

CT Health Policy Project
Basics of Health Policy
August 2016



Many people believe that health care policy is too complex for the average person to understand. While it can be confusing, it is not as challenging as it seems. This is our health policy module for student, intern and volunteer training at the CT Health Policy Project.

There is no need to memorize statistics; health care changes too quickly. They are offered to suggest trends and general themes.

What looks large from a distance,
up close ain't never that big.

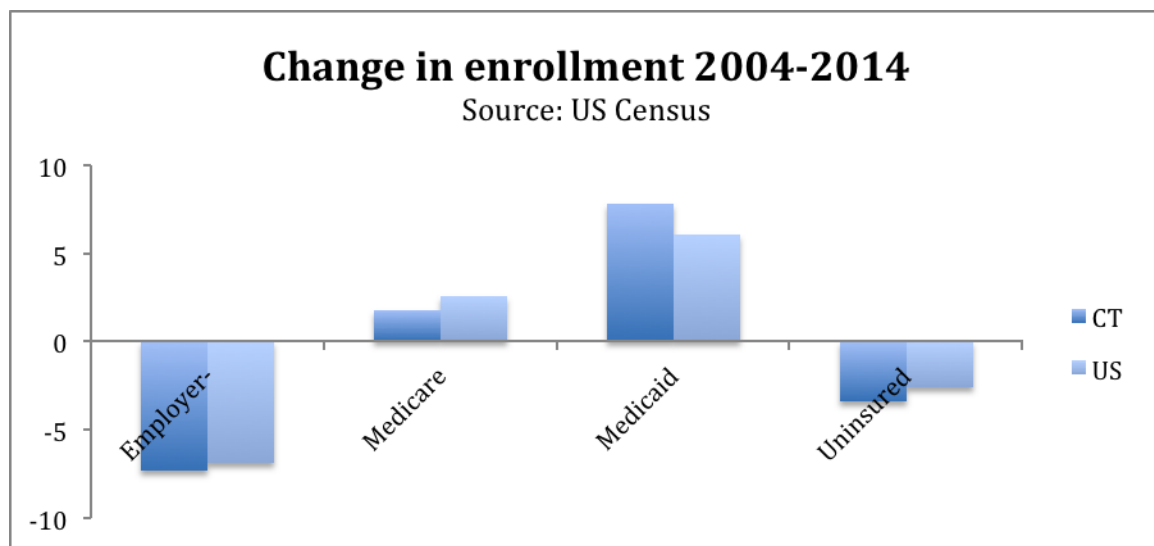
-- Bob Dylan

Outline:

- A) Public insurance -- Medicare and Medicaid/CHIP
- B) Private insurance
- C) The uninsured
- D) Health care financing
- E) Health care reform – what happened, what it means
- F) Role of states

A) Public Insurance

Both in Connecticut and across the nation, the trend is toward declining employer-sponsored health care coverage and rising Medicaid enrollment. This trend pre-dates the Affordable Care Act and was part of the impetus to pass national health reform.



There are two big public health coverage programs in the US – Medicare and Medicaid/CHIP. While both are government programs, they are different in important ways.

Medicare and Medicaid were created in 1965 under the Social Security Act. Medicare is a social insurance program offering a good scope of health care services to seniors and people with disabilities at all income levels. Medicaid was first created to provide health coverage to people receiving cash assistance or “welfare”. It has been expanded over the years to include other low income and working people. Medicaid is also the largest funder of nursing home care for seniors. The State Children’s Health Insurance Program (CHIP) was added to the Social Security Act in 1997 to expand health coverage to children.

Medicare

The federal government alone administers Medicare; there are few differences between the program across the nation. Medicare has four parts, each with its own services, consumer costs, funding sources and eligibility rules.

- Part A covers inpatient hospital services
- Part B covers outpatient, physician, home health and preventive services
- Part C, also known as Medicare Advantage, allows beneficiaries to join managed care plans to receive their health care services
- Part D is the prescription drug benefit delivered through a choice of 886 private plans now, down from 1,875 in 2007

Because Medicare doesn’t cover some services and includes coinsurance on others, nine out of ten members have supplemental coverage through private insurance -- Medigap plans -- and/or Medicaid that addresses some or all of those costs. Some purchase Medigap plans directly, but some receive it as part of retirement benefits. The proportion of large firms offering retiree health benefits dropped by half from 1988 to 2006.

	Medicare	Medicaid/CHIP
<i>How many Americans and Connecticut residents are enrolled?</i>	55.5 million US (2015) 630,333 in CT (2015)	Medicaid and CHIP– 72.4 million US (April 2016) CT Medicaid – 842,956 (June 2016) CT CHIP – 15,362 (July-Sept 2015)
<i>Who is eligible?</i>	Age 65 and over Disabled Patients with end stage renal disease No income limits	Low income children and families Low income adults Low income seniors, disabled

		Children with special health care needs Income limits are set by states and vary between states and between eligibility categories
<i>Entitlement?</i>	Yes	Yes
<i>Stigma, political clout</i>	No stigma for patients Strong political constituencies Generally seen as an earned benefit	Significant stigma for single adults and families, little stigma for seniors Less political strength
<i>What services are covered?</i>	Hospital care Outpatient care Preventive care Skilled nursing facility Hospice Home health care Optional prescription plan	Hospital care Outpatient care Preventive care Skilled nursing facility Hospice Home health care Prescriptions Family planning Dental Vision Mental health For children – all “medically necessary care”, definition set by states
<i>Who runs the programs?</i>	Federal government through CMS (Centers for Medicare and Medicaid Services)	States with minimal oversight by CMS
<i>Who funds the programs?</i>	Federal	State/federal joint funding
<i>Level of flexibility</i>	Very little	A great deal
<i>How much does it cost consumers annually? (2016)</i>	Most pay between \$104.90/month with deductible, copays, and coinsurance There is no cap on out-of-pocket expenses Premiums vary for managed care, prescription drug and supplemental insurance plans	Medicaid – little to nothing CHIP – cannot exceed 5% of income
<i>How much does it cost per</i>	\$10,365 US, \$11,086 in CT	Medicaid -- \$6,502 US

<i>person total?</i>	(2009)	\$8,122 in CT (2011)
<i>Historic annual rate of increase in per person cost</i>	US 6.3%, CT 6.5% (1991-2009)	US 3.7%, CT 4% (1991-2009)
<i>How much does the program cost total?</i>	\$618.7 billion, 20% of total US health care spending (2014)	Medicaid -- \$495.8 billion, 15% of total US health care spending (2014) CT- \$6.1 billion (FY 2016)
<i>How many US providers participate in the program?</i>	92% of US physicians take new Medicare patients (2015)	69% of US and 73% of CT physicians accept Medicaid patients (2013)
<i>Are provider rates reasonable? How are they set?</i>	Set to cover reasonable costs, set by federal administration Approved by Congress	Set by states, generally low US average 66% of Medicare (2014) In CT Medicaid rates average 90% of Medicare rates, 8 th highest in US
<i>Future prospects</i>	Medicare trust fund will run out of funding in 2028, ten years later due to national health reform	Varies with government budgets – policymakers want to spend on these programs when the economy is good and taxes are up, but that is when there is less pressure on health costs and fewer unemployed/uninsured Constant tension between states and feds over funding
Sources: CMS, Kaiser Family Foundation, State Health Facts Online, S. Zuckerman & D Goin, Kaiser Issue Paper, December 2012, CT DSS, Medicare.gov, Medicare Board of Trustees, National Health Accounts, HHS		

Medicaid

Unlike Medicare, which is available to Americans at all income levels, Medicaid eligibility is generally income limited. Medicaid provides comprehensive health services to low income children and their parents or caretaker relatives, picks up costs and extra services for low-income elderly and people with disabilities, particularly long term care services (including nursing homes) which have limited Medicare coverage. However, in January 2014 under national health reform, all Americans (citizens and legal immigrants)

living in households with incomes at or below 133% FPL will qualify for Medicaid regardless of family circumstance or age at each state's option. Thirty-one states, including Connecticut, and the District of Columbia have currently chosen to expand Medicaid eligibility.

While most providers accept Medicare, far fewer accept Medicaid despite the fact that the program covers over one in four children and 41% of births in the US. In Connecticut Medicaid covers one in three children and 28% of births. In 2011, just 60% of Connecticut physicians accepted Medicaid patients, the fourth worst rate in the US. However, because of significant Medicaid policy improvements, administrative simplification and some rate increases participation in Connecticut Medicaid was up to 73% just two years later.

Even though the federal government pays at least half the costs of Medicaid services, states have wide latitude in administering the program, including defining covered benefits, income eligibility levels, costs charged to families, and rates paid to providers. Connecticut is a wealthy state, so the federal government covers just half our costs. National health reform provides higher matching rates for newly eligible Medicaid beneficiaries for three years.

Medicaid regulations are complex, but states can gain permission to bend the rules with state plan amendments and waivers. The processes to gain waivers vary by state, but the federal government generally requires public input into state applications for waivers. Connecticut state law requires legislative review of all waivers. This is an important opportunity for the public to have input into a critical coverage option and a significant driver of Connecticut's health care economy.

Per person spending in Medicaid varies significantly. Elderly and disabled recipients make up 24% of the Medicaid population, but incur 63% of expenditures nationally; in Connecticut elderly and disabled recipients make up 24% of the population but incur 61% of costs. The elderly and people with disabilities have significantly higher per person costs than children or other adults mainly due to more intense use of acute and long term care services. Medicaid funds care for six out of ten US nursing home residents. Only 7% of US Medicaid recipients use long-term care, but they account for 52% of spending. Medicaid spending per person for children and their parents is far lower than in private insurance, and it is growing more slowly.

Medicaid is a critical safety net for low-income working families. A study found that every 1% increase in the unemployment rate results in an increase in Medicaid/CHIP enrollment of 1 million, 1.1 million more uninsured and \$3.4 billion more in Medicaid/CHIP spending. Unfortunately, this happens just when state budgets are tight (due to rising unemployment and lower tax revenue) giving them fewer resources to meet the need.

Unfortunately, despite significant advances and savings in the program, to address the overall budget deficit, the state chose to cut Medicaid eligibility for working parents as of August 1, 2016. While some were able to remain on the program in other eligibility categories or because wages fell, and some were able to afford subsidized coverage from the state's health insurance exchange, thousands of Connecticut working parents lost coverage, very likely joining the ranks of Connecticut's uninsured.

CHIP, the Children's Health Insurance Program, was added to the Social Security Act in 1997 in response to concerns about the rising number of uninsured American children. Since CHIP was enacted, the rate of uninsurance among children living in low-income families (200% of the federal poverty level or lower) has dropped from 23% to 14%. Connecticut was the first state to implement a CHIP program (HUSKY Part B). States receive a higher federal reimbursement for children covered under CHIP than under Medicaid (Connecticut gets the minimal CHIP match at 65%), providing an incentive for states to cover children. Most states run their CHIP programs together with their Medicaid programs providing similar services, but charging higher income families something for their care. Connecticut runs its CHIP program separately from Medicaid for families -- the two programs have different benefits, different costs to families, and families have different rights. Unlike Medicaid and Medicare, CHIP is not an entitlement program -- if states run out of their allotted funding, the federal government will not automatically provide more. States are then placed in the difficult position of freezing enrollment for low-income children or paying out of tight state budgets. Connecticut's attempts at outreach to eligible families have been problematic and largely ineffective.

Federal Poverty Level (FPL) 2016

An archaic standard of what it costs to live in the US, the FPL serves as a benchmark for many income-related programs. Updated every April, the FPL varies by family size.

Family size	2016 Federal Poverty Level
1	\$11,880
2	\$16,020
3	\$20,160
4	\$24,300

2016 Federal Poverty Guidelines, US Dept. of Health & Human Services,
<https://aspe.hhs.gov/poverty-guidelines>

For comparison, the US Census Bureau found that Connecticut's median household income in 2010-2014 was \$69,899.

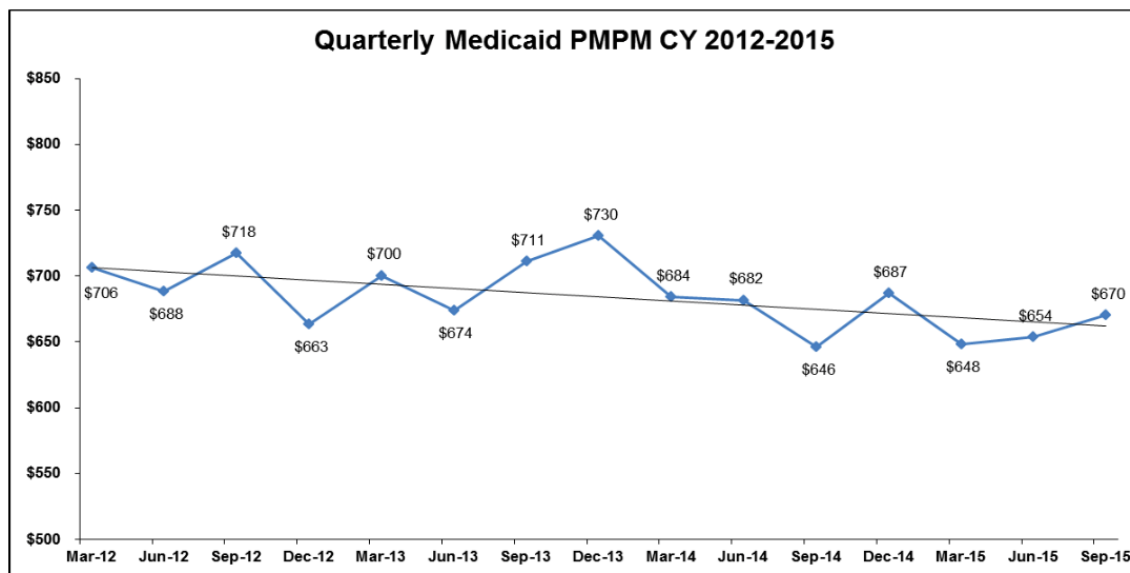
<http://www.census.gov/hhes/www/income/data/statistics/index.html>

Optional: Coverage for immigrants

The federal government will not fund Medicaid coverage of legal immigrants who have been in the US less than 5 years. Many states, including Connecticut, cover some recent legal immigrants with full state funding. Connecticut used to cover all income-eligible recent legal immigrants but due to budget cuts in 2009 reduced eligibility to only children, pregnant women and people in institutions. Some states also cover undocumented immigrants with state programs; Connecticut does not. For more, go to <http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/>

Connecticut Medicaid spending and quality trends

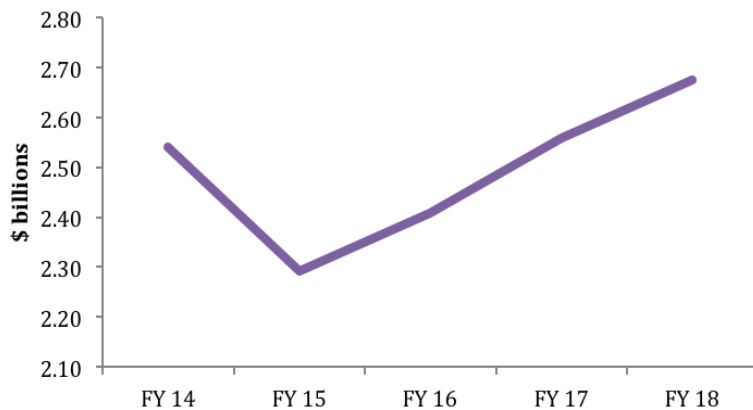
Connecticut spent \$6.1 billion total on Medicaid in Connecticut during the last fiscal year (July 1, 2015 to June 30, 2016). About 60% of that amount was reimbursed by the federal government. Connecticut has done a much better job of controlling costs than most states. Between 2000 and 2010 per enrollee health costs dropped by 17.5% in Connecticut while the national average rose by 5.0%. That early performance has persisted.



Source: DSS, January 8, 2016

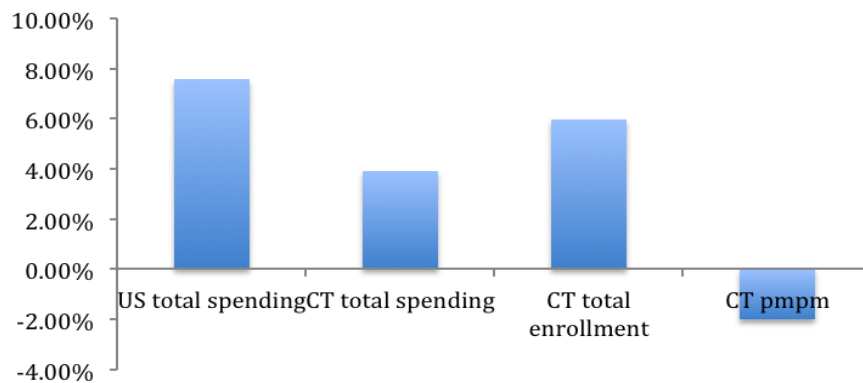
Predictions for future Connecticut spending on Medicaid are encouraging. Projections from the Governor's budget office predict that Connecticut will experience a decrease in state Medicaid spending so significant that it will take about three years to climb back to prior state Medicaid spending levels.

CT Medicaid state spending



On January 1, 2012 Connecticut's Medicaid program shifted payment models from capitated managed care organizations to self-insuring with person-centered medical homes to coordinate care for clients. Since that time, access to care, the number of participating providers and most quality measures are up; costs per member per month (pmpm) are down.

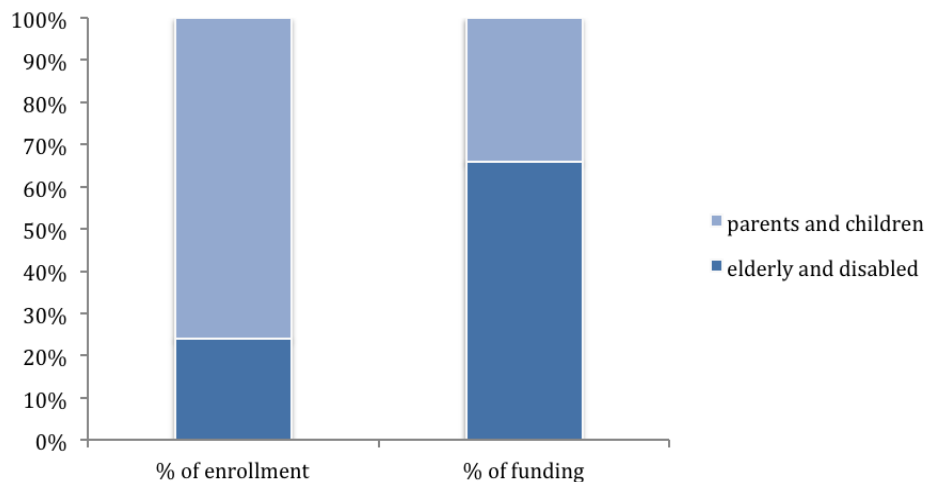
Medicaid FY 12 to FY 13 % difference



Metric		Performance	Timeframe
Providers participating in Medicaid	↑	Up 5,180 32% increase	Jan 2012 to June 2013
Person centered medical homes (PCMHs) -- providers	↑	Up 243 35% increase	Q3 2012 to Q2 2013
PCMHs – clients in one	↑	205,905 25% increase	Q3 2012 to Q2 2013
Hospital admissions	↓	Down 3.2%	Q1 2012 to Q1 2013
Days in hospital	↓	Down 5.0%	Q1 2012 to Q1 2013
Inpatient costs per member per month	↓	Down 1.8%	Q1 2012 to Q1 2013
Cost per hospital admission	↓	Down 2.7% or \$200 each	Q1 2012 to Q1 2013
ED visits	↓	Down 3.2%	Q1 2012 to Q1 2013
Non-urgent ED visit costs	↓	Down 11.7%	Q1 2012 to Q1 2013

As in most states, the costs of care for all Connecticut Medicaid enrollees are not all equal. In 2011 elderly and disabled enrollees made up 24% of total enrollment but consumed 61% of funding. The average cost of care for a Connecticut elderly (\$30,560) or disabled (\$31,004) Medicaid member was far higher than for adults (\$4,538) and children (\$3,158).

CT Medicaid 2010



Source: State Healthcare Spending on Medicaid, Pew Charitable Trusts, July 2014

Dual Eligibles

For impoverished older adults, Medicaid supplements Medicare, creating another eligibility category “dual eligibles” (see <http://www.cms.gov/Center/Special-Topic/People-With-Medicare-and-Medicaid-Center.html>). There are over 70,000 dual eligibles in Connecticut. Medicare continues to serve as the primary means of health insurance for this group of adults. While Medicare pays for short-term nursing home care (less than 100 days), Medicaid pays for long-term care (more than 40% of total long-term care). This figure can be deceiving, especially to people who are concerned about the perceived burden of covering impoverished elders. Many believe that middle- and upper-class elders shield their assets in order to qualify for Medicaid, but there is little evidence to support this.

For more information –

Kaiser Family Foundation on long term care, -- <http://kff.org/medicaid/fact-sheet/medicaids-role-in-meeting-seniors-long-term-services-and-supports-needs/>

CMS -- <http://www.cms.hhs.gov>

Medicare page for consumers -- <http://www.medicare.gov>

MedPac -- Setting Medicare policy and rates – <http://www.medpac.gov>

Kaiser Family Foundation (2015). Medicare: A Primer --

<http://kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/>

Kaiser Family Foundation (2015). Medicare Spending and Financing

<http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/>

Kaiser Family Foundation (2013). Medicaid: A Primer. <http://kff.org/medicaid/issue-brief/medicaid-a-primer>

Graduate Medical Education (GME)

The federal government and some states provide a great deal of funding to train new physicians through Medicaid and Medicare payments to teaching hospitals for direct and indirect services.

See <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dgme.html> and <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Indirect-Medical-Education-IME.html>

B) Private insurance

Two out of three Americans are covered by private insurance -- 209 million in 2014, according to the US Census. 175 million of those are covered through their own or a family member’s employment – a system that is unique in the world and has drawn criticism. Half of Connecticut firms offered health benefits to their workers in 2015, down from 64% in 2009.

Employer-sponsored coverage is paid for in four ways – by workers, by employers, by insurers and by taxpayers. However, ultimately consumers pay all those bills – through our premiums, out-of-pocket costs, taxes and lost wages. Most economists agree that employer spending on health benefits is funded through lost wages. Connecticut family premiums grew 8.2 times faster than median earnings from 2000 to 2007. The share of those premiums that workers pay grew 10.5 times faster than earnings. Health insurance premiums are highest in the Northeast and lowest in the Southern US. In a particularly cruel twist, health insurance premiums at companies with more low income workers average 8% **higher** than at companies with higher income workers.

Workers pay for coverage in a variety of ways, all of which are termed “cost sharing” by policymakers. Not all workers pay all these costs, and the costs for workers often vary depending on which benefit plan they choose. It is important to note that implementation of national health reform has moderated or eliminated many costs for consumers.

- Premiums – Set monthly amounts, usually deducted from paychecks, not subject to taxes. In Connecticut in 2015, workers paid on average 26% of the total premium for single coverage and 30% for family coverage. Employers pay the rest of the premium.
- Deductible – Set amount of health care costs that workers must pay before insurance will begin covering costs. Deductibles are generally set (and re-set) annually. 83% of Connecticut workers in private coverage plans had a deductible in 2015. Deductibles in Connecticut averaged \$1,733 for individuals and \$3,407 for family coverage.
- Copayment (copay) – Flat amounts patients pay for each service. In 2015, 54% of Connecticut workers in private coverage had copays, averaging \$25.13 for physician visits. Copayments generally vary by service, for instance:
 - Preventive vs. acute care – national health reform prohibits copayments or any cost sharing for preventive care
 - Primary care vs. specialist
 - Generic vs. name brand and formulary vs. non formulary medications
 - By service type -- i.e. dental, vision and in some states mental health services
 - Copays can vary based on provider quality or efficiency measures set by the insurer
- Co-insurance – A percentage of service costs that patients must pay. Co-insurance rates averaged 18% for the 36% of Connecticut workers who had coinsurance requirements in 2015.
- Annual or lifetime maximum limits – Many policies, especially directly purchased policies, used to have limits on how much the insurer will cover; patients were responsible for all costs over that amount. National health reform eliminated all such limits as of 2014, with rare exceptions.

Private insurance terms to know	
Community rating	A system of insurance pricing found in some states where members in a given area are charged the same rate regardless of age, sex, health history, geography or other personal characteristics. Under national health reform, all coverage is priced by a modified community rating system, allowing limited variation within categories based only on age, geography and tobacco use.
Mental health parity	A legal prohibition against charging different costs or offering different coverage for mental health services than for other health services. A federal mental health parity law passed in 2009, but some states, including Connecticut, have had stronger laws in place for years before that.
Cost shifting	The process of shifting the costs of caring for some patients onto another group. For instance, hospitals are paid less than their costs of providing care under Medicaid and, consequently, charge privately insured patients more for the same services to make up the difference.
Cost sharing	Costs of care borne by workers and patients. There is significant evidence that higher cost sharing, particularly on individual services or medications, reduces access to care and compliance with treatment plans.
Capitation	A flat payment, usually per member per month, paid to insurers or provider groups by employers or government to cover all health care costs for each member's care. Capitated payments generally vary by at least age, sex and geography. If costs exceed that capitation payment, the insurer loses money. If they are able to keep costs below the capitation payment, the insurer keeps the extra.
Adverse selection	A theory that people who are at higher risk of needing health care, due to chronic conditions, family history, personal habits, risky jobs, etc., are more likely to purchase health coverage avoiding personal financial risk. Insurance companies devote a great deal of resources to avoiding adverse selection and to ensure that they are covering a healthier population. This practice is often called "cherry picking". Effective in 2014, national health reform includes provisions designed to limit this practice.
Moral hazard	A theory that people with insurance alter their behavior because they have coverage, i.e. use more health services than they may need or engage in riskier behavior than they would have if they were uninsured.

Under national health reform, employers with over 50 workers who do not offer health benefits pay fines of up to \$2,000 per employee. 49% of Connecticut employers offer health benefits to their workers, however that rate varies considerably by firm size. All (100% of) Connecticut employers with 100 or more employees offer health benefits, while only 22% of those with ten or fewer employees do (2015).

Even at Connecticut firms that offer health benefits, only 56% of workers are enrolled (2015). Reasons for missing employer coverage vary. Workers may not be eligible (part-time or temporary workers or have not worked for the company long enough to qualify, the coverage may not be affordable, it may not cover what they need, or they may choose to go without coverage.

Insurers and self-insured employers (see below) pay for the costs of care that exceed the payments they collect from workers. Insurers are also required to have large financial reserves, generally held in investments, to cover any catastrophic costs of care for those they insure.

Taxpayers pay a great deal for private insurance, albeit indirectly. Both employers' and workers' share of health premiums are tax-deductible as are consumers' out-of-pocket and premium costs above 10% of income. Tax credits at the federal level alone are over \$200 billion each year, more than half what the federal government spends on Medicare. People who buy coverage on the individual market do not share equally in these tax breaks.

Health insurance has traditionally been regulated at the state level, with one very large exception described below. Regulation varies significantly between individual policies (few regulations), small groups (most regulated) and large groups (very few regulations). States vary in how they define group size. Other regulations include benefit mandates (i.e. requiring coverage for cancer screenings, contraceptives, or infertility) and direct access to various types of providers. The CT Insurance Department also must review and approve rate increases for small group and individual plans.

The major exception to state regulation of insurance is self-insured plans. Self insurance is the practice by most large employers of assuming all the financial risk for worker health benefits. Many self-insured employers hire insurance companies to administer health benefits, but the insurer does not take any financial risk for workers' health care needs. Consequently many Americans are unaware that their employer is self-insuring and that they are not protected by state regulations. The federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured health plans. 57% of insured CT workers are in self-insured plans (2013).

For more information --

Kaiser Employer Health Benefits 2015 Annual Survey

<http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>

Tax subsidies for health insurance – <http://www.kff.org/healthreform/7962.cfm>
2015 MEPS survey, Agency for Health Care Research and Quality
https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&year=2015&tableSeries=-1&tableSubSeries=&searchText=&searchMethod=1&Action=Search

C) The Uninsured

37 million Americans went without any health coverage in 2014 – 11.7% of us. This was down by 8.5 million from 2013 due to implementation of the Affordable Care Act. 245,000 Connecticut residents lacked health coverage in 2014 – 7% of us.

Myth: Uninsured people don't buy health insurance because they don't think they need it.
Truth: The vast majority are uninsured because they can't afford it or they are not eligible for coverage at work and can't get individual coverage. Only 1.5% of the uninsured report that the main reason they are uninsured is because they don't think they need

Who are the uninsured?

- Three out of four uninsured adults are working.
- One in four has a family income under \$25,000/year, another 21% have incomes between \$25,000 and \$50,000; less than 8% have family incomes over \$75,000.
- 65% do not have a college degree.
- The uninsured are more likely to be self-employed, part-time and temporary workers.
- Half the uninsured are between the ages of 18 and 34 years.
- Hispanics are three times and blacks twice as likely to be uninsured as white Americans.
- About half of non-citizens are uninsured, but they are not a large proportion of the total uninsured, as they constitute a small fraction of the total population.
- The uninsured rate varies significantly by geography – between states and even within communities.
- Many uninsured are in poor health; one in five uninsured adults has a chronic condition.
- Most uninsured adults currently are not eligible for Medicaid – Medicaid is mainly available to families with children, pregnant women, seniors and people with disabilities. In 2014, Medicaid will be expanded significantly in Connecticut under national health reform.

How does it matter if people are uninsured?

- It's not healthy to be uninsured.
 - The uninsured are seven times more likely to forgo needed health care because of cost.
 - They are six times more likely not to fill a prescription due to cost.

- It is estimated that three Connecticut residents die each week due to lack of health coverage.
- It's not cheap to be uninsured.
 - Over 14% of the uninsured spend more than 10% of their income on health care.
 - One third of the uninsured report cutting back on other basic needs such as food and heat to pay medical bills.
 - When they access health care, uninsured patients are often charged two to four times what public programs pay for services.
 - 62% of US bankruptcies are a result of high medical bills.
 - 18% of the uninsured report being contacted by a collection agency in the past year over unpaid medical bills.
- It's not good for the health of communities when many people are uninsured.
 - Taxpayers fund 75% of the cost of care for the uninsured.
 - Communities with high numbers of uninsured have fewer health care resources including fewer hospital beds and are less likely to offer trauma and burn care.
 - Public health hazards of large numbers of people who do not have access to regular health care.

However, it is very important to note that coverage does not guarantee access to care. It is estimated that in 2007 in addition to the 46 million uninsured, there were 25 million under-insured Americans, up 60% from 2003. Underinsurance is defined as spending more than 10% of income on health care or having a deductible that exceeds 5% of income. Under-insured Americans face similar challenges accessing and paying for care as the uninsured. 53% of under-insured Americans report missing needed care, in comparison to only 31% of the insured. Almost half the under-insured reports difficulty paying bills, being contacted by a collections agency or changing their way of life to pay medical bills. Many take on loans, mortgages or credit card debt to pay for health care.

For more information –

Kaiser Family Foundation Uninsured Primer

<http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-era-of-health-reform/>

US Census – latest numbers – this is the gold standard for measuring the uninsured

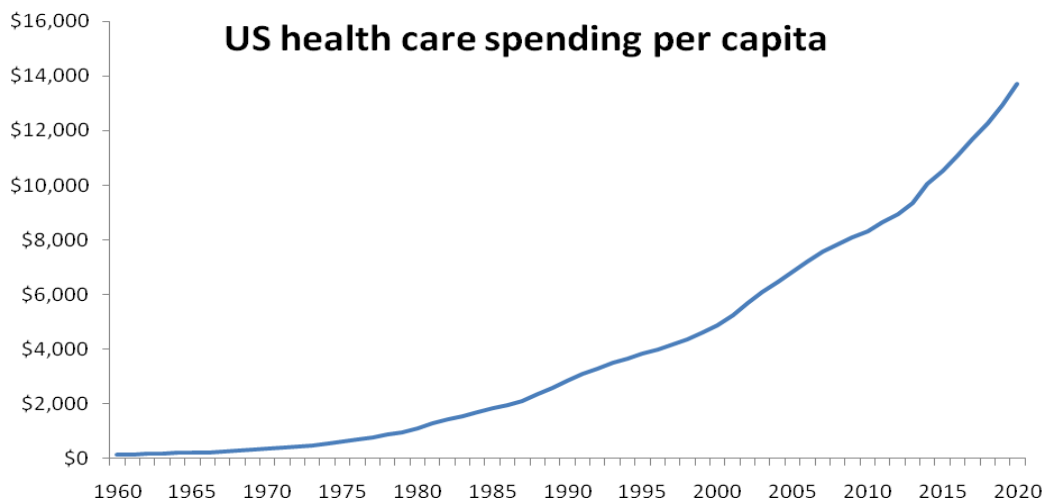
<http://www.census.gov/hhes/www/hlthins>

Racial and ethnic disparities --

Racial and ethnic minorities in the US are more likely to suffer poor health and difficulty accessing care, even within income categories. While minorities are more likely to be uninsured, other factors are also significant. For more on these factors and the effects, go to <http://www.kff.org/minorityhealth>

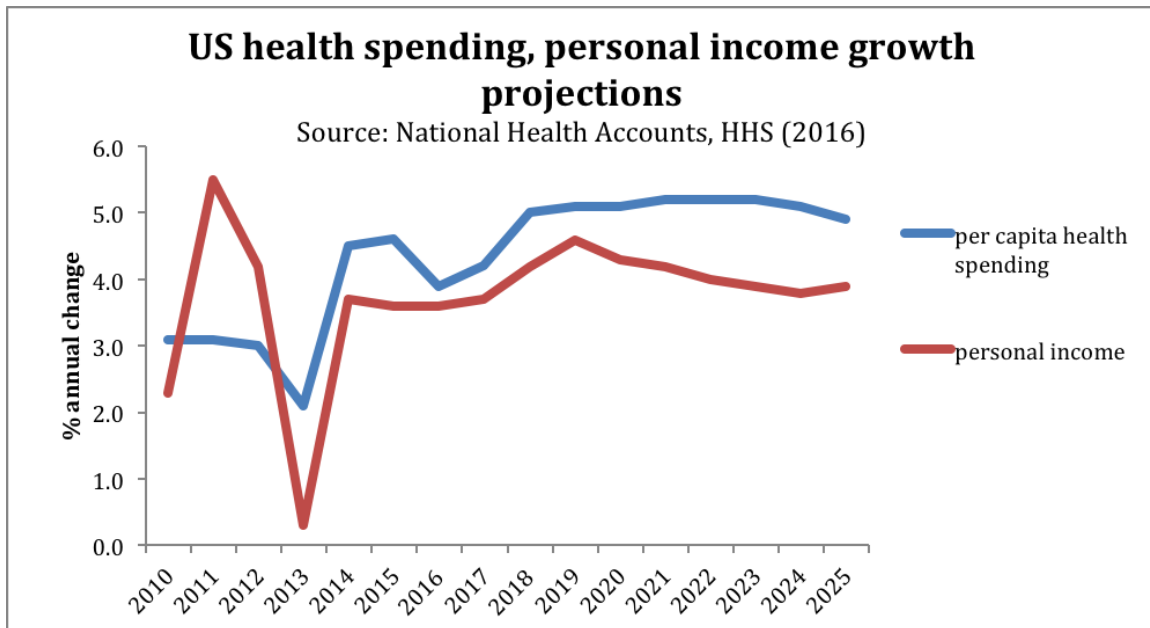
D) Health Care Financing

America's health care system is expensive and fragmented with payers each seeking to shift costs onto each other. This year the federal Health and Human Services agency estimates that Americans are averaging \$6,815 per person on health care costs; that amount is up more than a third since 2007 and is expected to grow by more than a half again by 2025. By 2014, health care spending consumed 17.5% of the entire US economy (GDP).

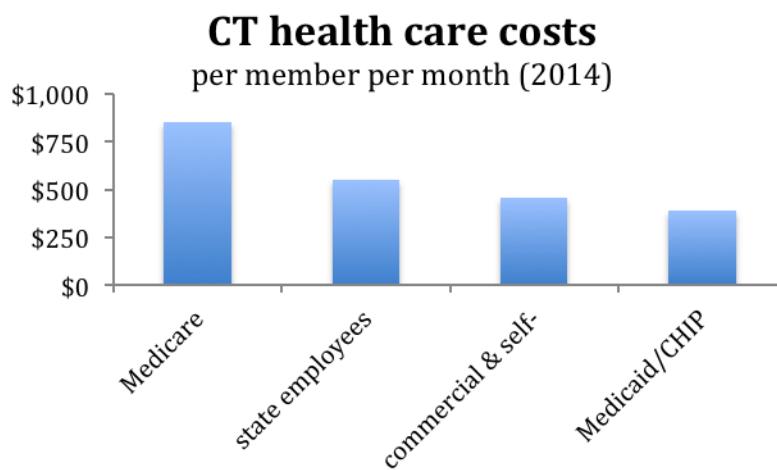


Source: CMS National Health Expenditure Accounts

However there are indications that health care spending growth is moderating. In 2014 per capita health care spending rose 4.5%, faster than the year before but still well below double digit increases of a decade ago. The federal Centers for Medicare and Medicaid Services report that in 2012 health care spending grew only 3.7% while the overall US economy grew 4.6%. 2012 was the fourth year in a row with low spending. Rising prices are the main driver of rising health care spending, followed by population growth, demographic shifts, and changes in use and intensity of services. American households pay the largest share of health care spending, followed closely by the federal government, private businesses and state/local government.



Per person health care costs vary significantly by population and payer source in CT. Medicare beneficiaries have the highest health care spending per person, followed by state employees, private commercially or self-insured state residents, with Medicaid members the least expensive on average. It is important to note that there is additional wide variability within each of these groups.

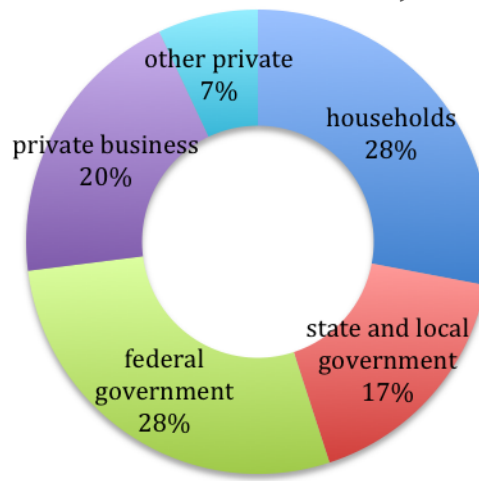


Source: CT State Innovation Model Test Grant application, 7/23/2014

Households pay the largest share of health care costs, through premiums, cost sharing and non-covered services. However federal and state government and private businesses' share are similar.

US health care payment sources 2014

Source: Martin et. al. Health Affairs Jan 2016

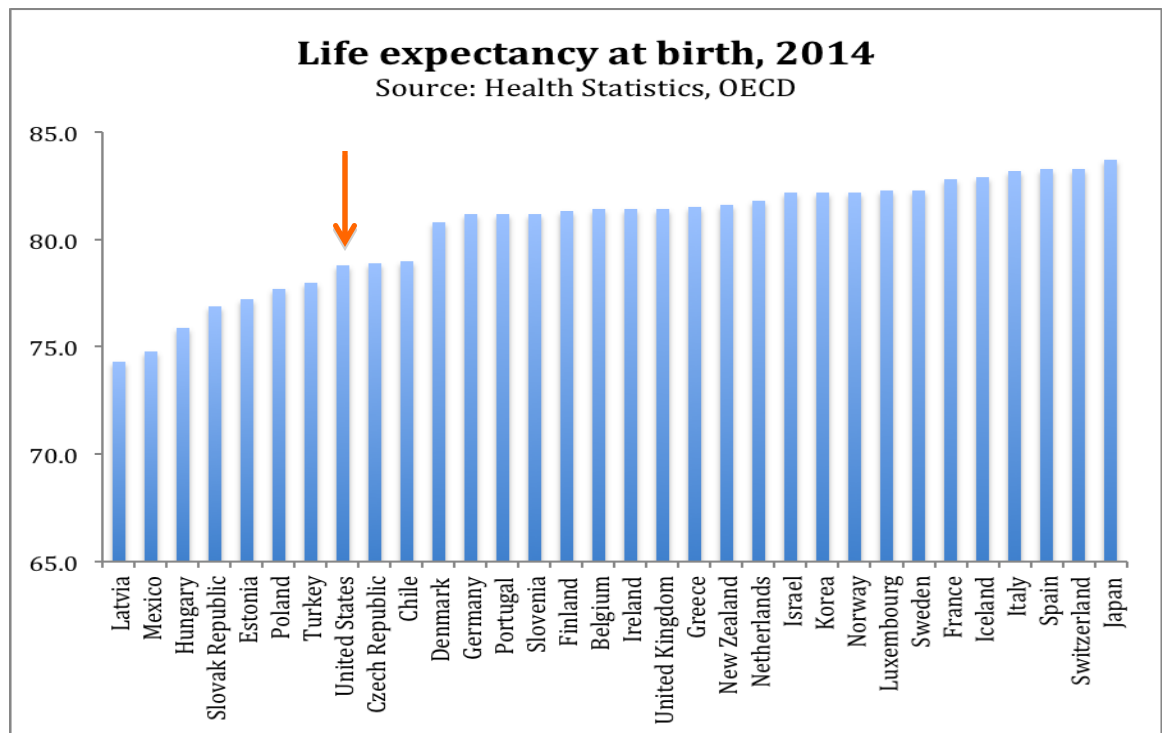
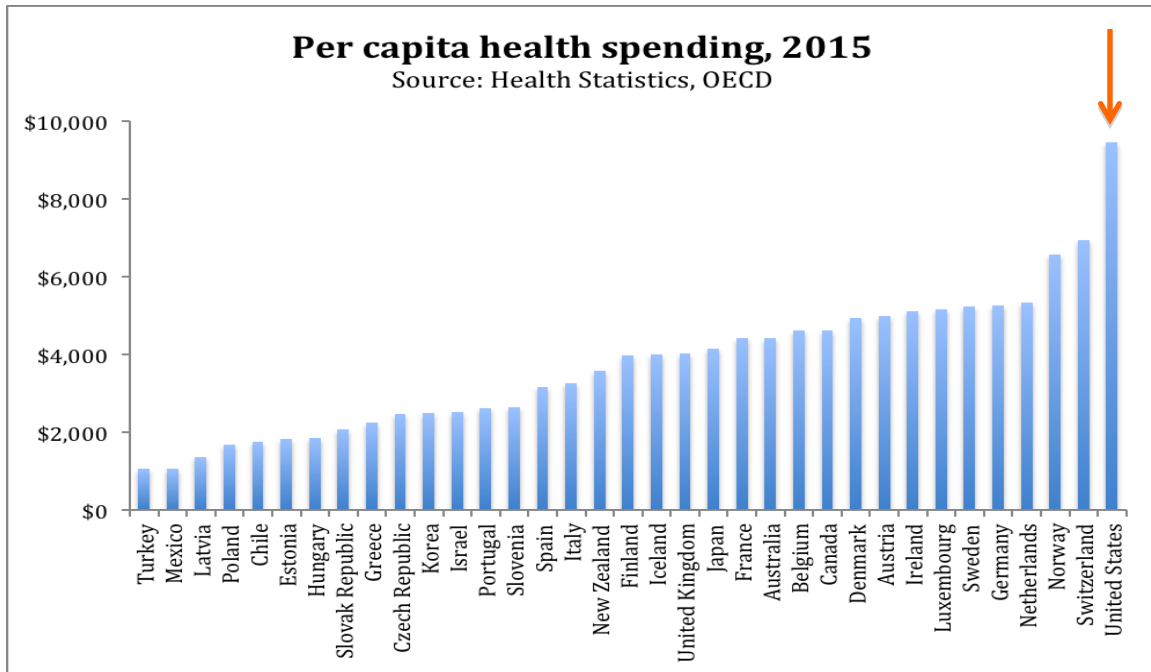


A small proportion of Americans account for a large share of health care spending. Almost half of US health care spending was used to treat only 5% of Americans with health expenses over \$13,387 in 2004. Seniors average seven times the spending of children and women average 31% more health care spending than men.

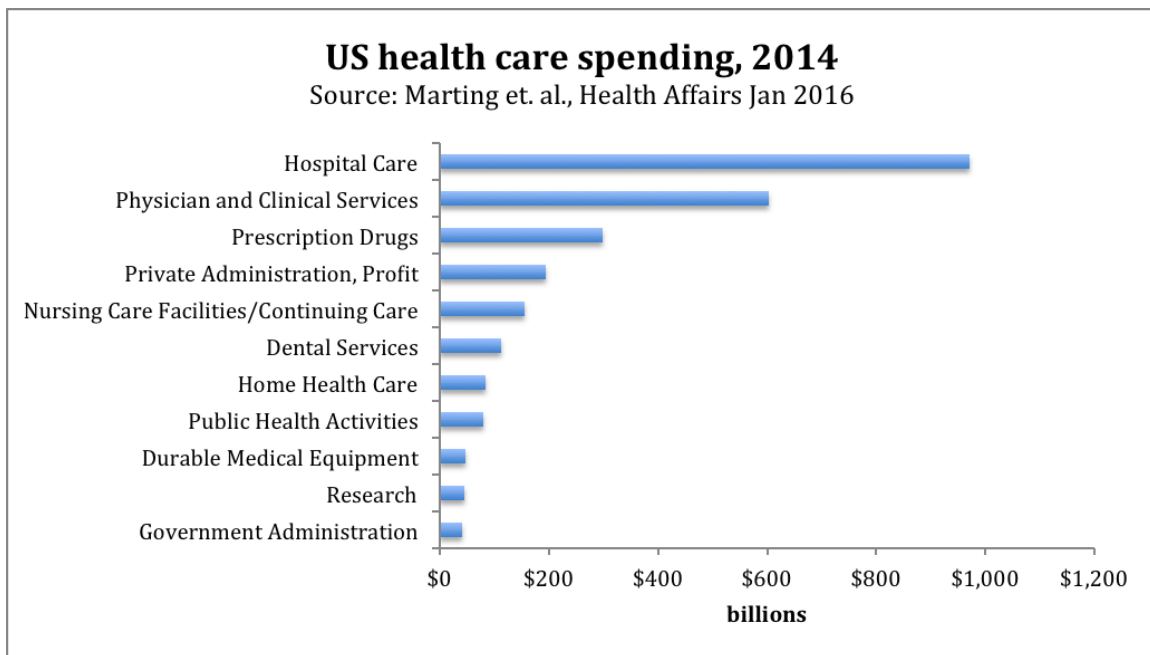
Why is health care so expensive?

- Because we choose to spend more on health care – wealthier countries can afford to spend more and health is highly valued by consumers
- The US population is getting older but this often-cited factor is estimated to account for only 2% of the increase in health care spending
- The rising incidence of diseases, particularly chronic diseases, is a significant driver of health costs. Obesity alone accounted for 22% of the rise in per capita health spending from 1987 to 2009.
- According to the Congressional Budget Office the major driver of rising health costs, accounting for 38 to 65% of rising costs, is improving technologies and services. Some medical advances are critical to improving health outcomes but some have little or no clinical value. For too many conditions, there is not enough scientifically valid information to determine which treatments are cost effective and should be adopted.

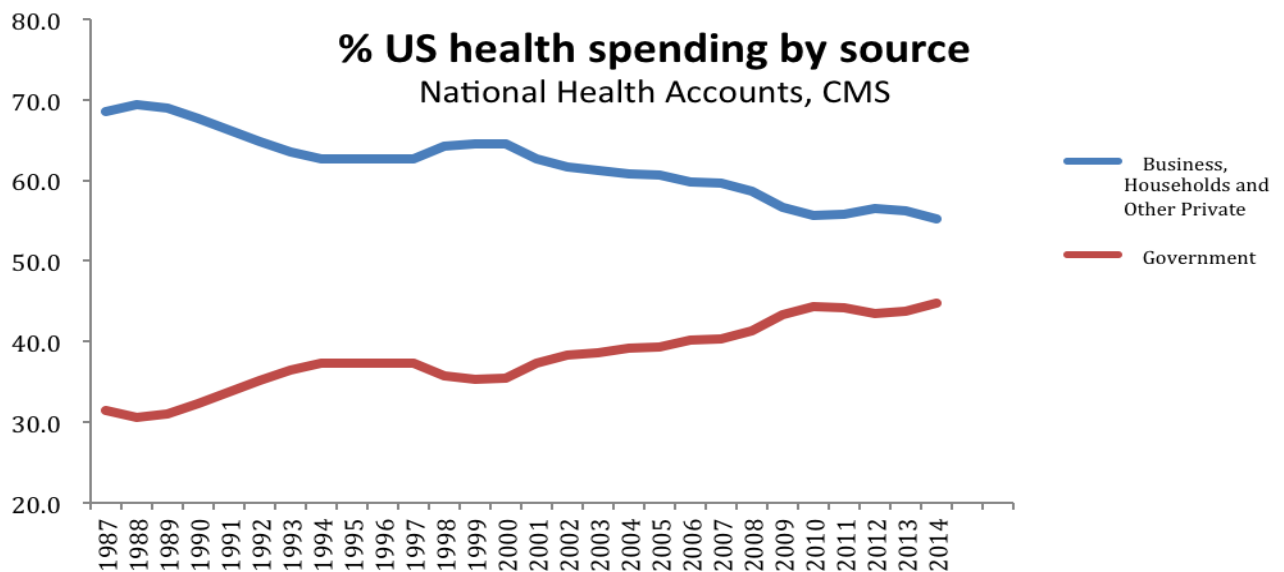
Americans spend more per person for health care than any other country. 16.4% of Connecticut's economy was devoted to health care in 2009 up from 9% in 1980. This is far higher than other developed countries. Many Americans believe that although we pay more than other countries that we have the best health care system in the world. In some respects that is true, but overall our health outcomes do not match the rest of the world in important respects.



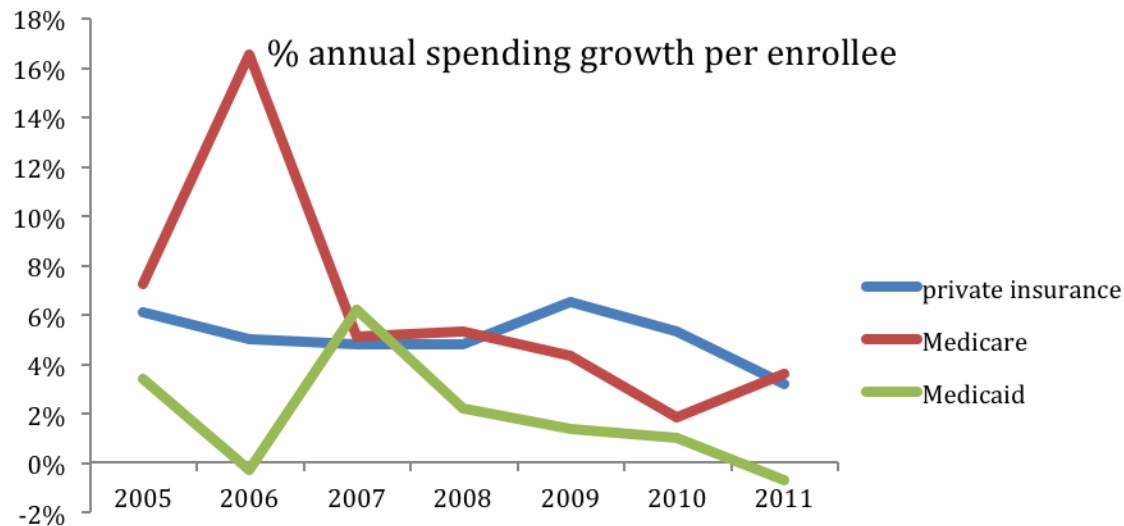
Where was the money spent?



Over the years, the proportion of US health care paid for with tax dollars has grown significantly and private funding has fallen.



Nationally, Medicaid has consistently out-performed Medicare and private insurance rates of controlling growth in spending per person.



Source: M Hartman, et. al., Health Affairs 32:87-99, May 2013

What proposals are being considered to reduce the growth in health care spending?

- Evidence based medicine and comparative effectiveness research -- to assess the relative cost benefit and effectiveness of new technologies before adoption.
- Reducing unnecessary overtreatment – The Choosing Wisely Campaign has lists, developed by physician societies, with dozens of procedures that should be reduced or eliminated.
- Wellness, disease management programs and other consumer incentives for healthy living
- Electronic medical records and information sharing to help coordinate care and reduce duplication of services
- Improving provider effectiveness –pay more for better performance
- Payment reform – restructuring how we pay for health care services from a volume-based system to one based on value, bundling payments for episodes of care, shared savings, or a global payment for each person, based on individual health needs. Re-aligning payment incentives to emphasize prevention, primary care and care management and away from episodic, expensive, acute care services.
- High deductible plans and other means to make consumers sensitive to health care prices, to reduce demand for care.
- Reducing geographic differences in treatment that do not affect quality of care.
- Increasing transparency in pricing – giving doctors and patients price lists for treatments, allowing them to shop for services and use scarce resources wisely
- Restricting physician gifts from drug companies and other suppliers, restriction or disclosure of physician ownership of medical service providers such as labs, outpatient treatment centers

For more information –

KFF primer on health care costs -- <http://kff.org/health-costs/issue-brief/health-care-costs-a-primer/>

CMS—National Health Accounts -- <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html>

Quality based purchasing <http://www.valueovervolume.org>

E) Health Care Reform

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of the Nation.

- President Harry Truman, Special Message to the Congress Recommending a Comprehensive Health Program, Nov. 19, 1945

After generations of gridlock and no progress on health reform, in 2010 Congress passed and the President signed the Patient Protection and Affordability Care Act (ACA). In June 2012 the Supreme Court upheld the constitutionality of large majority of the ACA. The ACA offers Connecticut exciting opportunities to expand health coverage, improve the quality of care and reduce costs. However, it also creates new responsibilities for our state.

National health reform in a nutshell:

- *Individual mandate* – As of Jan. 1, 2014 residents with incomes over the federal poverty level (FPL, now \$11,880 for an individual) are required to have health care coverage, either through a public program, through an employer's plan or by direct purchase. Subsidies are available for people with incomes up to four times the Federal Poverty Level. Penalties currently range from \$695 to \$2,085 per person based on income. There are several exemptions from the tax penalty, including financial hardship.
- *Employer mandate* – Under the ACA, employers with over 50 workers will be assessed fines up to \$2,160 per worker not offered coverage, depending upon circumstances.
- *Small business tax credits* – Provides refundable credits to some small businesses (fewer than 25 employees) with low-income workers (average wages below \$40,000/yr).
- *Medicaid* – On Jan. 1, 2014 Connecticut exercised the option under the ACA to expand Medicaid coverage to all state citizens and legal immigrants below 138% of the Federal Poverty Level regardless of family circumstance. The federal government will pay the full costs of care for newly eligible recipients through

- 2016, at which point federal reimbursement gradually lowers to and continues into the future at 90%. This is a significant change to Medicaid eligibility in Connecticut, as for many states, which had been limited to children, their parents, and elderly and disabled residents. National reform also increased Medicaid primary care provider payment rates to Medicare levels for 2013 and 2014, with the federal government picking up the full cost. Connecticut was one of a few states that have continued to pay those higher rates with state funds.
- *State insurance exchange* – National reform provides grants for states to develop an insurance marketplace to help consumers shop intelligently for good coverage. The federal government also provides subsidies for lower income residents to purchase coverage in the exchange. Coverage offered in the exchange has to meet minimum standards of coverage. Connecticut has developed its own exchange, AccessHealthCT, using federal start up funding.
 - *Insurance reforms* – National reform prohibits denials of coverage for pre-existing conditions, limits lifetime and annual coverage maximums, and requires insurers to spend 80 or 85% of premiums on medical care and quality enhancements. Last year insurance plans covering 22,166 consumers in Connecticut sent rebates back to consumers and employers averaging \$177 for exceeding that standard. Under national reform, insurers can no longer cancel policies just when policyholders get sick. Insurers cannot charge more based on gender or health status– pricing can only be based on age, geography and tobacco use, with limits on how much rates can vary.
 - *Allows children to stay on their parents' coverage to age 26* – Although Connecticut was one of a handful of states with similar laws, passage of the federal act covers all employer coverage policies and exempts the benefits from taxes.
 - *Health care workforce* – National reform includes some programs to address looming shortages across health care fields including doctors, nurses, and other professionals, particularly in primary care.
 - *Closes the Medicare prescription drug donut hole by 2020*. National reform has also stabilized Medicare's funding for an additional decade, in part by reducing overpayments to Medicare Advantage HMOs.
 - *Taxes on high value health plans* – In 2018, national reform includes taxes on expensive health plans. The tax is intended to raise revenue and to hold down premium costs.
 - *Nutrition labeling on menus* – To help consumers make healthier choices, chain restaurants will have to post nutritional information, including calories, for their food.

Connecticut reform progress

Since January 2014 hundreds of thousands of Connecticut residents have been able to enroll in coverage through our state's health insurance exchange, AccessHealthCT. Most

are enrolled into Medicaid and the rest into private insurance coverage in the exchange. Evidence suggests that many of the new Medicaid enrollees were eligible before the Affordable Care Act but came in because of increased outreach. Of those who have enrolled in exchange insurance coverage, the large majority qualified for federal subsidies. It is unclear how many of the new members were previously uninsured. National surveys suggest it may be a minority.

For more information –

CT Health Reform Dashboard -- www.cthealthreform.org

KFF health reform -- <http://kff.org/health-reform>

F) Role of States in Health Care

Responsibility for health care policy is predominantly at the state and federal levels of government. States have a special role being closer to providers and consumers, closer to local health care systems, and understanding local influences. Advocates can have an enormous impact in state level policymaking, because state capitols are closer, have fewer state policy staff who then have to rely on community resources and information sources, and state elected officials are more accessible than federal representatives.

States have critical roles in policymaking including:

- License and regulate health care providers and institutions.
- Limit expansions and reductions in size and services provided by health care institutions.
- Finance and administer health care for large numbers of residents. Between Medicaid, state employees and retirees, corrections and safety net programs state governments are generally the largest purchaser of health care in their states.
- Regulate environmental health hazards and standards.
- Fund and administer public health programs.
- Set policy and administer important federal health programs such as Medicaid, Title V and health related block grants.
- Fund and administer safety net programs.
- Educate and subsidize the education of health workers in public schools and universities.
- Regulate health insurance and insurers.
- Regulate and fund local health departments.
- Coordinate and fund electronic health interoperability standards and initiatives.
- States are responsible for implementing the majority of reforms included in the ACA.

For more reading –

The Commonwealth Fund on states' roles in high performing health systems --
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=676496
NASHP State Reform -- <http://www.statereform.org>