OBAMACARE FOR CONNECTICUT:

Dr. SustiNet's Prescription for Big Government Healthcare

Yankee Institute for Public Policy
Creating New Ideas for Better Government and Lower Taxes in Connecticut

Located on the campus of Trinity College

The Yankee Institute for Public Policy

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About the Yankee Institute For Public Policy

The Yankee Institute is a think tank that develops and advocates free-market and private sector solutions to public policy issues. Founded in 1984, Yankee has offices on the campus of Trinity College in Hartford, Connecticut. The Yankee Institute is a non-partisan research and educational organization and is classified by the IRS as a 501 (c) (3) non-profit.

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Executive Summary

In 2009, the Connecticut General Assembly overrode a veto by Governor Jodi Rell and passed an ambitious health care proposal called SustiNet. The dramatic final vote came after a years-long campaign funded by tens of millions of dollars by the Universal Health Care Foundation of Connecticut. The bill created a state commission to develop a plan to expand government health care and report back to the legislature in 2011.

SustiNet has two broad and laudable stated goals: to reduce the number of Connecticut residents without health insurance, and to reduce the growth of state health care costs.

This Yankee Institute study of the SustiNet proposal predicts that government-driven health care will likely succeed in reducing the number of state residents without health insurance, but that doing so as envisioned by SustiNet's backers will cost Connecticut taxpayers billions in new government spending each year while doing little to reduce health care costs for those who currently have insurance.

- 90 percent of Connecticut residents have insurance coverage.
- Of the 343,000 people who do not have health insurance, 16 percent are eligible for existing government-sponsored health insurance programs
- Another 38 percent of the uninsured live in families above 300 percent of the federal poverty level ($54,930 for a family of three) and could likely afford some form of health insurance
- This leaves 158,000 people who are truly chronically uninsured, and even this figure includes considerable "churn" among people who may be without insurance for limited periods of a few months
- Connecticut spends $4.1 billion a year on its existing taxpayer-funded state health care programs, including Medicaid and three state health insurance programs
- SustiNet will cost Connecticut taxpayers at least $2 billion more in new, annual government spending

SustiNet understates or ignores the higher costs that will come by:

- Underestimating the cost of expanding the HUSKY program;
- Understating the cost of subsidizing insurance;
- Ignoring "crowd out" effects, the tendency of taxpayer-subsidized insurance plans to cause some of those with existing private insurance to drop that coverage and switch to government plans;
- Ignoring "adverse selection," by which new enrollees have higher medical expenses than current enrollees.

Other negative effects of SustiNet will likely include:

- **Higher taxes.** Tellingly, the law is silent about how any plan developed by the SustiNet commission will be paid for. It is apparent that raising $2 billion in new revenue can only be achieved by significant increases of a point or more in the state income tax, the state sales tax, or both.

[1] *All information about the uninsured rate comes from the U.S. Census Bureau, unless otherwise noted, available at http://www.census.gov/hhes/www/hlthins/hlthin08.html.*

- **Reduced employment** due to new taxes on employment in the form of potential fines for employers that do not offer health insurance.
- **Longer waits** to see health professionals due to increased demand.
- **Higher costs** for those with private insurance coverage due to cost shifting.
- **Higher prices** in the individual market due to guaranteed issue and community rating.
- **Higher costs** for practitioners who will be required to conform to reporting mandates.
- **Fewer choices** for consumers.
- Rationing of care.

There are market-based alternatives to SustiNet's big government approach to health insurance change that can achieve some of SustiNet's stated goals at a fraction of its likely costs. These include:

- Allowing Connecticut residents to purchase health insurance across state lines.
- Relaxing Scope of Practice and Certificate of Need laws that artificially limit supply and drive up costs.
- Reforming existing state health insurance programs.

Expanding government insurance will indeed lower the uninsured rate. But a program that will cost over $2 billion annually will neither reduce the growth of state health care spending nor save Connecticut families money. The likely result of SustiNet will be a program that is more expensive than its sponsors anticipate and that will cause a number of unintended consequences for health care consumers, those with private insurance, health care providers, and taxpayers.

Connecticut's Current Health Care Situation

The Uninsured

At any given time, approximately 343,000 Connecticut residents do not have health insurance coverage.

Before discussing the challenge of the uninsured, it is important to keep in mind that the vast majority of Connecticut residents are insured. Connecticut ranks above the national average when it comes to residents who are insured and those who have private health insurance coverage. Eighty-nine percent of Connecticut residents under 65 had health insurance coverage during 2008 (those 65 and older have access to Medicare), compared to 83% nationally.[1]

Employer-based health insurance coverage is the way most were covered, with 70% of Connecticut residents under 65 taking advantage of it, compared to a national rate of 62%. Medicaid covered almost 12% of the Connecticut's residents, a lower percentage than the 14% of U.S. residents on the program. The remaining 7% are covered by military insurance, Medicare, or they purchase health insurance on their own.

Furthermore, a significant portion of those without insurance are eligible for existing government-sponsored health care coverage. Statistics about the uninsured in Connecticut illustrate an important fact often overlooked in the health care debate: some of those eligible for health care coverage do not take advantage of it. For instance, in Connecticut every child in a family making under 300% of the federal poverty level (FPL), or $54,930 for a family of three, is eligible for free or subsidized health care coverage. Yet, there are still 27,000 children in this category without coverage. These children, who have access to free health care, make up 61% of all the uninsured children in the state.

Often the discussion of the uninsured assumes that no one chooses to go without insurance. However, the statistics also indicate that at least some Connecticut residents choose to go without insurance even though they can afford it. For Connecticut residents living in families of three making over 300% of FPL (again, $54,930), a level of income that would give many enough money to buy at least high-deductible insurance, 7.4% are uninsured. Their children, who can buy into the HUSKY program, have an uninsured rate of 3.4%.

Many younger, healthy single people also choose not to carry insurance. And, a significant portion of those without insurance at any given time are temporarily so.

While it is appropriate to be concerned about the fact that some state residents do not have health insurance, the number of uninsured who truly don't have access to health insurance may not quite rise to the level of crisis that advocates of expanded government health insurance programs claim it to be.

Existing State Health Care Programs

Medicaid, the government health care program for the poor and the disabled, is the single biggest line item in the state budget. In the Fiscal Year 2010 budget, Medicaid consumed $3.848 billion, over 20% of total spending.[2]

Even without SustiNet, Connecticut has three other existing state government programs that offer health care coverage to the poor and middle class in the state: HUSKY, SAGA, and Charter Oak.

HUSKY: Husky is the state Medicaid and Children's Health Insurance Program (CHIP). These programs provide health care coverage that is theoretically open to all children in the state and many low-income adults.

Children and their caregivers who have family incomes under 185% of FPL ($21,693 for a family of three) are covered under HUSKY A. Pregnant women with family incomes under 250% of FPL ($22,875 for a family of three) are also covered. The federal government contributes 50% of the funding for this program most years, although in 2009 this funding was increased slightly as part of the federal stimulus package.

All Connecticut children are eligible to be covered under HUSKY B. Those with incomes between 185% and 300% of FPL received subsidized care, although premiums and copayments are charged. Children in families with income in excess of 300% of FPL can receive coverage if purchased at the full price of the program. The federal government pays 65% of the cost of HUSKY B for those in families under 300% of FPL.

SAGA: State Administered General Assistance (SAGA) offers medical benefits for low-income Connecticut residents. Those making up to $506.22 or $610 per month (depending on one's residence) and having a household asset limit of $1000 are eligible.

Charter Oak: This state insurance program is offered to Connecticut residents of all incomes. Its premiums and deductibles vary based on income, but those on the program face a variety of copayments, deductibles, and an annual limit on benefits. Roughly 2,700 people use this program.[3]

Government Health Care Growth

In the Fiscal 2010 budget, Medicaid costs are at $3.848 billion; SAGA costs $244 million; HUSKY consumes an additional $34.3 million; and Charter Oak is another $13.7 million.[4] Combined, Connecticut spends $4.1 billion a year on its health care programs.

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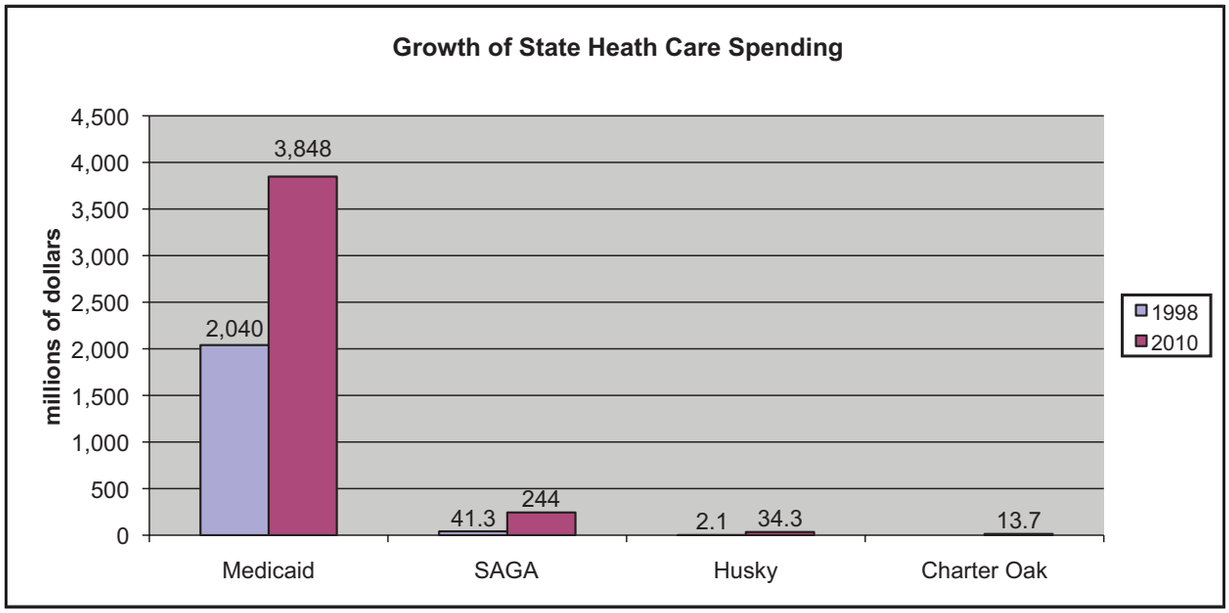
[2] *Appropriations Summary Document for FY10 Budget, p. 12. Accessed at http://www.cga.ct.gov/ofa/Documents/OFABudget/2009/Book/Contents.pdf*

[3] *HealthFirst Connecticut Authority, Report to Legislature, March 11, 2009, p. 9.*

[4] *Appropriations Summary Document for FY10 Budget, Department of Human Services Section, p. 1. Accessed at http://www.cga.ct.gov/ofa/Documents/OFABudget/2009/Book/hsrWorksheet.pdf.*

In 1998, Connecticut spent $2.04 billon on Medicaid, $41.3 million on SAGA, and $2.4 million on the Children's Health Initiative.[5] During that same period, spending on these programs has risen from 18% of the state budget to over 20%. If federal spending is excluded, spending on these programs has risen from 33% of state spending to 38%.[6]



Existing Health Insurance Markets

There are different health insurance markets in Connecticut: the individual market, for those individuals who buy health insurance on their own; the small employer group market, for those businesses with 50 or fewer employers; and the large employer group, for those businesses with over 50 employees. Businesses that run their own insurance programs (what's called self-insured) are covered by federal, not state, regulations.

Other than self-insured policies, all insurance sold in Connecticut must comply with 54 health benefit mandates imposed by the legislature and approved by the governor, regardless of whether the consumer desires them or not. These mandates cover both procedures (such as drug abuse treatment and in vitro fertilization) as well as the provision of services by certain providers (such as chiropractors). The state also mandates that certain people must be covered by insurance policies, such as non-custodial children and domestic partners.[7]

In the individual market, insurance companies are not forced by state law to sell to everyone (that is, there is no "guaranteed issue") and insurers can charge rates based on age, health condition, and other factors (that is, there is no "community rating").

The state imposes more regulations on the small group market. There is guaranteed issue in this market, which means all who want to buy a policy can buy one. There is also a form of community rating imposed, which allows insurers to vary rates based on age and gender but not on health condition. The large group market has fewer regulations but is still subject to state benefit mandates.[8]

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[5] *Appropriations Summary Document for FY1999 Budget, Human Services Section, p. 2. Accessed at http://www.cga.ct.gov/ofa/Documents/OFABudget/1999/Book/13.%20Human%20Services.pdf*

[6] *HealthFirst, p. 9.*

[7] *Bunce, Victoria Craig and JP Wieske, "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance. Accessed at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf.*

[8] *HealthFirst Connecticut Authority, p. 6.*

Connecticut health insurance premiums are higher than the national average. In 2008, the average total single premium per enrolled employee in the United States was $4,386. In Connecticut it was $4,740,[9] or 8% higher. For a family plan, nationally the average cost was $12,298. In Connecticut, that cost was $13,436,[10] or 9% higher.

According to Federal Trade Commission Horizontal Merger Guidelines, the health insurance market in Connecticut is "highly concentrated," with a few firms controlling most of the health insurance policies sold.[11]

While it is appropriate to be concerned about the fact that some state residents do not have health insurance, the number of uninsured who truly don't have access to health insurance may not quite rise to the level of crisis that advocates of expanded government health insurance programs claim it to be.

SustiNet—From Conception to Law

The original SustiNet plan proposed by the Universal Health Care Foundation of Connecticut in January, 2009 consisted of these provisions:

1. Establish a self-insured health coverage plan initially consisting of government retirees, state employees, and HUSKY and SAGA enrollees. This plan would expand to include those who cannot afford health insurance and those without employer-sponsored insurance. Eventually all employers in the state would have access to purchase coverage under the new plan.
2. HUSKY would be expanded to cover those with incomes under 300% of FPL ($54,930 for a family of three).
3. Premiums for health care coverage would be offered to those with incomes between 300% and 400% of FPL ($73,240 for a family of three).
4. SustiNet would automatically enroll eligible residents when they began or ended jobs, enrolled in school, applied for unemployment benefits, filed taxes, or sought medical care. Residents who wished to opt out could do so.[12]

Instead of adopting the UHCFC proposal, the General Assembly passed (over the governor's veto) legislation to set up a SustiNet Health Partnership Board of Directors that would recommend by January 1, 2011 a plan to implement a self-insured health care coverage system. The board must address the following things in developing its plan:

1. Create a public entity that would work with insurers, set reimbursement rates, establish "medical homes" for SustiNet recipients, and create advisory committees.
2. Phase-in the SustiNet plan to the following groups: state employees and retirees, recipients of HUSKY A and B, those who don't have employer-sponsored insurance, those whose employer-sponsored insurance is "unaffordable," and small and large employers.
3. Set guidelines for what SustiNet's benefits should be.
4. Reach out to the public and find the uninsured using community-based organizations.

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[9] Agency for Healthcare Research and Quality, Department of Health and Human Services, Table for average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State: United States, 2008. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiic1.htm

[10] Agency for Healthcare Research and Quality, Department of Health and Human Services, Table for average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State: United States, 2008. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiid1.htm

[11] American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets," 2007 update. Accessed at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.

[12] Universal Health Care Foundation of Connecticut (UHCFC), "SustiNet: Health Care We Can Count On." Accessed at http://www.healthcare4every1.org/site/DocServer/Sustinet_Proposal_Text.pdf?docID=563.

5. Define the insurance mandate that will be included in SustiNet.[13]

The Board must design SustiNet so that it improves the health of Connecticut residents, improves the quality of and access to health care, insures those who would otherwise be uninsured, increases the range of health insurance options in the state, and slows the growth of health care spending. It should also consider providing subsidies for those with incomes between 300% and 400% of FPL (between $54,930 and $73,240 for a family of three), mandating that individuals purchase health insurance, mandating guaranteed issue on health insurance companies and eliminating the ability to refuse coverage due to pre-existing conditions, and setting new payment methods for health care providers, among other things.

With such an expansive mission, it is hard not to view SustiNet as other than big government health care, filled with mandates and regulation.

SustiNet Board: The SustiNet Board is made up of representatives from various stakeholder groups,[14] and it is not a state government agency or department. Its initial charge is to design the SustiNet Plan, which must be approved through the legislative process. After this legislation is passed, though, the SustiNet Board will have vast power to set the details and regulations of SustiNet. The Board met throughout 2009.

Likely Policy Outcomes:

While the SustiNet proposal that will come out of the Board's deliberations is unknown, it is safe to assume that it will resemble UHCFC's proposal. It will likely consist of a large state-run insurance program provided free of charge to the poor and near-poor (possibly up to 300% of FPL). Coverage will be subsidized for many others in the state. The state will contract with private insurance companies for administrative purposes.

If SustiNet is enacted as envisioned, it will reduce the number of uninsured in the state as its sponsors intend, mostly by providing wider access to government health care. The other goal of SustiNet, that it will slow the growth in health care spending or lower health insurance premiums, is almost certain not to happen, though.

With such an expansive mission, it is hard not to view SustiNet as other than big government health care, filled with mandates and regulation.

One of the methods of lowering both health care spending and health insurance premiums is through SustiNet's supposed greater efficiency. Current government health programs are riddled with waste, fraud, and abuse, though.[15] And while many claim that Medicare has lower administrative

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[13] *These are the conditions on the insurance package:*

1. *Current state health insurance mandates will apply to it.*
2. *Preventive care is mandated and cannot be subject to deductibles or copayments*
3. *Drug coverage is mandated, is not subject to deductibles, but it is subject to copayments*
4. *Office visits are mandated and subject to copayments*
5. *Behavioral and mental health services must be covered at the same rate as other services*
6. *Dental coverage must be included*

[14] *These members are:*

1. *Nancy Wyman, the state comptroller*
2. *Kevin Lambo, the state healthcare advocate*
3. *Norma Gyle, RN, a representative of the nursing or allied health professions, appointed by the governor;*
4. *Bruce Gould, MD, a primary care physician, appointed by the Senate president pro tempore;*
5. *Sal Luciano, a representative of organized labor, appointed by the House speaker;*
6. *Joseph McDonagh, an individual with expertise in providing employee health benefit plans for small businesses, appointed by the Senate majority leader;*
7. *Jeff Kramber, an individual with expertise in health economics or policy, appointed by the House majority leader;*
8. *Jamie Mooney, an individual with expertise in health information technology, appointed by the Senate minority leader; and*
9. *Paul Grady, an individual with expertise in actuarial sciences or insurance underwriting, appointed by the House minority leader.*

This information is taken from http://www.cga.ct.gov/2009/SUM/2009SUM00148-R03HB-06600-SUM.htm and from http://www.ct.gov/sustinet/cwp/view.asp?a=3822&q=449900.

[15] *See, for instance, the October 2009 GAO report on Medicare's contract management system (http://www.gao.gov/new.items/d1060.pdf), a recent a report from OMB on billions of dollars in improper payments by Medicare and Medicaid (http://www.cnbc.com/id/34009267), or various news stories on Medicare's waste (http://www.nytimes.com/2007/11/30/business/30golden.html?_r=1, http://www.washingtonpost.com/wp-dyn/content/article/2008/06/12/AR2008061203915.html).*

costs than private insurance, this assertion rests on dubious assumptions and accounting.[16] There does not seem to be any plausible evidence that expanding government health coverage results in greater efficiency in the health care system. One cannot rely on this to occur in order to promote SustiNet's potential savings.

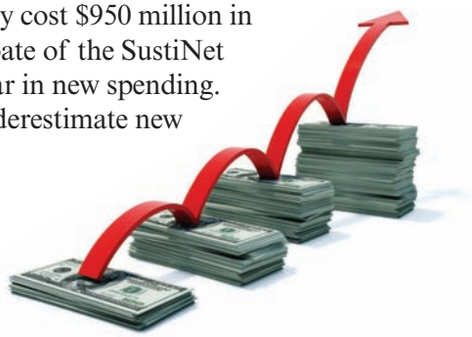
The proponents of SustiNet also claim that reducing the number of uninsured will reduce the amount of uncompensated care in the state, leading to less cost-shifting. It does not seem the uninsured impose a significant cost burden on those with insurance or taxpayers, though. A study co-authored by MIT economist Jonathan Gruber concluded, "Our best estimate is that physicians provide negative uncompensated care to the uninsured, earning more on uninsured patients than on insured patients with comparable treatments."[17] Reducing the number of uninsured will not necessarily lead to a significant reduction in the amount of uncompensated care.

A more plausible claim is that raising the reimbursement rates of HUSKY will result in less cost-shifting to those with private insurance. If this happens then it is likely health care providers will not be tempted to overcharge privately-insured patients, which could lower insurance rates (or keep them from increasing as much). However, this will only lead to another form of cost-shifting as taxes will be increased to pay for these higher reimbursement rates.

Reducing the growth of health care spending will not come from expanding government health care. Instead, there is growing evidence that savings are best achieved through consumer-directed health care plans. A recent American Academy of Actuarials review noted that with consumer-directed health care plans, health care spending decreased with no negative effect on the health of those who had such plans.[18]

Potential Problems: Costs

Proponents of the original SustiNet plan claim it would only cost $950 million in new spending from implementation through 2014.[19] During debate of the SustiNet legislation, cost was often estimated at more like $1 billion a year in new spending. This figure gets closer to the likely actual costs, but may still underestimate new expenses.



HUSKY expansion: The main reason for SustiNet is to provide coverage to all Connecticut residents who are uninsured. An early draft of the SustiNet legislation would accomplish this in part by enrolling uninsured Connecticut families under 300% of the FPL in the HUSKY programs. The Office of Fiscal Analysis estimated this would cost at least an additional $800 million annually.[20]

"Crowd out:" But even OFA noted this figure is probably low. The estimate assumed that no one who currently has private insurance coverage would drop it in order to take advantage of the expanded HUSKY eligibility, which is almost certainly wrong. The tendency of public health insurance programs to attract those who already have insurance is known as "crowd out" and has been noted in both the Medicaid and SCHIP programs. The extent of this crowding out is debated, but it is a real phenomenon and could account for as much as 60% of new enrollees.[21]

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[16] For a good discussion on Medicare's administrative costs, see Benjamin Zycher's "Comparing Public and Private Health Insurance" (http://www.manhattan-institute.org/html/mpr_05.htm) or Merrill Matthews' "Medicare's Hidden Administrative Costs (http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf).

[17] Gruber, Jonathan and David Rodrigues, "How Much Uncompensated Care do Doctors Provide?", NBER Working Paper No. 13585, November 2007. Accessed at http://www.nber.org/papers/w13585.

[18] American Academy of Actuaries, "Emerging Data on Consumer-Driven Health Plans," May 2009. Accessed at http://www.actuary.org/pdf/health/cdhp_may09.pdf.

[19] UHCFC, p. 13.

[20] Office of Fiscal Analysis cost estimate of HB 6600. Accessed at http://www.cga.ct.gov/2009/FN/2009HB-06600-R000615-FN.htm.

[21] See Gruber, Jonathan and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Health Insurance Expansions Crowded Out Private Health Insurance?", NBER Working Paper No. 12858, January 2007. Accessed at http://papers.nber.org/papers/w12858. Also see Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, p. 12. Accessed at http://www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf.

"Adverse selection:" OFA included another caveat on why its estimate may be too low: new HUSKY enrollees may cost more to serve than current enrollees. It is likely that many of the uninsured who would be covered by SustiNet will have some form of health problems and cost more than the average adult currently in the program. This happened with the Healthy Indiana Program[22] due to what is called "anti-selection" or "adverse selection."

Higher Reimbursement Rates: The original SustiNet proposal also called for raising HUSKY reimbursement rates up to the same level as commercial reimbursement rates. If the Board recommends this, OFA estimated that HUSKY reimbursement rates would need to increase by 75% to come in line with commercial rates, which would mean a cost of $900 million.[23] However, since HUSKY would have more enrollees under SustiNet than it currently has, this estimate is likely too low.

Subsidies: It is likely the SustiNet Board will also recommend offering subsidies to purchase SustiNet insurance. The original SustiNet proposal envisioned such subsidies going to families making between 300% and 400% of FPL. OFA notes that 174,000 households would be eligible for this subsidy. It is uncertain exactly how much subsidies for these families will be, but if each received a $1,000 a year, that would add $174 million onto the cost of the program.

On top of subsidies to purchase insurance, the state has two options for setting the price of premiums for those it enrolls in SustiNet: set premiums on an actuarially-sound basis; or set premiums on the ability of families to pay. If it follows the first course, SustiNet will operate much like any other insurance company, with premiums paid in covering the cost of services provided. There will be no need for taxpayer subsidies to cover the cost of those who have SustiNet insurance (as opposed to those who receive HUSKY coverage).

This actuarially-sound method of pricing premiums is unlikely, though. The original SustiNet proposal explicitly says premiums will be charged based on a family's ability to pay. Furthermore, those with expensive medical conditions will not be charged more for SustiNet coverage. This will either mean that both higher-income and healthier residents who buy SustiNet insurance will pay higher premiums to subsidize lower-income families and the less healthy; or that taxpayers will pay a portion of these families' costs. Given that higher-income and healthier consumers will still have the ability to buy lower-priced policies in the private market, it seems certain that taxpayers will provide a direct subsidy to SustiNet. How much this subsidy will be is unknown until the SutiNet Board sets the actual insurance premium rates.

SustiNet Component	Conservative Estimate of Cost
Medicaid Expansion	$1 billion
Reimbursement Rate Increase	$900 million
Insurance Subsidies	$174 million
Direct Subsidy	Unknown
Total New Spending	At least $2.074 billion annually

Effect on Taxpayers

As noted above, it's hard to estimate what SustiNet will cost state taxpayers. Adding up the very conservative estimates leads to a total of $2.074 billion a year in new spending once the program is fully implemented. As was the case in other states, actual costs will likely exceed this estimate. Some of this sum may be offset by federal Medicaid matching funds, but most of SustiNet's new costs will be borne by Connecticut taxpayers.

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[22] Damler, Rob, "Experience under the Healthy Indiana Plan," Milliman Health Reform Briefing Paper, August 2009 p. 1. Accessed at http://www.milliman.com/perspective/healthreform/pdfs/experience-under-healthy-indiana.pdf

[23] According to OFA, Medicaid currently pays 67% of actual costs while private insurance pays 118% of actual costs.

To fund their health care programs, some states have raised cigarette and alcohol taxes. Connecticut recently raised its cigarette tax to help deal with the state's existing budget problems. That tax hike resulted in Connecticut having the second-highest cigarette tax in the nation. For liquor and beer taxes, Connecticut levies higher rates than all its neighbors with the exception of New York's liquor tax.[24]

State	Cigarette	Liquor (per gallon)	Beer (per gallon)
Connecticut	$3.00	$4.50	$.20
New York	$2.75	$6.44	$.14
Rhode Island	$3.46	$3.75	$.11
Massachusetts	$2.51	$4.05	$.11

Raising these taxes will not do much to offset the cost of SustiNet. In Fiscal Year 2008, the alcoholic beverages tax produced $47 million and the cigarette tax produced $330 million (the cigarette tax has since been increased by fifty percent)[25]. Doubling 2008 rates and revenue would produce under $400 million addition revenue, and that assumes consumers do not cut back or shift purchasing across state lines.

Another method of raising revenue to pay for SustiNet is to charge penalties for companies that do not offer health insurance coverage. The original SustiNet proposal recommended that medium-to-large companies that do not offer insurance be subject to a fine. The fiscal impact of such a charge would likely be small, however. Ninety-five percent of Connecticut's full-time employees work at firms offering health insurance. Those companies that do not are typically smaller firms that would presumably not be subject to a fine.[26]

Of the 80,521 private-sector firms in Connecticut that existed in 2008, only 3,424 would likely be subject to the fine proposed in the original SustiNet plan. Of that number, 2,475 are firms with between 10 and 24 employees, which would likely mean their fines would produce little in the way of significant revenue for the state.[27]

Raising sales and income taxes is one of the few ways to bring in enough revenue to pay for such a massive government program as SustiNet. In 2010, personal income taxes are expected to raise $6.6 billion and sales taxes are estimated to bring in $3.2 billion.[28] Raising another $2 billion annually would require an income tax hike of at least a point in a state where the state and local tax burden is already third highest in the nation.[29]

Effects on Health Care Actors

Consumers: While the intent of SustiNet is partially to lower insurance costs, its likely effect will be to increase costs for Connecticut consumers, especially those who remain on private insurance.

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[24] The Tax Foundation, "State Sales, Gasoline, Cigarette, and Alcohol Tax Rate by State 2008-2009," July 10, 2009. Accessed at http://www.taxfoundation.org/taxdata/show/245.html.

[25] State of Connecticut Department of Revenue Services, "Annual Report: Fiscal Year 2007-2008," p. 8. Accessed at http://www.ct.gov/drs/lib/drs/research/annualreport/drs_fy08_annual_report.pdf.

[26] Agency for Healthcare Research and Quality, Department of Health and Human Services, Table showing percent of private-sector full-time employees at establishments that offer health insurance by firm size and State: United States, 2008. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2008/tiib3b.htm.

[27] Agency for Healthcare Research and Quality, Department of Health and Human Services, Table showing the number and percent of private sector establishments by firm size and State. Accessed at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&year=-1&tableSeries=2&searchText=&SearchMethod=1&Action=Search

[28] Office of Fiscal Analysis, Connecticut State Budget, Section V, Financial Tables. Accessed at http://www.cga.ct.gov/ofa/Documents/OFABudget/2009/Book/Financial_Schedules.pdf.

[29] The Tax Foundation, "Connecticut: The Facts on Connecticut's Tax Climate," July 1, 2009. Accessed at http://www.taxfoundation.org/research/topic/17.html.

One of the ways that government health care plans raise the cost of coverage for those who have private insurance is through cost-shifting. The reimbursement rates for Medicare and Medicaid are lower than commercial payment rates, and so providers charge more to private insurance companies to compensate, raising the price of their premiums. One estimate concluded that such cost-shifting adds 15% to the rates of hospitals and physicians.[30]

If SustiNet sets its rates at the commercial level, this cost-shifting would be eliminated. If reimbursement rates are not raised or only raised partially, cost-shifting would continue to occur. As more Connecticut residents move into SustiNet and away from private insurance, this would further increase the premiums of those with private insurance.

SustiNet will likely also increase non-monetary costs of obtaining health care. For instance, in Massachusetts, one of the effects of more people obtaining health care coverage is an increased amount of time patients wait to see doctors.[31]

The SustiNet Board is also empowered to consider a mandate that individuals must purchase health insurance, as in Massachusetts. This mandate would force consumers to buy a policy that satisfies the government's desires, not theirs. This has caused problems in Massachusetts, where individuals who had insurance found themselves defined as "uninsured" and forced to buy more insurance to meet state mandates.[32]

The SustiNet legislation also empowers the SustiNet Board to consider imposing guaranteed issue and community rating on the individual health insurance marketplace. Six states have laws that do this, and these states, health insurance consumers paying higher prices than they would otherwise.[33]

Employers: The original SustiNet proposal advocated fining employers who did not provide health insurance, and while the SustiNet law does not explicitly endorse this view, such fines are possible.[34]

"...it is exceedingly difficult, if not impossible, to simultaneously expand coverage to a large population, offer a generous package of benefits and still check the excessive growth of the total budget."[40]

As discussed above, the original SustiNet plan called for medium and large employers that do not offer health insurance to be subject to a fine. Most of the potentially affected employers have between 10 and 24 employees. It is likely that employers do not offer health insurance because the financial burden of doing so is too great. These employers – and their employees, who accepted the jobs knowing health care was not a provided benefit – are trading higher employment for lower benefits. Subjectively, this may not be ideal for the employee, but isn't it better to have a job with no health insurance than to have no job at all?

If SustiNet imposes a fine on these employers, business owners will respond in four ways: reducing employee head counts to ten or fewer so they are below the fine's limit; reducing wages or other benefits to pay the fine or pay for health insurance; raise prices; or go out of business. Certainly a tax on employment can be expected to reduce employment.

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[30] "Hospital and Physician Cost Shift," Millman, December 2008, p. 3. Accessed at http://www.ahip.org/content/default.aspx?docid=25216.

[31] Kowalczyk, Lynn, "Across Mass., Wait to See Doctors Grows," Boston Globe, September 22, 2008. Accessed at http://www.boston.com/news/health/articles/2008/09/22/across_mass_wait_to_see_doctors_grows/.

[32] As health care policy analyst Michael Tanner writes, " To qualify under the mandate, the [government] has decreed that insurance must now (1) include prescription drug coverage; (2) cover preventive care services; (3) have a deductible of no more than $2,000 for individuals or $4,000 for families, with drug deductibles of no more than $250 for individuals and $500 for families; (4) have an in-network out-of-pocket maximum (including deductibles, co-payments, and coinsurance) of no more than $5,000 for individuals and $10,000 for families; and (5) have no limit on annual or per sickness benefits. These rules do not apply just to the previously uninsured. Individuals who already had health insurance, but whose insurance did not meet these requirements, were required to give up their current insurance and purchase insurance that conformed to the new rules."

Quoted from "Massachusetts Miracle or Massachusetts Miserable," The Cato Institute, June 9, 2009, p. 5. Accessed at http://www.cato.org/pubs/bp/html/bp112/bp112index.html.

[33] New AHIP Report Takes a Ten Year Look at the Unintended Consequences of State Efforts to Change the Insurance Market, America's Health Insurance Plans, September 7, 2007. Accessed at http://www.ahip.org/content/pressrelease.aspx?docid=20794.

[34] It does this by allowing the Board to find "a way to collect payments from employers whose employees would have received ESI, but instead enroll in SustiNet."

[**] Footnote for quote

Health Care Providers: If SustiNet covers government employees, retirees, and most low-income Connecticut residents, it is likely that almost all health care providers in the state would participate in SustiNet. Participation in SustiNet will force these providers to comply with many new state demands.

A centerpiece of the SustiNet proposal is that all enrollees should have a "medical home" to coordinate their care. This model of health care delivery differs significantly from the way most people currently receive their health care. And while it may have certain benefits, it will mean changes for providers.

The providers chosen as medical homes will see their responsibilities increase and will also likely see state oversight increase. Other providers in the state will see their autonomy decrease. For instance, the SustiNet legislation would mandate that "specialty referrals include prior consultation between the specialist and the medical home to determine whether the referral is medically necessary." If the medical home does not determine this referral is "medically necessary," it won't happen, regardless of what the patient or specialist thinks.

Another burden that will be shouldered by providers is the information technology requirement in the legislation. In order to participate in SustiNet, providers would be forced to comply with state requirements for information technology usage, likely leading to large-scale upgrades in existing health care information technology.

Insurers: Part of the legislature's charge to the SustiNet Board is to consider more mandates and regulations on health insurance. Not only will new mandates result in higher costs to consumers, but also increased regulation will likely lead to health insurance companies departing the state.[35]

Reform in Other States

Similar large-scale efforts to extend coverage to the uninsured or lower health insurance costs have taken place in Massachusetts, Maine, Tennessee, and Indiana in recent years. While these efforts did result in broader coverage for the uninsured, they also occasioned higher-than-anticipated costs.

Massachusetts: Connecticut's neighbor to the north has enacted the most sweeping health care legislation in the nation. In 2006 a bipartisan group of legislators and the governor crafted a plan that mandates that most Massachusetts residents purchase health insurance, provides subsidies for insurance, expands government health care programs, and made changes to the state's insurance market.

While the number of uninsured in Massachusetts has dropped, the program has proven to be 30% more expensive than anticipated.[36] Insurance premiums increased at a rate higher than the national average and are far more expensive in Massachusetts than elsewhere.[37] Massachusetts is now grappling with how to pay for its health care plan's costs.

Tennessee: In 1994, Tennessee launched TennCare, an expanded Medicaid program that was open to Tennessee residents living in families under 200% of FPL and those who were uninsurable due to pre-existing medical conditions. While enrollment remained relatively stable, the cost of the program exploded. At its inception, TennCare cost $2.64 billion a year. In 2005, it cost $8.5 billion.[38] Due to this cost explosion, TennCare's benefits were reduced and some recipients lost eligibility. The TennCare program exists today in a much scaled-back form.

Maine: In 2001 Maine established Dirigo, a government-run health care plan to compete with private insurers in the state. Instead of covering the uninsured, though, Dirigo insurance plans were mainly sold to those who already had insurance. The monthly premiums for this insurance did not cover

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[35] Wachenheim, Leigh and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman, August 2007. Accessed at http://www.americanhealthsolution.org/assets/Reform-Resources/Individual-Market/MillimanIndivMarket.pdf.

[36] Tanner, pp. 5, 6

[37] Tanner, p. 4.

[38] Chang, Cyril, "Evolution of TennCare Yields Valuable Lessons," Managed Care, November 2007, p. 45. Accessed at http://www.managedcaremag.com/archives/0711/0711.peer_tenncare.pdf.

the cost of operating the program and so taxes on private health insurance plans were increased. Ultimately, Dirigo stopped accepting new enrollees and the state is still struggling to pay for it.[39]

Indiana: Indiana went another way for its government health coverage expansion. The Healthy Indiana Plan (HIP) began on January 1, 2008, to cover adults in Indiana with incomes up to 200% of FPL. HIP enrollees receive high-deductible managed care insurance and an account that resembles a health savings account to help them meet their health insurance deductible. With HIP being so new, there is little data on how well the program is performing. New enrollees are costing the state more than expected.

Lessons for Connecticut

Looking at these states' health care experiences, it is hard to escape the conclusion that, as one observer said in summing up the TennCare experience, "…it is exceedingly difficult, if not impossible, to simultaneously expand coverage to a large population, offer a generous package of benefits and still check the excessive growth of the total budget."[40] Government can expand coverage to the uninsured, but taxpayers pay a heavy price, and the growth of spending for these programs may prove unsustainable.

Furthermore, there is no evidence that expansion of coverage in other states reduced the growth of health care spending. In fact, just the opposite: expansions of coverage lead to higher-than-anticipated health care spending growth.

Another lesson to be drawn from these state programs, as well as other expansions of government health care such as Medicaid, is that whatever policymakers predict SustiNet will cost, the actual cost of the program is likely to be higher. It is likely that taxes will need to be raised one or two years into SustiNet's implementation to cover the program's higher-than-anticipated costs.

Health Care Reform Alternatives

There are market-based reforms that can help meet the goals of SustiNet at a fraction of SustiNet's cost.

Reduce the Cost of Private Insurance: State health care regulation contributes to the high cost of health insurance in Connecticut in two ways. One, regulation directly increases prices by mandating insurance cover more treatments. Two, regulations drive out competition in the market, allowing the companies that offer policies to charge higher prices than they could otherwise charge. States with less regulation have, on average, lower insurance costs. Idaho, for instance, has far less regulation on its health insurance providers. The average cost of a single premium in that state was only $4,104 and the average cost of a family policy was only $10,837[41] – nearly 20% less expensive than in Connecticut.

There are two ways the state can lower the price of insurance premiums in the state. One is to reduce state regulations on the product. By eliminating mandated benefits and loosening up state regulations on how insurance companies sell policies, prices for insurance policies will decrease. This will also reduce problems that come with the Connecticut health insurance market being, in the formulation of the federal Department of Justice, "highly concentrated." This can also be accomplished if Connecticut law were changed to allow residents and business owners to buy health insurance policies from other states.

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[39] Bragdon, Terren and Martin Sheehan, "A Series of Unfortunate Events: Maine's Failed Experiments with Big Government Controlling Health Insurance," Maine Heritage Policy Center, June 17, 2009. Accessed at http://www.mainepolicy.org/resources/media/177_542938462.pdf.

[40] Chang, p. 49.

[41] Agency for Healthcare Research and Quality

This approach will be opposed by those who contend that reducing regulations or allowing out-of-state insurance purchases will undermine consumer protections. Opponents will suggest that policies will drop services such as mammography. This concern is largely unfounded, however. Self-insured policies are not covered by state mandates but routinely cover services such as mammography and contraception. If consumers want policies that covers these things, insurance companies have an incentive to provide them. Consumers should be free to pay for only those services they want covered with deductibles and copayments they desire.[42]

Reduce the Cost of Health Care: Connecticut has laws in place that drive up prices for health insurance providers and reduce competition. Eliminating or scaling back these laws will reduce the cost of health care and indirectly reduce the cost of insurance.

Certificate of Need: Government permission, in the form of a Certificate of Need, "is required when a health care facility proposes a medical equipment purchase, introduction of an additional functional or service, a reduction or termination in services, or changes in ownership or control."[43] This sweeping grant of authority to a state agency to determine what health care facilities offer in Connecticut impedes the expansion of medical care, creates an artificial restriction on supply, and increases costs.[44] It should be up to providers and consumers to determine what medical services are needed, not bureaucrats.

Scope of Practice Laws: These laws limit the type of services certain medical professionals can perform. They artificially limit the supply of health care personnel and force consumers to go to higher cost doctors to deal with issues that could be addressed by a nurse practitioner, for example. Eleven other states allow nurse practitioners to practice without physician supervision or collaboration.[45] This allows those seeking health care a wider range of options to meet their needs at a lower price. Connecticut prohibits nurse practitioners from practicing without physician collaboration, a policy supported by doctors who do not want the competition and which results in higher costs.

Reform State Health Care Programs: There will still be those who cannot afford to purchase health care coverage. The state has existing programs to serve these individuals, and reforming programs for the poor should be the focus of Connecticut legislators. There are two types of people who would have trouble obtaining health insurance even if health insurance costs were reduced by the above recommendations: The poor and those whose pre-existing conditions.

The poor: All individuals living in families up to 100% of FPL ($18,310 for a family of three) should be eligible for Medicaid. If they have access to employer-based insurance, subsidies should be provided to move them onto private insurance. Medicaid should be restructured along the lines of Florida's system, where a risk-adjusted premium is paid for each Medicaid patient to enroll in his or her choice of managed care organizations.[46]

For the poor who have incomes in excess of 100% of FPL, the state should establish a program similar to the Healthy Indiana Program. These individuals should be provided with a high-deductible health insurance policy and a health savings account to help meet the deductible.

Those with Pre-Existing Conditions: The state should continue to operate the Charter Oak program for Connecticut residents who, because of pre-existing conditions, cannot find an affordable health insurance policy. Premiums should be based on ability to pay.

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[42] Peter Suderman's article, "States' Failed Experiments," in the January 2010 issue of Reason magazine has a good summary of the consumer problems caused by excessive government regulation of health care. It can be accessed at http://reason.com/archives/2009/12/22/the-states-failed-experiments.

[43] State of Connecticut Office of Health Care Access, Certificate of Need Process webpage. Accessed at http://www.ct.gov/ohca/cwp/view.asp?a=1733&Q=276936&ohcaPNavCtr=|#42044.

[44] There are a number of studies indicating that CON laws increase the cost of health care. The testimony of the Chief of the Litigation Section of the Department of Justice's Antitrust Division, Mark J. Botti, at the Georgia legislature (http://www.healthwatchusa.org/downloads/CON_Folder/20070223-CON-Competition-Healthcare-Botti.pdf) has a good summation of them.

[45] A full list of states' nurse practitioner laws is located here: http://www.health.state.mn.us/healthreform/workforce/npcomparison.pdf.

[46] See Dr. Michael Bond's report for the James Madison Institute, "Florida's Medicaid Reforms: A Progress Report," available at http://www.jamesmadison.org/pdf/materials/587.pdf.

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