230	$30,323,664	$34,281,826	$0	$0
PREMIUM ASSESSMENT	$0	$0	$16,907,681	$27,446,795	$37,245,550
CARRIER NON-PARTICIPATION FEE	$0	$0	$1,000,000	$1,000,000	$1,000,000
TOTAL OPERATING REVENUE	*$19,761,230*	*$30,323,664*	*$52,189,507*	*$28,446,795*	*$38,245,550*
NON OPERATING REVENUE					
INVESTMENT INCOME	$0	$0	$179,077	$327,274	$320,460
OTHER NON-OPERATING REVENUE	$0	$0	$0	$0	$0
TOTAL NON-OPERATING REVENUE	*$0*	*$0*	*$179,077*	*$327,274*	*$320,460*
OPERATING EXPENSES					
HUMAN RESOURCE EXPENSE	$3,295,550	$5,411,940	$8,125,183	$8,822,375	$9,565,685
CONSULTING COSTS	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
EXCHANGE ADMINISTRATIVE EXPENSE	$120,680	$308,094	$339,660	$294,960	$294,960
CALL CENTER /PREMIUM BILLING	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
WEB SITE CREATION/MAINTENANCE	$1,200,000	$1,800,000	$1,000,000	$750,000	$500,000
STATE ELIGIBILITY CHARGEBACK	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
APPEALS PROGRAM	$0	$0	$903,381	$432,736	$422,375
COMMUNICATIONS / MARKETING	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
NAVIGATOR EXPENSE	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
OUTREACH EXPENSE	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
IT DEVELOPMENT COST	$10,695,000	$9,250,000	$3,392,500	$1,357,125	$1,424,975
TOTAL OPERATING EXPENSES	*$19,761,230*	*$30,323,664*	*$34,281,826*	*$31,892,915*	*$36,135,375*
OPERATING PROFIT / (DEFICIT)	***$0***	***$0***	***$18,086,758***	***($3,118,846)***	***$2,430,634***
NET ASSETS BEGINNING OF YR	***$0***	***$0***	***$0***	***$18,086,758***	***$14,967,912***
NET ASSETS END OF YEAR	***$0***	***$0***	***$18,086,758***	***$14,967,912***	***$17,398,546***

2. Exchange Participation Fixed Fee

Revenues generated by the assessment of a fixed participation fee upon all health insurance contracts purchased through the Exchange are outlined in Table 7-2, below. To be financially self-sustaining, the Exchange would need to charge a fee of $19 per month[2]. The fee could be assessed upon participating health insurance carriers on a per covered member basis or could be added to monthly premiums charged through the Exchange to enrollees. This projection again assumes Exchange costs consistent with the "high" estimates described in this paper.

Table 7-2: Five Year Budget Projection: $19.00 Per Contract/Per Month Fee for Exchange Coverage

	2012	2013	2014	2015	2016
CASELOAD					
INDIVIDUAL MARKET CONTRACTS	0	56,000	72,118	110,793	138,600
SHOP CONTRACTS	0	5,500	11,963	18,549	24,750
MEMBERS	0	90,000	124,775	192,000	243,000
MEMBER MONTHS	0	270,000	1,497,300	2,304,000	2,916,000
EXCHANGE PREMIUMS	$0	$0	$603,842,500	$980,235,000	$1,330,200,000
OPERATING REVENUE					
FEDERAL EXCHANGE GRANTS	$19,761,230	$30,323,664	$34,281,826	$0	$0
EXCHANGE FEE REVENUE	$0	$0	$19,170,240	$29,489,805	$37,243,800
TOTAL OPERATING REVENUE	*$19,761,230*	*$30,323,664*	*$53,452,066*	*$29,489,805*	*$37,243,800*
NON OPERATING REVENUE					
INVESTMENT INCOME	$0	$0	$534,521	$370,064	$364,519
OTHER NON-OPERATING REVENUE	$0	$0	$0	$0	$0
TOTAL NON-OPERATING REVENUE	*$0*	*$0*	*$534,521*	*$370,064*	*$364,519*
OPERATING EXPENSES					
HUMAN RESOURCE EXPENSE	$3,295,550	$5,411,940	$8,125,183	$8,822,375	$9,565,685
CONSULTING COSTS	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
EXCHANGE ADMINISTRATIVE EXPENSE	$120,680	$308,094	$339,660	$294,960	$294,960
CALL CENTER / PREMIUM BILLING	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
WEB SITE CREATION/MAINTENANCE	$1,200,000	$1,800,000	$1,000,000	$750,000	$500,000
STATE ELIGIBILITY CHARGEBACK	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
APPEALS PROGRAM	$0	$0	$903,381	$432,736	$422,375
COMMUNICATIONS / MARKETING	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
NAVIGATOR EXPENSE	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
OUTREACH EXPENSE	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
IT DEVELOPMENT COST	$10,695,000	$9,250,000	$3,392,500	$1,357,125	$1,424,975
TOTAL OPERATING EXPENSES	*$19,761,230*	*$30,323,664*	*$34,281,826*	*$31,892,915*	*$36,135,375*
OPERATING PROFIT / (DEFICIT)	***$0***	***$0***	***$19,704,761***	***($2,033,046)***	***$1,472,943***
NET ASSETS BEGINNING OF YR	***$0***	***$0***	***$0***	***$19,704,761***	***$17,671,715***
NET ASSETS END OF YEAR	***$0***	***$0***	***$19,704,761***	***$17,671,715***	***$19,144,658***

[2] The $19.00 per case/per month fee was calculated by comparing assumed Connecticut Exchange operating costs for 2015 and 2016 against assumed Exchange membership. The calculation assumes 1.4 members per case in the individual market Exchange and 1.8 members per case in the Small Business Health Options Program (SHOP) Exchange.

3. Statewide Premium Assessment

The final major broad-based revenue option the team considered is charging an assessment upon all health coverage provided through commercial health carriers and health maintenance organizations. The State of Connecticut currently administers a premium tax that impacts all commercial health coverage purchased in the State. This may be an existing assessment that could be modified to support Connecticut's Exchange operations. Financial projections linked to a statewide premium assessment are provided through Table 7-3[3].

Table 7-3: Five Year Budget Projection Statewide Premium Assessment of 0.2%

	2012	2013	2014	2015	2016
CASELOAD					
INDIVIDUAL MARKET CONTRACTS	0	56,000	72,118	110,793	138,600
SHOP CONTRACTS	0	5,500	11,963	24,750	24,750
MEMBERS	0	90,000	124,775	192,000	243,000
MEMBER MONTHS	0	270,000	1,497,300	2,304,000	2,916,000
EXCHANGE PREMIUMS	$0	$0	$603,842,500	$980,235,000	$1,330,200,000
OPERATING REVENUE					
FEDERAL EXCHANGE GRANTS	$19,761,230	$30,323,664	$34,281,826	$0	$0
PREMIUM ASSESSMENT REVENUE	$0	$0	$31,950,000	$34,346,250	$36,922,219
TOTAL OPERATING REVENUE	*$19,761,230*	*$30,323,664*	*$66,231,826*	*$34,346,250*	*$36,922,219*
NON OPERATING REVENUE					
INVESTMENT INCOME	$0	$0	$662,318	$676,780	$722,717
OTHER NON-OPERATING REVENUE	$0	$0	$0	$0	$0
TOTAL NON-OPERATING REVENUE	*$0*	*$0*	*$662,318*	*$676,780*	*$722,717*
OPERATING EXPENSES					
HUMAN RESOURCE EXPENSE	$3,295,550	$5,411,940	$8,125,183	$8,822,375	$9,565,685
CONSULTING COSTS	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
EXCHANGE ADMINISTRATIVE EXPENSE	$120,680	$308,094	$339,660	$294,960	$294,960
CALL CENTER / PREMIUM BILLING	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
WEB SITE CREATION/MAINTENANCE	$1,200,000	$1,800,000	$1,000,000	$750,000	$500,000
STATE ELIGIBILITY CHARGEBACK	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
APPEALS PROGRAM	$0	$0	$903,381	$432,736	$422,375
COMMUNICATIONS / MARKETING	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
NAVIGATOR EXPENSE	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
OUTREACH EXPENSE	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
IT DEVELOPMENT COST	$10,695,000	$9,250,000	$3,392,500	$1,357,125	$1,424,975
TOTAL OPERATING EXPENSES	*$19,761,230*	*$30,323,664*	*$34,281,826*	*$31,892,915*	*$36,135,375*
OPERATING PROFIT / (DEFICIT)	***$0***	***$0***	***$32,612,318***	***$3,130,115***	***$1,509,561***
NET ASSETS BEGINNING OF YR	***$0***	***$0***	***$0***	***$32,612,318***	***$35,742,433***
NET ASSETS END OF YEAR	***$0***	***$0***	***$32,612,318***	***$35,742,433***	***$37,251,993***

[3] The projection in Table 7-3 assumes a broad-based premium assessment of 0.2% to support the Exchange. This figure was derived through a comparison of assumed Exchange operating cost in 2015 and 2016 against revenue generated through an assessment imposed upon a base of $16.0 billion with assumed growth of 7.5% per year.

At this stage of Exchange planning, estimates of cost and revenue are still dependent upon a number of assumptions about the Exchange's structure and governance, number of enrollees and the insurance premiums associated with coverage provided through the Exchange. It will be necessary in the months ahead for Connecticut to continue to revisit these estimates as more complete information about internal and external factors influencing the financing of Connecticut's Exchange become clearer.

The Mercer/HMA team reviewed several additional revenue options that did not provide the same revenue potential as the methods outlined above. A review of these options is provided in this report.

Budget Model

The Mercer/HMA team built a comprehensive budget model to garner a broad understanding of the likely costs of Connecticut's Exchange. The results of this model are presented below in a manner consistent with the reporting requirements necessary for a state application for federal Exchange grant funds. Cost estimates are provided within an assumed higher and lower bound for each year between 2012 and 2016. Basic estimates about the likely fund sourcing for Connecticut's Exchange are presented as follows:

- Total costs are identified as Gross Cost
- Costs that would be incurred by Connecticut State government and the Connecticut Exchange are recognized as a State/Exchange Cost

Budget Model Assumptions

Creation of budget estimates for Connecticut's Exchange required a number of assumptions about the structure of the Exchange and likely changes in the health insurance market in Connecticut. These assumptions about the structure of Connecticut's Health Insurance Exchange are largely consistent with language included in Public Act 11-53, legislation authorizing creation of Connecticut's Exchange enacted in July of 2011. Major assumptions used to generate the estimate include:

- Membership: The number of individuals participating in the Exchange where individual market coverage can be purchased and the SHOP where small businesses can purchase coverage is assumed to be consistent with the estimates provided in Appendix 7B. These numbers depend upon a robust outreach and marketing campaign, the participation of key health insurance carriers, the availability of a sufficient choice of health plans and partnering with health insurance brokers
- Legal and tax status of the Connecticut Exchange: The budget model assumes that Connecticut's Exchange will be structured as a quasi-public entity

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

- Exchange structure: The model assumes that operation of the Exchange will not be deferred to the federal government, Connecticut will not partner with other states for complete operation of its Exchange and multiple subsidiary Exchanges will not be established throughout Connecticut

- Administration of the Exchange and SHOP: The model assumes that administration of the Exchange and SHOP Exchange will be consolidated

- Insurance broker reimbursement: The model assumes that commissions provided to insurance brokers for health coverage purchased through Connecticut's Exchange are built into existing health coverage premiums. The model provides additional funds for marketing which could be utilized to provide additional reimbursement to insurance brokers for enrolling eligible individuals and entities into Connecticut's Exchange. Outside of these marketing funds, the budget model does not assume brokers' fees would be paid through the Connecticut Exchange

- Information technology (IT) development: To be conservative, the model assumes that development of necessary information technology tools to support Connecticut's Exchange will not be undertaken through the New England States Consortium. Connecticut's Exchange may incur lower costs in IT development through coordination of IT planning through the New England States Consortium

- Connecticut eligibility system modifications**:** The budget model does not assume Exchange costs associated with modification or replacement of Connecticut's existing eligibility system. To date, Connecticut has not identified the plan for enhancing or replacing the existing eligibility system

The budget model assumes a range of costs associated with developing and operating the Exchange between 2012 and 2016. The model generates a "high" estimate and "low" estimate for each unknown Exchange cost. The factors used to generate each estimate include:

- "High" estimate: The model assumes greater staff levels within the Exchange at both junior and senior levels, greater State of Connecticut staff involvement, more aggressive utilization of professional consultants to support the design of Exchange systems and processes and a more comprehensive outreach and education effort as well as a greater cost for contracted Exchange services

- "Low" estimate: The lower bound estimate assumes fewer staff to support the major Exchange functions, a less intensive effort by State staff to support Exchange planning, more limited need for consulting services, a less aggressive effort to support the outreach and education campaign, and lower costs to support contracted Exchange services

Budget Model Results

Table 7-4, below, provides a summary of likely Exchange costs in Connecticut between 2012 and 2016. This figure represents the sum of all the costs outlined in tables 7-5 to 7-19.

Table 7-4: Connecticut Health Insurance Exchange Cost: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	12.0	22.0	44.0	44.0	44.0
GROSS COST	$19,761,230	$30,323,664	$34,281,826	$31,892,915	$36,135,375
STATE/EXCHANGE COST	$0	$2,020,565	$2,186,463	$31,627,761	$35,848,291
LOW ESTIMATE					
FTE	12.0	21.5	30.0	30.0	30.0
GROSS COST	$16,523,123	$22,392,970	$24,661,194	$24,796,794	$28,347,015
STATE/EXCHANGE COST	$0	$1,014,396	$1,130,524	$24,611,186	$28,146,056

Outlined in the sections to follow is a detailed discussion of each component used to build the budget estimate including the key assumptions and variables used to generate each element of cost.

Salary and Wage Costs

Table 7-5: Connecticut Health Insurance Exchange Salary Cost: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	12.0	22.0	44.0	44.0	44.0
GROSS COST	$1,459,645	$2,234,136	$3,424,665	$3,510,281	$3,598,038
STATE/EXCHANGE COST	$0	$0	$0	$3,510,281	$3,598,038
LOW ESTIMATE					
FTE	12.0	21.5	30.0	30.0	30.0
GROSS COST	$1,459,295	$2,205,590	$2,725,631	$2,793,772	$2,863,616
STATE/EXCHANGE COST	$0	$0	$0	$2,793,772	$2,863,616

Assumptions about likely salary cost were generated through the use of the Connecticut Exchange's draft organizational chart, combined with information from Exchange experience in Massachusetts. The staffing model for Connecticut's Exchange assumed that staff would be necessary to oversee the higher-level functions and administration of the Exchange. Functions such as operation of a customer call center are assumed to be provided through contracted vendors. Exchange staff is assumed to be necessary in the following functional areas:

- Executive management of the Exchange (i.e. a Chief Executive Officer and related staff)
- In-house legal services and management of an appeals process

- Research and policy analysis
- Communications, community outreach and marketing
- Information technology
- Finance and accounting

Assumed staff by job title for both the high and low cost budget estimates is outlined in Table 7-6 provided below.

Table 7-6: Assumed Staff by Job Title

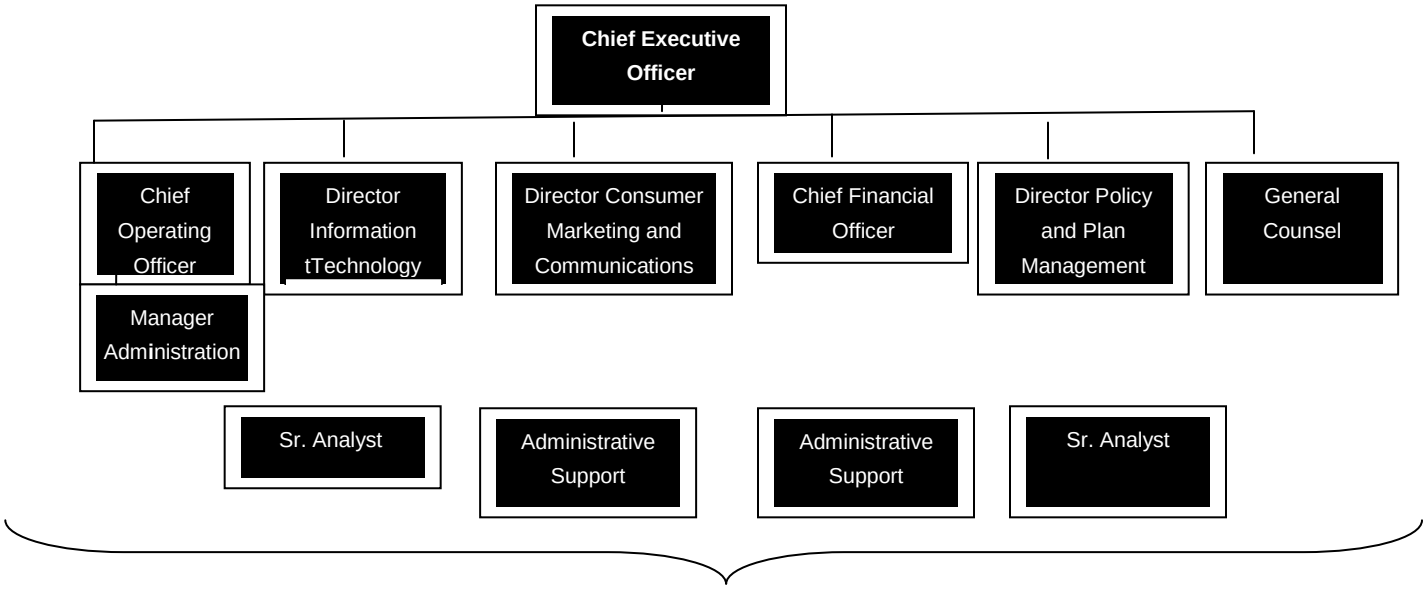
	HIGH	LOW
EXECUTIVE STAFF		
CHIEF EXECUTIVE OFFICER	1.0	1.0
CHIEF OPERATING OFFICER	1.0	1.0
OFFICE MANAGER	1.0	1.0
ADMINISTRATIVE SUPPORT	2.0	2.0
MANAGER ADMINISTRATION	1.0	1.0
LEGAL & APPEALS SECTION		
GENERAL COUNSEL	1.0	1.0
APPEALS UNIT MANAGER	1.0	1.0
APPEAL STAFF	4.0	0.0
POLICY & RESEARCH		
DIRECTOR POLICY & RESEARCH	1.0	1.0
POLICY ANALYST	2.0	1.0
COMMUNICATIONS		
DIRECTOR MARKETING & COMMUNICATION	1.0	1.0
OUTREACH DIRECTOR	1.0	1.0
COMMUNICATIONS DIRECTOR	1.0	1.0
COMM / OUTREACH / MARKET STAFF	6.0	3.0
FINANCE / ACCOUNTING		
CHIEF FINANCIAL OFFICER	1.0	1.0
FINANCIAL ANALYST	2.0	1.0
DIRECTOR OF ACCOUNTING	1.0	0.0
ACCOUNTANT	1.0	1.0
INFORMATION TECHNOLOGY STAFF		
DIRECTOR, INFORMATION TECHNOLOGY	1.0	1.0
COMPUTER ENGINEER	1.0	1.0
IT ANALYST	2.0	2.0
EXCHANGE STAFF		
PROGRAM DIRECTOR CT EXCHANGE OPERATIONS	1.0	1.0
SENIOR MANAGER INDIVIDUAL EXCHANGE	1.0	1.0
SENIOR MANAGER SHOP EXCHANGE	1.0	1.0
EXCHANGE STAFF	8.0	4.0
TOTAL	**44.0**	**30.0**

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

The assumed salary associated with each position was taken from estimated salaries reported to the Federal government in Connecticut's Level One Implementation Grant application and average 2010 salary data (by job description) reported through the Federal Bureau of Labor Statistics for the State of Connecticut. The model assumed average annual salary growth for each funded position between 2012 and 2016 at 2.8% per year.

Provided below is an organization chart detailing the assumed major functions necessary for the operation of Connecticut's Exchange and the likely arrangement of this staff within the Exchange.

Figure 7-1: Connecticut Health Insurance Exchange Assumed Organization Chart



Major responsibilities assumed for each major staff position are assumed as follows:

- Chief Executive Officer (CEO): The Exchange CEO will be responsible for the overall leadership of Exchange staff. The CEO will devote much of his/her time and effort to working with the Exchange governing board in development and implementation of Exchange policy and overseeing the operations, financing, personnel and planning tasks with Connecticut's Exchange. The CEO will serve as a connection to high-level stakeholders to adapt Connecticut's Exchange to the meet the needs of targeted consumers and carriers

- Chief Operating Officer (COO): The COO will report directly to the Exchange CEO and will oversee the daily operation of the Connecticut Exchange. This will require more hands-on work with Exchange staff and developing initial contracts with vendors

- Chief Financial Officer (CFO): The CFO is responsible for the financial management of the Connecticut Exchange. The CFO and support staff will be responsible for the management of Exchange administrative expenses, projection of future revenue available to the Exchange, premium and subsidy calculations, and accounting and financial reporting tasks associated with Exchange operations. Specifically, the CFO will need to ensure that the Exchange can meet all federal and state reporting requirements and will manage any related audits. The CFO will also oversee the Exchange's risk adjustment and reinsurance programs

- Director of Information Technology: The Director of Information Technology will be responsible for the development, maintenance and improvement of the Connecticut Exchange web site and supporting IT systems. This will include and interfaces with state and federal eligibility systems. The Director of Information Technology and his/her support staff will be further responsible for the maintenance and support of IT systems used on a day to day basis by Exchange staff

- Director of Consumer Marketing and Communications: The Director of Consumer Marketing and Communications will be required to create and implement a marketing plan intended to increase consumer awareness of the Connecticut Exchange services and products. The staff will be further responsible for building and maintaining positive relationships between the Exchange and the media, political decision makers and the public

- General Counsel: The General Counsel is responsible for management of all legal matters in the Exchange. The General Counsel and staff will be responsible for negotiating contracts with health insurance carriers, vendors and consultants. The General Counsel will manage the interfaces between the Connecticut Exchange and the State Medicaid program, State insurance regulators and the Federal government on issues of compliance with State and Federal law. The General Counsel is also responsible for creating a process for adjudicating consumer requests for appeals, waivers and hardship exemptions associated with required premium sharing and the individual insurance mandate

- Director of Policy and Plan Management: The Director of Policy and Plan Management is responsible for shaping organizational strategy and long term planning to ensure that Exchange policy objectives are realized. The Director of policy works with the Insurance Department, the Department of Revenue, state agencies, providers and payers on regulations and policy issues to ensure that policy objectives are realized. Additionally, the Director of Policy is responsible for identifying the implications of national and state health reform for the Exchange and developing strategy to move to compliance

Actual salary costs experienced by the Exchange will be influenced by the following factors:

- Decisions made by the Exchange Chief Executive Officer about appropriate staff levels

- The organization chart of the Exchange

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

- The experience and skills (and corresponding salary needs) individual staff provide to the Exchange
- Decisions about which functions should be handled through the Exchange and which functions could be secured through a contracted vendor.

All State/Exchange costs reported in Table 7-5 are assumed to be paid through the Exchange.

Fringe Benefit Costs

Table 7-7: Connecticut Health Insurance Exchange Fringe Benefit Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$1,007,155	$1,541,554	$2,363,019	$2,422,094	$2,482,646
STATE/EXCHANGE COST	$0	$0	$0	$2,422,094	$2,482,646
LOW ESTIMATE					
GROSS COST	$510,753	$771,956	$953,971	$977,820	$1,002,266
STATE/EXCHANGE COST	$0	$0	$0	$977,820	$1,002,266

The model assumes additional human resource costs associated with the provision of fringe benefits. These costs are typically related to the provision of medical, dental and vision coverage for an employee and funding for an employee retirement plan. Table 7-7 relies upon the staffing model used to generate salary estimates and assumes benefit costs equal to 69% of employee salary cost for the high estimate and 35% of employee salary cost for the low estimate.

Benefit costs realized by Connecticut's Exchange will be influenced by the number and type of benefits provided through the Connecticut Exchange, the actual number of employed staff within the Exchange and external factors that will influence the cost of health coverage once the PPACA is fully implemented in 2014.

State/Exchange costs are not assumed until expiration of the Federal implementation grant funding at the end of 2014. Benefit costs will be fully borne by the Exchange and not the State of Connecticut.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

State of Connecticut Exchange Planning Costs

Table 7-8: Connecticut Health Insurance Exchange State Staff Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$828,750	$1,636,250	$2,337,500	$2,890,000	$3,485,000
STATE/EXCHANGE COST	$0	$0	$0	$2,890,000	$3,485,000
LOW ESTIMATE					
GROSS COST	$541,875	$1,126,250	$1,986,875	$2,592,500	$3,187,500
STATE/EXCHANGE COST	$0	$0	$0	$2,592,500	$3,187,500

The budget model assumes that design, implementation and operation of federal health care reform in Connecticut, including Connecticut's Exchange, will require the cooperation and input of State staff in existing state agencies. In addition to performing the initial research and analysis functions prior to the creation and staffing of the Exchange, State staff will be necessary to support the following functions, as required under the Affordable Care Act:

- Coordination of necessary processes to integrate Medicaid eligibility determination and related functions into Exchange processes
- Manual work to support "exception processing" for Exchange and Medicaid eligibility determination
- Changes in existing State information technology (IT) systems to support new Exchange IT tools
- The design and administration of health plan rating and certification processes
- The design and implementation of premium rate review processes
- Administration of carrier reinsurance and risk adjustment processes

The model assumes staff effort to support the Exchange will be necessary in the Office of the Governor (through the newly established Office of Health Reform, the Office of the Lieutenant Governor and the Office of Policy and Management), the Department of Social Services, the Insurance Department and the Department of Information Technology. Costs are assumed on a Full Time Equivalent (FTE) basis and an average annual FTE cost (accounting for salary, benefits and additional overhead) is assumed at $85,000. Assumed FTE needed by each State agency is outlined in the table below, followed by a list (by agency) of the details of additional workload requirements. (It should be noted that while the calculations of additional workload were made on an FTE basis, state agencies might choose to invest the resources in the hiring of short-term consultants, automation, or other means to help extend the work of existing state staff.)

The assumptions of state agency staffing levels are based generally on the experience in Massachusetts, where some initial funds were provided by the state for new activities related to the launch and operation of the Massachusetts Health Connector. The Health Connector assumed some (but not all) of these costs in subsequent years. The "high" estimates for Connecticut reflect the potential need for state agency staff to handle the unknowns of still undefined federal requirements and to reflect the relative needs of Connecticut due to recent state staffing shortages.

Table 7-8.1: Connecticut Health Insurance Exchange-Related FTEs by Department: 2012–2016

State Dept./Agency	2012	2013	2014	2015	2016
		High Estimate			
Executive office	3.25	4.0	2.0	1.0	1.0
Social services	2.0	7.25	19.5	28.0	35.0
Insurance	2.0	4.0	3.0	3.0	3.0
Information tech.	2.5	4.0	3.0	2.0	2.0
Total	9.75	19.25	27.5	34.0	41.0

State Dept./Agency	2012	2013	2014	2015	2016
		Low Estimate			
Executive office	2.0	4.0	2.0	1.0	1.0
Social services	0.9	5.25	18.4	27.0	34.0
Insurance	1.0	2.0	1.5	1.5	1.5
Information tech.	1.5	2.0	1.5	1.0	1.0
Total	5.4	13.25	23.4	30.5	37.5

The following paragraphs describe the assumed state staffing needs in more detail, including the functions that need to be performed. These assumptions are used to develop the high and low FTE estimates presented in the tables above. These assumptions may differ from the staffing structure ultimately chosen by Connecticut, but they are provided in this report to assist with informing the State about the types of staff positions, including the roles and functions of the positions, so that they may be used in supporting the development of the Exchange, as well as implementing certain other federal health reform provisions in Connecticut. The additional workload related to implementing the Connecticut Health Insurance Exchange, as well as certain other federal health care reform provisions, is assumed as follows:

- Executive Office: The Governor's Office of Health Reform, the Office of the Lieutenant Governor, the Office of Policy and Management, and the Department of Social Services (at the executive office level), all need key staff members dedicated to coordinating the implementation of federal health reform across Connecticut's state government. These staff

are also needed to help coordinate Connecticut's response to the federal government's requests for input in their rule-making processes, as well as many other organization's requests for input (including the National Governor's Association and the National Association of Insurance Commissioners). The need for these staff will be greater before health reform is fully implemented in 2014, and is expected to diminish over time. The estimates assume one staff member per Executive Office during the early phases. It may be possible to leverage existing state staff for some of the workload initially, which is what the "low" estimate reflects.

- Social Services: While federal health reform contemplates a fully automated eligibility determination process, there has begun to be discussion about the need for "exception processing" at the state level, for those people who do not have accurate or updated information on their income or citizenship status through the federal data sources. In addition, the state of Connecticut has not yet determined what its automated eligibility system solution will be. Therefore, the budget assumes that the state will need to support some funding for additional eligibility determination workload for state staff. The workload is calculated based on an estimate of 10% of cases each year will be exceptions needing manual intervention. For these exception cases, the model assumes a workload of 600 cases/FTE, which is based on the current social services workload in a state with some similar characteristics

- Insurance Department: Federal health reform calls for a number of new responsibilities for each state insurance department. These include establishing a premium rate review and oversight program, establishing network adequacy and marketing standards for health insurance issuers, and establishing a reinsurance and risk adjustment program for the small group and individual markets. The Insurance Department may also help to conduct various analyses, such as on whether to merge the small group and non-group insurance markets in a state, as well as analyzing the value of proposed Essential Health Benefits for the state. They will also be coordinating with the state Exchange on many implementation issues, and may help to provide guidance on certain matters, such as determining actuarial value for the metal tiers. There will be significant overlap between the Insurance Department and the state Exchange for certain functions. Given the uncertainty about the allocation of the new workload, the budget provides a range of staffing estimates for the Connecticut Insurance Department, and builds in additional positions for the "high" estimate to address this uncertainty. The number of state staff needed for these new functions is expected to be highest in 2013, when the programs are being designed, and will diminish slightly in subsequent years

- Department of Information Technology: The information technology requirements of federal health reform are significant, including eligibility systems and Exchange systems, the details of which are provided in Section 8 of this report. While many of the needs will be addressed through hiring consultants and vendors, it is important for Connecticut to have enough state staff to properly procure and oversee this significant body of work. As discussed above, the

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number of state staff needed for these new functions is expected to be highest in 2013 and 2014, when the information technology systems are being built and launched, and will diminish in subsequent years

The model assumes that Federal reimbursement for State support for Exchange planning will be available through the end of 2014 with the State of Connecticut paying these costs in 2015 and beyond. As Connecticut works to determine the appropriate level of revenue to support its Exchange, the state may want to explore using a portion of Exchange revenue to support these staff costs in other Departments. (The budget model assumes that the Exchange revenue supports these staff.) These revenues could be distributed through a statutorily created fund created for the collection and distribution of Exchange revenues or through an inter-departmental transfer of funding to the appropriate agency through the quasi-public health insurance Exchange.

Consultant Costs

Table 7-9: Connecticut Health Insurance Exchange Consultant Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
STATE/EXCHANGE COST	$0	$0	$0	$2,125,000	$2,125,000
LOW ESTIMATE					
GROSS COST	$1,845,000	$1,875,000	$2,370,000	$2,295,000	$2,295,000
STATE/EXCHANGE COST	$0	$0	$0	$2,295,000	$2,295,000

The creation of Connecticut's Health Insurance Exchange will require a broad range of experience and skills, and some will only be needed on a limited or short-term basis, which argues for the hiring of consultants rather than staff in some instances. Connecticut's Exchange will need to rely upon professional consulting services to assist in the design and operation of a number of Exchange functions. Table 7-9 provides an estimate of likely consulting costs necessary to support Connecticut's Exchange. The estimate relied upon the staff model used to generate the salary estimate and an assumption that consulting support will be necessary to support the following:

- Design of an eligibility determination and enrollment processes
- Integration of the Exchange program with the Medicaid program
- Creation of a quality rating system
- Actuarial and financial modeling
- Design of a health plan certification system

- Design of an appeals system
- Support and design of a process for selection of participating health carriers
- Design of customer service procedures
- Management and design of procurement processes
- Marketing support

Provided below is a summary of assumed consulting cost by likely function. The budget model focuses more attention to needed consulting support for Exchange implementation in 2012 and 2013. The need for consultant support between 2014 and 2016 will be determined by staffing decisions made by the leadership of Connecticut's Exchange. Estimates in these out years are largely calculated as a Full Time Equivalent (FTE) equivalent. Assumed cost per FTE is $85,000.

Table 7-9.1: Detailed View of Assumed Consultant Need: 2012–2016

TASK	2012	2013	2014	2015	2016
HIGH ESTIMATE (THOUSANDS)					
Design Eligibility and Enrollment System	$400	$250	$0	$0	$0
Exchange Integration into Medicaid	$400	$200	$0	$0	$0
Quality Rating Design/Implementation	$200	$100	$100	$0	$0
Actuarial and Financial Modeling	$200	$200	$200	$0	$0
Health Plan Certification Process Design	$200	$100	$100	$0	$0
Appeal System Design	$150	$75	$0	$0	$0
Carrier Selection	$100	$250	$100	$0	$0
Customer Service	$100	$250	$125	$0	$0
Procurement Assistance	$100	$250	$125	$0	$0
Marketing	$250	$750	$2,000	$0	$0
Additional Consulting Need (Staff Equiv)	$850 (10)	$1,275 (15)	$1,700 (20)	$2,125 (25)	$2,125 (25)
TOTAL	$2,950	$3,700	$4,450	$2,125	$2,125
LOW ESTIMATE					
Design Eligibility and Enrollment System	$200	$100	$0	$0	$0
Exchange Integration into Medicaid	$150	$100	$0	$0	$0
Quality Rating Design/Implementation	$150	$75	$0	$0	$0
Actuarial and Financial Modeling	$150	$100	$0	$0	$0
Health Plan Certification Process Design	$150	$100	$0	$0	$0
Appeal System Design	$75	$75	$0	$0	$0
Carrier Selection	$75	$75	$0	$0	$0

TASK	2012	2013	2014	2015	2016
Customer Service	$75	$75	$0	$0	$0
Procurement Assistance	$75	$75	$0	$0	$0
Marketing	$150	$250	$500	$0	$0
Additional Consulting Need (Staff Equiv)	$595 (7)	$850 (10)	$1,870 (22)	$2,295 (27)	$2,295 (27)
TOTAL	$1,845	$1,875	$2,370	$2,295	$2,295

The model assumes that the State/Exchange costs will not be incurred until the expiration of Federal grant funding at the end of 2014. Consulting costs in 2015 and 2016 will be exclusively paid with Exchange revenues.

General Administrative Costs

Table 7-10: Connecticut Health Insurance Exchange General Administrative Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
EQUIPMENT GROSS	$8,000	$68,000	$61,000	$50,000	$50,000
EQUIPMENT STATE/EXCHANGE	$0	$0	$0	$50,000	$50,000
SUPPLIES GROSS	$3,600	$6,600	$13,200	$13,200	$13,200
SUPPLIES STATE/EXCHANGE	$0	$0	$0	$13,200	$13,200
TRAVEL GROSS	$15,000	$15,014	$14,500	$10,800	$10,800
TRAVEL STATE/EXCHANGE	$0	$0	$0	$10,800	$10,800
OTHER GROSS	$94,080	$218,480	$250,960	$220,960	$220,960
OTHER STATE/EXCHANGE	$0	$0	$0	$220,960	$220,960
TOTAL GROSS	**$120,680**	**$308,094**	**$339,660**	**$294,960**	**$294,960**
TOTAL STATE / EXCHANGE	**$0**	**$0**	**$0**	**$294,960**	**$294,960**
LOW ESTIMATE					
EQUIPMENT GROSS	$4,000	$14,000	$21,500	$18,000	$18,000
EQUIPMENT STATE/EXCHANGE	$0	$0	$0	$18,000	$18,000
SUPPLIES GROSS	$1,800	$3,225	$4,500	$4,500	$4,500
SUPPLIES STATE/EXCHANGE	$0	$0	$0	$4,500	$4,500
TRAVEL GROSS	$15,000	$15,008	$9,750	$9,000	$9,000
TRAVEL STATE/EXCHANGE	$0	$0	$0	$9,000	$9,000
OTHER GROSS	$50,400	$100,650	$87,000	$85,500	$85,500
OTHER STATE/EXCHANGE	$0	$0	$0	$85,500	$85,500
TOTAL GROSS	**$71,200**	**$132,883**	**$122,750**	**$117,000**	**$117,000**
TOTAL STATE /EXCHANGE	**$0**	**$0**	**$0**	**$117,000**	**$117,000**

Table 7-10, above, provides estimates of a number of the administrative costs associated with the day-to-day operation of the Connecticut Exchange. The categories outlined above are consistent with Federal budget reporting requirements and are described in more detail below.

Equipment Costs

Equipment costs are defined as the information technology (including computer hardware, computer software, computer server and copier/printer) necessary to support Exchange staff. The equipment estimate was generated using the staff estimate used to generate the salary cost estimate and publicly available information about the prices necessary to purchase these items. It is likely that this cost could be reduced if the Exchange were able to access existing purchasing arrangements established by Connecticut State government.

Supplies Cost

The supply category assigns an assumed cost for office supplies used by Exchange staff. This estimate was generated as an assumed fixed cost per on-board FTE.

Travel Costs

The model assumes that the Exchange will incur travel costs within the State to support outreach activities and to meet with stakeholders and potential vendors and out of state costs for conferences and meetings with the Federal government and other states. The model assumes travel costs on a per FTE basis.

Other Costs

Additional administrative cost is defined as “other” in the Federal documents. This category includes assumed costs for internet and phone access, rent and office furniture. The assumed cost is generated on a per-FTE basis and utilizes publicly available furniture costs and rental rates in the creation of the final estimate.

General administrative costs are assumed to be funded through Federal Exchange grant funding through 2014 with full Exchange funding in 2015 and beyond. Again these costs could be reduced if the Exchange is able to access existing State purchasing arrangements and office space.

Contractual Costs

Table 7-11: Connecticut Health Insurance Exchange Contracted Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
CALL CNTR / PREM. BILL GROSS	$0	$1,353,630	$7,746,101	$12,219,469	$15,841,581
CALL CNTR/PREM. BILL STATE/EXCHANGE	$0	$20,565	$186,463	$11,954,315	$15,554,496
WEB SITE GROSS	$0	$0	$1,000,000	$750,000	$500,000
WEB SITE STATE/EXCHANGE	$0	$0	$0	$750,000	$500,000
STATE ELIGIBILITY GROSS	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE ELIGIBILITY STATE/EXCHANGE	$0	$0	$0	$1,391,250	$1,460,800
OUTREACH GROSS	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
OUTREACH STATE/EXCHANGE	$0	$0	$0	$1,500,000	$1,500,000
NAVIGATOR GROSS	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
NAVIGATOR STATE/EXCHANGE	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
APPEALS GROSS	$0	$0	$903,381	$432,736	$422,375
APPEALS STATE/EXCHANGE	$0	$0	$0	$432,736	$422,375
COMMUNICATIONS GROSS	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
COMMUNICATIONS STATE/EXCHANGE	$0	$0	$0	$2,000,000	$2,000,000
TOTAL GROSS	**$1,500,000**	**$9,853,630**	**$17,974,483**	**$19,293,455**	**$22,724,756**
TOTAL STATE /EXCHANGE	**$0**	**$2,020,565**	**$2,186,463**	**$19,028,301**	**$22,437,671**
LOW ESTIMATE					
CALL CNTR / PREM. BILL GROSS	$0	$1,131,291	$6,445,998	$10,176,326	$13,205,920
CALL CNTR/PREM. BILL STATE/EXCHANGE	0	$14,396	$130,524	$9,990,719	$13,004,961
WEB SITE GROSS	$0	$0	$1,000,000	$750,000	$500,000
WEB SITE STATE/EXCHANGE	$0	$0	$0	$750,000	$500,000
STATE ELIGIBILITY GROSS	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE ELIGIBILITY STATE/EXCHANGE	$0	$0	$0	$1,391,250	$1,460,800
OUTREACH GROSS	$0	$1,000,000	$1,000,000	$750,000	$750,000
OUTREACH STATE/EXCHANGE	$0	$0	$0	$750,000	$750,000
NAVIGATOR GROSS	$0	$1,000,000	$1,000,000	$500,000	$500,000
NAVIGATOR STATE/EXCHANGE	$0	$1,000,000	$1,000,000	$500,000	$500,000
APPEALS GROSS	$0	$0	$518,469	$285,000	$238,438
APPEALS STATE/EXCHANGE	$0	$0	$0	$285,000	$238,438
COMMUNICATIONS GROSS	$1,000,000	$3,000,000	$2,000,000	$1,000,000	$1,000,000
COMMUNICATIONS STATE/EXCHANGE	$0	$0	$0	$1,000,000	$1,000,000
TOTAL GROSS	**$1,000,000**	**$6,631,291**	**$13,289,467**	**$14,852,576**	**$17,655,158**
TOTAL STATE /EXCHANGE	**$0**	**$1,014,396**	**$1,130,524**	**$14,666,969**	**$17,454,199**

The Connecticut Exchange will need to enter into contracts to support a number of day-to-day operating functions. It is advisable to use contractors because demand for certain supports may be variable throughout the year. Dramatic changes in the enrolled population in need of assistance makes administration of these functions with Exchange employees difficult to manage and inefficient. Additionally, the Exchange may want to avoid purchasing and designing

the systems necessary to fulfill call center, premium billing and related functions. It may be more effective to utilize a vendor with specialized expertise in these tasks and purchase these services on a per-member basis. Table 7-11, above, provides an estimate of likely contracted costs associated with managing several major Exchange business functions. Detailed explanations about the assumptions and inputs used to generate these projections are provided below.

Call center and Premium Billing Costs

Table 7-12: Connecticut Health Insurance Exchange Call Center and Premium Billing Cost: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
AHBE GROSS COST	$0	$1,140,000	$5,872,425	$9,292,325	$11,973,317
AHBE STATE/EXCHANGE COST	$0	$0	$0	$9,292,325	$11,973,317
SHOP GROSS COST	$0	$172,500	$1,500,750	$2,396,836	$3,294,095
SHOP STATE/EXCHANGE COST	$0	$0	$0	$2,396,836	$3,294,095
MCAID GROSS COST	$0	$41,130	$372,926	$530,308	$574,169
MCAID STATE/EXCHANGE COST	$0	$20,565	$186,463	$265,154	$287,084
GROSS COST	**$0**	**$1,353,630**	**$7,746,101**	**$12,219,469**	**$15,841,581**
STATE /EXCHANGE COST	**$0**	**$20,565**	**$186,463**	**$11,954,315**	**$15,554,496**
LOW ESTIMATE					
AHBE GROSS COST	$0	$960,000	$4,945,200	$7,825,116	$10,082,794
AHBE STATE/EXCHANGE COST	$0	$0	$0	$7,825,116	$10,082,794
SHOP GROSS COST	$0	$142,500	$1,239,750	$1,979,995	$2,721,209
SHOP STATE/EXCHANGE COST	$0	$0	$0	$1,979,995	$2,721,209
MCAID GROSS COST	$0	$28,791	$261,048	$371,216	$401,918
MCAID STATE/EXCHANGE COST	$0	$14,396	$130,524	$185,608	$200,959
GROSS COST	**$0**	**$1,131,291**	**$6,445,998**	**$10,176,326**	**$13,205,920**
STATE / EXCHANGE COST	**$0**	**$14,396**	**$130,524**	**$9,990,719**	**$13,004,961**

The call center and premium billing contract costs are estimated using an assumed per member per month (PMPM) charge. The estimate provided in Table 7-12, above, assumes a new standalone contract with a vendor for call center and premium billing services[4]. The estimate assumes the following PMPM charges for each element of assumed Exchange membership:

- A PMPM charge between $4.75 in 2014 and $5.04 in 2016 applied for assumed Exchange (individual market) membership

[4] For the purposes of this analysis, the model assumes that the Connecticut Exchange will perform the premium billing function for both the Exchange and SHOP . The law allows for carriers to perform this function for individual (non-group market) subscribers, rather than the Exchange.

- A PMPM charge between $5.75 in 2014 and $6.10 in 2016 for support of the SHOP (small group market) Exchange membership

- A PMPM charge of $0.50 associated with assisting individuals who are Medicaid-eligible. The model assumes an amount equivalent to 20% of those currently eligible for Medicaid and 65% of those who will be newly eligible for Medicaid under the expansion implemented in 2014 will utilize the Exchange call center for assistance with identifying and purchasing health coverage

Estimated program membership used to generate these estimates is consistent with the assumptions reported in Appendix 7B.

Because call center and premium billing costs are estimated on a PMPM basis, any action taken by the Connecticut Exchange that influences the size of the Exchange membership will impact these costs. Additionally, decisions by the Connecticut Exchange to modify current vendor contracts for call center and premium billing services could reduce the PMPM cost of providing these services.

The model assumes that a small percentage of Exchange costs within the call center will be eligible for Federal Medicaid reimbursement and not Exchange implementation grant funding. The Medicaid-eligible costs are assumed to be linked to providing call center support to people who are eligible for Medicaid and Medicaid recipients through the Exchange. Table 7-12 assumes a small State cost incurred in 2013 and 2014, equivalent to the non-Federal Medicaid match necessary to access Medicaid funding. It is not clear whether this cost would be paid by State General Fund or out of Exchange revenues. In 2015 and 2016 when Federal Exchange grant funding will no longer be available to the Exchange, the Exchange will continue to earn Federal Medicaid funds associated with supporting Medicaid recipients through the call center.

Website Maintenance Costs

Table 7-13: Connecticut Health Insurance Exchange Website Maintenance: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$0	$1,000,000	$750,000	$500,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$500,000
LOW ESTIMATE					
GROSS COST	$0	$0	$1,000,000	$750,000	$500,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$500,000

Table 7-13 provides a summary of likely Exchange costs associated with maintaining the Exchange portal. These costs include addressing website functionality issues, and making modest enhancements to the existing Exchange web tool.

The model assumes that maintenance costs incurred in 2014 would be funded with Federal Exchange grant funds and that further costs would be paid out of Exchange-generated revenues.

State Chargeback

Table 7-14: Connecticut Health Insurance Exchange State Chargeback Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE / EXCHANGE COST	$0	$0	$0	$1,391,250	$1,460,800
LOW ESTIMATE					
GROSS COST	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE / EXCHANGE COST	$0	$0	$0	$1,391,250	$1,460,800

The budget model assumes State incurred costs associated with state eligibility software acquisition, development and/or modification (at a modest level), as well as system hosting and data center operations. The integration of processes necessary to determine eligibility for Federal subsidy dollars, as well as to determine and communicate eligibility for Medicaid, will require integration of existing state systems – particularly the Eligibility Management System (EMS) under the assumption that it is not replaced, into new information systems deployed for the Exchange. Because Connecticut has not yet identified its plan for enhancing or replacing the existing eligibility system, the model only assumes a modest “placeholder” amount for minor software acquisition or enhancements related to the eligibility system. The cost incurred by the State of Connecticut is recognized in Table 7-14.

Much like the State support costs outlined above, the costs described in Table 7-14 would be incurred by the State of Connecticut. The State should explore creating statutory authorization or some other formalized arrangement with the Exchange to permit utilization of Exchange-generated revenues to support State costs associated with system hosting and data center operations.

It should be noted that the assumed State Chargeback costs outlined above does not reflect the possible cost associated with the Exchange‘s use of Core-CT (PeopleSoft) as the Exchange’s Enterprise Resource Planning (ERP) solution for supporting Exchange entity administrative functions including but not limited to financial accounting, accounts receivable and payable, purchasing, human resources and payroll, time and attendance and asset management. As part of the planning work done under Task 8, our team recommended further exploration of this option.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Outreach Costs

Table 7-15: Connecticut Health Insurance Exchange Outreach Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
STATE / EXCHANGE COST	$0	$0	$0	$1,500,000	$1,500,000
LOW ESTIMATE					
GROSS COST	$0	$1,000,000	$1,000,000	$750,000	$750,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$750,000

This report has recommended that Connecticut conduct an aggressive consumer education and outreach initiative. This initiative should be carefully coordinated with the Navigator program and the Communications and Marketing efforts, described in the sections below. The benefits of this type of combined initiative are to drive quick growth in Exchange membership which will help to reduce the number of uninsured in Connecticut, create a sufficiently large risk pool for commercial carriers and create a revenue base to support the Exchange's fixed costs. Proposed Federal regulations released in July of 2011 would require state Exchanges to administer an open enrollment period between October, 2013 and February, 2014. The open enrollment period, the only chance that the majority of Exchange eligible individuals will have to purchase coverage through Connecticut's Exchange for 2014, will make an aggressive education and outreach effort necessary to ensure appropriate membership within Connecticut's Exchange. This model assumes an aggressive outreach initiative to be undertaken between early 2013 and 2016, with planning to begin in 2012.

The budget estimates for the outreach, Navigator and Communications and Marketing programs are based on similar programs that were conducted during the roll-out of statewide health reform in Massachusetts, including the launch of the state's Health Connector, in 2006-2007. With a larger population than Connecticut and a similar percentage of uninsured, Massachusetts initially spent close to $3 million per year in its statewide outreach program. Based on the success of these programs in Massachusetts, this report is recommending a similar level of funding (a range of $2–4 million per year for the first two years for outreach and Navigators combined) for the outreach and Navigator programs in Connecticut. In Massachusetts, these funds were awarded as grants to grassroots and community-based organizations to educate consumers about health reform, with a focus on lower-income populations. These organizations engaged in outreach activities such as making presentations in community meetings, knocking on doors and creating educational handouts. Some organizations performed "Navigator-like" functions, although Massachusetts did not have a formal Navigator program.[5] Connecticut should review the lessons learned in Massachusetts and other health care access initiatives and use this information to help inform the design of an outreach and Navigator program that will serve the unique needs of its state.

[5] As a part of its Health Reform Toolkit Series, the Blue Cross Blue Shield Foundation of Massachusetts is planning on publishing a complete guide to how Massachusetts conducted its health reform-related outreach programs.

The model assumes outreach costs to be paid through the Federal implementation grant between 2012 and 2014 with Exchange revenue supporting outreach efforts in 2015 and 2016.

Navigator Costs

Table 7-16: Connecticut Health Insurance Exchange Navigator Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
STATE/EXCHANGE COST	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
LOW ESTIMATE					
GROSS COST	$0	$1,000,000	$1,000,000	$500,000	$500,000
STATE/EXCHANGE COST	$0	$1,000,000	$1,000,000	$500,000	$500,000

The PPACA requires Exchanges to operate a Navigator program. Through this program the Exchange would contract with community organizations, trade associations and/or licensed insurance agents or brokers to provide guidance to individuals and small businesses eligible for Exchange coverage. This program should be carefully coordinated with the Outreach program described above, and the Communications and Marketing program described below.

An Exchange-operated Navigator program could be structured and resourced in a variety of ways. The estimates provided in Table 7-16 above provide an assumed placeholder cost for operating a statewide Navigator program. The estimates are based on the scale of a similar program in Massachusetts. Actual costs experienced by the Connecticut Exchange will be largely influenced by final decisions made by Exchange leadership about an appropriate number of funded Navigators and the size of the grants necessary to support their activities. A key consideration for the state is that the PPACA requires the Navigator program to be financially supported with non-Federal funds. The model above assumes Navigator grants supported with State funds in 2013 and Exchange-generated revenues starting in 2014.

Appeals Administration Costs

Table 7-17: Connecticut Health Insurance Exchange Appeals Program Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
MANDATE APPEAL GROSS	$0	$0	$362,500	$225,000	$162,500
MANDATE APPEAL STATE/EXCHANGE	$0	$0	$0	$225,000	$162,500
ELIGIBILITY APPEAL GROSS	$0	$0	$540,881	$207,736	$259,875
ELIGIBILITY APPEAL STATE/EXCHANGE	$0	$0	$0	$207,736	$259,875
GROSS COST	**$0**	**$0**	**$903,381**	**$432,736**	**$422,375**
STATE / EXCHANGE COST	**$0**	**$0**	**$0**	**$432,736**	**$422,375**
LOW ESTIMATE					
MANDATE APPEAL GROSS	$0	$0	$362,500	$225,000	$162,500
MANDATE APPEAL STATE/EXCHANGE	$0	$0	$0	$225,000	$162,500
ELIGIBILITY APPEAL GROSS	$0	$0	$155,969	$60,000	$75,938
ELIGIBILITY APPEAL STATE/EXCHANGE	$0	$0	$0	$60,000	$75,938
GROSS COST	**$0**	**$0**	**$518,469**	**$285,000**	**$238,438**
STATE / EXCHANGE COST	**$0**	**$0**	**$0**	**$285,000**	**$238,438**

Connecticut's Exchange will be responsible for the adjudication of consumer requests for waivers from the individual insurance mandate, appeals of eligibility determinations and hardship waivers (as defined in the PPACA). Adjudication of appeals of applications for individual consumer waivers from the individual insurance mandate are solely the responsibility of the Connecticut Exchange. The Exchange must account for this workload in its decisions related to staffing, administration and contracting. Table 7-17 accounts for this cost under the "Mandate Appeal" line. While the budget model assumes that appeals related to determination of eligibility for subsidies offsetting the cost of individual insurance product would be also handled through Connecticut's Exchange, it is possible to structure this process through the Connecticut Department of Social Services. Costs would likely be similar under both structures although there may be some efficiencies that could be generated through consolidation of Medicaid and Exchange eligibility appeal processes.

The costs projected in Table 7-17 are constructed using the membership assumptions provided in Appendix 7B and additional projections about the number of post-reform uninsured in Connecticut between 2014 and 2016. These assumptions are consistent with reported levels experienced in Massachusetts during the implementation of the Massachusetts Health Connector.

The cost projection assumes funding for the appeals program would be covered by Federal Exchange grant funding in 2014 and through Exchange-generated revenue from 2015 and beyond.

Communications and Marketing

Table 7-18: Connecticut Health Insurance Exchange: Communications and Marketing: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
STATE/EXCHANGE COST	$0	$0	$0	$2,000,000	$2,000,000
LOW ESTIMATE					
GROSS COST	$1,000,000	$3,000,000	$2,000,000	$1,000,000	$1,000,000
STATE/EXCHANGE COST	$0	$0	$0	$1,000,000	$1,000,000

It is critically important that individuals and small business be made aware of the coverage options available through Connecticut's Exchange. It is likely that the rapidity of the changes associated with implementation of the PPACA in 2014 and the implementation of new mechanisms for purchasing coverage will create confusion for consumers and small businesses. Over and above funding provided for outreach and Navigators, the budget model recognizes additional costs associated with 1) marketing, 2) education of those typically engaged in assisting consumers in purchasing health coverage and perhaps 3) targeted incentives to insurance brokers for assisting consumers (especially small businesses) in purchasing health insurance coverage through Connecticut's Exchange.

As discussed above, the budget estimates for the outreach, Navigator, and Communications and Marketing programs are based on similar programs that were conducted during the roll-out of statewide health reform in Massachusetts, including the launch of the state's Health Connector, in 2006-2007. With a larger population than Connecticut, and a similar percentage of uninsured, Massachusetts initially spent $4 million of state funds on Communications and Marketing during its first 18 months.[6] In addition, outside organizations contributed another $3 million to a fund to help advertise the new law. There was also good deal of pro bono advertising from numerous private sector organizations. Based on the success of these programs in Massachusetts, this report is recommending a slightly higher level of public funding (a range of $3–4 million in 2013 and $2–3 million in 2014) for the Communications and Marketing program in Connecticut. These funds can be used for many purposes, including consumer research (to help define the customer), the design of a media and public relations campaign and purchase of media coverage (such as radio, print, and other media). In addition to providing state funds for Communications and Marketing; Connecticut should explore ways to leverage its public funds by building a coalition of interested stakeholders and developing ways

[6] For more information, see "Implementing a Successful Public Education and Marketing Campaign to Promote State Health Insurance Exchanges," published in May, 2011 by the Blue Cross Blue Shield Foundation of Massachusetts as part of its Health Reform Toolkit series.

in which private organizations can provide pro bono assistance to the statewide marketing efforts (as Massachusetts did).

Information Technology Development Costs

Table 7-19: Connecticut Health Insurance Exchange Information Technology Development Program Costs: 2012–2016

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$11,895,000	$11,050,000	$3,392,500	$1,357,125	$1,424,975
STATE/EXCHANGE COST	$0	$0	$0	$1,357,125	$1,424,975
LOW ESTIMATE					
GROSS COST	$11,095,000	$9,650,000	$3,212,500	$1,168,125	$1,226,475
STATE/EXCHANGE COST	$0	$0	$0	$1,168,125	$1,226,475

The Exchange will need to develop or purchase a number of information technology (IT) systems to support all the requirements outlined in the PPACA. The projection outlined in Table 7-19 assumes both IT costs that would be directly incurred by the Exchange for the operation of IT tools as well as IT development costs that will likely be incurred by both the Exchange and the State of Connecticut. Exchange IT costs are assumed for the creation/purchase of the following functions[7]:

- The Exchange portal comprised of both Web-accessible functionality and functionality that could be accessible via an interactive voice response (IVR) solution

- An information system that supports the Plan Management functions of an Exchange; the system may be comprised of multiple “components” (refer to the Exchange Reference Architecture guidance issued by CMS for more information on the *Plan Management* function)

- An information system that supports the Financial Management functions of an Exchange; the system may be comprised of multiple “components” (refer to the Exchange Reference Architecture guidance issued by CMS for more information on the *Financial Management* function)

- An Exchange Business Rules Management System (BRMS) that would house all of the business rules that ultimately drive Exchange eligibility and enrollment determinations, subsidy eligibility and subsidy amount calculations, and other Exchange functions; it is CMS’s expectation that this system would exist outside of the other systems on this list which are more geared towards managing transactions or providing information to Exchange consumers

[7] These functions are addressed more completely in Task 8.

- An Exchange Customer Relationship Management (CRM) System that captures data for and supports all customer service/contact management activities
- Exchange data/document management system(s) (may be multiple components)
- An Exchange entity ERP solution (refer to the State Chargeback section of this report for a note that relates to this solution)
- Exchange entity administrative systems, e.g. office automation and electronic messaging products which are a variable cost based on the number of Exchange entity FTEs
- Exchange interfaces to the federal Data Services Hub and other state systems with which Exchange information systems will need to exchange data
- System hosting/management/operations services associated with all of the above systems

The information technology development costs outlined in Table 7-19 do not assume costs associated with modification or replacement of existing eligibility determination information systems utilized by the Connecticut Department of Social Services. At this time the State of Connecticut has not publicly announced any firm plans about any changes to its current eligibility determination infrastructure.

The sections below contain a series of three tables (7-19.1 through 7-19.3) that further detail the projected information technology costs for the Exchange and the state of Connecticut. The budget estimates in these three tables combine to equal the total budget estimate in Table 7-19 above. The first of the tables (7-19A) provided below is a table detailing assumed Exchange costs for IT development services provided by third party specialized contractors.

Table 7-19.1: Assumed Exchange IT Development Costs for Third Party Services from Specialized Providers: 2012–2016

FUNCTION	2012	2013	2014	2015	2016
			HIGH ESTIMATE (thousands)		
Creation of Exchange Portal	$1,200	$1,800	$0	$0	$0
Exchange Customer Relation Mgt System	$800	$300	$165	$173.3	$181.9
Plan Mgt System	$400	$200	$90	$94.5	$99.2
Financial Mgt System	$500	$250	$112.5	$118.1	$124.0l
Admin. Authority	$250	$200	$70	$73.5	$77.2
Business Rules Mgt. System	$600	$400	$150	$157.5	$165.4
Document Mgt. System	$800	$400	$180	$189	$198.5
Hosting & Data Center Ops	$100	$500	$525	$551.3	$578.8

FUNCTION	2012	2013	2014	2015	2016
TOTAL	$4,650	$4,050	$1,292.5	$1,357.2	$1,425.0
LOW ESTIMATE (thousands)					
Creation of Exchange Portal	$1,200	$800	$0	$0	$0
Exchange Customer Relation Mgt System	$800	$300	$165	$173.5	$181.9
Plan Mgt System	$400	$200	$90	$94.5	$99.2
Financial Mgt System	$500	$250	$112.5	$118.1	$124
Admin. Authority	$250	$200	$70	$73.5	$77.1
Business Rules Mgt. System	$600	$400	$150	$157.5	$165.4
Hosting & Data Center Ops	$100	$500	$525	$551.3	$578.8
TOTAL	$3,850	$2,650	$1,113	$1,108	$1,226

In order to ensure the success of the implementation of Connecticut's Exchange, additional IT development funds will be necessary for the following functions, for both the State of Connecticut and the Exchange. Large-scale systems projects require strong leadership and sufficient project supports. While the Exchange's systems requirements are smaller in scale than developing a new eligibility system, they are still numerous, not yet fully-defined, will have overlapping functionality requirements and are likely to require multiple vendors – these factors add complexity to the systems projects. To help mitigate the risk of this complexity, it will be important for the State to be well-resourced in key project support and oversight areas in both the Exchange and the State's IT department. Due to the short-term nature of these projects, it is advisable to hire consultants or vendors to help meet some of these needs.

Specifically, the State and the Exchange will need support in the following areas:

- Purchase and development of software: The State is likely to need to enhance its existing software or purchase new software to interface with some of the Exchange's technology solutions

- Procurement support: Given the rapid ramp-up timeframes for state Exchanges in PPACA, the State is likely to need assistance with documenting its business requirements in advance of procuring IT solutions for the Exchange. The State may also need assistance with developing its purchasing strategy for these solutions. (Due to the variety and "newness" of the technology requirements for state Exchanges, it is unlikely that a single vendor can provide a "turnkey" solution, which means that the State will need to strategize on how it wants to conduct multiple interrelated procurements.) Finally, given some of the staffing shortages at the State level, the State is likely to need assistance with drafting, issuing and reviewing multiple Requests for Proposals for the Exchange's vendors and software solutions

- Project management: It is common for state agencies conducting systems implementation projects to hire independent project managers to coordinate all of the project's tasks and functions across numerous vendors and state agency staff. This is an important way to manage project risk and help to ensure the success of the implementation of the Exchange

- Contractor Independent Verification and Validation (IV&V) services: The federal government typically requires states to hire an IV&V contractor to independently review the work of the systems implementation vendor(s) when states are using federal funds for their projects

Given the availability of federal funds to support the implementation of PPACA, Connecticut has an opportunity to request sufficient federal funding to support these IT projects. Given the complexity of implementing multiple solutions simultaneously, and the short timeframes, the Mercer/HMA team recommends that the State solicit sufficient resources to properly design, procure and oversee the implementation of these projects.

Cost estimates for the functions listed above are detailed in the two tables below.

Table 7-19.2 below provides a summary of assumed costs to the State of Connecticut associated with development of IT systems to support the operation of Connecticut's Exchange.

Table 7-19.2: Assumed Exchange-related Development Costs, State of Connecticut (thousands): 2012–2016

FUNCTION	2012	2013	2014	2015	2016
Software costs	$2,500	$3,000	$0	$0	$0
Procurement support	$600	$0	$0	$0	$0
Project management	$700	$800	$420	$0	$0
Contractor IV&V	$900	$1,200	$630	$0	$0
TOTAL	$4,700	$5,000	$1,050	$0	$0

Table 7-19.3 below provides a summary of assumed costs to the Connecticut Exchange associated with development of IT systems to support the operation of Connecticut's Exchange.

Table 7-19.3: Assumed IT Development Costs, Connecticut Health Insurance Exchange (thousands): 2012–2016

FUNCTION	2012	2013	2014	2015	2016
Procurement support	$845	$0	$0	$0	$0
Project management	$800	$800	$420	$0	$0
Contractor IV&V	$900	$1,200	$630	$0	$0
TOTAL	$2,545	$2,000	$1,050	$0	$0

Revenue Options

Policymakers have a number of available options to generate revenue for Exchange operations. Identifying an appropriate method for providing support to a new public-sector entity can be a complicated process. Connecticut should keep the following standards in mind while comparing revenue options:

- Stability: Will revenue generated be predictable year-to-year and sufficient to cover Exchange operating expenses?
- Simplicity: Is the method of revenue generation easy for the Exchange or State to administer? Is compliance with any fee or assessment simple for consumers or other entities?
- Fairness: Are insurers, consumers and other interests who benefit from an Exchange bearing an appropriate financial burden for its operation? Are insurers/consumers who do not access benefits through an Exchange contributing a disproportionate share of revenue to an Exchange?
- Affordability: Is the Exchange financing mechanism kept at a reasonable enough level to be affordable to the parties who are charged?
- Insurance market effects: Does the mechanism for funding an Exchange inappropriately distort the insurance market in Connecticut? Do health carriers enjoy a financial advantage over their competitors by offering or not offering Exchange coverage?

There are a number of strategies that a state could utilize to provide financial support for its Exchange. Most of these require the imposition of some sort of assessment or fee upon health coverage purchased through the Exchange, or if a state wanted to broaden its revenue base statewide across all purchased coverage.

Option 1: 2.8% Premium Assessment and Carrier Non-participation Fee

The Mercer/HMA team reviewed a number of Exchange financing options. The most appropriate strategy, in our view, is relying primarily upon a premium assessment for all health coverage offered through the Exchange. To reach a financially sustainable level of revenue, based on the assumed budget model, the premium assessment would need to be 2.8%. Additional revenue would be generated through a fee assessed upon all health insurance carriers who choose not to participate in Connecticut's Health Exchange. This fee would be set to generate approximately $1 million in revenue.

The model assumes the majority of Exchange revenue would be generated through the premium assessment. Through this mechanism, Connecticut's Health Insurance Exchange would retain a designated percentage of the premium cost of every plan sold through the Exchange. The fee could be collected by the Exchange through the health insurance carrier or retained from insurance premium payments made by, or on the behalf of, the consumer.

Additional revenue would be generated through a fixed fee imposed upon carriers who choose not to participate in the Exchange. This fee would serve as a financial incentive for carrier participation in the Exchange and reduce the impact that the premium assessment would have upon health coverage costs in the Exchange. The structure of this type of fee would need to be tailored by Connecticut's Exchange to any decisions that had been made about the Exchange's structure or plan selection approach. For example, if the Exchange acts as a selective contractor, the Exchange may not wish to impose the fee on carriers that had made a good faith effort to participate in the Exchange.

Advantages of Approach

A premium assessment provides a number of benefits to Connecticut's Exchange. Major positive impacts associated with this mechanism include:

- Administrative simplicity: This mechanism would be administratively simple for the Exchange to manage and easy to communicate to Exchange consumers

- Sufficient revenue: The approach relies upon an assessment on business written through the Exchange so that revenue generated through this method would be strongly correlated with the Exchange volume (and presumably funding need). The assessment could be reduced as premium levels increase and/or the Exchange reaches economies of scale in its operations

- Appropriate revenue base: The base of revenue would come from Exchange consumers or participating health carriers; this would mean that financial support for Exchange operations would come from entities that utilized its services

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Creation of a fee upon health carriers unwilling to participate in Connecticut's Exchange could provide additional benefits:

- The fee would provide a financial incentive for all health carriers in Connecticut to participate in the Exchange. This would increase the number of plan and carrier options available to Exchange consumers

- The fee would also overcome any financial benefit that may be associated with not participating in the Health Insurance Exchange. To the extent that offering individual and small group insurance outside the Exchange may become financially advantageous to a health insurance carrier, a non-participation fee would overcome this financial advantage

A more complete analysis of the non-participation fee is included below.

Disadvantages of Approach

The PPACA requires insurers to price identical insurance products exactly the same whether they are provided on or off an Exchange. The existence of this premium assessment would increase retained revenue for an insurance carrier for non-Exchange coverage (equivalent to the Exchange fee) making provision of off-Exchange coverage more attractive to carriers. The impact of this issue is largely offset by the ability of lower and middle income consumers to exclusively access federal subsidies within the Exchange.

An Exchange-based premium assessment would likely make Exchange coverage less price-competitive with similar (not identical) products offered outside the Exchange. Insurers who do not participate on the Exchange could offer the same coverage at a lower consumer cost and insurers who do participate on the Exchange could offer similar but not identical coverage off the Exchange at a lower cost. Again this issue is blunted by the ability of lower and middle income consumers to exclusively access federal subsidies within the Exchange. Additionally, consumers who will be required to purchase more costly coverage through the Exchange (families, those with poor health status, those impacted by insurance rating permitted under the PPACA like smokers and those who are older and those with limited access to federal subsidy because of their income) will contribute more per contract through the Exchange fee. This means that if the assessment is structured as a percentage of premium cost, those with greater health needs may contribute a disproportionate share of Exchange revenue.

Assumed Revenue

Table 7-20 provides a summary of assumed revenue that could be generated through an Exchange premium assessment at varying rates. The membership figures in Table 7-20 are consistent with assumed combined membership in the Individual and SHOP Exchanges outlined in Appendix 7B.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Table 7-20: Assumed Revenue Exchange Premium Assessment: 2012–2016

	YEAR		
	2014	**2015**	**2016**
ASSUMED CT EXCHANGE MEMBERSHIP	124,775	192,000	243,000
ASSUMED CT EXCHANGE MEMBER MONTHS	1,497,300	2,304,000	2,916,000
BLENDED AVERAGE EXCHANGE PREMIUM	$403.29	$425.45	$456.17
ASSUMED EXCHANGE PREMIUM BASE	$603,845,751	$980,242,680	$1,330,198,200
REVENUE 2.0% PREMIUM ASSESSMENT	$12,076,915	$19,604,854	$26,603,964
REVENUE 2.5% PREMIUM ASSESSMENT	$15,096,144	$24,506,067	$33,254,955
REVENUE 2.8% PREMIUM ASSESSMENT	**$16,907,681**	**$27,446,795**	**$37,245,550**
REVENUE 3.0% PREMIUM ASSESSMENT	$18,115,373	$29,407,280	$39,905,946
REVENUE 3.5% PREMIUM ASSESSMENT	$21,134,601	$34,308,494	$46,556,937

Option 2: Exchange Transaction Charge

Connecticut's Health Insurance Exchange would charge consumers a fixed fee whenever they utilized Exchange services. The fee could be structured as a single charge upon a consumer upon enrollment or could be rolled into monthly premium payments. This fee could also be imposed on a per contract or per covered person basis. The Exchange could require the health carrier to pay this fee or mandate that the fee be attached to any health premium for coverage sold through the Exchange.

Advantages of Approach

User fees, much like the premium assessment outlined above, are viewed to be an efficient method of funding a public entity like an Exchange where the cost for operating the Exchange is largely borne by those who are using its services. Additionally the revenue generated through this mechanism would be consistent with changes in Exchange volume making a transaction charge, with an appropriate rate, a stables source of revenue.

A single fixed fee would be easy for consumers to understand and the charge would be the same across health benefit plans. A fixed fee would also be a more stable charge for consumers on a year to year basis. Health premium costs typically have grown at an aggressive rate and a fixed fee ensures that the charge imposed upon consumers will not grow with the premium but with assumed Exchange cost.

Disadvantages of Approach

Depending upon how fees are structured, this method of funding may not account for a consumer's ability to pay. Low income consumers will provide a greater proportion of their resources to this fee than those with higher income. This may reduce the number of low-income participants in an Exchange or (depending upon the size the fee) could lead to them choosing less comprehensive coverage through an Exchange.

This plan would likely make Exchange coverage less price-competitive with similar products offered outside the Health Exchange. The impact of this would be largely offset by the ability of lower and middle income consumers to exclusively access Federal subsidies within the Exchange.

Assumed Revenue

Table 7-21 provides a summary of likely revenue that could be generated by an Exchange-imposed fee on health insurance coverage sold through Connecticut's Exchange. The fee would be assessed on a per-case per month basis. Membership in the Exchange is assumed at the level reported for the Individual and SHOP Exchanges in Appendix 7B of this paper.

Table 7-21: Assumed Revenue Exchange Fee: 2012–2016

	2014	2015	2016
ASSUMED CT EXCHANGE MEMBERSHIP	84,080	129,341	163,350
ASSUMED CT EXCHANGE MEMBER MONTHS	1,008,960	1,552,095	1,960,200
REVENUE $15 CASE/MONTH FEE	$15,134,400	$23,281,425	$29,403,000
REVENUE $17.50 CASE/MONTH FEE	$17,656,800	$27,161,663	$34,303,500
REVENUE $19 CASE/MONTH FEE	**$19,170,240**	**$29,489,805**	**$37,243,800**
REVENUE $20 CASE/MONTH FEE	$20,179,200	$31,041,900	$39,204,000
REVENUE $22.50 CASE/MONTH FEE	$22,701,600	$34,922,138	$44,104,500

Option 3: Exchange Health Insurance Carrier Participation Fee

Connecticut's Exchange could require all health insurance carriers offering Exchange coverage to pay a fee to support the operations of the Exchange.

Advantages of Approach

This fee could be imposed on an annual basis upon all insurance carriers participating in the Exchange. The fee could be structured to be a predictable funding source for the Exchange, making financial and program planning going forward easier upon Exchange administration.

Disadvantages of Approach

This plan would obviously create disincentive for health insurance carriers to provide coverage through an Exchange. Additionally, this annual fee (depending upon how it is structured) may not be tied to Exchange volume. This could either lead to excessive revenue generated (if volume is lower than anticipated) or could make it difficult for an Exchange to manage sudden increases in Exchange volume. Also this plan could lead to smaller/regional plans to avoid participation. Carriers would need to ensure a sufficient volume of insured to offset cost of flat participation fee.

Assumed Revenue

Assumed revenue generated through this approach would be entirely dependent upon the number of participating carriers and the size of the fee established by Connecticut's Exchange.

Option 4: Broad-based Health Insurance Carrier Fee

Connecticut could require all health insurance carriers offering coverage in the state to provide a fee to support the operations of the Exchange. This fee could also be limited to just health insurance carriers who sell insurance on the small and individual group market. The structure of this fee could be a flat amount for each carrier, adjusted to reflect the size of each carrier or imposed as a percentage of each premium sold in the State. Connecticut could utilize an existing tax imposed upon all commercial insurance and HMO premiums as a vehicle to collect this revenue.

Advantages of Approach

A broad-based health carrier fee could be imposed upon an annual basis upon insurance carriers. Available revenue to the Exchange would be stable and predictable, assisting financial and program planning for each year. This type of fee avoids differences between carriers on- and off-exchange and spreads costs across a large group of policies. Additionally, Connecticut currently has a mechanism in place to collect tax revenue, across insurance carriers, based upon premium volume.

Disadvantages of Approach

An annual fee, depending upon how it is structured, may not be tied to Exchange volume. This could either lead to excessive revenue generated (if volume is lower than anticipated) or could make it difficult for an Exchange to manage sudden increases in Exchange volume.

Assumed Revenue

Table 7-22 provides a summary of likely revenue assumed through a broad-based health insurance carrier Connecticut Exchange fee. The Table assumes a fee imposed upon all commercially sold health coverage sold in the State of Connecticut. The revenue base is assumed to grow 7.5% per year.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Table 7-22: Assumed Revenue Broad- Based Carrier Participation Fee: 2012–2016

	2014	2015	2016
ASSUMED COMMERCIAL INSURANCE REVENUE (DOMESTIC)	$8,900,000,000	$9,567,500,000	$10,285,062,500
ASSUMED COMMERCIAL INSURANCE REVENUE (FOREIGN)	$575,000,000	$618,125,000	$664,484,375
ASSUMED MANAGED CARE REVENUE	$6,500,000,000	$6,987,500,000	$7,511,562,500
ASSUMED TOTAL COMMERCIAL TAX BASE	$15,975,000,000	$17,173,125,000	$18,461,109,375
ASSUMED REVENUE .01% ASSESSMENT	$15,975,000	$17,173,125	$18,461,109
ASSUMED REVENUE .015% ASSESSMENT	$23,962,500	$25,759,688	$27,691,664
ASSUMED REVENUE .02% ASSESSMENT	**$31,950,000**	**$34,346,250**	**$36,922,219**
ASSUMED REVENUE .025% ASSESSMENT	$39,937,500	$42,932,813	$46,152,773
ASSUMED REVENUE .03% ASSESSMENT	$47,925,000	$51,519,375	$55,383,328

Option 5: Health Insurance Carrier Non-Participation Fee

The Exchange could require all health insurance carriers that choose not to offer coverage through the Exchange to pay a fee to support Exchange operations. This type of fee would not be appropriate to finance the full cost of Exchange operations but could be used as a supplemental source of Exchange revenue. Legislative authorization permitting the Exchange or another public entity to administer and collect the non-participation fee would have to be provided before revenue from this strategy could be collected.

Advantages of Approach

The major advantage of this approach is that it could be used as a weight against any financial benefits that may exist for a health carrier to decide to avoid participation in the Exchange. Exchanges, when fully implemented, will change the dynamics of the individual and small group insurance markets and it is conceivable that there will be secondary effects associated with the implementation of health reform that could create incentives for health carriers (or other entities) to compete against an Exchange in a way that could damage the financial viability or risk pool of the Exchange. The existence of a non-participation fee could give policymakers a tool to offset any of these incentives.

Disadvantages of Approach

While a non-participation fee is an interesting, and possibly valuable, tool to support Exchange operations and achieve some policy goals, it is key that the structure of the fee be carefully designed to ensure that it is not unduly damaging to health insurance carriers in Connecticut.

The strategy utilized by Connecticut's Exchange in qualifying health plans will impact how appropriate use of a non-participation fee may be. If the Exchange does not take steps to limit the number of carriers offering coverage in the Exchange beyond Federal requirements, a non-participation fee would be a helpful tool in ensuring robust participation within the Exchange. If the Exchange limits the number of carriers offering coverage, a non-participation fee may be viewed as inappropriate, especially for carriers that actively worked to participate in the Exchange and failed.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

The State would also need to resolve questions related to the authority to collect the fee. The fee would need to be collected through a state entity, since the Exchange will likely not have the authority to impose fees upon entities that no relationship with the Exchange.

Assumed Revenue

Revenue generated through this type of mechanism is difficult to project at this time. Information about the restrictions Connecticut's Exchange may place upon carriers wishing to participate is not yet clear and the number of health insurance carriers who are not interested in participating in the Exchange is not known at this time (and could change from year-to-year). Additionally, revenue from the fee is dependent upon the size of the fee.

Option 6: Advertising Revenue

Another non-traditional approach that the Exchange might consider as a supplemental revenue stream is selling advertising. In its simplest form, this strategy could encompass nothing more than selling advertising space on the Exchange website. In this model, revenue could be generated by charging the advertiser for the ability to display their advertisement on the Exchange website for a specified period of time or on a "pay-per-click" basis where the advertiser only pays when a consumer clicks on its link.

Alternatively, the Exchange could pursue a model similar to the ones employed by companies such as Expedia® or priceline.com® whereby Exchange shoppers would be offered products or services that are complementary to the product that they came to the website to purchase. In the case of the Exchange, this might include ancillary insurance products (e.g. dental, vision, disability and term life), health/fitness club memberships, charitable events such 5K runs, health education programs, or products and services that support public health objectives such as weight loss or smoking cessation. In this model, the Exchange would effectively become a distribution channel for these products and services and compensation would likely be based on the volume of sales that are generated for each partner's product or service.

Advantages of Approach

Although this would be a new approach to generating revenue for an Exchange, it is potentially very attractive in several respects. Most notably, advertising and marketing partnerships present an opportunity to generate revenue without increasing the prices of the products offered on the Exchange or requiring non-Exchange users to contribute to the cost of operating the Exchange. Moreover, because of the nature of the arrangements between the Exchange and its partners, it is likely that the revenue generated would scale with Exchange participation to a significant extent.

Additionally, to the extent that the Exchange achieves its vision of becoming a true "one-stop shop" for a consumer's health care needs and it is able to increase its regular traffic; advertising revenue could conceivably offer the Exchange the ability to reduce the administrative fee levels.

Disadvantages of Approach

Unfortunately, there are also several key concerns that probably make generating revenue from advertising a more realistic medium- to long-term goal. In particular, there is (potentially significant) administrative complexity in implementing a comprehensive advertising strategy. Accordingly, there will be, at least initially, a cost to build the necessary infrastructure.

Furthermore, generating revenue from advertising depends on consumers regularly visiting the Exchange website. Taking this, in conjunction with the fact that establishing the Exchange is set to undergo a tremendous amount of resources between now and 2014, it is difficult to project that advertising could be a stable source of revenue in the short run.

Finally, the concept of advertising on the Exchange website also carries some unique, but important, philosophical and practical issues that must be addressed as well. First, the potential revenue that could be generated from advertising needs to be appropriately balanced with concerns regarding conflict of interests. For example, allowing a particular insurance carrier or provider to advertise on the Exchange may create an appearance of impropriety. Second, because the Exchange will be certifying the plans and products it offers in accordance with PPACA requirements, it is important to be cognizant of the possibility that consumers could impute the Exchange's "seal of approval" on products or services that are advertised on the Exchange website. These factors are likely to limit the number of prospective advertising partners that the Exchange would be able to pursue and may, therefore, preclude the Exchange from realizing the full potential of this revenue stream.

Assumed Revenue

Table 7-23 provides an estimate of likely revenue that would be generated from selling advertising on the Exchange website. The revenue projection provided below assumes revenue from banner ads sold for the Exchange website. Advertising would be priced on a fixed price per 1,000 visitors that would view the website. Table 7-23, below provides a summary of likely revenue generated through the selling of advertising through the Exchange portal. The table assumes space for ten ads within the Exchange portal.

Table 7-23: Assumed Revenue Advertising: 2012–2016

	2014	2015	2016
ASSUMED INDIVIDUAL MARKET CASELOAD	72,118	110,793	138,600
ASSUMED SHOP CASELOAD	11,963	18,549	24,750
TOTAL CASELOAD	84,080	129,341	163,350
ASSUMED WEEKLY VISITS	42,040	48,172	58,250
TOTAL VISITS / 1,000	547	841	1,062
ASSUMED REVENUE 2.50 PER 1,000 VISITORS	$13,663	$21,018	$26,544
ASSUMED REVENUE $5.00 PER 1,000 VISITORS	**$27,326**	**$42,036**	**$53,089**
ASSUMED REVENUE $7.50 PER 1,000 VISITORS	$40,989	$63,054	$79,633
ASSUMED REVENUE $10.00 PER 1,000 VISITORS	$54,652	$84,072	$106,178

Appendix 7A

Estimated Total Connecticut Health Insurance Exchange Cost

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	12.0	22.0	44.0	44.0	44.0
GROSS COST	$19,761,230	$30,323,664	$34,281,826	$31,892,915	$36,135,375
STATE/EXCHANGE COST	$0	$2,020,565	$2,186,463	$31,627,761	$35,848,291
LOW ESTIMATE					
FTE	12.0	21.5	30.0	30.0	30.0
GROSS COST	$16,523,123	$22,392,970	$24,661,194	$24,796,794	$28,347,015
STATE/EXCHANGE COST	$0	$1,014,396	$1,130,524	$24,611,186	$28,146,056

Estimated Salaries and Wages

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
FTE	12.0	22.0	44.0	44.0	44.0
GROSS COST	$1,459,645	$2,234,136	$3,424,665	$3,510,281	$3,598,038
STATE/EXCHANGE COST	$0	$0	$0	$3,510,281	$3,598,038
LOW ESTIMATE					
FTE	12.0	21.5	30.0	30.0	30.0
GROSS COST	$1,459,295	$2,205,590	$2,725,631	$2,793,772	$2,863,616
STATE/EXCHANGE COST	$0	$0	$0	$2,793,772	$2,863,616

Estimated Exchange Fringe Benefit Cost

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$1,007,155	$1,541,554	$2,363,019	$2,422,094	$2,482,646
STATE/EXCHANGE COST	$0	$0	$0	$2,422,094	$2,482,646
LOW ESTIMATE					
GROSS COST	$510,753	$771,956	$953,971	$977,820	$1,002,266
STATE/EXCHANGE COST	$0	$0	$0	$977,820	$1,002,266

Estimated State of Connecticut Exchange Planning and Support Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$828,750	$1,636,250	$2,337,500	$2,890,000	$3,485,000
STATE/EXCHANGE COST	$0	$0	$0	$2,890,000	$3,485,000
LOW ESTIMATE					
GROSS COST	$541,875	$1,126,250	$1,986,875	$2,592,500	$3,187,500
STATE/EXCHANGE COST	$0	$0	$0	$2,592,500	$3,187,500

Estimated Consultant Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$2,950,000	$3,700,000	$4,450,000	$2,125,000	$2,125,000
STATE/EXCHANGE COST	$0	$0	$0	$2,125,000	$2,125,000
LOW ESTIMATE					
GROSS COST	$1,845,000	$1,875,000	$2,370,000	$2,295,000	$2,295,000
STATE/EXCHANGE COST	$0	$0	$0	$2,295,000	$2,295,000

Estimated Equipment Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$8,000	$68,000	$61,000	$50,000	$50,000
STATE/EXCHANGE COST	$0	$0	$0	$50,000	$50,000
LOW ESTIMATE					
GROSS COST	$4,000	$14,000	$21,500	$18,000	$18,000
STATE/EXCHANGE COST	$0	$0	$0	$18,000	$18,000

Estimated Supplies Cost

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$3,600	$6,600	$13,200	$13,200	$13,200
STATE / EXCHANGE COST	$0	$0	$0	$13,200	$13,200
LOW ESTIMATE					
GROSS COST	$1,800	$3,225	$4,500	$4,500	$4,500
STATE / EXCHANGE COST	$0	$0	$0	$4,500	$4,500

Estimated Exchange Travel Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$15,000	$15,014	$14,500	$10,800	$10,800
STATE / EXCHANGE COST	$0	$0	$0	$10,800	$10,800
LOW ESTIMATE					
GROSS COST	$15,000	$15,008	$9,750	$9,000	$9,000
STATE / EXCHANGE COST	$0	$0	$0	$9,000	$9,000

Estimated Other Costs (Internet/phone, furniture, rent, printing)

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$94,080	$218,480	$250,960	$220,960	$220,960
STATE / EXCHANGE COST	$0	$0	$0	$220,960	$220,960
LOW ESTIMATE					
GROSS COST	$50,400	$100,650	$87,000	$85,500	$85,500
STATE / EXCHANGE COST	$0	$0	$0	$85,500	$85,500

Estimated Exchange Call Center/Premium Billing Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
AHBE GROSS COST	$0	$1,140,000	$5,872,425	$9,292,325	$11,973,317
AHBE STATE/EXCHANGE COST	$0	$0	$0	$9,292,325	$11,973,317
SHOP GROSS COST	$0	$172,500	$1,500,750	$2,396,836	$3,294,095
SHOP STATE/EXCHANGE COST	$0	$0	$0	$2,396,836	$3,294,095
MCAID GROSS COST	$0	$41,130	$372,926	$530,308	$574,169
MCAID STATE/EXCHANGE COST	$0	$20,565	$186,463	$265,154	$287,084
GROSS COST	**$0**	**$1,353,630**	**$7,746,101**	**$12,219,469**	**$15,841,581**
STATE /EXCHANGE COST	**$0**	**$20,565**	**$186,463**	**$11,954,315**	**$15,554,496**
LOW ESTIMATE					
AHBE GROSS COST	$0	$960,000	$4,945,200	$7,825,116	$10,082,794
AHBE STATE/EXCHANGE COST	$0	$0	$0	$7,825,116	$10,082,794
SHOP GROSS COST	$0	$142,500	$1,239,750	$1,979,995	$2,721,209
SHOP STATE/EXCHANGE COST	$0	$0	$0	$1,979,995	$2,721,209
MCAID GROSS COST	$0	$28,791	$261,048	$371,216	$401,918
MCAID STATE/EXCHANGE COST	$0	$14,396	$130,524	$185,608	$200,959
GROSS COST	**$0**	**$1,131,291**	**$6,445,998**	**$10,176,326**	**$13,205,920**
STATE / EXCHANGE COST	**$0**	**$14,396**	**$130,524**	**$9,990,719**	**$13,004,961**

Estimated Web Site Maintenance Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$0	$1,000,000	$750,000	$500,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$500,000
LOW ESTIMATE					
GROSS COST	$0	$0	$1,000,000	$750,000	$500,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$500,000

Estimated State Eligibility Chargeback Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE / EXCHANGE COST	$0	$0	$0	$1,391,250	$1,460,800
LOW ESTIMATE					
GROSS COST	$0	$500,000	$1,325,000	$1,391,250	$1,460,800
STATE / EXCHANGE COST	$0	$0	$0	$1,391,250	$1,460,800

Estimated Exchange Outreach Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$2,000,000	$2,000,000	$1,500,000	$1,500,000
STATE / EXCHANGE COST	$0	$0	$0	$1,500,000	$1,500,000
LOW ESTIMATE					
GROSS COST	$0	$1,000,000	$1,000,000	$750,000	$750,000
STATE / EXCHANGE COST	$0	$0	$0	$750,000	$750,000

Exchange Navigator Program Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
STATE/EXCHANGE COST	$0	$2,000,000	$2,000,000	$1,000,000	$1,000,000
LOW ESTIMATE					
GROSS COST	$0	$1,000,000	$1,000,000	$500,000	$500,000
STATE/EXCHANGE COST	$0	$1,000,000	$1,000,000	$500,000	$500,000

Exchange Appeals Program Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
MANDATE APPEAL GROSS	$0	$0	$362,500	$225,000	$162,500
MANDATE APPEAL STATE/EXCHANGE	$0	$0	$0	$225,000	$162,500
ELIGIBILITY APPEAL GROSS	$0	$0	$540,881	$207,736	$259,875
ELIGIBILITY APPEAL STATE/EXCHANGE	$0	$0	$0	$207,736	$259,875
GROSS COST	**$0**	**$0**	**$903,381**	**$432,736**	**$422,375**
STATE / EXCHANGE COST	**$0**	**$0**	**$0**	**$432,736**	**$422,375**
LOW ESTIMATE					
MANDATE APPEAL GROSS	$0	$0	$362,500	$225,000	$162,500
MANDATE APPEAL STATE/EXCHANGE	$0	$0	$0	$225,000	$162,500
ELIGIBILITY APPEAL GROSS	$0	$0	$155,969	$60,000	$75,938
ELIGIBILITY APPEAL STATE/EXCHANGE	$0	$0	$0	$60,000	$75,938
GROSS COST	**$0**	**$0**	**$518,469**	**$285,000**	**$238,438**
STATE / EXCHANGE COST	**$0**	**$0**	**$0**	**$285,000**	**$238,438**

Exchange Communications/Marketing Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$1,500,000	$4,000,000	$3,000,000	$2,000,000	$2,000,000
STATE/EXCHANGE COST	$0	$0	$0	$2,000,000	$2,000,000
LOW ESTIMATE					
GROSS COST	$1,000,000	$3,000,000	$2,000,000	$1,000,000	$1,000,000
STATE/EXCHANGE COST	$0	$0	$0	$1,000,000	$1,000,000

Exchange Information Technology Development Costs

ESTIMATE	2012	2013	2014	2015	2016
HIGH ESTIMATE					
GROSS COST	$11,895,000	$11,050,000	$3,392,500	$1,357,125	$1,424,975
STATE/EXCHANGE COST	$0	$0	$0	$1,357,125	$1,424,975
LOW ESTIMATE					
GROSS COST	$11,095,000	$9,650,000	$3,212,500	$1,168,125	$1,226,475
STATE/EXCHANGE COST	$0	$0	$0	$1,168,125	$1,226,475

Appendix 7B

Projected Connecticut Exchange membership

Estimated Individual Market Health Insurance Exchange Membership

PERIOD	INDIVIDUAL EXCHANGE MEMBERSHIP	INDIVIDUAL MARKET %
2014 1ST QUARTER	100,000	30.3%
2014 2ND QUARTER	102,000	30.9%
2014 3RD QUARTER	104,000	31.5%
2014 4TH QUARTER	106,100	32.2%
2015 1ST QUARTER	153,800	46.6%
2015 2ND QUARTER	156,900	46.0%
2015 3RD QUARTER	159,600	46.8%
2015 4TH QUARTER	162,800	47.7%
2016 AVERAGE ANNUAL	198,000	58.1%

Estimated Small Group Small Business Health Options (SHOP) Exchange Membership

PERIOD	SHOP MEMBERSHIP	SMALL GROUP MARKET %
2014 1ST QUARTER	18,700	8.7%
2014 2ND QUARTER	20,600	9.6%
2014 3RD QUARTER	22,700	10.6%
2014 4TH QUARTER	25,000	11.7%
2015 1ST QUARTER	31,300	15.1%
2015 2ND QUARTER	32,900	15.9%
2015 3RD QUARTER	34,500	16.7%
2015 4TH QUARTER	36,200	17.5%
2016 AVERAGE ANNUAL	45,000	14.8%

Appendix 7C

Sensitivity Analysis Connecticut Exchange Membership

The table below provides a view of assumed Exchange operating costs at different levels of assumed Exchange membership. The table represents the product of all assumptions used to generate the Exchange cost estimate summarized in Table 7-5 at different Exchange membership levels. The purpose of this analysis is to generate greater insight into the extent to which membership will impact the likely costs of operating a Health Insurance Exchange in Connecticut.

Estimated High and Low Ecxhange Costs by Membership (2012-2016)

	75% OF BASELINE	90% OF BASELINE	BASELINE	110% OF BASELINE	125% OF BASELINE
2016 MEMB.	**182,250**	**218,700**	**243,000**	**267,300**	**303,750**
2012: HIGH	$19,761,230	$19,761,230	$19,761,230	$19,761,230	$19,761,230
2012: LOW	$16,523,123	$16,523,123	$16,523,123	$16,523,123	$16,523,123
2013: HIGH	$29,931,789	$30,171,164	$30,323,664	$30,497,414	$30,736,789
2013: LOW	$22,053,595	$22,261,470	$22,392,970	$22,545,720	$22,753,595
2014: HIGH	$31,942,061	$33,341,670	$34,281,826	$35,200,731	$36,621,590
2014: LOW	$22,714,715	$23,878,352	$24,661,194	$25,422,786	$26,607,674
2015: HIGH	$28,408,691	$30,533,225	$31,892,915	$33,337,605	$35,462,139
2015: LOW	$21,820,516	$23,640,282	$24,796,794	$26,038,305	$27,858,071
2016: HIGH	$31,573,554	$34,327,647	$36,135,375	$37,943,104	$40,697,197
2016: LOW	$24,447,030	$26,804,021	$28,347,015	$29,890,009	$32,247,000

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

TASK 8 – Assessment of Technical Requirements and Development of Specifications for Accounting and Financial System Functions for the Exchange

Background

In order to prepare for implementation of a Health Insurance Exchange (Exchange) in Connecticut (State), the State tasked the Mercer/Health Management Associates (HMA) team with assessing the capabilities of pertinent State-owned and operated information systems against federal guidance for the financial management Exchange business process area. Specifically, our assessment covered Core-CT, the instance of the PeopleSoft Enterprise Resource Planning (ERP) suite of applications used by Connecticut State agencies. The scope and methodology for this assessment was based on a task scope of work submitted to the State in August of 2011 and approved by the State in September of 2011. The task scope of work is included in this report as Appendix 8A.

Our assessment covered:

- Identifying the potential for leveraging capabilities of Core-CT in support of Exchange financial management functions as defined in the Patient Protection and Affordable Care Act (PPACA) and subsequently categorized by the Centers for Medicare & Medicaid Services (CMS). Exchange financial management functions per the PPACA include premium and subsidy administration, exchange of funds between the Exchange and Exchange plans, some of the activities related to risk management and critical data collection and reporting activities, including encounter data management. Although the Request for Proposal (RFP) and the revised scope of work for this task as approved by the State did not call for the following, our assessment also touched on Core-CT´s capabilities related to internal controls and functionality that would specifically support audits and related program integrity activities.

- Determining whether Core-CT could be utilized in support of the administrative functions of the Exchange entity. These functions include financial accounting, human resources and payroll, supply chain management and asset management. All of these are functions that any self-sustaining business entity needs to be able to perform.

Our assessment activities were grounded on the most up-to-date federal guidance available at the time of the assessment on Exchange establishment, operations and the role of information technology (IT) in key functions. The specific sources of guidance used are listed in Appendix 8B.

For further context, Appendix 8D includes a diagram that shows the activities that fall within the scope of the financial management function as previously described.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Methodology

To complete our analysis, Mercer/HMA built a tool for assessing the extent to which Core-CT could support Exchange financial management and administrative functions. The tool was based on the Mercer/HMA team's understanding of federal guidance, our extensive knowledge of ERP products and our experience managing ERP projects (including, most recently, in Georgia where PeopleSoft was also deployed). The outputs of this assessment were a profile of Core-CT and an evaluation of this system, along the following six information system domains, described in further detail in Appendix 8D:

- Functionality
- Interoperability
- Security
- Capacity and availability
- Accessibility by external users
- Conformance with CMS information systems standards and conditions

Our assessment was completed through:

- Interviews with staff from the Comptroller's Office, including State Comptroller Kevin Lembo, Deputy Comptroller Martha Carlson, Dr. Thomas Woodruff, Director of Healthcare Policy & Benefit Services, Scott Anderson and Angelo Romano, among others
- Completion by the Comptroller Office's team of the assessment tool
- Conclusions derived by Mercer/HMA of Core-CT's strengths and drawbacks based on the aforementioned interviews and assessment and our experience with PeopleSoft implementations in other states

The outputs of our activities were designed to serve as the starting point for business operations and IT requirements elaboration activities to be funded out of the Level 1 Exchange Establishment grant. As discussed in the Level 1 Establishment grant application, and in the subsequently issued Business Operations and IT Planning RFP, these activities will lead to the development of an *IT Architectural Model*, with information system functionality requirements bundled into application components as deemed appropriate, and *capability acquisition strategies* for addressing these technology needs.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Key Findings

Based on the detailed profile and assessment of Core-CT, the details of which can be found in the completed assessment tool (Appendix 8E), we have ascertained the following:

1. FUNCTIONALITY: Core-CT lacks needed Exchange financial management functionality. Based on the Comptroller's Office assessment of Core-CT capabilities, the system does not possess any of the expected functionality. Moreover, the system's architecture and constrained system support resources limit the ability to build or enhance existing functionality. Furthermore, the lack of functionality to perform Exchange financial management functions would severely limit the ability of this system to support program integrity functions. On the other hand, Core-CT does possess most of the ERP functionality which the Exchange entity would need to support its own administrative functions. According to the Comptroller's Office assessment of Core-CT capabilities, and as supported by our experience working on PeopleSoft implementations, all of the functionality needed to support "Entity Financial Management" activities is either already in place or partially in place in Core-CT. Additionally, PeopleSoft functionality as it relates to data management, including the system's inherent ability to track the history of transaction records, including who may have accessed or altered a particular record, could support some program integrity activities such as audits of the use of federal funds for certain functions (refer to line items 142, 239, 249, 273 and 274 in Appendix 8E).

2. INTEROPERABILITY: As an ERP solution, PeopleSoft is designed to provide "built-in" interoperability across all entity financial management functions, e.g., with interfaces to State banking and through built-in work flow and transaction management between purchasing, accounts payable and asset management activities. However, the system does not provide native support to Exchange-specific functions such as eligibility and enrollment and plan management.

3. SECURITY: PeopleSoft's security and user access models are both very robust. PeopleSoft products are widely utilized by both private and public sector organizations without any significant reports of security breaches or concerns. Moreover, PeopleSoft already possesses internal controls and audit support capabilities that are aligned with guidance contained in the Statement on Standards for Attestation Engagements (SSAE) No. 16 and consistent with requirements contained in Section 404 of the Sarbanes-Oxley Act. These are important considerations for determining the suitability of a financial management system.

4. CAPACITY AND AVAILABILITY: The system does not appear to have significant transaction processing or data storage capacity issues, nor does it appear to have availability issues. The system resides in a stable operating environment in the State's data center, which is a secure facility. Provisions for business continuity are in place with recovery time objectives that are in line with generally accepted industry practices.

5. ACCESSIBILITY BY EXTERNAL USERS: Since this system would not have a "consumer-facing" aspect to it – i.e., given the business functions that would support it would not be

directly accessed by external users – the assessment of Core-CT did not have an accessibility component.

6. CONFORMANCE WITH CMS INFORMATION SYSTEMS STANDARDS AND CONDITIONS: Core-CT conforms with some but not all of the CMS information systems standards and conditions referenced above. Specifically, PeopleSoft does not conform with the *Modularity* and *Reuse/Leverage* conditions – which call for a system to be built primarily as easily replaceable "components" or from "services" available in and accessible through the Internet or residing in a "cloud computing" environment. While PeopleSoft is often referred to as a "commercial off the shelf" solution, it is a very complex application with multiple modules which, while flexible, requires extensive (often very costly) configuration for it to be deployed effectively.

Overall, Core-CT falls short in terms of its capabilities when assessed against CMS guidance regarding the numerous and complex financial management functions required of an Exchange. As a result, Mercer/HMA has concluded that Core-CT is not a viable financial management solution for Connecticut's Exchange. However, given PeopleSoft's robust ERP capabilities, we believe that it could be a viable administrative system solution for the Exchange entity. State agencies have been using Core-CT successfully for several years and, as a relatively small organization, the Connecticut Exchange could benefit from not having to acquire or build an Exchange ERP system.

Recommendations

As noted earlier in the report, we structured this task to pave the way for more detailed planning, cost-benefit analysis and procurement work that will be funded through the Exchange Level 1 Establishment grant. The following recommendations are designed to further inform this work:

1. ACQUISITION AND/OR DEVELOPMENT OF AN EXCHANGE FINANCIAL MANAGEMENT SYSTEM SHOULD BE EXPLORED FROM A COST BENEFIT STANDPOINT. It is our understanding that the State will explore this option as part of the upcoming *Exchange Business Operations and IT Planning* project. States will have through the end of 2014 to leverage federal funding from CMS (100% federal funding participation per the Level 1 and Level 2 Exchange Establishment grants) to build/buy and implement new system functionality (or, through cost allocation, to fund part of the build-up of a system like Core-CT to handle certain functions for multiple agencies or programs). As noted previously, the availability of enhanced federal funding is conditioned on states demonstrating their ability to (a) conform to the standards and conditions referenced previously and (b) adhere to the Exchange information system life cycle management activities described in the document titled Collaborative Environment and Life Cycle Governance – Exchange Reference Architecture Supplement.

2. THE STATE SHOULD EXPLORE AN APPROACH TO ACQUIRING EXCHANGE OPERATIONAL CAPABILITIES THROUGH BUSINESS PROCESS OUTSOURCING RATHER THAN THROUGH ACQUISITION OR DEVELOPMENT OF INFORMATION

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

SYSTEMS. CMS encourages states, particularly those with limited IT resources or management capabilities, to explore an approach in which they focus on the outsourcing and integration of Exchange *business processes* (e.g., call center operations, application intake and processing, premium processing and aggregation) rather than the actual development and integration of information systems. The former approach positions the State as manager of business process outsourcing (BPO) vendors rather than as an integrator and manager of information systems. These two approaches require very different skill sets. It could be argued that the State should pursue a BPO strategy for establishing its insurance Exchange, especially given its budget situation and its declining IT workforce.

A variation of this approach is the use of an application service provider for some of these capabilities based on a "software as a service" (SaaS) model. In this approach, the large upfront outlays traditionally associated with information systems projects can be minimized. Systems as large as SAP and as comparatively small as Microsoft Dynamics are now available via this model.

3. THE STATE COULD EXPLORE LEVERAGING "INFORMATION SYSTEM COMPONENTS" BEING DEVELOPED OUT OF THE EXCHANGE EARLY INNOVATOR PROJECTS, INCLUDING THE NEW ENGLAND STATES COLLABORATIVE INSURANCE EXCHANGE SYSTEMS (NESCIES). CMS expects these components to be designed to be relatively easy and inexpensive to integrate for states to assemble a complete *information systems stack* that would enable all Exchange functions, including financial management. Furthermore, as a participant in NESCIES Connecticut might be able to derive considerable benefit from the information system solutions emerging from that Collaborative assuming it is able to exert significant influence in their design.

4. THE EXCHANGE ENTITY COULD EXPLORE UTILIZING CORE-CT AS ITS ERP SOLUTION FOR ADMINISTRATIVE FUNCTIONS. This option is contingent upon working out a suitable usage and service level agreement between the Comptroller's Office, a State agency and the Exchange which is technically not an agency of state government. Moreover, from a technical perspective the Exchange entity would have to operate within the constraints built into Core-CT, such as the State's standard Chart of Accounts and the work flows built into Core-CT for processes such as purchasing. That being said, the Exchange entity could benefit from leveraging Core-CT to the extent that Exchange employees would participate in State government programs such as the State Employee Health and Retirement plans. The extent to which the benefits of leveraging Core-CT would be outweighed by technical constraints or other factors would be ascertained as part of the Business Operations and IT Planning project.

Appendix 8A

Scope of Work, Task 8 (as approved by the State)

See attached file labeled: *CT HIX Proj Task 8 Disc Doc for St - 2011*

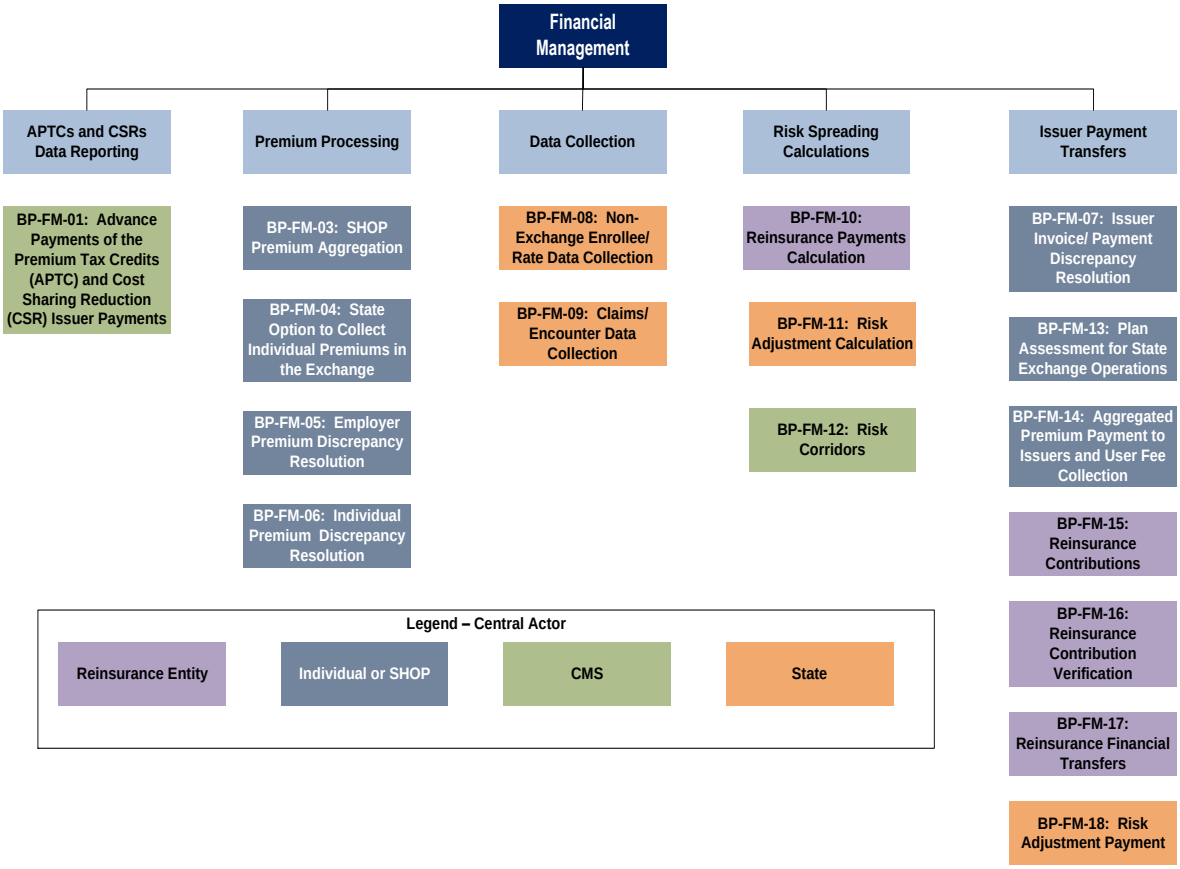
Appendix 8B

Sources of Relevant Guidance

- *Guidance for Exchange and Medicaid Information Technology (IT) Systems version 2.0,* issued by CMS' Center for Consumer Information and Insurance Oversight (CCIIO), May 2011
- *Exchange Reference Architecture: Foundation Guidance version 0.99* issued by CCIIO, March 2011. This document provided the business process framework for conducting this assessment. This guidance is an outgrowth of the Medicaid Information Technology Architecture (MITA), a framework developed to support Medicaid Management Information System (MMIS) planning and design
- *Financial Management Blueprint – Exchange Business Architecture Supplement version 1.0*, May 2011
- *Harmonized Security and Privacy Framework – Exchange TRA Supplement version 0.95*, March 2011
- Section 1313 of the PPACA
- Notice of Proposed Rulemaking (NPRM) regarding Exchange Risk Adjustment, Reinsurance, Risk Corridors, July 2011
- Presentations to Exchange Grantee Conference, September 2011
- The NPRM regarding Exchange establishment and operations, issued by CMS, July 2011
- The work being performed by the Early Innovator grant recipients, including the NESCIES, the consortium of New England states facilitated by the University of Massachusetts, which is working on developing insurance Exchange information system components

Appendix 8C

Analytical Framework for Exchange Financial Management Function, CMS – May 2011



Appendix 8D

Exchange Information System Assessment, Exchange Financial Management and Exchange Entity Administration: System Assessment Domains

- Functionality – A detailed assessment of Core-CT functionality against the more than 100 requirements laid out by CMS in the *Financial Management Blueprint – Exchange Business Architecture Supplement* referenced earlier and a matrix of administrative support functions developed by Mercer/HMA based on its experience with ERP solutions
- Interoperability – The degree to which Core-CT was architected to interoperate (Exchange data and support transaction processing, ideally in real time) with other systems whether "upstream" (i.e., with an online application for multiple health and human services programs) or "downstream" (i.e., with the State's bank(s) for formal movement of funds)
- Security – The degree to which Core-CT conformed with security and privacy assurance standards and guidelines outlined in the Health Insurance Portability and Accountability Act and related guidance, and in more recently issued guidance such as the *Harmonized Security and Privacy Framework – Exchange TRA Supplement* referenced earlier
- Capacity and availability – The degree to which Core-CT could "scale" to support a whole new set of transactions prompted by the implementation of the insurance Exchange in accordance with the PPACA and the aforementioned (proposed) rules
- Accessibility by external users – If applicable, the degree to which Core-CT conforms with Section 508 standards and guidelines and to PPACA-driven expectations for the "Exchange Portal" which would enable individuals to apply for health insurance
- Conformance with CMS information systems standards and conditions – Earlier this year CMS published seven standards and conditions with which Medicaid and Exchange information systems must conform in order for states to have access to enhanced federal funding in support of these systems (whether this involved system changes and/or the acquisition and/or development of new systems). These standards and conditions are described in the *Guidance for Exchange and Medicaid Information Technology (IT) Systems* referenced earlier

Appendix 8E

Exchange Information System Assessment as Completed for CORE-CT

See attached file labeled: *Appendix 8E - CT HIX Task 8 ERA BPM and Assessment*

TASK 9 – Exchange Information System Assessment, Exchange Financial Management and Exchange Entity Administration: System Assessment Domains

Background

As part of its planning activities related to implementation of a Health Insurance Exchange (Exchange) in Connecticut, the State needs to understand the extent to which its Medicaid eligibility and enrollment (E&E) system must interface with Exchange E&E systems as called for in proposed rules issued in July and August of 2011 by the Centers for Medicare and Medicaid Services (CMS). Moreover, the State also needs to understand the extent to which its Medicaid E&E system could support the Exchange in the E&E business area. To that end, the State must assess the capabilities of its Medicaid E&E system in the context of both the rules mentioned above and the guidance CMS has published to date that articulates specific E&E functionality which Exchange information systems must support.

To assist the State in meeting these needs, the Mercer/Health Management Associates (HMA) team conducted the following activities:

1. Identify key IT requirements for enabling the E&E business processes of Exchange(s), including interfaces to relevant programs such as Medicaid and the Children's Health Insurance Program (CHIP).

2. Assess Connecticut's existing IT capabilities and associated gaps related to Exchange E&E management and interfaces to relevant "in-scope" systems related to this business process area.

The scope and methodology for this assessment was based on a task scope of work submitted to the State in August of 2011 and approved by the State in September of 2011. The task scope of work is included in this report as Appendix 9A. Additionally, on October 17, 2011 the State issued the *Business Operations and IT Planning* Request for Proposal (RFP). In that RFP, the State outlined a rigorous processes which will be funded out of a Level 1 Exchange Establishment grant that will result in (a) development of an IT Architectural Model for Connecticut's Exchange, (b) progressive elaboration on information system functionality requirements, (c) bundling of said requirements into application or application components as deemed appropriate and (d) deliberation and agreement on capability acquisition strategies for meeting these requirements. As such, the outputs of our activities were designed to serve as the starting point for the activities that will be undertaken by the team that is awarded the Business Operations and IT Planning contract.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Our activities were centered on two systems/groupings of functionality:

1. The *Eligibility Management System (EMS)*, the State-owned-and-operated information system maintained by the Connecticut Department of Social Services (DSS) and used to determine and manage eligibility for Medicaid as well as other health and human services programs.

2. By extension, Web-accessible "customer facing" Medicaid and CHIP eligibility and enrollment functionality supported by DSS.

Given EMS's function as the "integrated eligibility system" for health and human services programs in Connecticut, and as called for in the RFP, our analysis focused on EMS. That notwithstanding, we also discussed with the IT leadership at DSS:

- The instance of HP Enterprise Services' *InterChange* which the State deployed as its Medicaid Management Information System, to establish how it is currently interfaced with EMS and how it would need to be interfaced with an Exchange E&E system.

- The *Modernization of Client Service Delivery (MCSD)* initiative which is currently underway and for which Deloitte has been contracted to provide a wide array of "customer facing" and "back office" functionality in support of DSS functions including program eligibility and enrollment. It should be noted that the scope of this initiative does not contemplate any modifications to, or the replacement of, EMS.

All of our activities were grounded on federal guidance on Exchange establishment, business operations and the role of IT in key functions, and on authoritative sources of relevant IT guidance other than Exchange-specific guidance. The specific sources of guidance applied in our project are listed in Appendix 9B. Based on this aforementioned guidance, we defined the scope of Exchange eligibility and enrollment functions to include the following business processes, which support individuals, businesses which are deemed able to purchase health care coverage for their employees via the Exchange – through the *Small Business Health Options Program (SHOP)* – and its employees:

- Initial application submission and subsequent updates

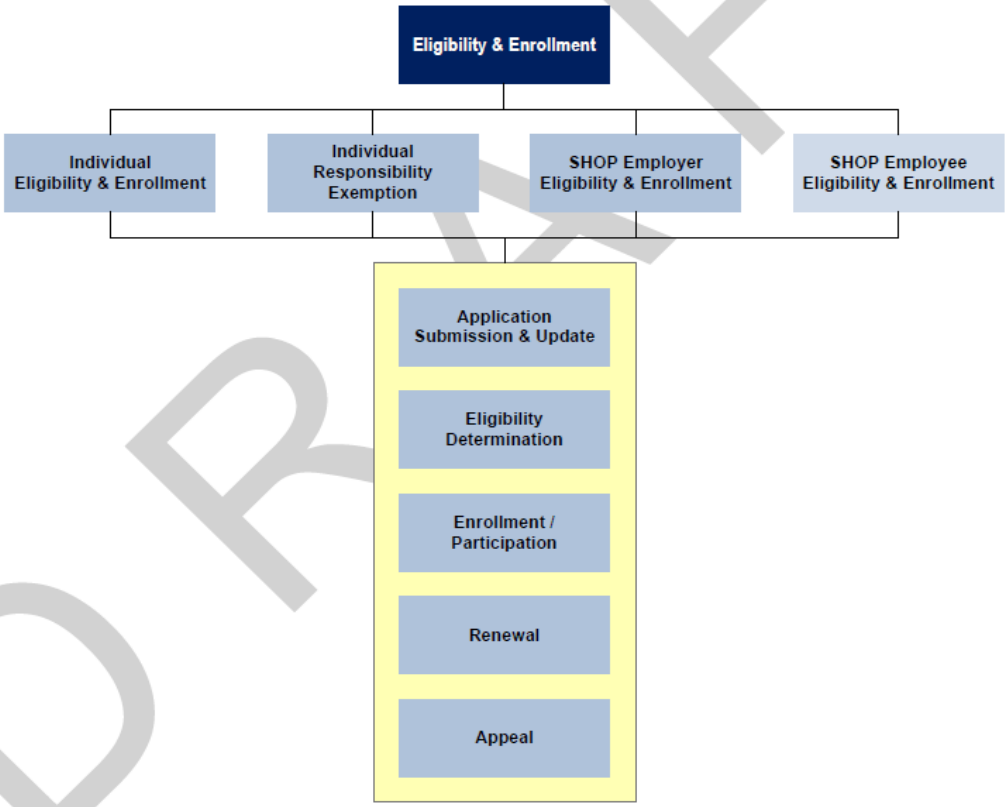
- Initial eligibility determination and subsequent renewals/updates

- Enrollment (for businesses, this represents being set up to access health care coverage options via the Exchange)

- Appeals of decisions made by the Exchange based on application data

The following diagram (Exhibit 9-1), from the *Eligibility and Enrollment Blueprint – Exchange Business Architecture Supplement* published by CMS in May of 2011, illustrates these business processes and the relationships between them.

Exhibit 9-1. Exchange Eligibility and Business Processes



For further context on these business processes and the role that the federal government expects IT to play in supporting them, Appendix 9C includes two diagrams that provide a visual depiction of these processes and key information systems.

- The first diagram was published by CMS' Center for Consumer Information and Insurance Oversight (CCIIO), the federal entity responsible for implementation of the Exchange provisions within the Patient Protection and Affordable Care Act (PPACA). The diagram provides high-level architectural guidance as it relates to determination of E&E into the Exchange and other government-funded health insurance programs based on the expectation, confirmed by the aforementioned guidance, that Exchanges must have the capability to determine eligibility for both Medicaid and CHIP.

- The second diagram is from a use case developed by CCIIO as part of the "Enroll 11" project, an initiative tied to the creation of the federal Data Services Hub which will provide authoritative data on income, citizenship and other attributes in support of Exchange eligibility and subsidy determinations. The Enroll 11 project's goal is to provide both the federal government and states with clearly defined processes and expectations regarding E&E functionality which would be based in an Exchange.

Methodology

To complete our analysis, our team built two assessment tools:

- One for assessing the extent to which EMS could support Exchange E&E functions

- A second tool for assessing existing DSS Web-based "customer facing" E&E functionality against federal guidance regarding said functionality for an Exchange.

The tools were built on our understanding of interface requirements between Exchange and Medicaid E&E functions and systems based on federal guidance, and on our review of all applicable and available federal laws, regulations and guidance related to expected E&E functionality as listed in Appendix 9B. In keeping with federal guidance, the assessment covered both EMS as well as existing online "consumer-facing" functionality maintained by DSS that theoretically could be enhanced and extended to enable applications for enrollment into either Medicaid or Exchange-based health plans and the provision of pertinent information.

The outputs of this assessment were:

- An evaluation of the online E&E functionality

- A comprehensive assessment of EMS capabilities along with the following six information system domains, described in further detail in Appendix 9D:

  Functionality:
  1. Interoperability
  2. Security
  3. Capacity and availability
  4. Accessibility by external users
  5. Conformance with CMS information systems standards and conditions

Our assessment was completed through a series of activities, including:

- Interviews with Lou Polzella, DSS Chief Information Officer, and the team that supports EMS that ultimately reports to him

- Completion by the State's EMS IT support team of the assessment tool for EMS

- Our independent evaluation of the DSS online functionality

- At the suggestion of Mr. Polzella, our review of an *EMS Risk Assessment Report* produced by Gartner and published in September 2011 (refer to Appendix 9E). The focus of this report was on addressing more immediate needs related to the maintenance and support of EMS, but it also contained valuable information about the history and current state of the system that was germane to our assessment

As part of our assessment, and even though it was not in our scope of work, our team also reviewed the contract scope of work for the *Modernization of Client Service Delivery (MCSD)* initiative, which DSS is preparing to undertake over the next couple of years. This initiative is focused on creating a user-friendly, online entry point into the many health and human services programs managed by DSS and to facilitate the management of a consumer's E&E into these programs. As such, our assessment considered whether aspects of the MCSD project could be leveraged to help Connecticut comply with federal Exchange requirements. We believed that completing this assessment as part of this Task would provide valuable input to the aforementioned Business Operations and IT Planning work that would follow our activities.

Key Findings

EMS

Based on the assessment of EMS, the details of which can be found in Appendix 9F, we have ascertained the following:

- FUNCTIONALITY: EMS lacks needed Exchange E&E functionality – less than 25% of expected functionality, as determined by the count of unique requirements as captured in the assessment tool and met by the system as a percentage of all pertinent requirements[1], is in place and only partially at that. Moreover, none of this functionality is either "real time" or "near real time" as expected by the federal government. For instance:

  - The eligibility determinations performed by EMS – for a variety of programs including Medicaid, SNAP and cash assistance – do not occur in real time

  - While there is currently a batch data exchange between EMS and CMS for the purposes of citizenship and Identity verifications, to modify this functionality to make it more "real time" would be very difficult given how the system is constructed

  - The system generates notices to clients, but again not in real time

  - The system has no referral capabilities

[1] In the Assessment Tool, *pertinent requirements* can be identified by isolating requirements with "Exchange", "In-State Medicaid, CHIP of Basic Health Program" or "Info Source TBD" as the Activity Owner.

Furthermore, the system's architecture and constrained system support resources – the State has lost the majority of staff dedicated to EMS programming and system support since the system was deployed in 1989 and is expected to lost most of the remaining staff over the next couple of years due to retirement – limit the ability to build or enhance existing functionality.

- INTEROPERABILITY: According to the Gartner report (Appendix 9E), there have been numerous issues over the years regarding how EMS interfaces with other states. The report notes issues with the system's interfaces to Social Security Administration databases and with the state's Child Care Support Enforcement system. Moreover, the very important interface between EMS and *InterChange*, which supports downstream enrollment into managed care organizations (MCOs), fee-for-service payment for certain Medicaid services, capitation payments to the aforementioned MCOs, and other mission-critical Medicaid program functions has been problematic for quite some time. Based on these findings, we must conclude that EMS, as architected or otherwise maintained, is not highly interoperable.

- SECURITY: The system as architected makes it difficult to restrict access to information on an absolute need-to-know or use basis as expected under federal law and other guidance. Moreover, the Garner report cites several instances of security incidents that were traced back to the inability to implement these access controls.

- CAPACITY AND AVAILABILITY: A plus to this system is that it does not appear to have significant transaction processing or data storage capacity issues, nor does it appear to have availability issues. Additionally, the system resides in a stable mainframe environment in a State data center, which is a well-secured facility. Moreover, provisions for business continuity are in place with recovery time objectives that are in-line with generally accepted industry practices. All of this notwithstanding, functionality, interoperability and security considerations must outweigh capacity and availability considerations in our assessment of whether EMS is a viable E&E solution for Connecticut's Exchange.

- ACCESSIBILITY BY EXTERNAL USERS: As recognized by the MCSD initiative, EMS does not have "consumer-facing" E&E functionality, and while DSS has worked on building such functionality outside of EMS it is considerably less than what federal law and guidance have set forth for Exchanges. EMS was designed to serve mainly as a "backend" system – an eligibility determination "engine" with related functionality such as notice generation.

- CONFORMANCE WITH CMS INFORMATION SYSTEMS STANDARDS AND CONDITIONS: EMS does not conform to any of the CMS information systems standards and conditions. Specifically:

  - The system is not built on a service oriented architecture paradigm or with any degree of reliance on Web services

- The system was built and implemented in the late 1980s, long before *Medicaid Information Technology Architecture (MITA)* principles and business model constructs – which CMS expects be used in the design and construction of these systems – were developed and published

- The system was built at a time when ¨modular¨ application development, which in theory supports reuse of application components (in a manner analogous to how many automobiles can be maintained or repaired using parts built by different manufacturers as long as the parts conform to certain standards) was not the norm

- While some reporting on staff productivity exists within EMS, little if any consumer satisfaction surveying or other reporting is conducted systematically

In accordance with the rule related to this matter issued by CMS in April of 2011, the seven standards and conditions articulated in that rule – *Modularity*, *Alignment with MITA*, *Adherence to Industry Standards for System Development*, *Reuse/Leverage*, *Performance Management*, *Reporting*, and *Interoperability* - must be met by relevant state systems for CMS to authorize federal funding for their development, maintenance and operations.[2]

EMS is a very old system – originally deployed in 1989 – which fundamentally is not designed to meet the needs of the modern Exchange envisioned in the PPACA. Moreover, its limited support resources are already challenged to meet existing needs. Overall, EMS falls short in terms of its capabilities when assessed against CMS guidance regarding the numerous and complex E&E functions required of an Exchange. Moreover, the Gartner report highlights the challenges that DSS is already facing just to maintain the system in its current state. As a result, our team has concluded that EMS is not a viable E&E solution for Connecticut's Exchange.

DSS Web-accessible "Customer Facing" Functionality

Based on the assessment of EMS, the details of which can be found in Appendix 9F, we have ascertained that while the DSS website provides valuable information (static content) to prospective applicants for government-funded health care programs, including application templates and instructions, it does not provide the type of real-time functionality that the Exchange rules and guidance envision. For instance, a prospective applicant cannot apply online for Medicaid or HUSKY – the application must be downloaded from the DSS website, completed by hand and then delivered via mail or in person. We included screenshots from the DSS website in this report as Appendix 9G.

With the MCSD initiative getting underway, it is not likely that DSS would engage on much new website development but rather would rely on Deloitte to build upon existing capabilities. We reviewed several documents provided to us regarding the MCSD initiative, included in this report

[2] http://edocket.access.gpo.gov/2011/pdf/2011-9340.pdf

as Appendix 9H, and identified potential leveraging opportunities as discussed in detail in Appendix 9F and in our Recommendations.

Recommendations

As noted earlier in the report, we structured this task to pave the way for more detailed planning, cost-benefit analysis and procurement work that will be funded through the Exchange Level 1 Establishment grant. The following recommendations are designed to further inform this work:

1. Acquisition and/or development of a new Medicaid E&E solution should be explored from a cost benefit standpoint. Alternatively, an "integrated eligibility system" solution should be explored that would replace and improve upon the functionality currently available in EMS and support eligibility determination for multiple programs, as well as Exchange-subsidized plans.

It is our understanding that the State is actively exploring one or both of these options; an Advance Planning Document (APD) has been submitted to CMS.

In addition to federal Exchange establishment funding – which does not require state matching funds – that is currently available for the development of Exchange information systems, states will have through the end of 2015 to leverage enhanced federal funding – 90% federal funding participation – from CMS to build/buy and implement new Medicaid E&E system functionality (or, through cost allocation, to fund part of the build/buy and replacement of a system like EMS to handle E&E for multiple health and human services programs). As noted previously, the availability for states to access these two federal funding streams is conditioned on demonstrating that they will conform to the information systems standards and conditions referenced previously.

As it relates to this recommendation, it should also be noted that the MCSD initiative does not assume a replacement of EMS.

2. The State could explore leveraging "information system components" being developed out of the MCSD project, particularly those related to "consumer facing" online functionality.

   The State's contract with Deloitte calls for:

   - Web services that provide continuous, uninterrupted access to DSS services and information
   - The ability for clients to conduct pre-screening for benefits and services for determining preliminary eligibility
   - An online service that enables clients to apply for programs via a single, integrated online application

- Clients to have the ability to access information about their benefits, report changes, and conduct online redeterminations via secure *client accounts*

If properly configured, it would be possible for all of these technology "services" to support information regarding, and transactions involving, Medicaid, CHIP and Exchange-based plans. As such, the MCSD initiative could result in a "portal" that would support applying for multiple health and human services programs and the Exchange. To accommodate this change, the scope of the State's contract with the MCSD vendor might have to be amended. Additionally, introducing an Exchange component to the MCSD project could impact the project timeframe as Deloitte would have to accommodate the timeline for establishing Connecticut's Exchange.

3. The State could explore leveraging "information system components" being developed out of the Exchange Early Innovator projects, including New England States Collaborative Insurance Exchange Systems (NESCIES). CMS expects these components to be designed to be relatively easy and inexpensive to integrate for states to assemble a complete information systems stack that would enable all Exchange functions, including E&E.

   Related to NESCIES, Massachusetts issued an RFP for a "systems integration" vendor that is intended to support these efforts was issued in December of 2011. In the RFP (page 18) there is an indication that development of reusable components and development of plans for their reuse and implementation in other states will be a significant component of this project.

4. The State could explore an approach to acquiring Exchange operational capabilities through business process outsourcing rather than through acquisition or development of information systems. CMS encourages states, particularly those with limited IT resources or management capabilities, to explore an approach in which they focus on outsourcing and integrating Exchange *business processes* (e.g., call center operations, application intake and processing, premium processing and aggregation) rather than developing and/or integrating information systems. The former approach positions the State as manager of business process outsourcing (BPO) vendors rather than as an integrator and manager of information systems. These two approaches require very different skill sets. It could be argued that the State should pursue a BPO strategy for establishing its insurance Exchange, especially given its budget situation and declining IT workforce. An example of this type of arrangement is the State's current contract with Affiliated Computer Services, Inc. (ACS) for CHIP administration.[3]

[3] Given the nature of this contract, and the fact that at one point ACS had been hired to conduct this task, we concluded that an in-depth assessment of ACS capabilities was not appropriate. Moreover, the scope of work for this task per the RFP did not include an assessment of this contract.

A variation of this approach is the use of an application service provider for some of these capabilities based on a “software as a service” (SaaS) model. In this approach, the large upfront outlays traditionally associated with information systems projects can be minimized. Systems as large as SAP and as comparatively small as Quickbooks and Microsoft Office are now available via this model.

Appendix 9A

Scope of Work, Task 9 (as approved by the State)

See attached file labeled: *Appendix 9A – CT HIX Proj Task 9 Overview for DSS – 2011 08 19*

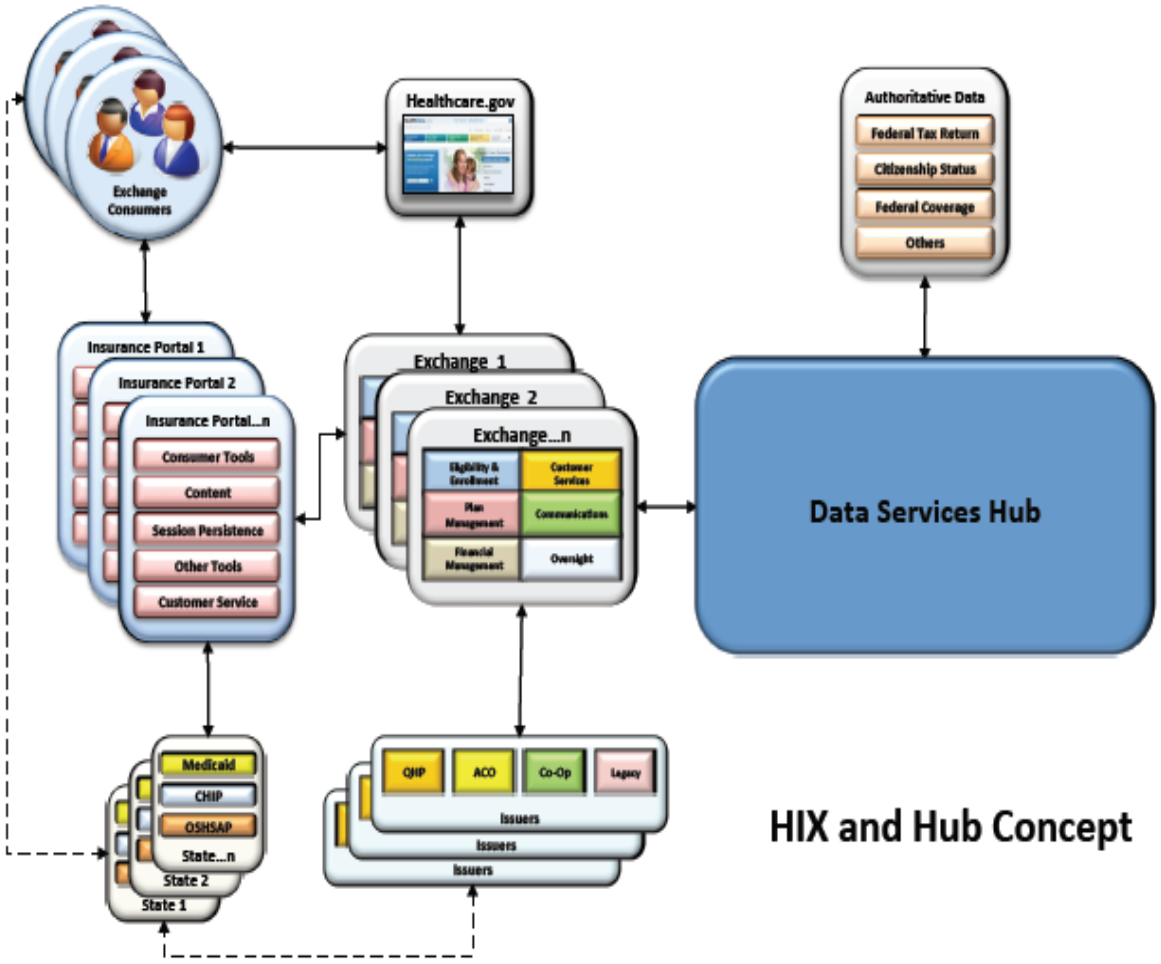
Appendix 9B

Sources of Relevant Guidance

- *Guidance for Exchange and Medicaid Information Technology (IT) Systems,* Version 2.0, issued by CMS' Center for CCIIO, May 2011.
- *Exchange Reference Architecture: Foundation Guidance, Version* 0.99, issued by CCIIO, March 2011. This document provided the business process framework for conducting this assessment. This guidance is an outgrowth of the Medicaid Information Technology. Architecture (MITA), a framework developed to support MMIS planning and design.
- *Eligibility and Enrollment Blueprint – Exchange Business Architecture Supplement,* Version 1.0, issued by CCIIO, May 2011.
- *Harmonized Security and Privacy Framework – Exchange TRA Supplement,* Version 0.95, issued by CCIIO, March 2011.
- Notice of Proposed Rulemaking (NPRM) regarding Exchange establishment and operations, issued by CMS, July 2011.
- NPRM regarding Medicaid, CHIP and Exchange eligibility, issued by CMS, August 2011.
- Expectations around the information which will be housed in, and functionality which will be provided by, the federal Data Services Hub as presented during the Health Insurance Exchange Planning Grantee Conference held in Washington, DC in September 2011.
- The work being performed by the Early Innovator grant recipients, including the NESCIES, the consortium of New England states facilitated by the University of Massachusetts which is working on developing insurance Exchange information system components.
- Relevant laws enacted other than the PPACA such as the Health Insurance Portability and Accountability Act (HIPAA) and the Rehabilitation Act (specifically with regards to the latter, Section 508, which sets accessibility standards for electronic and information technology).

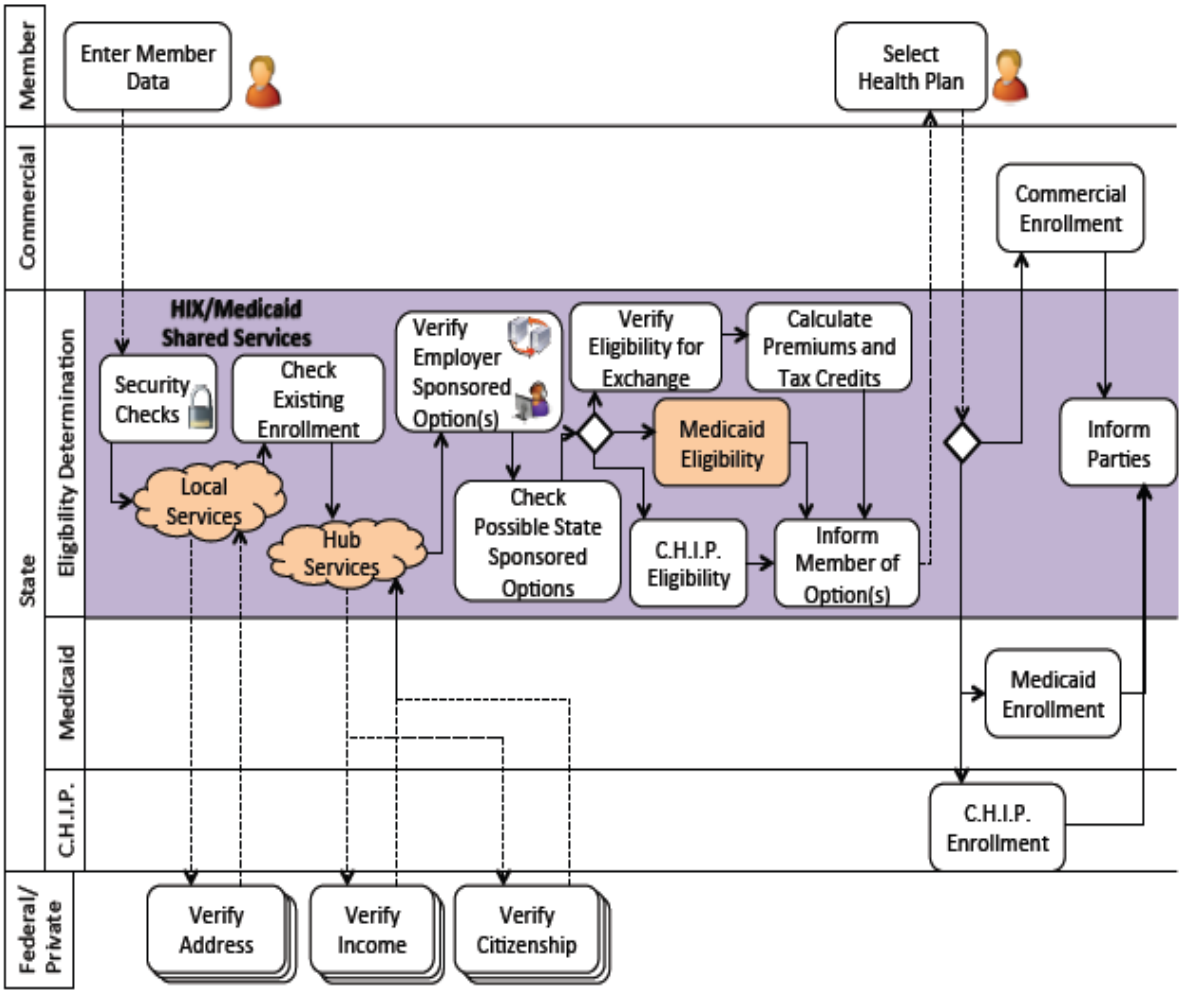
Appendix 9C

Diagram 9C-1 –Exchange Entity Interface Diagram CMS – August 2011



Appendix 9C (cont'd)

Diagram 9C-2 –Exchange Eligibility and Enrollment Use Case CMS – August 2011



Appendix 9D

Exchange Information System Assessment Domains

- FUNCTIONALITY – A detailed assessment of EMS functionality against the more than 100 requirements laid out by CMS in the *Eligibility and Enrollment Blueprint – Exchange Business Architecture Supplement* referenced in Appendix 9B.

- INTEROPERABILITY – The degree to which EMS was architected to interoperate (exchange data and support transaction processing, ideally in real time) with other systems whether "upstream" (i.e., with an online application for multiple health and human services programs) or "downstream" (i.e., with the State's MMIS to formally enroll an individual into Medicaid)

- SECURITY – The degree to which EMS conformed to security and privacy assurance standards and guidelines outlined in HIPAA and related guidance, and in more recently issued guidance such as the *Harmonized Security and Privacy Framework – Exchange TRA Supplement* referenced in Appendix 9B.

- CAPACITY AND AVAILABILITY – The degree to which EMS could "scale" to support a whole new set of E&E transactions prompted by the implementation of the Insurance Exchange in accordance with the PPACA and the aforementioned (proposed) rules.

- ACCESSIBILITY BY EXTERNAL USERS – The degree to which EMS and the online functionality described earlier conforms with Section 508 standards and guidelines, and to PPACA-driven expectations for the "Exchange Portal" which would enable individuals to apply for health insurance.

- CONFORMANCE WITH CMS INFORMATION SYSTEMS STANDARDS AND CONDITIONS – Earlier this year CMS published seven standards and conditions which Medicaid and Exchange information systems must conform with in order for states to have access to enhanced federal funding in support of these systems (whether this involved system changes and/or the acquisition and/or development of new systems). These standards and conditions are described in the *Guidance for Exchange and Medicaid Information Technology Systems* referenced earlier, and in http://edocket.access.gpo.gov/2011/pdf/2011-9340.pdf.

Appendix 9E

Gartner EMS Risk Assessment (Version Shared by DSS CIO with Our Team)

See attached file labeled: *Appendix 9E - Gartner EMS Risk Report*

Appendix 9F

Exchange Information System Assessment, as Completed for EMS and for Online "Consumer Facing" Functionality for Medicaid E&E Maintained by DSS

EMS Profile and Detailed System Assessment

See attached file labeled: *Appendix 9F - CT HIX Task 9 ERA BPM and Assessment*

Appendix 9F (cont'd)

A. DSS Website Functionality and Modernization of Client Services Delivery (MCSD) Proposed Functionality Compared to Exchange Website Expectations/Requirements

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN – Functionality already in place YELLOW – Functionality partially in place PINK – No functionality at present
(b) Internet website. The Exchange must maintain an up-to-date Internet website that: **(1)** Provides standardized comparative information on each available Qualified Health Plan (QHP), including at a minimum: **(i)** Premium and cost-sharing information; **(ii)** The summary of benefits and coverage established under section 2715 of the PHS Act; **(iii)** Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of	For HUSKY, DSS website contains link to an enrollment page that summarizes available health plan options. Information, including: • Links to participating health plans' HUSKY websites. • Links to participating health plans' Provider Directories (no tool that compares across health plans). • A "tips to choose a health plan option" document that is downloadable	The MCSD scope, which relates only to eligibility for programs, does not include the addition of any standardized, comparative information to support enrollment into health plans.	PINK. DSS website provides some limited enrollment information, but does not allow the user to compare side-by-side information. Could potentially build on MCSD functionality, perhaps as another function through "Client Accounts" (Section 4.5 of Scope of Work) or as additional steps following the eligibility determination process.

[1] DSS website accessed at http://www.ct.gov/dss/site/default.asp.

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN Functionality already in place YELLOW Functionality partially in place PINK No functionality at present
the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act; **(iv)** The results of enrollee satisfaction survey, described in section 1311(c)(4) of the Affordable Care Act; **(v)** Quality ratings assigned pursuant to section 1311(c)(3) of the Affordable Care Act; **(vi)** Medical loss ratio information as reported to HHS in accordance with 45 CFR 158; **(vii)** Transparency of coverage measures reported to the Exchange during certification in §155.1040; and **(viii)** The provider directory made available to the Exchange pursuant to §156.230.	and describes the health plan options, how to access care, etc. • A podcast about options available (note that podcast link does not appear to work). DSS website also contains link to a HUSKY benefit package page that describes the benefits and applicable cost-sharing. (Note: There is no variation across health plans, so no side-by-side comparison needed.) No information about items (v)–(vii): quality ratings, medical loss ratios of participating plans, transparency of coverage measures.		
(2) Is accessible to	Unclear if DSS	MCSD Scope of Work	PINK.

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN – Functionality already in place YELLOW – Functionality partially in place PINK – No functionality at present
people with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act and provides meaningful access for persons with limited English proficiency.	website is ADA and Section 504 compliant. Documents and most web content available in English and Spanish.	indicates the following: "Deloitte shall provide Web site screens with accessibility compliance and cross browser compatibility; involves requiring that the Web Services comply with the standards as laid out in Section 504 and 508, Subpart B, 1194.21 & 1194.22, and satisfy Priority checkpoints of the WCAG 2.0. These services are able to be rendered in standards compliant web browsers that understand and support HTML, XHTML, Cascading Style Sheets, ECMAScript and W3C Document Object Model." "Deloitte shall provide Web Services client-facing screens, including help capabilities in both English and Spanish with translations provided by DSS." "Deloitte shall provide client communications through a multitude of different avenues	Could build on MCSD project, which will be compliant with ADA and Section 504. Screens and help text will be translated into Spanish. Client communications will be tested against the Flesch Reading Ease Scale to confirm that they are presented at a sixth-grade reading level or lower.

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN Functionality already in place YELLOW Functionality partially in place PINK No functionality at present
		including Frequently Asked Questions (FAQs) and eligibility information. The client communications shall be tested against the Flesch Reading Ease Scale to confirm that they are presented at a sixth-grade reading level or lower."	
(3) Publishes the following financial information: **(i)** The average costs of licensing required by the Exchange; **(ii)** Any regulatory fees required by the Exchange; **(iii)** Any payments required by the Exchange in addition to fees under (i) and (ii) of this paragraph; **(iv)** Administrative costs of such Exchange; and **(v)** Monies lost to waste, fraud, and abuse.	DSS website contains an array of information about its program; however, no comparable financial information is currently provided.	Scope of Work indicates that clients will be able to access web services 24x7 for information about their benefits.	YELLOW. Could be incorporated into the current DSS website or the MCSD platform; both have the functionality to display financial information for clients. The financial information is not yet available from the Exchange.
(4) Provides applicants with information about Navigators as described in §155.210 and other consumer	HUSKY – Contains link to Contact Us page that provides information about the HUSKY call center for	MCSD scope indicates that clients will be able to access web services 24x7 for information about their benefits.	YELLOW. Could be incorporated into the current DSS website or the MCSD platform; both have the functionality to display information about Navigators or other consumer assistance services.

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN Functionality already in place YELLOW Functionality partially in place PINK No functionality at present
assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.	assistance. No information about how to access consumer assistance services in State.	MCSD scope refers to a call center service provided by Siemens that "provides the ability for DSS to scale call center capacity up or down to adjust to changing business needs."	
(5) Allows for an eligibility determination to be made pursuant to §155.200(c) of this subpart.	Applicants for SNAP, HUSKY and Charter Oak Plan must print paper applications that must be sent by mail to DSS for review. HUSKY and Charter Oak Plan application is a joint application that can be downloaded, completed online and then printed to be mailed to DSS.	MCSD Scope of Work states that "Web services will use the Internet to provide access to DSS services 24 hours per day, seven days per week (24x7). Clients will have the ability to conduct pre-screening for benefits and services to assess preliminary eligibility...The online application service will provide the ability for clients to apply for services via a single, integrated online application. Additionally, clients will have the ability to access information about their benefits, report changes, and conduct online redeterminations via secure client accounts." Applications will be "submitted through the	PINK No functionality at present, but MCSD platform could potentially be leveraged for its streamlined application service functions.

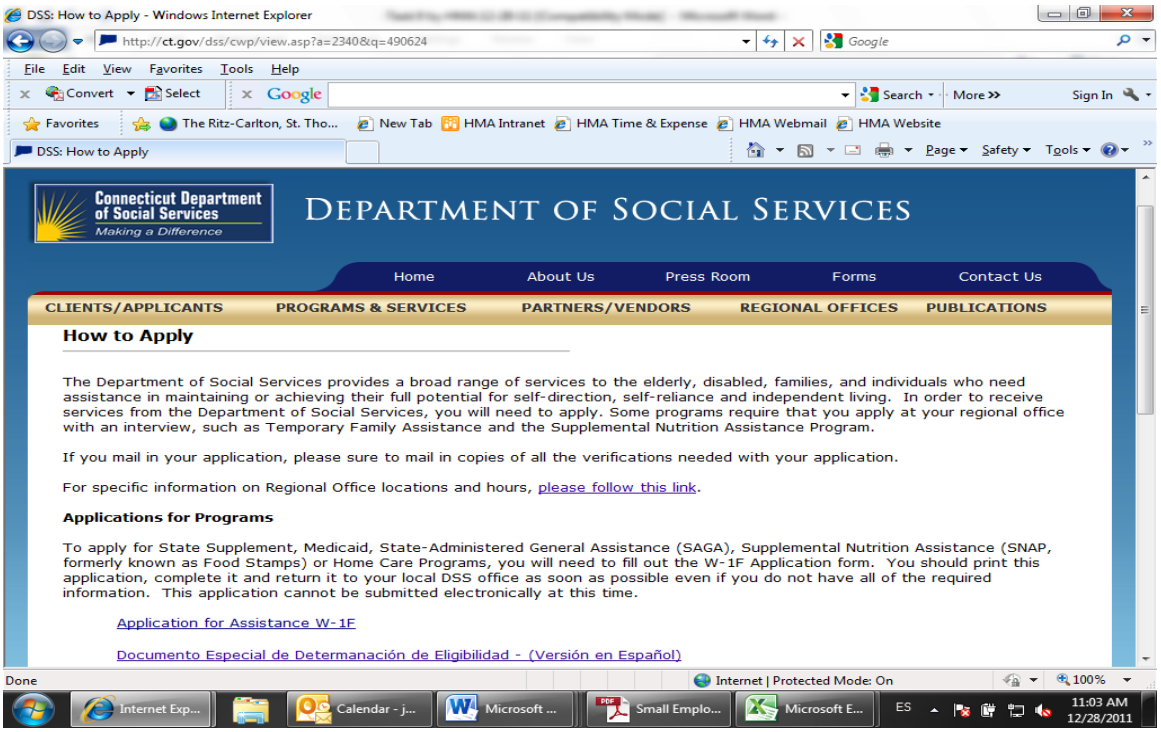
Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN Functionality already in place YELLOW Functionality partially in place PINK No functionality at present
		online application service and routed to the Worker Dashboard for verification and approval by a DSS worker. The DSS worker shall have the ability to view the application for approval and edit the application if necessary. This functionality shall be facilitated through an approval and verification screen. The DSS worker shall have the ability to electronically submit the application to EMS and/or ConneXion. The transaction of this data shall be handled through an industry standard Web-service interface. Deloitte shall work with DSS during the design phase to determine what data, and the format of the data, that shall be passed through this transaction."	
(6) Allows for enrollment in coverage into QHPs.	DSS website contains link to an enrollment page that indicates that qualified individuals must fill out an enrollment	MCSD scope only addresses eligibility support functions.	PINK. Could potentially build on MCSD functionality, perhaps as another function through "Client Accounts" (Section 4.5 of Scope of Work) or as additional steps following the eligibility

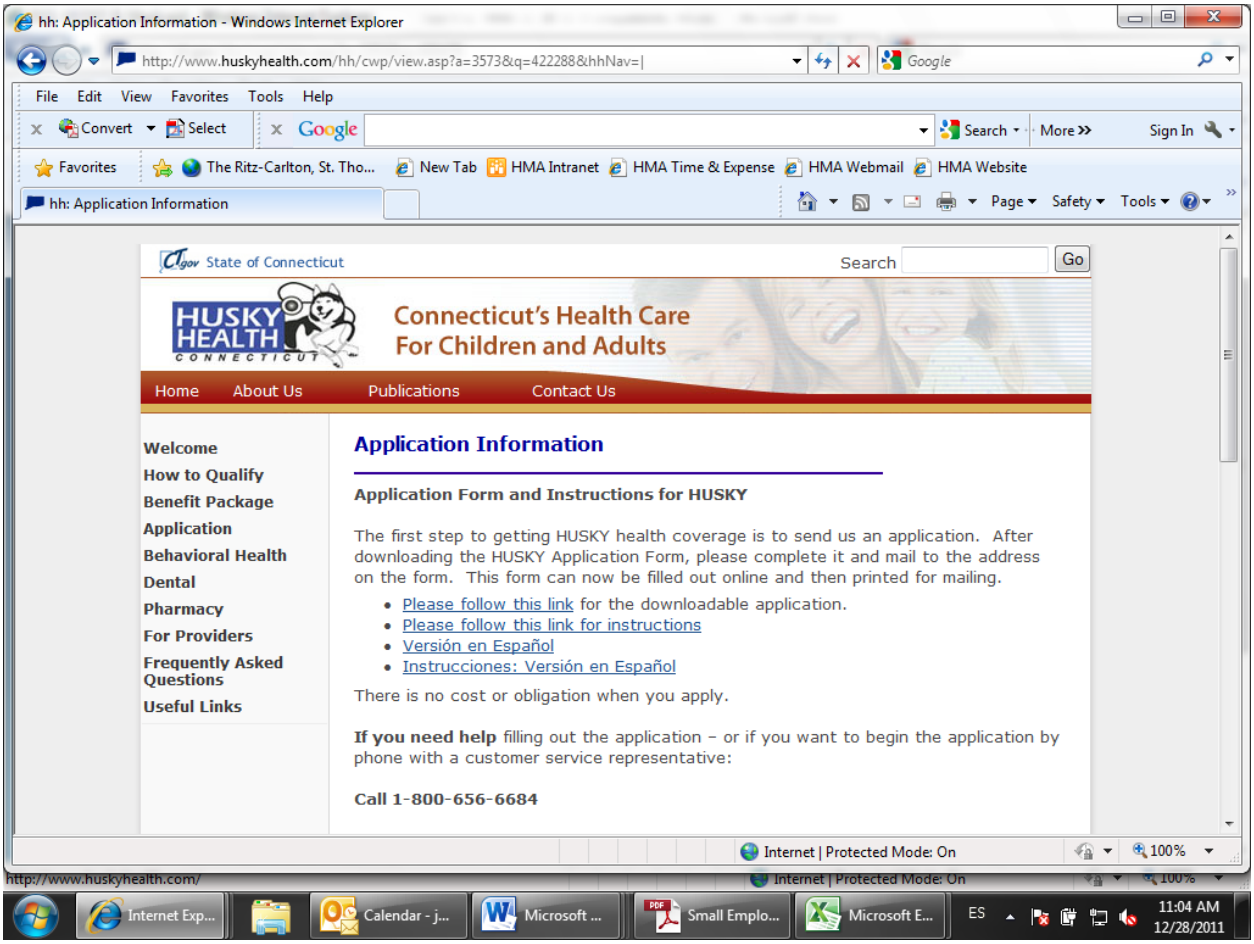
Proposed regulation §155.205: Required consumer assistance tools and programs of an Exchange	**DSS website**[1]	**MCSD project components**	**Assessment** GREEN Functionality already in place YELLOW Functionality partially in place PINK No functionality at present
	form or call the call center to select a health plan option.		determination process.
(c) Exchange calculator. The Exchange must establish and make available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.	Website does not contain a calculator function.	MCSD scope includes a "pre-screening eligibility" function, which is a similar concept to providing an Exchange calculator to facilitate consumer decision-making.	PINK. No current functionality. Could potentially build on MCSD functionality as an additional feature similar to the pre-screening functionality.

Appendix 9G

Sample Screenshots, DSS Web-accessible Customer Facing Functionality



DSS: HUSKY & Medicaid - Windows Internet Explorer
http://ct.gov/dss/cwp/view.asp?a=2353&q=490478
Connecticut Department of Social Services
Making a Difference
DEPARTMENT OF SOCIAL SERVICES
Home
About Us
Press Room
Forms
Contact Us
CLIENTS/APPLICANTS
PROGRAMS & SERVICES
PARTNERS/VENDORS
REGIONAL OFFICES
PUBLICATIONS
HUSKY & Medicaid
HUSKY Healthcare for UninSured Kids and Youth
The HUSKY Plan offers a full health insurance package for children and teenagers up to age 19, regardless of family income. HUSKY pays for doctor visits, prescriptions, vision and dental care, and much more.
Medicaid
The Medicaid program provides for remedial, preventive, and long term medical care for income eligible aged, blind or disabled individuals, and families with children. Payment is made directly to health care providers, by the department, for services delivered to eligible individuals. The program complies with federal Medicaid law (Title XIX of the Social Security Act) and regulations in order to receive 50% reimbursement from the federal government.
Medicaid for Low-Income Adults
Connecticut is the first state to receive federal approval to expand Medicaid under the Affordable Care Act (national health care reform legislation). This new Medicaid coverage is replacing the State-Administered General Assistance (SAGA) medical program. Medicaid for Low-Income Adults (MLIA) is open to Connecticut residents aged 19 through 64, who do not receive federal Supplemental Security Income or Medicare and who are not pregnant.
Medicaid for Employees with Disabilities
Medicaid for Employees with Disabilities, now known as MED-Connect, provides medical assistance to employed individuals with disabilities. Total income from work and other benefits must be below $75,000 per year. Some individuals may pay a monthly premium for this coverage. In general an eligible person with a disability, who is employed or becomes employed, can qualify for MED-Connect
Done
Internet | Protected Mode: On
100%
11:03 AM
12/28/2011


hh: Application Information - Windows Internet Explorer
http://www.huskyhealth.com/hh/cwp/view.asp?a=3573&q=422288&hhNav=|
File Edit View Favorites Tools Help
Favorites
The Ritz-Carlton, St. Tho...
New Tab
HMA Intranet
HMA Time & Expense
HMA Webmail
HMA Website
hh: Application Information
State of Connecticut
Search
Go
HUSKY HEALTH CONNECTICUT
Connecticut's Health Care For Children and Adults
Home
About Us
Publications
Contact Us
Welcome
How to Qualify
Benefit Package
Application
Behavioral Health
Dental
Pharmacy
For Providers
Frequently Asked Questions
Useful Links
Application Information
Application Form and Instructions for HUSKY
The first step to getting HUSKY health coverage is to send us an application. After downloading the HUSKY Application Form, please complete it and mail to the address on the form. This form can now be filled out online and then printed for mailing.
Please follow this link for the downloadable application.
Please follow this link for instructions
Versión en Español
Instrucciones: Versión en Español
There is no cost or obligation when you apply.
If you need help filling out the application – or if you want to begin the application by phone with a customer service representative:
Call 1-800-656-6684
Internet | Protected Mode: On
100%
http://www.huskyhealth.com/
11:04 AM
12/28/2011

Appendix 9H

Documents Reviewed RE: the Modernization of Client Services Delivery (MCSD) Initiative

See attached files labeled:
Appendix 9H – Deloitte MCSD Scope of Work
Appendix 9H – MCSD Presentation June 2011

TASK 10 – Impact of the PPACA on Connecticut Medicaid & CHIP Programs and the Interaction with Exchange Plans

Background

New Medicaid Coverage

Medicaid has provided health care coverage for millions of low-income Americans since its enactment under Title XIX of the Social Security Act in 1965. The program covers low income children and families who do not have access to employer-sponsored insurance, individuals with disabilities who lack private coverage or for whom adequate coverage is not available and low income seniors dually eligible for both Medicare and Medicaid. Medicaid is an optional program for states and all 50 states participate. The program is jointly financed by state and federal government as an entitlement program. States receive federal matching dollars at a rate based on state per capita income, with poorer states receiving more federal money. States also have the option to participate in the CHIP created by Congress in 1997. CHIP is a block grant program that provides health insurance coverage to uninsured children in families with modest incomes that are too high to qualify for Medicaid. States receive higher federal matching rates for CHIP than for Medicaid. (PPACA changes specific to CHIP are discussed below.)

In Connecticut, HUSKY A (Healthcare for Uninsured Kids and Youth) provides Medicaid coverage to low income children under age 19, pregnant women and some parents or relative caregivers of covered children with family income at or below 185% FPL (250% for pregnant women). HUSKY B provides CHIP for children in families with incomes between 186% and 300% of the federal poverty level (FPL). Seniors and people with disabilities may access Medicaid through community Medicaid below the medically needy income limit, the medically needy program (“spenddown”), home- and community-based waivers and Medicaid for the employed disabled (MED-Connect). In addition, the Medicare Savings Program (MSP) provides premium and copayment support to certain participants who are dually eligible for both Medicare and Medicaid. Figure 10-7 summarizes Connecticut’s Medicaid and CHIP income eligibility limits by FPL for the non-elderly/non-waiver population, including the MLIA program discussed below.

The PPACA established a new mandatory Medicaid eligibility category that provides coverage to individuals with MAGIs not exceeding 133% of the FPL who are not (1) elderly; (2) pregnant; (3) entitled to or enrolled in Medicare Part A or Medicare Part B; or (4) described in an already existing group for which Medicaid coverage is mandatory such as certain parents, children or disabled persons receiving Supplemental Security Income (SSI) benefits. This expanded eligibility standard begins January 1, 2014. The effect of the PPACA is to ‘fill-in’ gaps in Medicaid coverage nationwide where eligibility standards have varied widely depending on state-specific coverage of certain optional and waiver populations. Included in the new eligibility category are non-elderly adults without dependent children. This group of individuals has historically been excluded from Medicaid unless they were pregnant or disabled.

Existing federal law already limits Medicaid to American citizens and lawfully residing noncitizens who have been in the US more than five years. An exception to this law applies to pregnant women and children lawfully residing in the country under an option authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA). Connecticut has opted to cover this population as provided under CHIPRA.

Enhanced Medicaid Federal Financial Participation

For individuals who become newly eligible for Medicaid under the PPACA, the federal government will pay 100% of health care costs between 2014 and 2016. This percentage (known as the "Federal Medical Assistance Percentage" or FMAP) will phase down to 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and thereafter. By contrast, Connecticut will continue to receive 50% federal financial participation for most existing Medicaid covered populations, including those who were previously eligible but unenrolled in the program.

Figure 10:1: Medicaid FMAP, Calendar Years 2014–2020 (CY14–20)

Coverage groups	2014	2015	2016	2017	2018	2019	2020
Newly Medicaid eligible	100%	100%	100%	95%	94%	93%	90%
Previously Medicaid eligible[1]	50%	50%	50%	50%	50%	50%	50%

Early Medicaid Expansion (MLIA)

The health reform law provided states with the option to expand Medicaid to some or all of the individuals in the new eligibility group with MAGIs up to 133% FPL beginning April 1, 2010; however, states are required to bear the cost of the early expansion at their state's prevailing FMAP rate (50% in Connecticut), not the enhanced rates that begin in 2014. Connecticut was the first state in the country to receive federal approval to expand Medicaid under this option. Connecticut moved approximately 45,000 individuals enrolled in the State Administered General Assistance (SAGA) program into the newly created MLIA program. MLIA provides Medicaid health coverage to single adults and married couples up to 56% FPL (or 68% FPL in Region A – mostly southwestern Connecticut). Unlike SAGA, MLIA eligibility does not require an asset test. Enrollment in MLIA was originally estimated at about 45,000 single individuals; however, as of October 2011 enrollment was nearly 75,500.[2]

Currently, the federal government provides 50% federal financial participation of MLIA costs. Beginning January 1, 2014, when Medicaid eligibility is expanded for most individuals to 133% FPL, MLIA program expenditures will be eligible for the enhanced Medicaid federal reimbursement as described above.

[1] Family planning services reimbursed at 90%

[2] Department of Social Services administrative data file, November 1, 2011

Modified Adjustable Gross Income (MAGI)

The PPACA also requires states to adopt a consistent method for counting income based on an applicant's MAGI, which is an individual's (or couple's) total income reported to the Internal Revenue Service plus tax-exempt interest and foreign earned income. The new MAGI methodology will apply to most under-65 Medicaid and CHIP applicants and beneficiaries – not just those who are newly eligible under the law. The MAGI methodology will replace and standardize existing State rules for determining income and will also be used to determine eligibility for premium tax credits and cost sharing assistance in insurance Health Insurance Exchanges (Exchanges), thus aligning methodologies for determining income eligibility across multiple health programs. The law also specifies that an income disregard in the amount of 5% FPL will be used to determine Medicaid eligibility based on MAGI; thus, the effective maximum income-eligibility threshold for such individuals in this new eligibility group will be 138% FPL. PPACA also eliminates asset tests for applicants subject to the MAGI eligibility standard. Certain groups are exempted from MAGI-based income eligibility standards and states may continue to use pre-PPACA income counting rules and asset tests for these groups, which broadly include:

1. Individuals who are eligible for Medicaid through another federal or state assistance program (i.e., foster care children and individuals receiving SSI)

2. The elderly or Social Security Disability Insurance program beneficiaries

3. Certain disabled individuals who qualify for Medicaid on the basis of being blind or disabled without regard to whether the individual is eligible for SSI

4. The medically needy

5. MSP enrollees

In addition, MAGI does not affect determinations of eligibility for Medicaid long term care services such as nursing home care, and home- and community-based services such as home care, personal care, transportation and care management furnished under a Medicaid state plan or waiver.[3]

Maintenance of Effort (MOE)

The health reform law includes a Medicaid eligibility MOE requirement in which states lose access to federal financial participation under Medicaid if their eligibility standards, methodologies or procedures under the State's Medicaid plan (including any waivers) are more restrictive than were in effect as of the date of the law's enactment (March 23, 2010).

[3] Mulvey J, E Baumrucker, B Fernandez, C Scott. Definition of Income in PPACA for Certain Medicaid Provisions and Premium Credits. Washington, DC: Congressional Research Service; October 24, 2011.

For adult populations, the MOE requirements remain in effect from the date of the law's enactment through the date the State's Exchange is fully operational, as determined by the Secretary of Health and Human Services. For any Medicaid-eligible child who is under age 19 (or such higher age as the State may have elected[4]), the MOE requirement continues through September 30, 2019.[5] States are also required to maintain CHIP income eligibility standards for children through September 30, 2019 as a condition of receiving Medicaid federal financial participation.

Benefit Changes

The PPACA required that most of the newly eligible be enrolled in Medicaid "benchmark" or "benchmark-equivalent" plans, which have traditionally been less comprehensive than standard Medicaid benefits. The Deficit Reduction Act (DRA) of 2005 provided states with the authority to enroll Medicaid enrollees in benchmark plans, which are drawn from an approved comparison private plan.

The DRA made certain groups exempt from required participation in benchmark/benchmark-equivalent plans, and the PPACA extends those exemptions to those same groups among the newly eligible. Exempt groups include blind or disabled individuals (regardless of SSI eligibility); individuals who are dually eligible for Medicaid and Medicare; inpatients in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR); and individuals who are medically frail or have special needs.[6] Children can be enrolled in benchmark/benchmark-equivalent plans, but they must be provided with the full children's Medicaid benefit package (Early and Periodic Screening, Diagnosis and Treatment or EPSDT) either directly or through wrap-around coverage. The PPACA also exempts Medicaid-eligible former foster care children from participation in benchmark/benchmark-equivalent plans.

The PPACA required that all benchmark and benchmark equivalent plans provide at least "essential health benefits" (EHB), a set of minimum standard coverage requirements, effective January 1, 2014. Health plans offered through a state Exchange, as well as new individual and small-group health plans sold outside of an Exchange, will also be required to meet the EHB standard. Originally, the Secretary of Health and Human Services was expected to define EHB through regulation based on 10 PPACA-mandated categories of benefits; however, the Obama administration announced on December 16, 2011 that it plans to give states the discretion to

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[4] Connecticut's HUSKY A (Medicaid) program generally does not cover children over age 19, except that children who age-out of the State's foster care system are covered up to age 21 through the State's HUSKY A program. So-called severely disabled "Ribicoff Children," ages 19–20, are also covered as required by federal law.

[5] Stone J, et al Medicaid and the State Children's Health Insurance (CHIP) Provisions in the PPACA, Congressional Research Service; 19 Aug 2010. Available at: http://hrsa.dshs.wa.gov/MedicaidHealthCareReform/CRS/CHIPProvisions.pdf.

[6] Other groups are also exempt from benchmark coverage. See Sec. 1937(a)(2)(B) of the Social Security Act.

select an existing health plan to set the "benchmark" for the items and services included in the EHB package. States may choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state
- One of the three largest state employee health plans
- One of the three largest federal employee health plan options
- The largest HMO plan offered in the state's commercial market

While the PPACA requires states to defray the costs of state-mandated benefits in excess of EHB for individuals enrolled in any QHP in the Exchange, states await specific guidance from CMS regarding whether the costs of Medicaid benefits provided to newly eligible enrollees in excess of benchmark coverage would be eligible for the enhanced FMAP rates described above.

CHIP Provisions

CHIP is a discretionary federal/state program that provides health care coverage to low-income, uninsured children in families with income above Medicaid income standards. CHIP expenditures are eligible for a higher FMAP rate. While Connecticut receives 50% federal financial participation for most Medicaid expenditures, it receives 65% for CHIP expenditures.

In Connecticut, HUSKY B provides CHIP for children in families with incomes between 185% and 300% FPL. Currently, families with incomes above 300% FPL may "buy into" Husky B by paying a monthly premium; however, health costs for children in this category are not eligible for federal financial participation.

The health reform law provides federal CHIP appropriations through September 30, 2015. While the law does not provide appropriations beyond that date, it does increase federal financial participation for most CHIP expenditures by an additional 23 percentage points for FY16–FY19. Connecticut's CHIP FMAP rate is scheduled to increase from 65% to 88% during that time period. In the event that CHIP appropriations are not made beyond FY15, states will be required to enroll CHIP children not otherwise eligible for Medicaid into an Exchange plan determined to be at least as comparable to the benefits and cost-sharing provisions provided under the state's CHIP program.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Figure 10-2: CHIP FMAP, Federal FY14–20

Coverage group	2014	2015	2016	2017	2018	2019	2020
CHIP	65%	65%	88%	88%	88%	88%	65%

Data Sources

In order to estimate and model the impact of the PPACA on Connecticut's Medicaid and CHIP programs, as well as their interactions with the Exchange, this report relied on three principal sources of data:

1. POPULATION SURVEYS: This analysis uses 2008–2009 CPS data available through the Kaiser Family Foundation's "statehealthfacts.org" website, which includes Urban Institute adjustments to account for the fact that not everyone in a household is part of the same health insurance unit. Task 1 estimates the number of non-elderly adults and children in households with incomes less than 139% FPL (accounting for the 5% income disregard under MAGI) for the uninsured, those with employer sponsored insurance and individuals with non-group coverage.

2. DSS DATA WAREHOUSE: Connecticut's Department of Social Services (DSS or Department) provided Health Management Associates (HMA) with monthly enrollment data for all Medicaid and CHIP programs and the Charter Oak Health Plan from January 2009 through October 2011. The data can be grouped by age band, gender and MMIS medical eligibility (ME) codes. DSS also provided CY2010 payment data from MMIS for Medicaid and CHIP enrollees.

3. ACS CAPITATION PAYMENT FILE: DSS also provided CY2010 capitation data based on a payment file from Administration for Children's Services (ACS), a State vendor.

Assumptions

The Mercer/HMA team used the data sources as a basis for estimating the number and cost of new Medicaid and CHIP enrollees entering the programs beginning in 2014, as well as the number and cost of enrollees who could be transitioned into a health insurance plan on the Exchange. In order to do so, a number of assumptions and inputs were required and are summarized below. A full list of the assumptions used can be found in Appendix 10A.

Citizenship and Residency Requirements

Exact estimates of Connecticut's uninsured undocumented immigrants and legal immigrants living in the US less than five years were unavailable. The analysis assumed 12% of the uninsured and 2% of those with employer sponsored insurance (ESI) or non-group coverage were in this category.

Take-up Rates

Not all who are eligible for Medicaid and CHIP will necessarily enroll. Existing models by the Congressional Budget Office and the Urban Institute estimate uninsured take-up rates into Medicaid across a range of values from 57% to 75%.[7] Actual Medicaid take-up rates post-2014 may be on the high end of the range due to increased enrollment and outreach efforts (e.g., websites that can determine eligibility and automatically enroll people and presumptive eligibility authority for hospitals) and individual tax penalties.[8] However, the full effect of those efforts is unlikely to occur immediately in 2014. Therefore, take-up rates in this analysis are assumed to increase over time.

Crowd Out

One ongoing concern relating to health care reform implementation is the degree to which private firms, particularly those with a high percentage of low-income workers, will drop coverage for employees who would otherwise qualify for Medicaid or an Exchange health plan beginning in 2014. While the PPACA does not mandate that employers offer employees affordable health insurance coverage, it does subject employers with more than 50 employees who do not offer coverage to penalties beginning in 2014 if they have at least one employee who receives a premium tax credit through an Exchange. The same penalties do not apply to small employers.

Avalere Health, a research firm based in Washington, DC, published a June 2011 review of the available literature on employer decisions to offer coverage to employees after 2014.The paper reviewed micosimulation model estimates from RAND, the Urban Institute, the Lewin Group and the Congressional Budget Office which showed net changes to ESI under the PPACA ranging from -0.3% to 8.4%.[9] The paper also cited a notably different conclusion reached by Douglas Holtz-Eakin, whose research suggested that employers will drop ESI nationwide by 22.3% under the law. The Avalere paper includes criticisms of the Holtz-Eakin analysis and concludes that most research in this area suggests relative stability in the ESI market in the near term. The paper notes that while most models do not show a significant *net* change in ESI, they do predict shifts *within* ESI as some firms begin to offer coverage while others shift workers into the small business Exchange or drop coverage altogether.[10] Given that federal penalties do not apply to small firms, those with a large percentage of low wage workers would be the most likely to drop

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[7] Buettens M, J Holahan, C Carroll, Health Reform Across the States: Increased Coverage and Federal Spending on the Exchanges and Medicaid; March 2011. Available at: http://www.urban.org/uploadedpdf/412310-Health-Reform-Across-the-States.pdf

[8] Tax penalties do not apply to individuals with incomes below the tax filing thresholds.

[9] Avalere Health. The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Microsimulation Models and Other Analyses; June 17, 2011. Available at: http://www.avalerehealth.net/pdfs/2011-06-17_ESI_memo.pdf.

[10] Ibid, Avalere Health.

ESI and encourage employees to enroll in Medicaid or an Exchange plan in 2014. However, small employers with low wage workers have historically been less likely to offer ESI, so the number of employers who drop coverage is expected to be small.

Another report, based on a micro-simulation model by MIT economist Jonathan Gruber, concluded that 88% of Connecticut small business employees whose companies provide them with coverage under the present system will continue to be covered by their employers under the PPACA. The September 2010 memo to the Connecticut SustiNet Board of Directors concluded that only 2% of Connecticut small business employees will shift to Medicaid.[11]

While the debate about ESI crowd out projections under the PPACA is not settled, the conclusions reached by the studies in the Avalere literature review as well as the Gruber analysis suggest relatively small shifts to Medicaid from ESI coverage in Connecticut, particularly in the near term. Over the long term, there is more uncertainty about employer behavior.

Cost

Per enrollee cost and cost growth are difficult to estimate due to changes in how the Medicaid and CHIP programs will be administered. Effective January 1, 2012, the DSS will use an Administrative Services Organization (ASO) to administer the medical portion of its entire scope of health care programs identified as HUSKY Health. The Department's behavioral health and dental health programs are administered by other contractors. The Department's primary objective in contracting with an ASO is to improve quality of care and the care experience for members, while reducing cost.

The shift to an ASO requires an analysis to determine the appropriate fees used to reimburse providers under this new arrangement. Historically, the HUSKY A and HUSKY B programs were administered either through a fully capitated managed care system, or a hybrid system which maintained managed care rates of reimbursement while other Medicaid populations were reimbursed through the existing Medicaid fee schedules. The ASO system requires an analysis of these different reimbursement structures to determine provider fees appropriate to encompass the entire Medicaid population to be administered through the ASO arrangement. This information is not available for inclusion in this report.

Beginning in 2011 DSS also began pursing approaches to health care purchasing designed to promote improvements in service delivery and organization, and accountability among local health care systems, in an effort to improve patient outcomes and achieve efficiencies. The Department is supporting the emergence of medical homes for all Medicaid, HUSKY A, HUSKY B and Charter Oak recipients.

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[11] Dorn S, Effect of federal reform on small firms, Memorandum to SustiNet Board of Directors; 2 Sept 2010. Available at: http://www.ct.gov/sustinet/lib/sustinet/sdorn.memo.ppaca-small_firms.pdf.

As a result of these administrative and delivery system changes, per enrollee cost growth may be affected. The CBO estimated that the average per enrollee cost growth rate nationally increased by 3.9% across all eligibility groups between 1975 and 2002.[12] This report assumes a 4.0% annual per enrollee program cost growth through 2020. Potential impacts on DSS administrative costs are not included in the analysis.

Per enrollee cost estimates, particularly for the newly eligible, are further complicated by uncertainty regarding the definition of Connecticut's EHBs, the package of benchmark benefits that will be offered to newly eligible Medicaid enrollees, and the extent to which CMS will provide federal financial participation for Medicaid benefits in excess of the benchmark plan. Given these uncertainties, this analysis assumes CY10 per-member-per-month (PMPM) costs for selected populations, adjusted for cost growth assumptions, would apply to previously eligible enrollees, whereas PMPM costs for the newly Medicaid eligible would be based on 85% of CY10 PMPM costs. (See Appendix 10A for detailed PMPM cost assumptions.) Costs for the newly eligible are eligible for the enhanced FMAP rate, whereas previously eligible Medicaid groups would only be eligible for 50% FMAP.

Income

While the PPACA requires use of the MAGI standard for determination of income eligibility for most groups, CMS has yet to issue specific rules about how the standard will be implemented. With the exception of incorporating a 5% income disregard at the 133% FPL income threshold for Kaiser/Urban CPS data (income is stratified at "less than 139% FPL"), this analysis does not attempt to make further adjustments to account for MAGI.

The DSS enrollment data did not include information about enrollees' income. For the purposes of grouping existing Medicaid and CHIP enrollees into the income bands of interest for this report, HMA imputed the income distributions reported by the Kaiser/Urban CPS dataset and applied the distribution to Connecticut's enrollment data.

Methodology

Using the data sources discussed above, this analysis estimates the number and associated costs of new enrollees on Medicaid and CHIP programs, as well as the potential savings Connecticut may realize by transitioning some current Medicaid and CHIP coverage groups into an Exchange plan. To estimate incoming enrollees, growth and income distribution assumptions were applied to Task 1 estimates of non-elderly adults and children in households with incomes less than 139% FPL who are uninsured, have ESI or carry non-group coverage. To estimate the number of Medicaid and CHIP enrollees that could be transitioned to a health plan on the Exchange (or the BHP), eligibility coverage groups were reviewed to identify which individuals would be eligible for premium and cost sharing subsidies on the Exchange. Assumptions about the growth of all populations (absent the Medicaid expansion or Exchange) were also

[12] Marron, D. Medicaid Spending Growth and Options for Controlling Costs, Congressional Budget Office Testimony before the Special Committee on Aging, United State Senate; July 13, 2006.

generated. Finally, Medicaid and CHIP FMAP rates as described in the PPACA were used to estimate the federal and state share of costs.

Analysis: Anticipated Medicaid and CHIP Growth

Connecticut's Medicaid and CHIP enrollment is expected to grow as newly eligible individuals are covered, and individuals who were previously eligible but not enrolled apply due to expanded outreach efforts and awareness of tax penalties (if applicable) for failure to secure health insurance. For those who are newly Medicaid eligible, Connecticut will receive the enhanced FMAP rate described above. For those who were previously eligible, the State will receive the existing FMAP rates.

Individuals who are likely to enroll may be uninsured or receive partial or comprehensive health insurance benefits through alternative coverage. Existing coverage options, described below, include a mix of publicly-subsidized and private alternatives, which may have more limited benefits or higher cost sharing requirements than what will be provided under Connecticut's Medicaid and CHIP programs.

Charter Oak Health Plan

The Charter Oak Health Plan (COHP) is a State-subsidized program that provides Connecticut residents with access to a standard health benefit plan on a guaranteed basis with no pre-existing condition exclusion periods. To be eligible, individuals must be between the ages of 19–64; uninsured for at least six months (exceptions apply); and ineligible for Medicare, Medicaid, CHIP or other publicly-funded health insurance. There is an annual benefit maximum of $100,000, and premium assistance has historically been available to low-income individuals; however, legislation passed in 2010 prohibits the state from subsidizing the cost of the program for anyone who joined after May 31, 2010. COHP is not eligible for federal financial participation.

As of October 2011, 8,000 individuals were enrolled in the program, a 17.6% decline from August 2011 due to an increase in monthly premiums from $307 to $446 on September 1, 2011.[13] Based on 2011 average monthly enrollment, approximately 28% of the COHP population has incomes less than 150% FPL. Of these, it is estimated that a significant number are in COHP because they are otherwise ineligible for Medicaid (including MLIA) due to citizenship and residency requirements. For the purposes of this analysis, it is assumed that 15% of the total COHP population (approximately 1,200 individuals) would become eligible for Medicaid beginning January 1, 2014. (Most of the remaining COHP population would be eligible for subsidized coverage through the Exchange. See Task 6 for further discussion.) Medicaid costs for this incoming population are assumed to equal current COHP costs and take-up rates are assumed to be high given that this population is already in a state health insurance program.

[13] A. Levin Becker. Charter Oak health plan enrollment falls as premiums rise. The Connecticut Mirror. September 9, 2011.

High Risk Pools

Connecticut Pre-existing Condition Insurance Plan (PCIP)

Connecticut's PCIP provides comprehensive health benefits to legal US residents of Connecticut who have been uninsured for six months and have a qualified, diagnosed medical condition such as high blood pressure, diabetes or kidney disease. PCIP is a temporary federally-subsidized program authorized under the PPACA. The program ends in 2014 when PCIP enrollees will have the option to enroll in either Medicaid or an Exchange plan, depending on their eligibility. As of October 1, 2011 there were 110 individuals enrolled in PCIP.[14] Costs for this incoming population were assumed to be relatively high. This analysis used costs of current Medicaid enrollees with breast or cervical cancer as a proxy for cost for this very small group of people.

Connecticut High Risk Pool – Health Reinsurance Association (HRA)

The Connecticut Health Care Act of 1975 created the Health Reinsurance Association (HRA) to act as a high risk pool that makes available to eligible Connecticut residents a comprehensive health care plan. HRA is a non-profit association comprised of all private insurance companies and HMOs that provide health insurance in Connecticut. It guarantees access to health insurance for those individuals who cannot obtain coverage elsewhere because of their pre-existing conditions. State law caps HRA rates at between 125% and 150% of standard insurance rates. An applicant for a HRA plan must be a Connecticut resident between the ages of 19 and 65. Eligible dependents include: (1) the applicant's spouse, (2) his unmarried children under age 19 (23 if a full-time student attending an accredited institution of higher learning) who depend on him for support and (3) any other unmarried children under age 19 (23 if a full-time student attending an accredited institution of higher learning) who depend on him for support and lives with him in a regular parent-child relationship. Enrollment as of December 31, 2010 was 1,870.[15]

Employer-Sponsored Insurance (ESI)

The Kaiser/Urban data show there were 73,000 non-elderly adults below 139% FPL with ESI in 2008–2009. The number of children up to 300% FPL with ESI is estimated at 134,000 in 2008–2009. The distribution of this population between large business employees and small business employees is assumed to be split evenly.[16] For 2014, this report assumes a net zero

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[14] State communication.

[15] Kaiser Family Foundation, statehealthfacts.org, Connecticut High Risk Pool Programs and Enrollment as of December 31, 2010. Available at: http://www.statehealthfacts.org/profileind.jsp?rgn=8&ind=602&cat=7.

[16] The 2010 Medical Expenditure Panel Survey provides private-sector data by firm size. Among employees (across all income groups) that enrolled in health insurance at establishments that offer health insurance, 64.5% were employed at firms with 50 or more employees. Given that lower wage workers are more likely to work at small firms, this analysis assumes that 50% of the low wage ESI population are employed at firms with 50 or more employees and 50% at smaller firms.

change in ESI coverage for individuals with ESI from a large business and a 2% shift in coverage of individuals with ESI from a small business. These assumptions are in alignment with the Avalere and Gruber estimates discussed above. This analysis assumes crowd out rates will increase moderately over the next 10 years for both the small and large group markets.

New costs for this group were assumed to equal HUSKY A and HUSKY B PMPM spending. Of income eligible adults, 30% were assumed to be previously eligible for Medicaid, 68% were assumed to be newly eligible and 2% were assumed to be ineligible due to residency or citizenship status. All Connecticut children under 300% FPL are already eligible for Medicaid and CHIP programs; therefore, new spending on children is not eligible for the enhanced Medicaid FMAP rate.

Individual/Non-group Insurance

Some low and very-low income individuals and families purchase non-group insurance. The Kaiser/Urban data indicates there were 30,300 non-elderly adults below 139% FPL with individual coverage in 2008–2009. There were an insufficient number of survey responses for Kaiser/Urban to estimate the number of children in this category. This analysis estimates the number of children in households with income less than 300% FPL covered under a non-group policy based on the income distribution of children covered under ESI. This method suggests approximately 10,000 children fall into this category.

New costs for this group were assumed to equal HUSKY A and HUSKY B PMPM spending. Of income-eligible adults, 30% were assumed to be previously eligible for Medicaid, 68% were assumed to be newly eligible and 2% were assumed to be ineligible due to residency or citizenship status. All Connecticut children under 300% FPL are already eligible for Medicaid and CHIP programs; therefore, new spending on children is not eligible for the enhanced Medicaid FMAP rate.

Uninsured/Underinsured

The Kaiser/Urban data indicates there were 125,600 uninsured non-elderly adults below 139% FPL in 2008–2009. In estimating the number of uninsured in 2014, this analysis removed approximately 30,000 adults from the base to account for the increased enrollment in MLIA since the time of the CPS survey. New costs for adults in this group were assumed to equal MLIA per PMPM spending. Of income-eligible adults, 18% were assumed to be previously eligible for Medicaid, 70% were assumed to be newly eligible and 12% were assumed to be ineligible due to residency or citizenship status.

The Kaiser/Urban data indicates there were 30,100 children below 139% FPL in 2008/09. There were an insufficient number of survey responses for Kaiser/Urban to estimate the number of children in higher-income categories. This analysis makes assumptions about the number of uninsured children in households with income greater than 139% FPL and less than 300% FPL. New costs for children in this group were assumed to equal HUSKY B. All Connecticut children

under 300% FPL are already eligible for Medicaid and CHIP programs; therefore, new spending on children is not eligible for the enhanced Medicaid FMAP rate.

Results: Anticipated Medicaid and CHIP Growth

New Medicaid non-elderly adult enrollee and cost estimates are shown on Figure 10-5. This analysis suggests that as many as 61,000 adults, the majority are currently uninsured, will enroll in Medicaid in 2014. Net State costs for the newly enrolled adults would remain relatively low in the first three years of implementation ($10 to $18 million) – in part because the federal government is paying for 100% of costs for the newly eligible (including an increase in FMAP from 50% to 100% for currently eligible MLIA enrollees), but also because the State may save approximately $11 million that it would otherwise spend on COHP costs.

New Medicaid and CHIP child enrollee and cost estimates are shown on Figure 10-6. Net State costs for approximately 37,000 new child enrollees in 2014 will be considerably higher than for adults because none of the new costs are eligible for the enhanced Medicaid FMAP rate. The PPACA does increase the FMAP rate for most CHIP expenditures by an additional 23 percentage points for FY16–FY19. However, even with the temporary CHIP FMAP increase, Connecticut will still realize a net cost increase – estimated above $50 million in 2014 and increasing thereafter.

Analysis: Health Insurance Alternatives for Existing Medicaid and CHIP Enrollees

As soon as the Secretary of Health and Human Services certifies that Connecticut's Exchange is fully operational in 2014, Connecticut may, with CMS approval of any relevant Medicaid State Plan or waiver provisions, modify Medicaid eligibly requirements and transition certain existing non-elderly adult Medicaid enrollees into an Exchange plan or a State-optional BHP, both of which are described below. Transitioning existing enrollees off Medicaid would immediately relieve Connecticut of the State share (50%) of Medicaid costs associated with those enrollees. MOE requirements for Medicaid- and CHIP-eligible children continue through September 30, 2019 at which time Connecticut could transition children into an Exchange plan or BHP option. See Figure 10-7 for an illustration of Medicaid and CHIP coverage groups.

Exchange Plans

As discussed elsewhere in this report, the PPACA requires that Exchanges be available to consumers seeking individual and small group coverage by January 1, 2014. Exchanges will be required to offer four levels of benefit packages (categorized as Bronze, Silver, Gold, and Platinum) to individuals and small businesses that meet certain requirements. (A fifth package will be offered to those under age 30 providing catastrophic coverage.) The PPACA also authorizes federal premium and cost sharing subsidies to individuals who: (1) have household MAGI between 133% and 400% FPL, (2) are ineligible for Medicaid and CHIP and (3) have not otherwise been offered ESI that meets the PPACA's affordability and comprehensiveness standards. Premium tax credits and cost sharing subsidies are only available to individuals who purchase a QHP through an Exchange.

Basis Health Program (BHP)

The PPACA gives states the option of establishing a BHP in lieu of Exchange coverage for people who have household MAGI below 200% FPL and are otherwise ineligible for Medicare, Medicaid and CHIP, and are not offered ESI that meets the PPACA's affordability and comprehensiveness standards. The eligible population includes legal immigrants who, because they have less than five years of US residency, are ineligible for Medicaid. BHP coverage must include all essential health benefits defined by the Secretary of Health and Human Services and consumers cannot be charged premiums at levels higher than what they would have paid on the Exchange. States must use a competitive process to contract with health plans or provider groups to implement a BHP.

Medicaid Enrollees Eligible for Subsidized Health Insurance Alternatives in 2014

Certain non-elderly adult Medicaid enrollees with MAGI above 133% FPL would be eligible to receive health insurance coverage through a QHP or the BHP depending on their incomes as described below. Enrollees transitioned to a QHP would qualify for sliding scale federal premium assistance cost sharing subsidies. Out-of-pocket costs for enrollees transitioned to a BHP would depend on how the State would design such a program if it opted to create one. Federal financial support of BHP costs is discussed in Task 4.

HUSKY A: Parents and Pregnant Women

HUSKY A (Healthcare for Uninsured Kids and Youth) is a federal and state health insurance program for low-income children under age 19, pregnant women and some parents or relative caregivers of covered children with family income at or below 185% FPL (250% for pregnant women). Within HUSKY A, this analysis suggests that approximately 15,000 parents currently in managed care with MAGI between 134% and 185% could be transitioned to a QHP or BHP in 2014. Another 1,300 pregnant women could be transitioned to either a QHP or BHP alternative depending on their income.[17]

MED-Connect

Medicaid for Employees with Disabilities, known as MED-Connect, provides Medicaid benefits to employed Connecticut residents with disabilities. Total income from work and other benefits must not exceed $75,000 per year and a spouse's income is not counted in determining income eligibility. Based on 2011 FPL incomes by family size,[18] a $75,000 annual income equates to 510% FPL for a family of two. To qualify for MED-Connect, assets may not exceed $10,000 for individuals and $15,000 for married couples.

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[17] This analysis assumes that adults currently exempt from HUSKY managed care would not be transitioned to a QHP or BHP. If a HUSKY adult is receiving SSI income or is receiving Medicare, they are automatically exempt from managed care. If a pregnant women if found Medicaid eligible in her third trimester and her doctor does not participate with a Medicaid MCO, she is exempt from managed care until the baby is born.

[18] Federal Register; January 20, 2011; 76(13):3637–3638.

While disabled individuals are exempt from the MAGI standard and may face asset tests as a condition of Medicaid eligibility, they will be subject to MAGI rules for the purposes of determining eligibility for Exchange premium tax credits and cost sharing subsidies. Within MED-Connect, individuals with MAGI between 134% and 200% FPL would be eligible for premium and cost sharing subsidies in a QHP or eligibility for a BHP alternative. MED-Connect enrollees with MAGI between 201% and 400% FPL would only be eligible for premium and cost sharing subsidies in a QHP. Enrollees with MAGI above 400% FPL would not be eligible for QHP subsidies or the BHP. Approximately 1,300 employed disabled individuals could be transitioned to either a QHP or BHP alternative depending on their income.

Women with Breast or Cervical Cancer

Under the Breast and Cervical Cancer program, women with these diseases can receive Medicaid benefits if they were screened under the Center for Disease Control's Breast and Cervical Cancer Early Detection Program and have no other creditable coverage. Within this program, women with MAGI between 134% and 200% FPL would be eligible for premium and cost sharing subsidies in a QHP or eligibility for a BHP alternative. Women with MAGI between 201%–400% FPL would only be eligible for premium and cost sharing subsidies in a QHP. Only about 160 women with breast or cervical cancer could be transitioned to either a QHP or BHP alternative depending on their income.

Figure 10-3: Connecticut Medicaid Enrollees Eligible for Exchange Subsidies or BHP in 2014

Population by FPL (MAGI standard)	Eligible for Exchange subsidies	Eligible for BHP
HUSKY A		
Parents: 134%– 85%	✓	✓
Pregnant women: 134%–200%	✓	✓
Pregnant women: 201%–250%	✓	No
MED-Connect		
134%–200%	✓	✓
201%–400%	✓	No
≥ 401%	No	No
Breast or Cervical Cancer		
134%–200%	✓	✓
201%–400%	✓	No

Medicaid/CHIP Children Eligible for Subsidized Health Insurance Alternatives in 2019

Beginning October 1, 2019 Medicaid and CHIP children with MAGI above 133% FPL would be eligible to receive health insurance coverage through a QHP or the BHP, depending on their incomes. As discussed above, in the event that federal CHIP appropriations are not made beyond FY15, states will be required to enroll CHIP children not otherwise eligible for Medicaid into a QHP or BHP determined to be at least as comparable to the benefits and cost sharing provisions provided under the State's CHIP program.

HUSKY A/Medicaid

Within HUSKY A, children living in households with MAGI between 134% and 185% FPL would be eligible to enroll in a QHP or a BHP alternative beginning October 1, 2019. Currently, the State-share of Medicaid costs associated with those enrollees is 50%.

HUSKY B/CHIP

HUSKY B provides CHIP for children in families with incomes between 186% and 300% of the FPL. Children in households with income between 186%–235% of FPL qualify for HUSKY B – Tier 1 and pay no premium and some copays for health care. Children with household income between 236%–300% of FPL qualify for HUSKY B – Tier 2 and pay limited premiums and some copays. Families with incomes above 300% of the FPL may "buy into" Husky B by paying the full cost of premiums plus copays (and are not CHIP-eligible). State spending on health care costs for HUSKY B Tiers 1 and 2 is eligible for the CHIP FMAP equal to 65% (scheduled to increase to 88% from FY16–FY19). Within HUSKY B, children living in households with MAGI between 186%–200% FPL would be eligible to enroll in a QHP or a BHP alternative beginning October 1, 2019. Children in households with MAGI between 201%–400% FPL would only be eligible for premium and cost sharing subsidies in a QHP.

Figure 10-4: Connecticut Medicaid/CHIP Children Eligible for Exchange Subsidies or BHP in 2019

Population by federal poverty level	Eligible for Exchange subsidies	Eligible for BHP
HUSKY A (Medicaid)		
134%–185%	✓	✓
HUSKY B – Tier 1 (CHIP)		
186%–200%	✓	✓
201%–235%	✓	No
HUSKY B – TIER 2 (CHIP)		
236%–300%	✓	No
HUSKY B – TIER 3 (State-only program)		
301%–400%	✓	No
≥ 401%	No	No

Results: Health Insurance Alternatives for Existing Medicaid and CHIP Enrollees

Anticipated Medicaid and CHIP Growth

New Medicaid non-elderly adult enrollee and cost estimates are shown on Figure 10-5. This analysis suggests that as many as 62,000 adults, the majority are currently uninsured, could enroll in Medicaid in 2014. Net State costs for the newly enrolled adults would remain relatively low in the first three years of implementation ($14 to $24 million annually). State cost impacts are primarily influenced by several factors:

1. The federal government will pay 100% of the costs for the newly Medicaid eligible between 2014 and 2016. This includes an increase in federal financial participation from 50% to 100% for current MLIA enrollees.

2. Connecticut will only receive 50% federal financial participation for Medicaid covered populations who were previously eligible but unenrolled in the program. Assumptions regarding the size of this population and their rate of enrollment into Medicaid significantly influence estimated total State costs.

3. Connecticut will save State-only costs on what it would otherwise have spent for newly Medicaid eligible individuals previously enrolled in the COHP. Savings are estimated at approximately $12 million in 2014.

New Medicaid and CHIP child enrollee and cost estimates are shown on Figure 10-6. Net State costs for approximately 37,000 new child enrollees in 2014 will be considerably higher than for adults because none of the new health care costs are eligible for the enhanced Medicaid federal financial participation. The PPACA does increase federal financial participation for most CHIP expenditures by an additional 23 percentage points for FY16–FY19. Connecticut will still realize a net cost increase – estimated above $40 million in 2014. Estimates regarding the number of uninsured children eligible for HUSKY A or B significantly influence estimated total State costs.

Health Insurance Alternatives for Existing Medicaid and CHIP Enrollees

This analysis suggests that as many as 18,000 adults could be transitioned to a QHP in the Exchange or a BHP alternative, depending on income, for a savings of nearly $64 million in 2014 State spending. Non-elderly adult enrollee and cost estimates are shown in Figure 10-7. Estimates for children are shown in Figure 10-8. Due to the children's MOE requirement, estimates of the number of children who could be transitioned to a QHP or BHP do not begin until 2019. Enrollment and savings estimates should be considered as somewhat more tentative and approximate in light of the long time horizon and the numerous required assumptions that make forecasting difficult.

Recommendations

The net total impacts to enrollment in Connecticut's Medicaid and CHIP programs, as well as the State budget, will be influenced by decisions the State makes with regard to Medicaid and CHIP eligibility standards through 2020, as well as outreach and enrollment efforts. Three potential scenarios are summarized in Figure 10-10:

1. Maintain Medicaid/CHIP eligibility requirements through 2020

2. Reduce adult Medicaid eligibility in 2014; maintain children's eligibility requirements through 2020

3. Reduce adult Medicaid eligibility in 2014 and children's eligibility in 2019

It is recommended that the State review the analysis detailed in the appendices, understanding that the results rely on a series of assumptions and data sources, each of which has its own advantages and disadvantages. The results provide a directional sense of enrollment and cost impacts and give an estimate of order of magnitude of those impacts.

Population estimates should be updated using 2010 CPS data once CPS data with the Urban Institute HIU adjustment is available on the Kaiser Family Foundation's website. All estimates, including State Medicaid and CHIP enrollment and cost data, should be updated annually during the Exchange planning and implementation process in order to capture changes in the baseline data.

To the extent Connecticut decides to transition existing Medicaid enrollees into a QHP or BHP, the State will have to consider how benefits and out-of-pocket expenses may be different for those enrollees who are affected by the change.

Figure 10-5: Non-elderly Adult New Medicaid Enrollment

Non-Elderly Adults

New Medicaid Enrollment	2014	2015	2016	2017	2018	2019	2020
New Medicaid Enrollment from:							
Charter Oak Health Plan (Newly Eligible)	1,244	1,276	1,295	1,249	1,191	1,124	1,048
High Risk Pools (PCIP & HRA) (Newly Eligible)	574	635	657	680	703	727	751
Employer Sponsored Insurance							
Newly Eligible	882	1,145	1,879	2,394	2,923	3,466	4,020
Previously Eligible	389	505	829	1,056	1,290	1,529	1,774
Non-Group Insurance							
Newly Eligible	7,613	8,630	9,611	10,582	11,535	12,462	13,292
Previously Eligible	3,359	3,808	4,240	4,669	5,089	5,498	5,864
Uninsured							
Newly Eligible	38,198	40,260	42,294	44,203	46,095	47,872	49,537
Previously Eligible	9,822	10,353	10,876	11,367	11,853	12,310	12,738
Total New Enrollees							
Newly Eligible	***48,510***	***51,946***	***55,737***	***59,109***	***62,448***	***65,650***	***68,648***
Previously Eligible	***13,570***	***14,665***	***15,945***	***17,092***	***18,232***	***19,337***	***20,376***
TOTAL	**62,080**	**66,611**	**71,682**	**76,200**	**80,680**	**84,987**	**89,024**

Medicaid State Cost Increase/(Decrease) in $1,000s:	2014	2015	2016	2017	2018	2019	2020
Charter Oak Health Plan							
Decreased COHP State Cost	$ (11,477)	$ (12,244)	$ (12,926)	$ (12,963)	$ (12,858)	$ (12,615)	$ (12,239)
Increased Medicaid State Cost	$ -	$ -	$ -	$ 46	$ 55	$ 63	$ 87
High Risk Pools (PCIP & HRA)	$ -	$ -	$ -	$ 564	$ 728	$ 913	$ 1,401
Employer Sponsored Insurance							
Newly Eligible	$ -	$ -	$ -	$ 584	$ 891	$ 1,281	$ 2,208
Previously Eligible	$ 993	$ 1,341	$ 2,289	$ 3,033	$ 3,852	$ 4,749	$ 5,729
Non-Group Insurance							
Newly Eligible	$ -	$ -	$ -	$ 2,528	$ 3,439	$ 4,508	$ 7,143
Previously Eligible	$ 8,391	$ 9,893	$ 11,458	$ 13,120	$ 14,874	$ 16,712	$ 18,538
Uninsured							
Newly Eligible	$ -	$ -	$ -	$ 17,857	$ 23,240	$ 29,284	$ 45,021
Previously Eligible	$ 41,501	$ 45,491	$ 49,701	$ 54,022	$ 58,587	$ 63,279	$ 68,100
Medicaid for Low Income Adults (pre-2014 population) (1)	$ (24,968)	$ (25,967)	$ (27,005)	$ (25,277)	$ (25,704)	$ (26,124)	$ (25,274)
Total State Cost Increase/(Decrease) in $1,000s	**$ 14,440**	**$ 18,514**	**$ 23,517**	**$ 53,516**	**$ 67,103**	**$ 82,050**	**$ 110,714**

(1): Reflects state savings from enhanced FMAP beginning in 2014 as compared to 50% match rate pre-2014.

Figure 10-6: Children's Medicaid and CHIP Enrollment

Children

New Medicaid/CHIP Enrollment	2014	2015	2016	2017	2018	2019	2020
Medicaid (HUSKY A): New Enrollment from:							
Employer Sponsored Insurance	1,127	1,463	2,402	3,060	3,737	4,430	5,138
Non-Group Insurance	1,727	1,977	2,213	2,437	2,656	2,869	3,075
Uninsured	23,379	24,826	26,210	27,393	28,566	29,667	30,699
Total New HUSKY A Enrollees	***26,233***	***28,266***	***30,825***	***32,890***	***34,958***	***36,966***	***38,912***
CHIP (HUSKY B, Tiers 1 & 2): New Enrollment from:							
Employer Sponsored Insurance	1,227	1,592	2,614	3,330	4,067	4,821	5,592
Non-Group Insurance	1,879	2,152	2,408	2,652	2,891	3,123	3,347
Uninsured	7,869	8,356	8,822	9,221	9,615	9,986	10,333
Total New HUSKY B Enrollees	***10,975***	***12,100***	***13,845***	***15,202***	***16,572***	***17,929***	***19,272***
Total New Medicaid/CHIP Child Enrollees	**37,208**	**40,365**	**44,670**	**48,092**	**51,530**	**54,895**	**58,184**

State Cost Increase/(Decrease) in $1,000s:	2014	2015	2016	2017	2018	2019	2020
Medicaid (HUSKY A) State Cost Increase/(Decrease) in $1,000s							
Employer Sponsored Insurance	$ 1,592	$ 2,149	$ 3,669	$ 4,861	$ 6,174	$ 7,612	$ 9,182
Non-Group Insurance	$ 2,439	$ 2,904	$ 3,380	$ 3,871	$ 4,388	$ 4,931	$ 10,992
Uninsured	$ 33,019	$ 36,465	$ 40,039	$ 43,520	$ 47,197	$ 50,977	$ 54,861
Total State Cost Increase/(Decrease) in $1,000s	**$ 37,050**	**$ 41,518**	**$ 47,088**	**$ 52,252**	**$ 57,759**	**$ 63,520**	**$ 75,034**
CHIP (HUSKY B, Tiers 1&2) State Cost Increase/(Decrease) in $1,000s							
Employer Sponsored Insurance	$ 415	$ 468	$ 328	$ 434	$ 552	$ 1,006	$ 2,392
Non-Group Insurance	$ 635	$ 632	$ 302	$ 346	$ 392	$ 652	$ 1,432
Uninsured	$ 4,370	$ 4,033	$ 1,817	$ 1,975	$ 2,142	$ 3,422	$ 7,261
Net Savings for Enhanced CHIP FMAP for Base HUSKY B population (*)	$ -	$ (2,613)	$ (11,123)	$ (11,777)	$ (12,343)	$ (9,711)	$ -
Total State Cost Increase/(Decrease) in $1,000s	**$ 5,420**	**$ 2,521**	**$ (8,676)**	**$ (9,022)**	**$ (9,258)**	**$ (4,632)**	**$ 11,085**
Total State Cost Increase/(Decrease) in $1,000s	**$ 42,470**	**$ 44,039**	**$ 38,412**	**$ 43,230**	**$ 48,502**	**$ 58,888**	**$ 86,120**

(*): Reflects state savings from enhanced CHIP FMAP beginning in federal FY2016-2019 as compared to existing 65% match rate. Savings are shown by calendar year.

Figure 10-7: CT Medicaid/CHIP Income Eligibility by FPL for Non-elderly/Non-waiver Enrollees

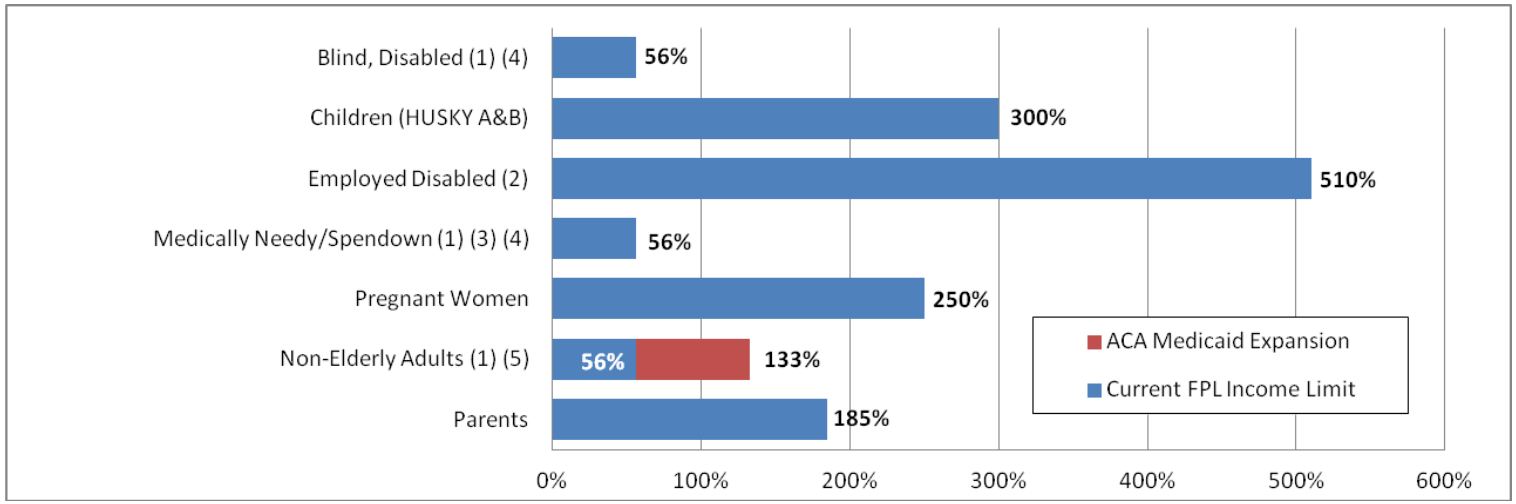


Figure 10-7 Footnotes:

(1): 68% FPL in Region A (southwest Connecticut).

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

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

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

(5): Current FPL income limit represents pre-2014 MLIA population. PPACA Medicaid expansion includes individuals with incomes not exceeding 133% FPL who are not (1) elderly; (2) pregnant; (3) entitled to or enrolled in Medicare Part A or Medicare Part B; or (4) described in an already existing group for which Medicaid coverage is mandatory, such as certain parents, children or disabled persons receiving supplemental SSI benefits.

Figure 10-8: Option: Transition Non-elderly Adult > 133% MAGI to QHP or BHP

Non-Elderly Adults

OPTION: TRANSITION MEDICAID ENROLLEES TO EXCHANGE OR BHP	2014	2015	2016	2017	2018	2019	2020
Enrollment from:							
Parents/Caregivers 134% - 185% FPL (HUSKY A)	(15,060)	(15,591)	(15,944)	(16,103)	(16,184)	(16,224)	(16,257)
Pregnant Women 134% - 250% FPL (HUSKY A)	(1,318)	(1,436)	(1,537)	(1,614)	(1,662)	(1,712)	(1,763)
Med-Connect 134% - 400% FPL	(1,347)	(1,374)	(1,387)	(1,387)	(1,360)	(1,332)	(1,306)
Breast or Cervical Cancer 134% - 400% FPL	(161)	(169)	(174)	(175)	(176)	(177)	(177)
Total Enrollees Eligible for Exchange Subsidies or BHP	**(17,885)**	**(18,569)**	**(19,042)**	**(19,280)**	**(19,382)**	**(19,445)**	**(19,503)**
State Cost Increase/(Decrease) in $1,000s							
Parents/Caregivers 134% - 185% FPL (HUSKY A)	$ (41,150)	$ (44,236)	$ (47,011)	$ (49,381)	$ (51,613)	$ (53,812)	$ (56,076)
Pregnant Women 200% - 250% FPL (HUSKY A)	$ (3,985)	$ (4,517)	$ (5,027)	$ (5,489)	$ (5,880)	$ (6,299)	$ (6,747)
Employed Disabled 134% - 400% FPL	$ (17,386)	$ (18,443)	$ (19,373)	$ (20,148)	$ (20,535)	$ (20,929)	$ (21,331)
Breast or Cervical Cancer 134% - 400% FPL	$ (1,393)	$ (1,521)	$ (1,629)	$ (1,712)	$ (1,789)	$ (1,865)	$ (1,944)
Total State Cost Increase/(Decrease) in $1,000s	**$ (63,914)**	**$ (68,718)**	**$ (73,041)**	**$ (76,730)**	**$ (79,817)**	**$ (82,904)**	**$ (86,098)**

Figure 10-9: Option: Transition Non-elderly Adult > 133% MAGI to QHP or BHP

Children

OPTION: TRANSITION MEDICAID ENROLLEES TO EXCHANGE OR BHP	2014	2015	2016	2017	2018	2019 (2)	2020
Enrollment from:							
Children 134% - 185% FPL (HUSKY A)	-	-	-	-	-	(10,695)	(11,113)
Children 186% - 235% FPL (HUSKY B, Tier 1)	-	-	-	-	-	(16,610)	(16,976)
Children 236% - 300% FPL (HUSKY B, Tier 2)	-	-	-	-	-	(17,661)	(18,791)
Total Enrollees Eligible for Exchange Subsidies or BHP	-	-	-	-	-	(44,966)	(46,880)
State Cost Increase/(Decrease) in $1,000s							
Children 134% - 185% FPL (HUSKY A)	$ -	$ -	$ -	$ -	$ -	$ (5,652)	$ (24,429)
Children 186% - 235% FPL (HUSKY B, Tier 1)	$ -	$ -	$ -	$ -	$ -	$ (4,995)	$ (21,236)
Children 236% - 300% FPL (HUSKY B, Tier 2)	$ -	$ -	$ -	$ -	$ -	$ (5,337)	$ (23,621)
Total State Cost Increase/(Decrease) in $1,000s	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (15,983)**	**$ (69,286)**

(2): Medicaid/CHIP Children MOE requirements through 9/30/19

Figure 10-10: Connecticut Medicaid and CHIP Eligibility Options and Financial Impact Estimates

Medicaid & CHIP Enrollment and Cost Scenario Estimates Under PPACA

IMPACTS	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019*	2020
TOTAL Base Enrollment (with Individual Mandate)	**544,777**	**587,544**	**615,920**	**635,372**	**648,076**	**680,930**	**703,292**	**717,693**	**723,647**	**727,376**	**729,258**	**730,771**
Annual % Change		*8%*	*5%*	*3%*	*2%*	*5%*	*3%*	*2%*	*1%*	*0.5%*	*0.3%*	*0.2%*
SCENARIO 1: Maintain Current Medicaid/CHIP Eligibility Requirements												
Net Enrollment Increase/(Decrease)						99,288	106,976	116,351	124,293	132,210	139,882	147,208
TOTAL Medicaid/CHIP Enrollment						**780,218**	**810,268**	**834,044**	**847,940**	**859,586**	**869,141**	**877,979**
Annual % Change						*20%*	*4%*	*3%*	*2%*	*1.4%*	*1.1%*	*1.0%*
State Cost Increase/(Decrease) in $1,000s						**$ 56,910**	**$ 62,553**	**$ 61,929**	**$ 96,746**	**$115,604**	**$140,938**	**$196,834**
SECNARIO 2: Reduce Adult Medicaid Eligibility in 2014; Maintain Current Children's Eligibility Requirements												
Net Enrollment Increase/(Decrease)						81,403	88,407	97,310	105,013	112,828	120,437	127,705
TOTAL Medicaid/CHIP Enrollment						**762,333**	**791,699**	**815,002**	**828,660**	**840,204**	**849,695**	**858,476**
Annual % Change						*18%*	*4%*	*3%*	*2%*	*1.4%*	*1.1%*	*1.0%*
State Cost Increase/(Decrease) in $1,000s						**$ (7,004)**	**$ (6,165)**	**$(11,111)**	**$ 20,016**	**$ 35,788**	**$ 58,034**	**$110,736**
SENARIO 3: Reduce Adult Medicaid Eligibility in 2014 & Children's Eligibility in 2019												
Net Enrollment Increase/(Decrease)						81,403	88,407	97,310	105,013	112,828	75,471	80,825
TOTAL Medicaid/CHIP Enrollment						**762,333**	**791,699**	**815,002**	**828,660**	**840,204**	**804,730**	**811,596**
Annual % Change						*18%*	*4%*	*3%*	*2%*	*1.4%*	*-4.2%*	*0.9%*
State Cost Increase/(Decrease) in $1,000s						**$ (7,004)**	**$ (6,165)**	**$(11,111)**	**$ 20,016**	**$ 35,788**	**$ 42,051**	**$ 41,450**

**Medicaid/CHIP Children MOE requirements through 9/30/19*

Appendix 10A – Baseline data and assumptions

Non-Elderly Adults

BASELINE POPULATION DATA	2009	2010	2011	Data Source:
Charter Oak Health Plan	8,472	11,869	9,411	DSS Data Warehouse: ME codes: V1, V2, V3, V4, V5
Medicaid for Low Income Adults/SAGA	46,792	58,678	76,462	DSS Data Warehouse: ME codes: J series
Preexisting Condition Insurance Plan	N/A	Not Avail	110	DSS as of 10/1/11
Employer Sponsored Insurance < 139% FPL	73,700	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
% Female	*57.7%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly adults with ESI
% Male	*42.3%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly adults with ESI
Non-Group Insurance < 139% FPL	30,300	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
% Female	*52.8%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly adults with non-group insurance
% Male	*47.2%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly adults with non-group insurance
Uninsured < 139% FPL	125,600	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
% Female	*56.6%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly uninsured adults
% Male	*43.4%*	Not Avail	Not Avail	CPS CT 2008/09 unadjusted data for non-elderly uninsured adults
Parents/Caregivers (HUSKY A)				
Female	81,957	91,540	95,547	DSS Data Warehouse: ME codes: F3, F4, F7; enrolled in an MCO (excludes members exempt from managed care)
Male	23,691	28,553	31,026	DSS Data Warehouse: ME codes: F3, F4, F7; enrolled in an MCO (excludes members exempt from managed care)
Pregnant Women (HUSKY A)	4,096	4,479	4,825	DSS Data Warehouse: ME codes: M1, M2, P1, P2, PZ
Employed Disabled (MED-Connect)	4,724	4,668	4,571	DSS Data Warehouse: ME codes DA, DC, DD, DE (excludes ~90 ABI and PCA waiver clients)
Breast or Cervical Cancer	350	397	426	DSS Data Warehouse: ME code M4

BASELINE COST DATA	2010 PMPM	Data Source:
Charter Oak Health Plan - Band 1	$ 657	Charter Oak CY2010 capitation (ACS file) + pharmacy + BH costs (DSS Warehouse) divided by total member month
Medicaid for Low Income Adults	$ 612	DSS Data Warehouse: MLIA CY2010 costs divided by MLIA CY2010 member months
Preexisting Condition Insurance Plan	Not Avail	
Parents/Caregivers (HUSKY A)		
Female	$ 431	HUSKY A Female CY10 capitation (ACS file) + dental + pharmacy + BH costs (DSS Warehouse) divided by member r
Male	$ 272	HUSKY A Male CY10 capitation (ACS file) + dental + pharmacy + BH costs (DSS Warehouse) divided by member mo
Pregnant Women (HUSKY A)	$ 384	HUSKY A Female CY10 capitation (ACS file) + dental + pharmacy + BH costs (DSS Warehouse) divided by member r
Employed Disabled (MED-Connect)	$ 1,839	DSS Data Warehouse: Employed Disabled FFS payments divided by member months
Breast or Cervical Cancer	$ 1,236	DSS Data Warehouse: Breast/Cervical Cancer FFS payments divided by member months

Non-Elderly Adults

POPULATION & ENROLLMENT ASSUMPTIONS	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Annual Growth Rates (Absent any Medicaid eligibility changes or creation of Exchange/BHP)											
Charter Oak Health Plan		-20.7%	-7.0%	-5.0%	5.0%	2.0%	1.0%	-4.0%	-5.0%	-6.0%	-7.0%
High Risk Pools (PCIP & HRA)		3.0%	3.0%	3.0%	15.0%	10.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Employer Sponsored Insurance < 139%	0.0%	0.0%	0.0%	0.5%	3.0%	2.0%	1.0%	0.5%	0.5%	0.5%	0.5%
Non-Group Insurance < 139%	0.0%	0.0%	0.0%	0.5%	3.0%	2.0%	1.0%	0.5%	0.5%	0.5%	0.5%
Uninsured < 139%	1.0%	1.0%	1.0%	0.8%	0.0%	0.0%	0.25%	0.25%	0.5%	0.5%	0.5%
Parents/Caregivers (HUSKY A)											
Female		4.4%	3.0%	2.0%	4.4%	3.0%	2.0%	1.0%	0.5%	0.3%	0.2%
Male		8.7%	6.0%	4.0%	8.7%	5.0%	3.0%	1.0%	0.5%	0.3%	0.2%
Pregnant Women (HUSKY A)		7.7%	5.0%	3.0%	7.7%	5.0%	3.0%	3.0%	1.0%	0.5%	0.3%
Employed Disabled (MED-Connect)		-2.1%	-1.0%	-1.0%	3.0%	2.0%	1.0%	0.0%	-2.0%	-2.0%	-2.0%
Breast or Cervical Cancer		7.3%	5.0%	3.0%	7.3%	5.0%	3.0%	1.0%	0.5%	0.3%	0.2%

COST ASSUMPTIONS				Notes on Cost Proxy Assumptions
Annual Cost Growth Rate Assumption		4.00%		Assumes moderated Medicaid cost growth
New Medicaid Costs	***Cost Proxy***	***Previously Eligible*** *2010 PMPM*	***Newly Eligible*** *85% of 2010 PMPM*	**For newly Medicaid eligible, PMPM assumed to be equal to 85% of PMPM for previously eligible, which assumes a less generous benefit package for the newly eligible.**
Charter Oak Health Plan	*COHP*	*N/A*	*$ 559*	Assumes COHP enrollees transitioned to Medicaid will have costs equal to 85% of current COHP enrollees.
High Risk Pools (PCIP & HRA)	*B/C Cancer*	*N/A*	*$ 1,051*	Assumes high risk pool enrollees transitioned to Medicaid will have costs equal to 85% of current Breast/Cervica
Employer Sponsored Insurance				
Female	*HUSKY A*	*$ 431*	*$ 366*	Assumes non-elderly adults with ESI who enroll in Medicaid will have costs equal to current HUSKY A enrollees.
Male	*HUSKY A*	*$ 272*	*$ 231*	Assumes non-elderly adults with ESI who enroll in Medicaid will have costs equal to current HUSKY A enrollees.
Non-Group Insurance				
Female	*HUSKY A*	*$ 431*	*$ 366*	Assumes non-elderly adults w/ non-group insurance who enroll in Medicaid will have costs equal to current HUS
Male	*HUSKY A*	*$ 272*	*$ 231*	Assumes non-elderly adults w/non-group insurance who enroll in Medicaid will have costs equal of current HUSI
Uninsured				
Female	*MLIA*	*$ 568*	*$ 483*	Assumes uninsured non-elderly adults who in enroll in Medicaid will have costs equal to current MLIA enrollees.
Male	*MLIA*	*$ 646*	*$ 549*	Assumes uninsured non-elderly adults who in enroll in Medicaid will have costs equal to current MLIA enrollees.
Medicaid for Low Income Adults	*MLIA*	*N/A*	*$ 521*	Assumes pre-2014 MLIA population will have costs equal to 85% of current PMPM.

Non-Elderly Adults

Other Assumptions	2014	2015	2016	2017	2018	2019	2020
Charter Oak Health Plan							
% of Total COHP Newly Eligible for Medicaid	15%	15%	15%	15%	15%	15%	15%
Medicaid Take Up Rate	95%	96%	96%	96%	97%	97%	97%
Preexisting Condition Insurance Plan							
% of Total Enrollment Newly Eligible for Medicaid	25%	25%	25%	25%	25%	25%	25%
Medicaid Take Up Rate	95%	96%	96%	96%	97%	97%	97%
Employer Sponsored Insurance < 139%							
% Small Business Employees	50%	50%	50%	50%	50%	50%	50%
% Small Business Employees who lose ESI	4%	5%	6%	7%	8%	9%	10%
% Large Business Employees	50%	50%	50%	50%	50%	50%	50%
% of Large Business Employees who lose ESI	0%	0%	2%	3%	4%	5%	6%
% ineligible due to residency or citizenship status	2%	2%	2%	2%	2%	2%	2%
% previously eligible but unenrolled	30%	30%	30%	30%	30%	30%	30%
% Newly Eligible for Medicaid	68%	68%	68%	68%	68%	68%	68%
Medicaid Take Up Rate of those who lose ESI	85%	87%	88%	89%	90%	91%	92%
Non-Group Insurance < 139%							
% ineligible due to residency or citizenship status	2%	2%	2%	2%	2%	2%	2%
% previously eligible but unenrolled	30%	30%	30%	30%	30%	30%	30%
% Newly Eligible for Medicaid	68%	68%	68%	68%	68%	68%	68%
Take Up Rate	35%	39%	44%	48%	52%	56%	59%
Uninsured < 139% FPL							
% ineligible due to residency or citizenship status	12%	12%	12%	12%	12%	12%	12%
% previously eligible but unenrolled	18%	18%	18%	18%	18%	18%	18%
% Newly Eligible for Medicaid	70%	70%	70%	70%	70%	70%	70%
Take Up Rate	62%	65%	68%	71%	74%	77%	79%
Parents/Caregivers (HUSKY A)							
% of 0 - 185% FPL population with incomes b/w 134% - 185% FPL	11%	11%	11%	11%	11%	11%	11%
Pregnant Women (HUSKY A)							
% of 0 - 250% FPL population with incomes b/w 134% - 200% FPL	12%	12%	12%	12%	12%	12%	12%
% of 0 - 250% FPL population with incomes b/w 201% - 250% FPL	10%	10%	10%	10%	10%	10%	10%
Employed Disabled (MED-Connect)							
% with incomes b/w 134% - 200% FPL	9%	9%	9%	9%	9%	9%	9%
% with incomes b/w 201% - 400% FPL	20%	20%	20%	20%	20%	20%	20%
Breast or Cervical Cancer							
% of 0 - 400% FPL population with incomes b/w 134% - 200% FPL	10%	10%	10%	10%	10%	10%	10%
% of 0 - 400% FPL population with incomes b/w 201% - 400% FPL	22%	22%	22%	22%	22%	22%	22%

Children

BASELINE POPULATION DATA	2009	2010	2011	Data Source:
Employer Sponsored Insurance	568,400	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
Non-Group Insurance	42,300	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
Uninsured	58,400	Not Avail	Not Avail	CPS CT 2008/09 data with Kaiser/Urban Institute Health Insurance Unit adjustment
Children 0 -18 (HUSKY A) MCO	13,498	15,255	13,229	DSS enrollment file: ME codes: F3, F4, F7, FA, FZ, P2; enrolled in an MCO
Children 19 - 20 (HUSKY A) MCO	435	503	565	DSS enrollment file: ME codes: FL, FZ; enrolled in an MCO
Children (HUSKY B) - 185% - 235% FPL	8,455	8,140	7,868	DSS enrollment file: ME codes: U1
Children (HUSKY B) - 236% - 300% FPL	5,633	5,682	5,628	DSS enrollment file: ME codes: U2
Children (HUSKY B) - over 300% FPL	1,095	1,352	1,648	DSS enrollment file: ME codes: U3

BASELINE STATE COST DATA	2010 PMPM	Premiums	Net of Premiums	Data Source:
Children 0 -18 (HUSKY A) MCO	$ 248	N/A		DSS cost file: HUSKY A, Age 0-18, CY10 capitation + dental + pharmacy + BH costs divided by member months
Children 19 - 20 (HUSKY A) MCO	$ -	N/A		DSS cost file: HUSKY A, Age 19-20 CY10 cap PMPM + non-elderly adult dental + pharmacy + BH PMPMs
Children (HUSKY B -1) - 185% - 235% FPL	$ 201	N/A	$ 201	DSS cost file: HUSKY B, ME Code U1, CY10 capitation + dental + pharmacy + BH costs divided by member months
Children (HUSKY B -2) - 236% - 300% FPL	$ 217	$ 15	$ 202	DSS cost file: HUSKY B, ME Code U2, CY10 capitation + dental + pharmacy + BH costs divided by member months
Children (HUSKY B -3) - over 300% FPL	$ 304	$ 304	$ -	DSS cost file: HUSKY B, ME Code U3, CY10 capitation + dental + pharmacy + BH costs divided by member months
				Premium data: DSS July - Oct 2011 average premiums by band; assumed Tier 3 premiums cover total PMPM cost

POPULATION & ENROLLMENT ASSUMPTIONS	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Annual Growth Rates (Absent any Medicaid eligibility changes or creation of Exchange/BHP)										
Employer Sponsored Insurance	0.0%	0.0%	0.5%	3.0%	2.0%	1.0%	0.5%	0.5%	0.5%	0.5%
Uninsured	1.0%	1.0%	1.0%	1.0%	0.75%	0.75%	0.3%	0.5%	0.5%	0.5%
Children (HUSKY A) MCO	-13.3%	3.0%	2.0%	7.0%	5.0%	3.0%	2.0%	1.0%	1.0%	1.0%
Children (HUSKY B -1) - 185% - 235% FPL	-3.3%	-1.0%	-1.0%	4.0%	3.0%	1.0%	0.0%	-2.0%	-2.0%	-2.0%
Children (HUSKY B - 2) - 236% - 300% FPL	-1.0%	0.0%	0.0%	3.0%	2.0%	1.0%	0.5%	0.3%	0.2%	0.2%
Children (HUSKY B - 3) - over 300% FPL	21.9%	15.0%	8.0%	15.0%	10.0%	8.0%	4.0%	3.0%	2.0%	1.0%

COST ASSUMPTIONS			Notes on Cost Proxy Assumptions
Annual Cost Growth Rate Assumption		3.50%	Assumes moderated Medicaid cost growth consistent with ongoing state budget pressures.
New Costs	*Cost Proxy*	*2010 PMPM*	
Children < 185% FPL	*HUSKY A*	*$ 201*	Assumes children < 185% FPL who enroll in Medicaid will have costs equal to current HUSKY A enrollees.
Children 185% - 235% FPL	*HUSKY B-1*	*$ 202*	Assumes children b/w 186% - 235% FPL who enroll in Medicaid will have costs equal to current HUSKY B - Tier 1 enrollees.
Children 236% - 300% FPL	*HUSKY B-2*	*$ -*	Assumes children b/w 236% - 300% FPL who enroll in Medicaid will have costs equal to current HUSKY B - Tier 2 enrollees.

Children

Other Assumptions	2014	2015	2016	2017	2018	2019	2020
Employer Sponsored Insurance							
% Small Business Employees	50%	50%	50%	50%	50%	50%	50%
% Small Business Employees who lose ESI	4%	5%	6%	7%	8%	9%	10%
% Large Business Employees	50%	50%	50%	50%	50%	50%	50%
% of Large Business Employees who lose ESI	0%	0%	2%	3%	4%	5%	6%
% of ESI children with incomes between 0 - 185%	11%	11%	11%	11%	11%	11%	11%
% of ESI children with incomes between 186% - 235% FPL	4%	4%	4%	4%	4%	4%	4%
% of ESI children with incomes between 236% - 300% FPL	8%	8%	8%	8%	8%	8%	8%
Medicaid/CHIP Take Up Rate of those who lose ESI	85%	87%	88%	89%	90%	91%	92%
Non-Group							
% of children with incomes between 0 - 185%	11%	11%	11%	11%	11%	11%	11%
% of children with incomes between 186% - 235% FPL	4%	4%	4%	4%	4%	4%	4%
% of children with incomes between 236% - 300% FPL	8%	8%	8%	8%	8%	8%	8%
Medicaid/CHIP Take Up Rate	35%	39%	44%	48%	52%	56%	59%
Uninsured							
% of uninsured children with incomes between 0 - 185%	62%	62%	62%	62%	62%	62%	62%
% of uninsured children with incomes between 186% - 235% FPL	12%	12%	12%	12%	12%	12%	12%
% of uninsured children with incomes between 236% - 300% FPL	9%	9%	9%	9%	9%	9%	9%
Medicaid/CHIP Take Up Rate	62%	65%	68%	71%	74%	77%	79%
HUSKY Children							
% of HUSKY A children with incomes > than 133% FPL	20%	20%	20%	20%	20%	20%	20%
% of HUSKY B - 1 children with incomes > than 133% FPL	100%	100%	100%	100%	100%	100%	100%
% of HUSKY B - 2 children with incomes > than 133% FPL	100%	100%	100%	100%	100%	100%	100%

TASK 11 – Multi-State Exchanges

Introduction

This report discusses issues associated with the option of a multi-state Health Insurance Exchange (Exchange) provided under the Patient Protection and Affordable Care Act (PPACA). Originally, this task was intended to analyze the pros and cons of operating a state-based Exchange as opposed to participating in a multi-state Exchange. After the State released the Planning Grant Request for Proposal, Connecticut's General Assembly enacted into law Public Act 11-53 creating the Connecticut Exchange, a quasi-public entity. The Connecticut Exchange is governed by an 11-member board of directors. According to the State's Planning Grant project narrative, the establishment of an Exchange in Connecticut signaled its commitment to establish the Exchange as a component of "meaningful reform that increases access to health insurance while also developing policies to improve individual and community health, reduce health care costs, and achieve long-term system sustainability."

Meanwhile, federal guidance and proposed regulations have provided greater definition to state options for governing and operating Exchanges. Finally, Connecticut is a participant in the NESCIES project, funded by a cooperative agreement from Center for Consumer Information and Insurance Oversight (CCIIO) known as an "Early Innovator" grant.

Under these circumstances, this report focuses on the Connecticut Exchange's options for partnering with other states or the federal government in operating its Exchange, and includes a focus on options that could leverage operational functions developed outside of Connecticut.

Multi-State Exchanges

States may form multi-state Exchanges with other states. The Mercer/HMA team's work across the country has allowed it to monitor developments in other states to determine whether there are models being developed for the kind of interstate collaboration that would be necessary to establish a multi-state Exchange. Our conclusion is that there are not significant models being developed that present opportunities for Connecticut to participate in a multi-state Exchange. There are significant challenges and issues that need to be addressed by states that are contemplating a multi-state Exchange.

First, there are regulatory considerations. States, through their Divisions of Insurance or Insurance Commissioners, have primary responsibility for regulating insurance sold within their borders. Exchanges will play – at a minimum – a role in defining the market for a new distribution channel by qualifying health plans. As is discussed more fully in the full report relating to Task 4, Connecticut has a robust and well-developed insurance market. Operating an Exchange with another state will require harmonizing regulatory rules that differ with partner states – something many states are understandably reluctant to do given the operational and political complexity of doing so.[1]

[1] The concept of multi-state cooperation is not foreign to insurance regulators or states. States have created interstate compacts for the purpose of addressing issues created by state-by-state variation in environmental and other regulatory arenas. Insurance compacts relating to non-health care policies are fairly common. The Interstate

While some private "multi-state" Exchanges exist today and allow member states to retain sovereignty over their insurance markets, an approved Exchange under the PPACA would at a minimum need to cooperate across state lines in the selection of qualified health plans (QHPs). Even assuming regulatory hurdles are not significant, cooperation on Exchange establishment with another state will require collaborative policy decisions about qualifying health plans for Exchange participation and operational decisions that affect how the Exchange interacts with existing state infrastructure and programs. Given the multitude of functions performed by an Exchange, perhaps the most challenging aspect of a multi-state Exchange is establishing governance structures that can swiftly and authoritatively make decisions on behalf of member states that will impact state government programs and agencies. Just as legislative authority and established governance is a precursor to a state-based Exchange, state legislation would be required from all participating states. This is particularly an issue in Connecticut, where it is likely that existing legislative authority for the Exchange would have to be modified.

The State of Connecticut has created the Connecticut Exchange. The Exchange has an enormous task ahead to establish itself as an organization, recruit executive leadership, develop its operational plan and execute the policies chosen by the board. Implementing the Exchange in partnership with another state or group of states would create further complexity and timeframes, and is simply not feasible given the requirements that will need to be in place by 2014. Given the State authorities necessary, the likelihood that a multi-state establishment will require additional legislation in Connecticut and in partner states, and the reality that there are not existing multi-state Exchanges in development that Connecticut may consider joining, we do not recommend this option for Connecticut.

Other Options for Collaboration on Exchange Functions

Aside from formally joining in a multistate Exchange, Connecticut could explore options for collaborations with other states that result in shared operations or infrastructure. Two potential approaches, one involving partnerships with the federal government and one involving collaborations with other states, are examined in turn. We recommend that Connecticut carefully monitor opportunities for collaboration that may be presented over the coming months, both from these approaches and from information about other state activities.

Insurance Product Regulation Commission (IIPRC), an affiliate of the National Association of Insurance Commissioners (NAIC) and an instrumentality of its 41 Member States (not including Connecticut), serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income and long-term care insurance. IIPRC is one of a number of affiliate programs of NAIC that are intended to smooth policy or operational issues created by state borders. However, interstate compacts involving health insurance do not exist, although section 1333 of the PPACA requires HHS and NAIC to develop regulations under which states can enter into Health Care Choice Compacts, beginning in 2016. Health Care Choice Compacts are intended to facilitate the interstate sale of insurance, but plans must meet both state licensure and certain regulatory standards and offer benefits that are comparable to otherwise approved Exchange plans. Certain policy thinkers support other means to allow individuals to "shop across state lines."
(See http://www.heritage.org/Research/Reports/2010/03/Interstate-Competition-and-Choice-in-Health-Insurance-The-American-Way)

A Federal-State Partnership Model

Many states have not decided whether to operate an Exchange at all. HHS and CCIIO have indicated a willingness to explore ways to work with states on partnership approaches that incorporate shared business functions from other states or the federal government. Those approaches, conceived as an alternative for states to a fully federally-operated Exchange, are not well defined, but could involve federal performance of significant functions of the Exchange. Such guidance as is available on these "partnership" approaches indicates that CCIIO will allow states to choose among three options.[2] The options are defined in relationship to the five core functions (as defined by CCIIO) of the Exchange:

- Consumer assistance
- Plan management
- Eligibility
- Enrollment
- Financial management

In all cases, CCIIO would perform functions 3–5 which are intertwined functions involving processing applications and determining eligibility for the Exchange, enrolling consumers into qualified health plans (QHPs) and supporting back-end financial management functions for Exchange consumers and plans.

The first option is for states to perform plan management functions only. Those functions generally encompass the Exchange's relationship to prospective and selected QHPs, including selecting and qualifying QHPs, and collecting and monitoring QHP information. In effect, the state is involved in the process of selecting QHPs but relies on federal infrastructure for operational activities.

A second option is for a state to perform selected consumer assistance functions. CCIIO specifies functions that would be reserved to states, including:

- In-person assistance
- Navigator management
- Outreach and education

[2] This section relies on information contained in a Microsoft PowerPoint presentation, since distributed to states, from a September 2011 State Exchange Grantee meeting. This document is reproduced in Appendix A. CCIIO has not released proposed regulations on the Exchange partnership model.

CCIIO would operate other consumer-related functions like the call center, the Exchange website and consumer notice functions. Similar to option one, the idea is to reserve to states more localized or hands-on functions, while core operational infrastructure is federally-administered.

The third option is a combination of the first two, in which a state would perform both plan management and the specified consumer assistance functions. Again, each of these approaches offers the prospect that federal government would provide substantial operational functions, while states would retain some measure of control over matters of greater local concern.

CCIIO has not released any formal guidance or regulations about Exchange partnership models. States have certainly requested the opportunity to provide input into the models and options that have been communicated, and it is likely that the final form of these models will be adapted based on state comments and preferences. Moreover, proposed CCIIO regulations contemplate some state flexibility during initial Exchange implementation by allowing HHS to issue "conditional approvals" to states that show they are making progress on systems development and contracting activities. The proposed rule also contemplates a process whereby states that do not seek approval by January 1, 2013 can transition to a state-based Exchange by submitting an Exchange plan 12 months in advance of offering coverage. How Exchange partnership models could relate to these elements of the Exchange approval process rule is unclear, but it is likely that federal regulators will be seeking to provide maximum flexibility to states as they struggle with the challenges of achieving approval to operate as an Exchange.

As currently defined, the partnership models leave relatively few, albeit important, functions to states. To the degree that the Exchange is a marketplace for the purchase of insurance, plan management is the fundamental element of an Exchange because it represents authority over which carriers participate in the market. In fact, it is difficult to imagine that a state would be interested in performing the operational functions of an Exchange without any control over this deeply local role – a fact that undoubtedly has informed the initial federal design of this model.

Discussion: Pros and Cons of Federal Partnership Models

Whether these initial partnership models offer opportunities to Connecticut is difficult to say at this point. First, the State is in the process of assessing for itself the opportunities and challenges that are presented by its state-based Exchange implementation. Second, federal communications about the models is informal and does not contain the level of implementation detail that is necessary to fully assess the implications of the choices.

It is important to emphasize that the Exchange partnership models (as now articulated) represent a significant deferral to the federal government for the Connecticut Exchange. Even with the state-reserved functions, Connecticut consumers would be interacting in important ways with federally run components of the Exchange over which the Connecticut Exchange will have little control, including: 1) the Exchange website; 2) the range of consumer interactions involving applications, eligibility determinations and plan enrollment, including open enrollment; and 3) the customer service and call center operation.

However, the Mercer/HMA reports on other tasks indicate significant operational challenges facing Connecticut in setting up its Exchange, many of which revolve around IT needs. It is possible that beginning implementation in partnership with CCIIO could allow for an easier transition to full-state operation in later years while retaining state authority over critical functions (notably, plan management) at the outset. There are certainly potentially negative consequences to establishing an Exchange using one set of operational infrastructure and then transitioning to a state-operated environment. Again, it is difficult to make a clear assessment of transition risks until the details of the relationship of the state, consumers and carriers to the federally-operated components of the Exchange is understandable in detail. Even with that recognition, we recommend that Connecticut monitor developments on the federal-state Exchange partnership model to determine whether there is the potential for models that will ease the path to implementation.

Multi-State Collaboration and State IT Infrastructure

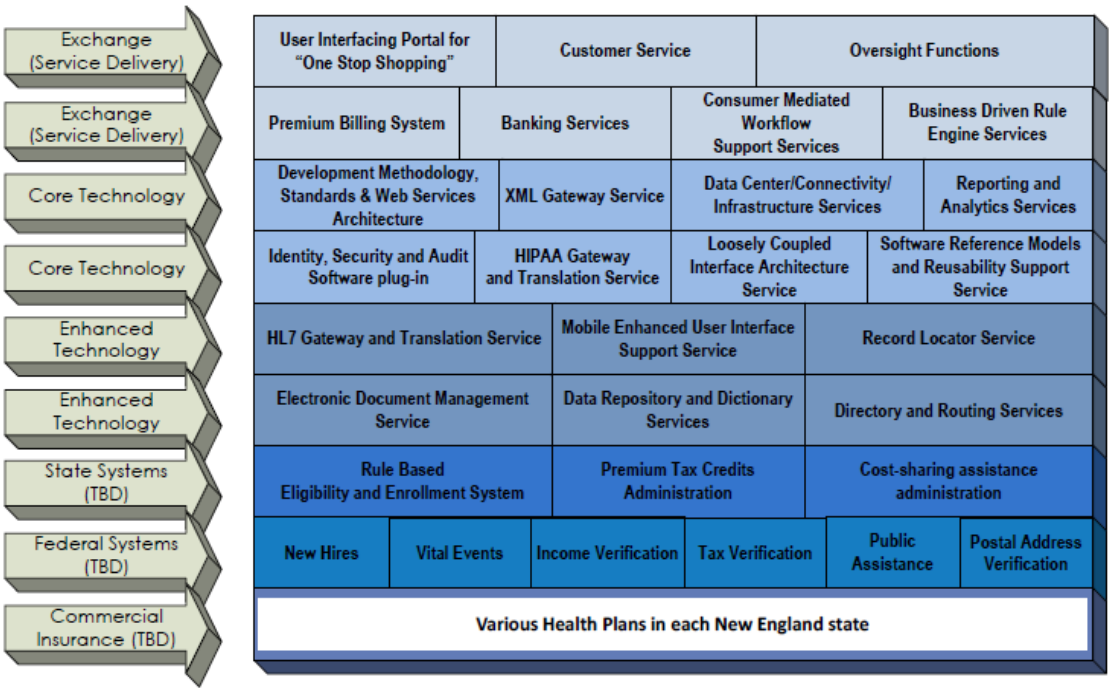
Connecticut is participating in the Early Innovator grant project through the NESCIES. In the Mercer/HMA team's view, this project holds significant promise for collaboration on Exchange implementation. Adopting IT systems developed through the NESCIES effort would be, as compared to a multi-state Exchange or the participation in an Exchange partnership model, less intrusive to existing expectations, state goals and governance structures.

The details of the NESCIES project are beyond the scope of this report, but its basic elements are summarized here.

Massachusetts is leading the NESCIES project with Connecticut, Maine, New Hampshire, Rhode Island and Vermont participating through a steering committee and technical work groups. The University of Massachusetts Medical School (UMMS) is managing the grant, with the involvement of the New England States Consortium Systems Organization (NESCSO), a non-profit organization which fosters collaboration among the New England states in health and human services policy and system needs.

The project is intended to leverage the existing information system capabilities utilized to operate the Massachusetts Health Connector (Connector). Under the grant proposal, the Connector will update and expand its technology to meet PPACA requirements. A central goal of the project – and of the Early Innovator grant initiative – is to create systems that are reusable by NESCIES (and other) states, and capable of being tailored to the particular state's unique needs. For this goal to be met, the systems would have to be designed to support "tailoring" (through system configuration and minimal customization) to the particular state's unique needs while retaining key features that would allow them to interoperate with other Exchange systems. The original conceptual framework for the NESCIES is represented in the figure below. The Early Innovator grant itself is provided at the following link: http://nescies.org/.

New England States Collaborative Insurance Exchange Systems (NESCIES) Component Framework



During the initial planning stages of the project, member states have more explicitly defined a plan for implementation. UMMS contracted with a business process redesign vendor to assess the Connector's information systems environment in relation to PPACA requirements and reuse potential, to more explicitly define system development requirements and to further organize the project. This fall, NESCIES is planning to procure a system integrator for the project. According to the recently issued Request for Proposal (RFP) announcement, the system integrator will be responsible for the "design, development, and implementation of a *Health Insurance Exchange and Integrated Eligibility System* in Massachusetts that is consumer-focused, cost-effective, reusable, and sustainable and that can be leveraged by other states according to federal health reform requirements."

Based on the Mercer/HMA team's discussions with project participants in Connecticut and Massachusetts, the design phase has included consideration of how current and future functions may be reused in other New England states. As with all Exchange IT development work, the project is organized according to a framework established by the Centers for Medicare and Medicaid Services (CMS). Six CMS-defined business areas are used to define the functions that participating states may consider reusing:

- Eligibility and enrollment
- Plan management
- Financial management

- Customer service
- Communications
- Oversight

Discussion: Pros and Cons of Utilizing NESCIES-Developed Functionality

The appropriateness of Connecticut adopting NESCIES-based technology to perform each, or any, of these Exchange business areas is dependent on interrelated strategic and technical considerations. An initial assessment of existing systems in the State appears to demonstrate that Connecticut will need to develop or acquire new technology to run its Exchange. NESCIES system components may support Connecticut's need to address gaps in IT infrastructure and allow the State to adequately perform the required functions of the Exchange. At the same time, NESCIES is facing an extremely challenging timeline to complete the project in time for states other than Massachusetts to adopt its functionality. Moreover, outside of NESCIES, the IT software and business process implementation vendor community is developing solutions that meet federal Exchange requirements.

Given these circumstances, it is recommended that Connecticut continue to devote resources to active participation and engagement with the project, including participation on the NESCIES Interstate Collaborative Steering Committee and in appropriate subgroups. Connecticut can then prioritize areas of focus based on its own assessment of potential priority business areas, and also be involved in project discussions about how best to ensure reusability of project components.

Recommendation

Both the federal partnership models and the NESCIES offer opportunities to identify technology or operational infrastructure in place of Connecticut developing or purchasing that infrastructure. If Connecticut is willing to defer significant operational authority to the federal government, federal partnership approaches should be carefully explored. If not, NESCIES may offer opportunities to create Connecticut-specific technology solutions that are critical components of Exchange operations. Both options carry some risk to the State, and both will require devoted resources to implement. A primary strategic consideration is whether the other options that Connecticut may have to acquire or develop infrastructure carry more or less risk to a smooth implementation. Most importantly, because there are areas of defined Exchange functionality that must be purchased or developed, there is considerable activity to address these needs in the private market, on the federal level, in the NESCIES project and in other states. Rather than a single solution, we recommend combining in-state business process and system assessments with a close monitoring of market and federal developments to identify those areas in which Connecticut could benefit from leveraging functionality developed for other Exchanges.

Please reference Section 2 of this report, *Health Care Reform Disclosures.*

Appendix 11A

CCIIO Presentation – "Exchanges: A Proposed New Federal-State Partnership"

Overview

- Exchange Guidance
- Core Functions of an Exchange
- HHS Support for State-based Exchanges
- Collaborative Resources for States
- Federally-facilitated Exchange
- Partnership Principles and Benefits
- State Operations under Proposed Partnership
- Grant Funding to States
- Timing and Next Steps

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Exchange Related Guidance Released

IT Guidance	IT Guidance 1.0 and 2.0, Guidance for Exchange and Medicaid Information Technology (IT) Systems Joint release with Medicaid -- Outline Cost Allocation and Funding for IT Systems
Exchange Grant FOAs	Exchange Planning Grant Early Innovator Cooperative Agreements Limited Competition Exchange Planning Grant Territory Cooperative Agreement Exchange Establishment Cooperative Agreement
NPRMs	Establishment of Exchanges and Qualified Health Plans (QHPs) Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers
Requests for Input	Basic Health Program, Employer Safe Harbor, Risk Adjustment, Definition of Full-Time Employee

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Upcoming Exchange Related Releases

- Best practices and recommended work plan for State-based Exchange and Partnership Exchange
- Essential health benefits and actuarial value
- Quality
- Oversight and appeals
- Payment notice
- Basic Health Program

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Five Core Functions of the Exchange

Consumer Assistance	Consumer support assistors; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.
Plan Management	Plan selection approach (e.g., active purchaser or any willing plan); collection and analysis of plan rate and benefit package information; issuer monitoring and oversight; ongoing issuer account management; issuer outreach and training; and data collection and analysis for quality.
Eligibility	Accept applications; conduct verifications of applicant information; determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conduct redeterminations and appeals.
Enrollment	Enrollment of consumers into qualified health plans; transactions with Qualified Health Plans and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
Financial Management	User fees; financial integrity; support of risk adjustment, reinsurance, and risk corridor programs.

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HHS Support for State-Based Exchanges

- HHS provides Exchange Grants to support State actions.
- HHS will manage a Data Services Hub or support system to connect to IRS, SSA, and DHS.
- HHS will provide financial management support related to payment processing of financial assistance.
- States can run their own risk adjustment program using their own certified model or the Federal risk adjustment model or allow HHS to run risk adjustment on their behalf.
- HHS will run risk corridors program.

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Collaborative Resources for States

- Early Innovator States are a resource to other States in a number of areas by:
  - Sharing administrative materials and templates;
  - Publishing business process flows and blueprints;
  - Posting planned system architecture and implementation timelines.
- States can access a web-based environment where States and Early Innovators can share documents and processes.
- States can participate in small groups focused on working through issues/concerns and sharing best practices.

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Federally-facilitated Exchange

- Federally-facilitated Exchange will perform core functions comparable to State-based Exchanges, including consultation with stakeholders.
- Federally-facilitated Exchange will make decisions where Exchanges have flexibility, including areas such as network adequacy and marketing.
- HHS will look to State standards to harmonize rules inside and outside of the Exchange.
- HHS can charge issuers user fees to run the Federally-facilitated Exchange.
- In fall 2011, HHS will devote resources to procurements for the Federally-facilitated Exchange.

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Federally-facilitated Exchange (cont'd)

- Federally-facilitated Exchange will work with local stakeholders through the Navigator program and other outreach efforts to educate consumers and small businesses about available options in 2014.
- Federally-facilitated Exchange will determine eligibility for qualified health plans, tax credits, cost sharing reductions, and Medicaid and CHIP eligibility based on modified adjusted gross income.
  - Federally-facilitated Exchange will provide eligibility information to the applicable State agency to enroll those individuals in coverage.
- HHS will solicit input from States when running the Federally-facilitated Exchange.

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Partnership Principles and Benefits

- Partnerships are Exchanges where both HHS and States operate functions of the Exchange; however, HHS is responsible and accountable for ensuring the Exchange meets all of the standards.
- HHS will maintain and coordinate with States for end-to-end system functionality to ensure a seamless consumer experience.
- States entering into Partnership will agree under the terms of their grants to ensure insurance department, Medicaid, and CHIP cooperation to coordinate business processes, systems, data/information, and enforcement.
- As part of their agreement, States may choose to operate plan management functions and/or some consumer services, using Exchange grant funding to establish functionality, thereby maintaining existing relationships and allowing for easier transitions to State-based Exchanges in future years.

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Summary of Proposed Partnership: Three Options

- Under the proposed Partnership, States may choose to operate the following Exchange functions:
  - Option 1 – Plan management functions;
  - Option 2 – Selected consumer assistance functions;
  - Option 3 – Both selected consumer assistance & plan management functions.
- Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.
- As appropriate, HHS will ensure that the Partnership meets all Exchange standards

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State Option under Partnership: Option 1: Plan Management

- Goal is to let States help tailor health plan choices for their State's Exchange.
- Plan management functions include (but are not limited to) –
  - Plan selection;
  - Collection and analysis of plan rate and benefit package information;
  - Ongoing issuer account management;
  - Plan monitoring, oversight, data collection and analysis for quality.
- Under this proposed option for plan management, the State helps select plans and collects a standardized set of data on them to plug into Federally-facilitated Exchange's eligibility and enrollment functions.
- HHS coordinates with the State regarding plan oversight, including consumer complaints and issues with enrollment reconciliation.

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State Option under Partnership: Option 2: Consumer Assistance

- Goal is to take advantage of State's experience to support a seamless consumer experience.
- Consumer assistance functions that a State would operate under this proposed Partnership option include:
  - In-person assistance;
  - Navigator management;
  - Outreach and education.
- Consumer assistance functions that HHS would operate under this proposed Partnership option include:
  - Call center operations;
  - Website management;
  - Written correspondence with consumers to support eligibility and enrollment.

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Availability of Federal Grant Funding to States

By year and model

	2012*	2013*	2014	2015
State Exchange	Yes	Yes, if the State is certified or conditionally certified on 1/1/13.	Yes, if State is fully certified.	No
Partnership Exchange	Yes	Yes, to improve/support functions the State will be performing.	Yes, to improve/support functions the State is performing.	No
Federally-facilitated Exchange	Yes	No	No	No

*In 2012 and 2013, grant funding is available until it is clear that an Federally-facilitated Exchange will operate in the State.

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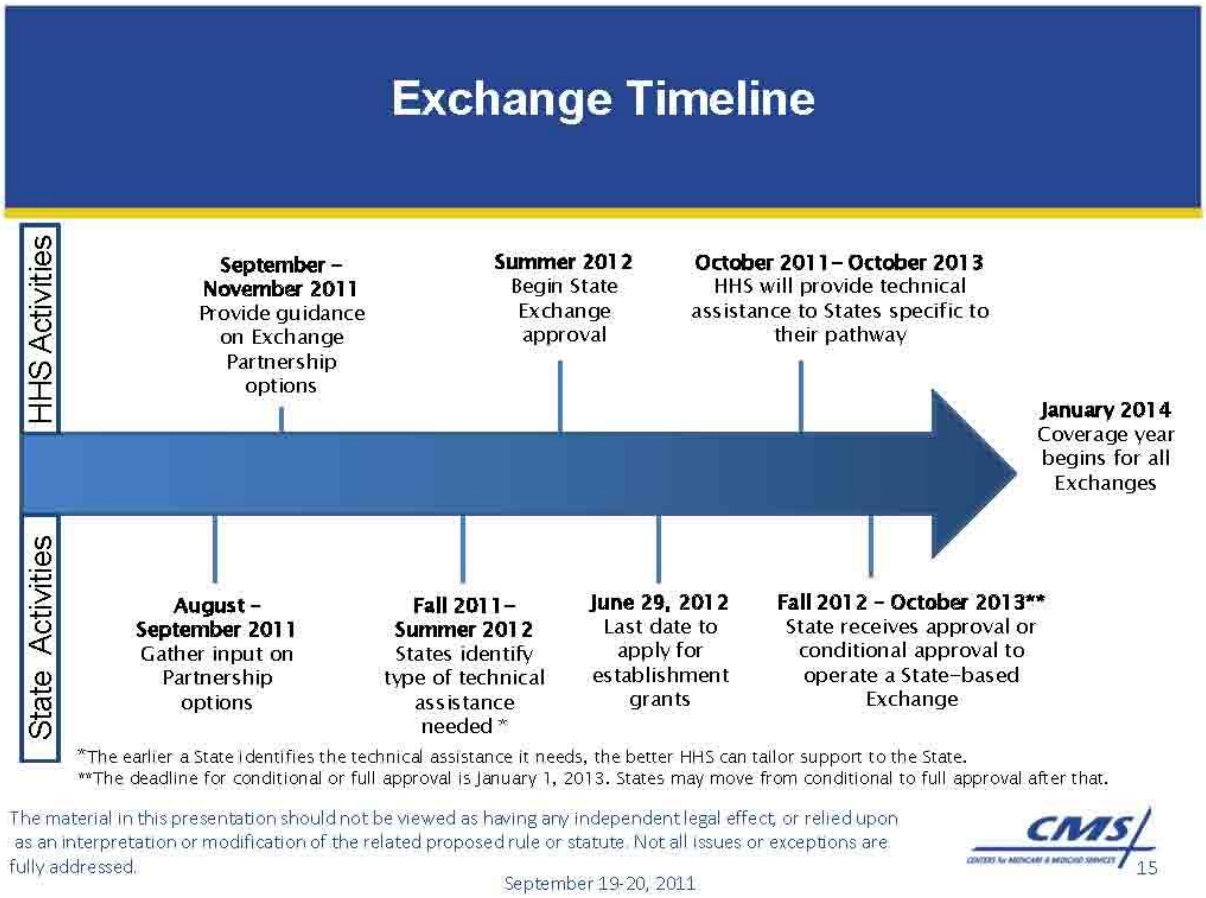
Exchange Timeline
HHS Activities
September – November 2011
Provide guidance on Exchange Partnership options
Summer 2012
Begin State Exchange approval
October 2011 – October 2013
HHS will provide technical assistance to States specific to their pathway
January 2014
Coverage year begins for all Exchanges
State Activities
August – September 2011
Gather input on Partnership options
Fall 2011 – Summer 2012
States identify type of technical assistance needed *
June 29, 2012
Last date to apply for establishment grants
Fall 2012 – October 2013**
State receives approval or conditional approval to operate a State-based Exchange
*The earlier a State identifies the technical assistance it needs, the better HHS can tailor support to the State.
**The deadline for conditional or full approval is January 1, 2013. States may move from conditional to full approval after that.
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Next Steps

- HHS will reach out to States and other stakeholders to receive input on Partnership.
- States and other stakeholders with feedback should submit formal comments through the Exchange proposed rule comment process ending on September 28, 2011.

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Technical Appendix - Oliver Wyman HRM Model

The Oliver Wyman HRM Model was used to assess potential enrollment in a Connecticut (State) sponsored Exchange. The model has three primary modules which are discussed in this technical appendix. The first module attempts to characterize the current population, the second module calibrates the simulated population to the current market and the third module projects the simulated population in future years given coverage options, choice and market reforms.

Market Simulation Module

When preparing the Acquisition Cost Survey (ACS) data for the first module, we first adjusted the basis on which the data are reported. The ACS requests information about households; we have built our models to reflect decisions for health insurance units (HIU). We define these HIUs as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. For example, an ACS household might only consist of a brother and sister; they would likely not be eligible for coverage under the same policy. In this example, we have created identifiers to treat them as separate HIUs for purposes of our modeling.

We have excluded a number of individuals who we assumed would not be materially affected by the presence of a Connecticut sponsored Exchange. In particular, we excluded HIUs where either the primary person or their spouse (if a spouse is present) is identified as a government worker. We also ultimately excluded anyone identified as an undergraduate student with employer-sponsored insurance (ESI) or individual coverage. Individuals with incomes below 185% federal poverty level (FPL) were assumed to be covered by Medicaid. Finally, we identified a number of individuals who were identified both as having ESI and as being unemployed. We assumed that these persons would behave in our modeled market as if they were uninsured.

Module Design and Data Restrictions

Ultimately, the Oliver Wyman HRM Model is designed to assess the economic incentives related to insurance coverage for each HIU. In this sense, the design is almost that of a seriatim model. However, we faced several challenges with this approach. First, there is no single data source with all the information necessary to create a seriatim model. Although the ACS contains information about demographics, current insurance coverage and income, it does not include insurance characteristics of a person's employer (i.e., group size), that person's health status, the source of coverage in the HIU (e.g., the husband or wife) or premiums for coverage. Also, the person record from the ACS does not correspond with a single individual in the population. Rather, each record is assigned weights so that one survey respondent might represent 250 individuals in the population while another respondent might only represent 50 individuals.

To address the issue of varying weights, we duplicated ACS records so that they roughly corresponded to the weight assigned to an individual. For example, a person with a weight of 250 might translate to 20 duplicated records (all with the same characteristics), while a person with a weight of 50 might translate to four duplicate records. Because of computing limitations,

we were not able to represent the entire State in this fashion, but we were able to reflect a robust, stratified subset of it.

To address the issue of incorporating non-ACS data (e.g., health status, insurance premium), we built a micro-simulation model. This model assigns health status to each person; it also assigns people with ESI to groups. This assignment of variables is then repeated many times to ensure that we have an accurate estimate of the range of possible results.

For health status, we developed coverage-specific assumptions from self-reported data in the Census Bureau's Current Population Survey (CPS). Individuals are classified into one of five health status categories, ranging from excellent to poor. We noticed that, within a coverage type, individuals generally had similar distributions across income levels. However, there was one exception to this observation: those uninsured individuals with higher incomes reported themselves as being in better health than their uninsured, lower-income counterparts. This dynamic likely results because individuals with the means to purchase insurance are less likely to do so if they have better health; individuals without the means to purchase insurance will remain uninsured regardless of their health status. Each person was then assigned a personal claim cost relative value based on their self-reported health status.

Synthetic Insurance Carriers

We issued a data call to the major carriers writing business in the State in 2010. The information obtained through the data call, in combination with information gathered through a review of recent rate filings, was specific enough to allow us to develop theoretical, or synthetic, insurance carriers. We note that these data were blinded so that we could not identify which carrier provided the data.

The information obtained from each small group carrier participating in the data call included premium, claims, enrollment, and the associated rating characteristics and variables (e.g., group size factor, age/gender factor, industry factor, etc.) for each small group with coverage in 2010. Using the information obtained, each group’s premium was normalized for all rating factors provided which, in effect, resulted in normalized premiums that reflected only benefit differences.

Because carriers are not yet designing products targeted to specific actuarial values, as they will in the reformed market, the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimated actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able to discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered by the carrier in 2010. Small groups were then grouped into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. This analysis was performed independently for each carrier.

Using this information, we were then able to develop a synthetic rating manual for each carrier. The observed premiums were normalized for all rating variables to arrive at a manual rate representing a 1.00 level for all rating variables. The range of current values for each rating

variable were developed from the carrier data and validated against information included in rate filings. A set of revised rating manuals for 2014 and beyond that reflects the adjusted community-rating methodology required under the PPACA were also developed.

Synthetic Groups

In addition to assigning health status to each person, we also assigned each person with group coverage to a theoretical, or synthetic, group. In describing their micro-simulation model, the Congressional Budget Office (CBO) discusses their approach to creating these synthetic groups. In our model, we have pooled individuals in similar industries into groups. The ACS data include industry classification for those persons that are employed. As we created synthetic groups, we ensured that health care providers were included in groups with other health care providers; we ensured that lawyers were included in groups with other lawyers, etc.

Our model also reflects the industries and corresponding group sizes in the State based on existing distributions of employers. For these distributions we relied on data prepared by Dun & Bradstreet (D&B). The D&B data show each employer in Connecticut, their industry, the number of employees at each establishment in the State and the number of employees across the entire organization. As with the ACS data, we took care to remove any government employers (either based in the US or other countries) from the data. These D&B data do not provide any information related to employee health benefits; so, we used data from the Medical Expenditure Panel Survey (MEPS) to supplement the missing information. Specifically, we relied on the blended results from the 2009 and 2010 MEPS insurance/employer component data to establish the rates at which coverage was offered at various group sizes. We also used the MEPS data to examine rates of eligibility and enrollment at various group sizes.

Based on these assumptions, the micro-simulation model assigned employees from the ACS data to groups of similar industries (at various group sizes) until all covered employees in the ACS data were assigned. For example, a lawyer in one iteration might be assigned to a large law firm and in the next iteration, that same lawyer would be assigned to a small practice. Employees in synthetic groups were then summarized and assigned a carrier based on the carrier's market share. The groups were assigned a premium based on the groups' characteristics and the synthetic rate manual of their assigned carriers. So, extending our example, the model might build a small group of lawyers, assign them a carrier and then assign them rating factors from that carrier for demographics (e.g., the age, gender and family composition of each employee) and group size.

In addition to examining the premium based on the carriers' present rating practices, we also examined the rate change (called “rate shock”) that each group would experience in 2014 as a result of new rating restrictions imposed on carriers by the PPACA. Consequently, groups that have benefited with lower premiums as a result of their characteristics (i.e., those who are younger) may see rather large rate increases, while groups that have paid higher premiums as a result of their characteristics (i.e., those who are older) will see rate decreases. The original group premium and the group premium resulting from the rate shock are both carried with the employee into subsequent modules.

For each small group we also estimate whether or not the group might be eligible for subsidies under the PPACA. Small groups meeting certain size, average wage and employer contribution requirements may be eligible for tax credits. Based on the simulated individuals in the synthetic groups, we have estimated eligibility for these credits.

Finally, we estimated the cost of individual coverage for every HIU in the model. This cost estimate is a key element in future modules. The cost of individual coverage is critical for estimating the behavior of those who currently have individual coverage, but it is equally important for those with ESI or even those who are uninsured. As employers choose to eliminate coverage and low income individuals become eligible for premium subsidies in the Exchange, many persons beyond the existing individual market will begin to examine coverage there.

As with our estimates for group costs, we assigned a carrier to each HIU with individual coverage based on the carrier's market share. We then built a premium for that HIU based on the carrier's rating practice and the rating characteristics of the HIU. Finally, we estimated a rate shock that the HIU would experience as a result of new rating restrictions under the PPACA (i.e., elimination of rating based on health status, gender, etc.) The original individual premium and the individual premium resulting from the rate shock are both carried with the HIU in subsequent modules.

Market Calibration Module

The second module in the Oliver Wyman’s HRM Model is a calibration module. The purpose of the calibration module is to solve for the model parameters that replicate the known insurance marketplace in Connecticut in 2010. The steps in the simulation module described above represent one iteration. These steps are repeated multiple times until the average results across multiple iterations replicate the known current population. If the known results are not replicated, model parameters are adjusted and the simulations are repeated.

The results are calibrated at a number of different levels. First, results are examined to ensure the appropriate number of people were simulated to have each type of current coverage (e.g., individual, small group, Medicaid, etc.). Within the individual and small group markets, the average premiums developed through the application of the synthetic rating manuals were also reviewed to ensure they were consistent with known premiums.

Once the simulation module is calibrated, the results are used to calibrate the market migration module (discussed in detail next). The market migration module uses the results of the 2010 populations created by the calibrated simulation module and projects the market into which individuals will enroll based on the options available to them. For those individuals that were enrolled in ESI coverage, the premium for that coverage is also passed from the calibrated market simulation module. Premiums in the individual market are calculated for each HIU and passed from the market simulation module. In order to ensure that an appropriate utility function is utilized in the market migration module, the model is calibrated to reproduce the status quo.

While a utility function can model people’s desire for consumption of health care services as well as their aversion to financial risk, it cannot predict certain behaviors such as why people eligible to enroll in Medicaid do not enroll, or why individuals with sufficient financial means to purchase

health insurance chose to be uninsured. It is because of these behaviors that the model calibration is necessary.

To perform this calibration, all of the information resulting from the simulation module is considered except the known market in which the individual was enrolled in 2010. Individuals with coverage through Medicaid, Medicare, military coverage and coverage through state or federal government employee programs were excluded from the calibration, as individuals with these types of coverage are assumed to continue with those coverages throughout the projection. For each of the remaining HIUs, the various coverage options available to them in 2010 are examined and the utility associated with each option is calculated. HIUs with household modified adjusted gross income (MAGI) greater than 185% FPL are not allowed to evaluate the option of enrolling in Medicaid. Once a utility is calculated for each of the allowable options, the option with the greatest utility is selected and the HIU is assumed to enroll in that health insurance option.

For HIUs where the current coverage is not the same for all family members, these “split decisions” were also an option that was evaluated in our model. For example, if the primary respondent to the ACS is reported to have ESI coverage, but the spouse is reported to have individual coverage, an option where the primary individual enrolls in single coverage under the simulated employer group plan is evaluated in combination with the spouse enrolling in any of the five coverage levels modeled to be available in the individual market.

For most of 2010, the PPACA reforms that became effective September 23, 2010 were not in effect; in particular the requirement that dependents be allowed to remain on their parent’s coverage up to age 26. Therefore, in performing this calibration, dependents under age 19 were handled separately from those ages 19–26. For the 19–26 population, we examined the actual coverage that the 19–26 year old had in 2010, relative to the rest of the HIU. If the primary respondent to the ACS had ESI or individual coverage, but the 19–26 year old dependent did not, we assumed it was because they were not eligible to enroll under the same coverage as the primary individuals. In this case, the 19–26 year old was evaluated as a separate HIU for purposes of the calibration. It is important to note that this rule was only used for the calibration, as these 19-26 year olds would be eligible to enroll on their parent’s coverage in 2014 and beyond.

The process of determining in which coverage option(s) each HIU would enroll based on application of the utility maximization methodology was repeated for each iteration of results from the simulation module. The projected enrollment in each market was aggregated across all simulations and compared to the known 2010 distribution (the distribution resulting from each iteration of the simulation model is referred to here as the known 2010 distribution) by market at several sub-population levels.

If the projected enrollment results did not replicate the known 2010 distribution, the various parameters in the utility function were revised until the projected enrollment was consistent with the known enrollment at several key sub-population levels. The following table compares the known 2010 distribution of State (excluding those enrolled in public programs and those covered

as government employees) employees (including their covered dependents) with the projected distribution resulting from the migration model, across all model iterations.

	Known Distribution	Modeled Distribution
Uninsured <=200% FPL	25.5%	24.5%
Uninsured 201%–400% FPL	10.5%	10.7%
Uninsured >400% FPL	5.4%	6.6%
Individual	14.1%	14.7%
Small group (1–50)	31.8%	31.1%
Mid-group	12.7%	12.4%
Total	100.0%	100.0%

The table above demonstrates that we were able to calibrate our model to reproduce the distribution of individual purchasing decisions that were made in 2010.

Market Migration Module

The final module in the Oliver Wyman's HRM Model is the market migration module. The purpose of the market migration module is to project the migration of individuals between the various coverage statuses that will be available to them in the post-reform insurance marketplace. We developed these projections based on the simulated population, along with many other medical and economic input variables, and also on the introduction of the PPACA changes that will occur in 2014 and beyond.

Limited aspects of the module were described previously when describing the model calibration; here we provide a more detailed overview.

For each iteration of the market simulation module, the resulting simulated population is input into the calibrated market migration module, and the purchasing decisions for each HIU are modeled for each of the years 2014 through 2018. Individuals currently enrolled in Medicaid, Medicare, those having coverage through the military and those receiving coverage as a result of being an employee or a dependent of an employee that works for the state or federal government are assumed to retain that coverage. In addition, large groups are assumed to continue offering coverage at the same rate at which they do today. As a result, all of these individuals are not run through the market migration module. These populations are projected to grow at the same population growth rate assumed in the model. Additional individuals with current individual or ESI coverage, and those currently uninsured, are allowed to enter the Medicaid population as described below.

The model assumes a steady State population from the perspective that the underlying mix of the population does not change with respect to many variables. Annual increases in population growth and income are projected. In projecting population growth, each individual in 2010 receives a population growth weight based on their age in 2010. These population growth weights allow each person in the 2010 population to represent an additional fraction of a person

in 2014 and beyond, with the weight increasing each year by the population growth for the age range to which they belong.

Incomes are increased by the assumed salary inflation factors, and FPL levels are projected based on the statutory formula for calculating FPL. Based on the income, family size and composition of each HIU, the modified adjusted gross income is calculated for each projection year. Projected MAGI levels for each HIU are then compared with projected FPL levels to determine each HIU's income as a percentage of FPL for each projection year. These FPL percentages are then used for:

- Determining whether the HIU is eligible for Medicaid or children within the HIU are eligible for CHIP
- Determining whether the HIU is eligible for premium subsidies within the Individual Exchange
- Determining whether the HIU is eligible for cost sharing subsidies within the Individual Exchange
- Determining whether the HIU is eligible for exemption from the individual mandate penalty if they elect not to enroll in coverage
- Determining whether the ESI coverage made available to HIU is deemed "unaffordable" and, as a result, the HIU is eligible to enroll in the Individual Exchange and receive premium and cost sharing subsidies

The market migration module evaluates several different options in which the HIU is eligible to enroll. The model calculates the utility for each one of these options. HIUs are only allowed to evaluate ESI coverage if they are currently enrolled in this market as the model does not assume new offerings of ESI coverage. HIUs are only allowed to evaluate the option of enrolling in Medicaid or subsidized coverage inside the Individual Exchange if they meet the income eligibility requirements.

The potential options that are evaluated for each HIU (where eligible) include:

- All individuals in the HIU enroll in ESI coverage at the level made available by the employer for the year modeled
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Bronze Level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Silver Level coverage in the individual market

- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Gold Level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Platinum Level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI remain uninsured
- All individuals in the HIU enroll in Silver Level coverage within the Individual Exchange and receive premium subsidies, and cost sharing subsidies where applicable
- All individuals in the HIU enroll in non-subsidized Bronze Level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Silver Level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Gold Level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Platinum Level coverage in the individual market
- All individuals in the HIU elect to remain uninsured

Individual Utility

Individual HIUs are assumed to make insurance purchasing decisions by evaluating the various options above and making an economically rational decision to select the option that maximizes the utility for the HIU. In cases where different members of an HIU enroll in different markets (e.g., the primary ACS respondent enrolls in ESI coverage but the spouse enrolls in individual coverage), the utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under that option.

In order to model this behavior, a utility function and associated parameters were selected. As described in the previous section, the utility function and parameters selected were those that best resulted in replicating the 2010 status quo across several iterations. The underlying utility function that resulted in this optimal model calibration is as follows:

$$U_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - \frac{1}{2} rVAR(OOP_{i,j}) + a * u(H_{i,j})$$

In the equation above, $OOP_{i,j}$ is the out-of-pocket health expenditures for HIU *i* under purchasing option *j*, r is the risk aversion coefficient and $U(H_{i,j})$ is the utility associated with consuming health services. $U(H_{i,j})$ is assumed to be proportional to the expected value of the total expenditures for health care services with the ratio a. In calibrating the model, we elected to vary the parameters r and a at three different ranges of incomes to reflect the fact that individuals with higher incomes are more risk averse.

Personal Claims Cost

Within the model a personal claims cost (PCC) is developed for each State resident and employee for the base calibration year and each subsequent year modeled. This PCC, or some multiple of it, is used as an approximation for the expected value of total expenditures for health care services in the utility function above.

The PCC for each individual is calculated as the base claims cost for the insured market for the year, multiplied times an adjustment to reflect the relative level of claims expected for someone of their age/gender, multiplied by an adjustment to reflect the relative level of claims expected for someone of their health status.

In evaluating the utility associated with being uninsured, the PCC for the individual is reduced by a factor in 2010 to account for the fact that those without current health insurance do not seek medical services at the same level as those with insurance. In evaluating the utility associated with a currently uninsured individual taking up insurance, the PCC is increased by a factor to account for pent-up demand. In 2014 and forward, the PCC for uninsured individuals is not reduced in order to reflect the mandate that individuals retain coverage and that there will be negative utility associated with remaining uninsured in 2014 and beyond.

Employer Demand Elasticity

The response from employers to changes in premiums and other financial incentives is a critical element of the model. Because of new rating requirements in the PPACA, many groups will see rate changes (both up and down), though these changes will be less in Connecticut than most other states due to Connecticut's early move to modified community rating. In addition, there are provisions in the PPACA that we assume will only increase the cost of coverage (i.e., fees collected by the federal government from insurers). These additional costs will generally discourage employers from offering coverage at their existing benefit levels. When trying to model a group's response to a price change, we rely on elasticity assumptions.

Generally speaking, these elasticities measure changes in behavior in response to changes in price (i.e., an increase in the price of bread causes a decrease in the quantity demanded). In our model, we have characterized an employer's response to increasing premiums by decreasing the benefits that the employer offers in their health plan. For example, an increase in premium might cause an employer to offer a Silver Level plan instead of a Gold Level plan. The employer responds to increasing premiums this way until the benefit levels no longer justify offering coverage.

One significant challenge with this particular assumption is the uncertainty associated with it. Employer coverage decisions occur in an environment with numerous financial incentives as well as qualitative considerations. (For example, a small group employer in today's market may absorb very high premium changes as long as it means that her employee's ill spouse is able to receive required care.) Any attempt to model behavior of this sort is going to have shortcomings. We reviewed numerous published sources. In particular, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica.[1] This report identifies ranges for price elasticity of employer offers from -0.14 to -5.80. In addition, we also relied on the CBO's assumptions employed in its own micro-simulation model. The final assumptions we employed varied by group size (identified as “GS”), were generally consistent with the results published in the Mathematica Report and are characterized by the following equations:

GS 1 to 10:	**-1.14**
GS 11 to 50:	0.4722 * ln (GS) – 2.2273
GS 51 to 350:	0.1182 * ln (GS) – 0.8424

As we reviewed the results from the model, we found that the expected group behavior was generally consistent with other estimates we have seen from independent studies of the PPACA's effect on small group coverage.

Inertia Factor

In many cases, the evaluation of two competing options using the selected utility function results in utility values that are very similar. For example, the utility associated with purchasing Bronze Level coverage in the individual market may be only marginally different than the utility associated with being uninsured. From year to year, the impact of medical trend and the change in the penalty under the individual mandate for not taking coverage do not change at the same rate. This can result in individuals alternating back and forth between these two options in subsequent years under a pure utility maximization approach.

Several studies have documented the inertia related to individual decision making, where people elect the status quo even though utility theory indicates it is rational to elect an alternate option.[2,3] Therefore, to reflect this behavior and add stability to the modeled results, we have built an inertia factor into the model such that if the utility associated with an option that has the maximum utility for a given year is not at least a stated percentage higher than the utility associated with the current option, the change in coverage is not made.

[1] Liu, S. and Chollet, D, “Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature,” Mathematical Policy Research, Inc., March 24, 2006.

[2] Su, X. (2009). “A Model of Consumer Inertia with Applications to Dynamic Pricing. Production and Operations Management.” 18: 365–380. doi: 10.1111/j.1937-5956.2009.01038.x.

[3] “The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior.” Brigitte Madrian and Dennis Shea..

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