A Connecticut State Planning Grant to Develop Coverage Options

2004
Pilot Planning and Continuation Limited Competition Grants

Proposal submitted to

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION
"State Planning Grant"

by

The State of Connecticut
Office of Health Care Access

June 2004

PROGRAM NARRATIVE

The Office of Health Care Access's overall goal as the lead agency for this State Planning Grant (SPG) project is to develop a plan to provide adequate and affordable health insurance coverage to all of Connecticut's citizens. OHCA and its interagency partners have steadily worked toward this goal since our initial HRSA SPG grant award in 2001. The project narrative below will describe our current SPG efforts and outline our proposed pilot planning initiative to develop a targeted approach to achieve this goal utilizing premium assistance programs. Connecticut is well positioned to undertake this pilot planning effort and looks forward to the award of grant funding.

Current Status of Health Insurance Coverage in Connecticut

Connecticut has one of the lowest rates of uninsured populations in the nation. According to national estimates, approximately 12 percent of Connecticut's non-elderly population remained uninsured in 2002. One of the reasons Connecticut has a low rate of uninsurance is a high incidence of employer based coverage - the majority of Connecticut's 3.4 million residents have access to private health insurance coverage - primarily through their employers. In addition, through its public programs, Connecticut provides access to health care coverage for all uninsured children, regardless of income, and to low income families who meet eligibility guidelines. Recent trends suggest that while private insurance is still the primary source of health insurance coverage for most individuals, employer-based insurance coverage has begun to decline, particularly for the lower paying service sector jobs that are contributing to Connecticut's economic recovery. At the same time enrollment in public programs has increased.

Connecticut has traditionally provided rich benefits to both its Medicaid and non-Medicaid indigent populations. Connecticut's **H**ealthcare for **U**nin**S**ured **K**ids and **Y**outh (HUSKY), a combination program encompassing the state's Medicaid and SCHIP populations, currently provides access to health insurance coverage to all uninsured children under age 19 regardless of income. In the design of its Title XXI SCHIP program, the state took advantage of provisions on income disregards to push eligibility for its SCHIP program up to 300 percent of the FPL, as well as to offer a non-SCHIP unsubsidized buy-in option to children in families with income greater than 300 percent of the FPL.

HUSKY A (Title XIX Medicaid) provides coverage to children under age 19 in families with incomes up to and including 185 percent of the Federal Poverty Level (FPL). HUSKY B (SCHIP) covers children under age 19 and consists of subsidized and unsubsidized components. The subsidized portion of HUSKY B includes children with a family income between 185 and 300 percent of the FPL. The benefit design for HUSKY B was modeled on the State Employee Benefit Package. The unsubsidized portion of HUSKY B includes a buy-in opportunity for uninsured children in families with incomes over 300 percent of the FPL. HUSKY Plus provides supplemental coverage for children enrolled in HUSKY B with intensive physical and/or behavioral health needs with income less than 300 percent of the FPL. Both HUSKY A and HUSKY B are managed

care programs. Through HUSKY, Connecticut provides universal access to health coverage to uninsured children under 19 years old regardless of income. In families with incomes below 100 percent of FPL, a parent or caretaker relative living with a HUSKY A eligible child is also eligible for HUSKY A. In addition, pregnant women with family incomes below 185 percent FPL are eligible for HUSKY A. HUSKY A and B are now known under the umbrella name of HUSKY to support the enrollment of children of all income levels into a health insurance program.

Connecticut exceeds the federally mandated one-year minimum benefit period for Transitional Medical Assistance Program (TMA) and currently provides up to two years of HUSKY A coverage to families (children < 19 and parents or caretaker relatives) who lose HUSKY A benefits due to increases in income (>100 percent FPL). The State Administered General Assistance (SAGA) and General Medical Assistance programs provide cash and medical assistance to eligible individuals and families who do not qualify for, or who are awaiting an eligibility determination, for other state or federal programs. SAGA and General Assistance Medical cover almost all services covered under Connecticut's Medicaid program with the exception of long-term care and non-emergency medical transportation. There are no categorical program requirements; eligibility is based on income and assets only. Persons receiving SAGA cash assistance are automatically eligible; others may qualify if income is insufficient to pay medical bills.

Current rate of uninsurance and a description of the characteristics of the state's uninsured

There are nearly 44 million Americans living without health insurance coverage – including 8.5 million children. In 2002, the number of people without health coverage increased by more than 2 million, the largest one-year increase in a decade. An estimated eight out of ten Americans without health coverage were in working families. Here in Connecticut, according to national sources, approximately 12 percent – or a total of nearly 350,000 of the state's non-elderly population (individuals under age 65, when eligibility for Medicare coverage begins) – were uninsured at some point during 2002, representing a 0.5 increase from the previous year. Of that number, 71,000 were children.

Connecticut utilized its initial HRSA SPG funding to collect state-level data on insurance coverage and the uninsured by fielding a statewide household survey in the fall of 2001. The State Health Access Data Assistance Center (SHADAC) Coordinated State Coverage Survey Instrument was utilized to identify key demographic factors affecting health insurance coverage and characteristics of the uninsured. Using this instrument saved time and resources by providing a high quality tested instrument. Among the 2001 survey findings were:

- An estimated 5.6 percent of Connecticut's residents, or 185,200 people, were uninsured *at the time* of OHCA's survey. Of those individuals, 3.8 percent, or 124,900 people were *continuously* uninsured (for the entire 12 months preceding the survey). Approximately 8.4 percent, or 278,500 residents, reported being uninsured *at some*

point during the 12 month period. As would be expected, state-level estimates were lower than national estimates, due to sample size and methodological differences.

- Nearly all working-age adults had health insurance coverage (93 percent); most through an employer (78 percent). Although there was widespread health insurance coverage, 7.3 percent or approximately 150,000 working-age Connecticut residents were uninsured.

- More than two-thirds of all uninsured working adults were gainfully employed. Nearly one-third of all uninsured workers held either part-time positions or worked full-time in temporary or seasonal jobs, positions that may not be eligible for employer-sponsored health coverage. Based on the survey, there were an estimated 101,300 uninsured, gainfully employed adults.

- Two-thirds of all uninsured workers were employed by small firms (50 or fewer employees), which are less likely to offer health benefits. Forty percent of uninsured workers reported that their employer did not offer health benefits and approximately 20 percent said they were not currently eligible for their employer's coverage.

- According to the most recent U.S. Department of Labor Statistics, 97.3 percent of Connecticut businesses are small (with fewer than 500 employees).

- Small businesses continue to be a source of economic strength nationally and in Connecticut. In 2000, businesses with fewer than 500 workers employed 50.2 percent of Connecticut's non-farm sector employees.

- Those workers with family incomes between $20,000 and $30,000 were the most likely to be uninsured. The majority of uninsured workers said they could not afford to purchase insurance on their own.

- The uninsured had low family incomes. People in Connecticut with family incomes under $30,000 made up nearly half of the uninsured and were three times as likely to be uninsured than those who earned more.

- Connecticut's population is largely white (80 percent) and most of the uninsured were non-Hispanic whites (69 percent). However, minorities were twice as likely to be uninsured than non-Hispanic whites.

- The uninsured tended to be young adults – nearly two-thirds were between 19 and 44 years of age, with 41 percent between 19 and 34.

- Although nearly all (96 percent) of Connecticut's children had health insurance coverage, an estimated 34,000 children were uninsured in 2001. Most children obtained coverage through a parent or guardian's employer.

- Three-quarters of uninsured adults did not have a college degree and those without a degree were twice as likely to be uninsured as college graduates.

- Among uninsured adults, 68 percent were not married, and thus may not have had the opportunity to obtain insurance through spouses' employers.

- For those "intermittently insured" (did not have insurance coverage for all of the 12 months preceding the survey) Connecticut residents, employment changes were linked with changes in insurance coverage, particularly as they affected access to employer-based coverage.

A series of issue briefs on survey results and access issues have been published over the course of the grant and are posted on OHCA's website at www.ohca.state.ct.us. Connecticut is currently fielding a 2004 Household Survey that will update 2001 results. Currently 70-75 percent of the 2004 survey interviews are complete. Data is expected to be available for release early this summer.

Key health issues related to access to care and insurance

According to national data released during this year's *Cover the Uninsured Week* there are several key issues related to access to care and insurance.

- Uninsured adults are less likely to get the medical care they need. Nationally, nearly one in five uninsured adults reports being unable to get needed medical care in the past 12 months, compared to one in 20 adults with health coverage.

- Uninsured adults are less likely to have a personal doctor or health care provider. Nationally, 56 percent of adults without health insurance say they do not have a personal doctor or health care provider, compared with just 16 percent of people with health insurance.

- Individuals who are uninsured are less likely to receive preventive services. Nearly half of all uninsured women who are the appropriate age for mammograms, as directed by CDC guidelines, say they do not have them in the recommended time frame, more than double the rate of insured women. About 70 percent of uninsured men who are the appropriate age for prostate cancer screenings, as directed by CDC guidelines, report not having them in the recommended time frame, compared with 47 percent of insured men.

- Adults who are uninsured are twice as likely to report being in poor or fair health as adults who are insured. Nationally, more than one in five uninsured adults say their health is fair or poor, nearly double the rate of adults with health coverage.

OHCA's 2001 household survey examined common access-related measures, including: usual source of care, delays in seeking both emergency and non-emergency care, barriers to care and health care provider use. OHCA's survey results reflect national findings

regarding the association between insurance coverage and the utilization of health care services. The 2001 survey revealed that:

- Insurance status had a clear and significant influence on the utilization of health care services and was the factor most strongly related to utilization of health care.

- Insurance coverage affected where people received primary care. Nearly all of the insured survey respondents received primary care in a physician or HMO office, compared to only half of the uninsured.

- One-third of the uninsured received primary care in public health clinics or hospital outpatient or walk-in centers. Accessing health services in this manner may affect patients' continuity of care because they are less likely to be seen over time by the same physicians who are acquainted with their medical history.

- Nearly 10 percent of the uninsured relied upon hospital emergency departments for primary care.

- Insurance status also affected access to necessary medical care. Nearly 20 percent of the uninsured did not seek care for an injury or illness, and almost one in ten had a medical emergency that went untreated. The uninsured cited lack of insurance and their inability to afford medical care as the major reasons they did not seek needed care.

- OHCA's 2001 Household Survey also found that a significant portion of Connecticut's population had unstable health insurance coverage. For these "intermittently insured," employment changes were linked with changes in insurance coverage, particularly as they affected access to employer-based coverage.

Based on the analysis of our 2001 survey data, we expect that our 2004 data will reflect similar issues and we plan to compare the results of both surveys to inform policy related to these key concerns. The availability of health care services does not ensure access to care; people need a means of paying for care, such as government programs, privately purchased coverage, or employer-sponsored health insurance. Income may affect the ability to purchase coverage and afford co-pays and deductibles. Even with Connecticut's extensive health care system and a large insured population, the relatively high cost of health care in the state may negatively affect access to services. Among states, Connecticut ranks near the top in both public and private health care spending. Escalating costs may threaten health care coverage, and ultimately access to care, as employers decide to limit plan offerings, reduce benefits, increase employee cost sharing, or even eliminate health coverage altogether.

Lack of adequate access to health care services can significantly affect health care services utilization and health outcomes. The uninsured have more difficulty gaining access to the health care system and use care less frequently than their insured

counterparts. Lack of insurance may influence the way individuals seek medical care. They may delay or go without needed care because of financial reasons. They are less likely to visit doctors for primary care, and they receive fewer preventive services.

Having an established source of primary care has implications for the health of individuals, as well as health care providers and payers. A 2002 report by the National Institutes of Medicine found that the uninsured were less likely to receive regular preventative care. Such regular primary care contributes to long-term health through early detection and treatment of serious medical conditions, thereby reducing the number of costly hospitalizations. The uninsured are more likely to be hospitalized for such health problems as diabetes, hypertension, and immunizable conditions that ordinarily are handled via ambulatory care according to OHCA's acute care hospital inpatient database. In 2003, an estimated 25,000 Connecticut hospitalizations of residents under age 65, with charges totaling $296 million, may have been prevented through timely and effective primary care.

Summary description of Connecticut's current delivery system

Connecticut has 31 acute care hospitals containing over 7,000 staffed beds. All but one of the state's acute care hospitals are not-for-profit. There are two schools of medicine at the University of Connecticut and Yale. In addition, the state has 19 Federally Qualified Health Centers (FQHCs), 12 specialty hospitals, 23 licensed and/or freestanding ambulatory surgical centers, 379 emergency medical service providers, and numerous walk-in clinics, ambulatory care centers and school-based clinics. In terms of medical personnel, the state ranked in the top five in the number of physicians and physicians assistants per person, according to recent national comparisons.

Connecticut's acute care hospital emergency departments serve as a "safety net" for the state's uninsured as no one can be denied access to care. Municipal health departments and voluntary or nonprofit health care agencies in the state also contribute to the state's health care safety net. However, the advent of managed care, a shifting client base, increased administrative costs, and decreased revenues have reportedly forced some safety net providers to consolidate operations, curtail services or cease operating. Weakening of this infrastructure threatens the state's capacity to care for the uninsured and populations at risk.

Connecticut currently has six licensed and operating Health Maintenance Organizations (HMOs), a decline from a high of 16 in 1997. While there were originally 11 managed care plans participating in HUSKY; currently, there are four plans participating in HUSKY A and three plans participating in HUSKY B. Managed care penetration increased from 31 to 49 percent of the Connecticut population between 1995 and 1999, but declined to 43 percent in 2002. Connecticut acute care hospitals experienced a 7 percent increase in inpatient utilization, and a 2 percent increase in average length of stay between 2000 and 2003, reflecting an aging population.

Connecticut laws require insurers to provide coverage for a wide variety of health care services, medical treatments, and specific diseases. As a consequence, health plans offered in the state provide comprehensive benefits. We have no "bare bones" insurance plans. The state ranks fifth in the nation in the number of mandated insurance benefits. Under statute, there are currently 42 mandated benefits for group health insurance and 38 for individual health insurance. (A list of mandated benefits is included in Appendix A). While 32 states have introduced legislation to study the financial effects of assessing new coverage requirements and evaluate current coverage mandates, Connecticut is not among them. Of employers responding to our 2001 survey that did not offer health insurance, 18 % indicated that they could not afford to signaling that cost is certainly a factor in a small employer's decision on whether to offer health benefits to employees. Although both the nation's and Connecticut's economic outlook is improving, many economists have noted that we are experiencing a "jobless recovery". The recent recession has jeopardized insurance coverage for a growing number of workers and their families. The number of persons covered by government health insurance programs is increasing. With interruptions in coverage, the uninsured and intermittently insured access care less frequently than the continuously insured, posing potential health and financial risks. Even in prosperous times Connecticut has always experienced a wide disparity between the wealthy and the poor. Connecticut leads the nation in per capita income; however, the state continues to be among ten states in which the gap between the incomes of the lowest-income and highest-income families with children is greatest. Connecticut currently ranks second among all states in the growth of income disparity between the highest-income and lowest-income families between the mid-1980s and the mid-1990s.

This income disparity, coupled with rising health care premiums, an increase in jobs that do not offer benefits, and the recent economic downturn, has policy makers concerned about the erosion of employment-based health insurance. Overall trends suggest that while private insurance is still the primary source of health insurance coverage for most individuals, employer-based insurance coverage has begun to decline, particularly for the lower paying service sector jobs that have contributed to Connecticut's economic recovery. At the same time enrollment in public programs has increased. This is why our policy focus has been centered on maintaining and providing access to employment based coverage.

Where state lacks data on the uninsured

Data from Connecticut's last statewide household are nearly three years old, in the intervening period, the state, like the rest of the nation, has experienced a significant economic downturn. State budget deficits resulted in layoffs and program reductions. Currently, the Connecticut economy is recovering. In particular, due to better than expected tax revenues, Connecticut will end the current fiscal year with a budget surplus.

Using supplemental SPG funds, Connecticut is currently fielding new household and employer surveys, in an effort to assess the impact of the recent recession and other social, economic and market forces on access to health insurance coverage for its

citizens. Survey results will be used, in part, to monitor changes in health insurance costs and to identify and respond to barriers to health insurance enrollment and utilization of care. HRSA funding of these data collection efforts provides the state an unprecedented opportunity to measure changes in the magnitude and characteristics of the uninsured over this fiscally turbulent time period.

Although these surveys will provide a wealth of information on the status of insurance coverage in the state, further information is needed in order to plan appropriately for future coverage expansions. If additional grant funds are procured, Connecticut will specifically plan to implement pilot premium subsidy programs that will subsidize coverage for employees in firms that currently offer coverage as well as encouraging small, currently uninsured businesses to begin offering coverage. Data collection activities will include carefully staged, focused surveys and in-depth interviews of specific household and business target groups to test feasibility for success of various subsidy models under consideration by the state.

National activities and other state approaches and how these relate to the state's own health insurance situation

This year SPG activities included participating in regional events that coincided with the National *Cover the Uninsured Week*. These events raised awareness of the issues facing the uninsured in a non-partisan way. In particular, the Connecticut SPG's role in collecting and disseminating data on the magnitude and characteristics of the uninsured was highlighted in a forum sponsored by the Connecticut Hospital Association. These activities will continue throughout the year as OHCA releases results from our 2004 household and business surveys. At the next event on June 30, 2004, OHCA Commissioner Cristine Vogel will release preliminary business survey results at a business forum in Bridgeport, Connecticut

Most recently both national and state proposals have taken approaches that combine numerous strategies to expand access to health insurance coverage incrementally. The uninsured population is diverse therefore applying different strategies may be necessary to meet the needs of the uninsured population. One such strategy is subsidizing the purchase of health insurance to make coverage more affordable. This is the strategy that led to the implementation of Federal Health Coverage Tax Credit (HCTC) Program for trade-impacted workers. OHCA participated in the interagency workgroup that implemented this program in Connecticut. Use of tax credits at the state level is currently being explored with current SPG funds.

Connecticut has also studied other state's approaches to covering the uninsured, concentrating in particular on those who have successfully implemented premium assistance programs. We have found our collaboration with our neighboring state, Rhode Island to be particularly helpful. It is hoped that knowledge gained from the successes and challenges Connecticut experiences in its activities in the 2004 grant program will be useful to other states in their insurance expansion programs, as well.

Earlier Efforts to Reduce the Number of Uninsured Residents

Historically, Connecticut has been very active in addressing the problem of the uninsured and implementing public programs that expand eligibility and enrollment. The General Assembly has been responsive in recognizing the need to regulate various areas of health care in order to improve access and contain costs. In 1992, the legislature approved the establishment of an uncompensated care program. Cost shifting had placed a disproportionate burden on hospitals with high Medicaid utilization, potentially placing them in financial jeopardy. The uncompensated care program improved access to acute care hospital services for both uninsured and underinsured residents as it required that the state's hospitals share the cost of uncompensated care.

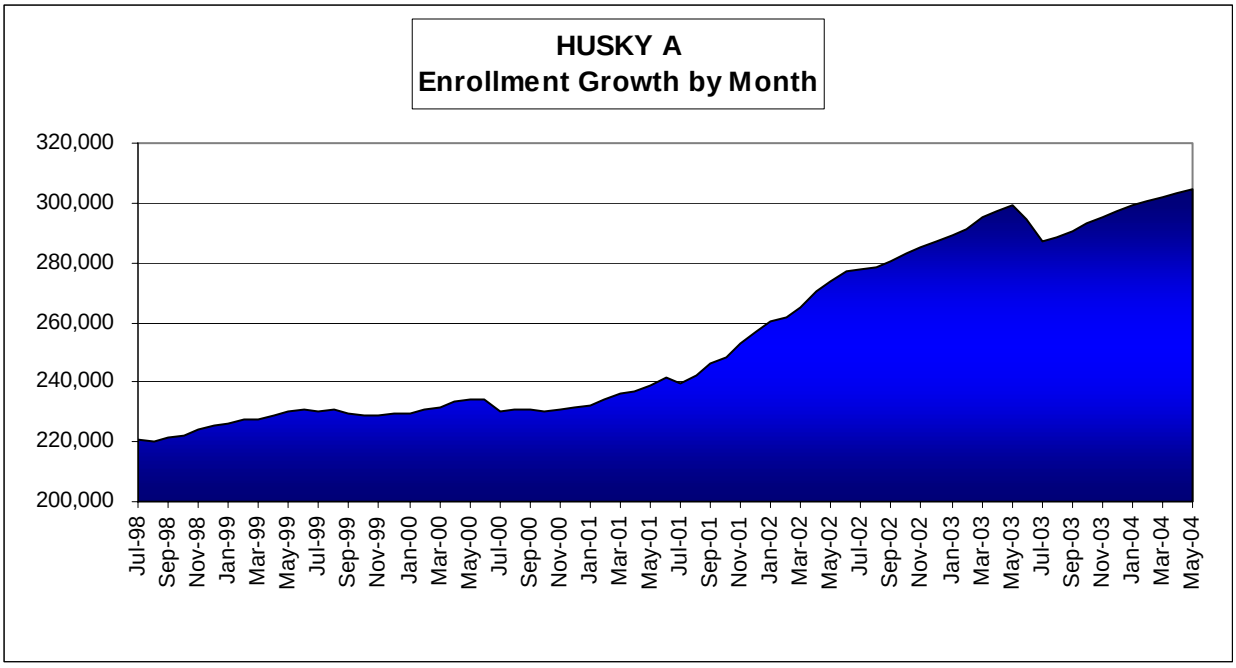
This was followed by legislative action in May 1994 by the General Assembly, which created the Office of Health Care Access (OHCA) and included as one of its major functions the development of a plan for health care reform in Connecticut. OHCA, working with members of the legislature, the governor's office, state officials and representatives of the private sector, developed four reform options ranging from a private incentive system to a single payer system. At the time the legislation was enacted it was anticipated that national health reform would pass and the state health system would have to adapt to federal reforms. With the failure of national health reform, the climate shifted and the major reforms proposed by OHCA were halted.

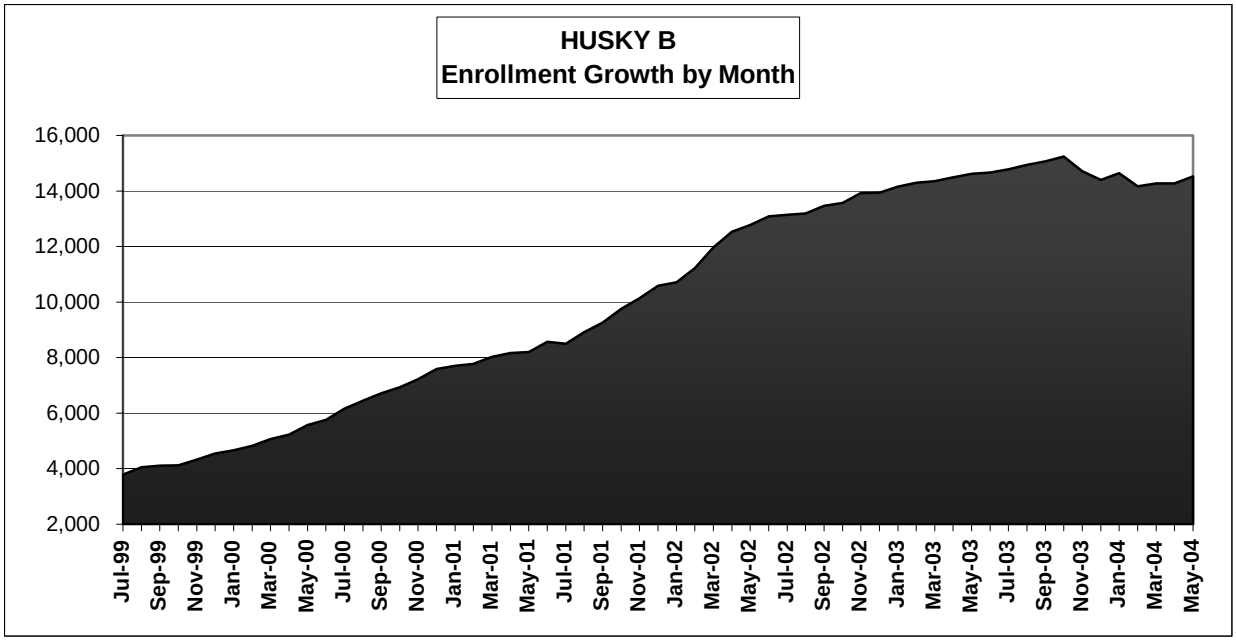
Since that time, health reform has continued to occur in Connecticut, but on a more incremental scale. The General Assembly became more involved in addressing the changes in access and quality that have occurred as a result of managed care. In the last decade, the legislative environment focused on the influx of the managed care industry into Connecticut. As market penetration rose steadily, policy makers recognized the need to monitor managed care and to respond to patient/consumer concerns. A comprehensive managed care regulatory bill was passed by the legislature and signed into law by Governor Rowland in 1997. Regulatory requirements in this law included the establishment of internal grievance procedures by all managed care organizations as well as the creation of an external appeals process within the Insurance Department. It also required that the Insurance Commissioner develop a consumer report card to facilitate consumer choice of health plans. In 1996, Connecticut and Minnesota were the first states to implement high-risk pools for individuals who have been denied health insurance because of a medical condition.

In addition, legislation was also passed in the early 1990s to encourage the creation of small group purchasing cooperatives. This led to the formation of the Connecticut Business and Industry Association's Health Connections cooperative. CBIA Health Connections is designed for companies with three to 50 employees, and allows small businesses to take advantage of the competitive premium rates and a greater variety and number of health plan choices that health care cooperatives typically provide their employees. There are 18 medical plan options in CBIA's Health Connections Program ranging from a $10 copay HMO plan to a comprehensive indemnity plan for members out of state.

Patient protection legislation was enacted in 1999 that included creation of a managed care ombudsman and mandated benefits. Additional mandated benefits included antibiotics for Lyme disease, expanded mental health parity, and prostate cancer screening.

In an effort to improve access to primary care and to control double-digit inflation in Medicaid costs the state experienced in the late 1980s, Connecticut implemented a mandatory managed care program in October 1995 that included children, temporary assistance for needy families (TANF) families, pregnant women, and the child welfare population. The state's Medicaid program covered children ages 0-13 in families with incomes up to 185 percent of the Federal Poverty Level (FPL). During the period of 1995 through 1997, Connecticut incrementally increased income eligibility guidelines for children. The success of the expansion of Medicaid managed care coverage for children positioned state policy makers to contemplate even more comprehensive coverage for children with the advent of Title XXI, the State Children's Health Insurance Program (SCHIP). Connecticut has significantly increased the number of children with health insurance through implementation of the HUSKY plans. As of May 2004, 304,633 individuals were enrolled in HUSKY A (213,377 children and 91,256 eligible adults), and 14,523 children were enrolled in HUSKY B. Historical enrollment growth is shown in the following charts.





Successes and implementation challenges

While we have the technical expertise both in house and via project consultants to advance our planning efforts, financial constraints and lack of political consensus have been our biggest challenges. Both Connecticut's legislative and executive branches have been responsive in recognizing the need to reduce the number of uninsured citizens by increasing access to affordable, adequate health insurance coverage. For example in early 2001 HUSKY A was expanded to cover parents and relative caregivers of children enrolled in HUSKY A, in families with incomes up to 150 percent of the FPL. However budget constraints led to a reduction in eligibility for this group to 100 percent of the FPL.

Current political, economic and social impediments to expansion

Until very recently, the main impediment to coverage expansions has been economic. Similar to most other states, Connecticut implemented measures to contain costs in the Medicaid and SCHIP programs in response to budget deficits. In fact Connecticut instituted premiums and co-payments and tightened eligibility as described in previous sections of this application. During this year's legislative session, which ran from January to May, the Governor's budget proposed substantial restructuring of the Medicaid program. A political battle ensued over the budget when current year estimates showed a surplus in state revenue, as 2003 tax revenues were higher than anticipated. Eventually, the legislature's proposed budget package prevailed over the one proposed by Governor Rowland and the administration. The Final budget included approximately $14.3 million to repeal Medicaid co-payments implemented last year, and $17.7 million to restore the Medicaid benefit package and to eliminate proposed premiums that were to scheduled to go into effect. HUSKY B premiums and co-pays were not repealed and remain in effect.

Although Connecticut's economy is improving with the rebounding of the stock market, rising state revenues and a projected surplus for the current fiscal year, as might be expected, there are philosophical differences between the Republican administration and the Democrat-controlled Legislature on how the Medicaid program, HUSKY and any coverage expansions should be shaped. Last year, the Legislature passed enabling legislation that mandated the Department of Social Services to redesign the Medicaid program for individuals who receive benefits through both fee-for-service and managed care to more closely resemble commercial insurance plans. Prior to that, the Governor had urged the federal Department of Health and Human Services to modernize the nearly 40-year-old Medicaid program by allowing states greater flexibility in administering the program. Governor Rowland continues to believe substantial restructuring is necessary in the Medicaid program and directed DSS to prioritize their efforts and have in place by January 1, 2005, a restructured benefits program under Medicaid. The final budget, however, restored the entire program to its original form and essentially prohibited DSS from a comprehensive restructuring of the Medicaid program. While a comprehensive restructuring of the state's Medicaid program was not approved, the administration expects to move forward with a small employer health insurance subsidy program and a premium subsidy program as incremental strategies to improve access to health care while focusing on the need to reduce cost. Connecticut, utilizing the HIFA model, would establish a capped non-entitlement small employer subsidy program for up to 6,000 enrollees. Federal reimbursement for such an initiative could be as high as 65 percent. While the precise nature of this subsidy program is subject to federal approval, the Governor nonetheless believes it is important to move ahead with the process during the next fiscal year and $3.6M has been included in the Department of Social Services budget for subsidy programs.

Awareness of approaches in other states to reduce the uninsured and how they may apply to CT

Connecticut has established relationships and collaborations with many of its fellow SPG grantee states over the last several years. In particular, contact was established with many states that currently operate premium assistance programs and states that have or plan to pursue HIFA 1115 Demonstration waivers. We also surveyed HIFA waiver states regarding the public input process utilized for waiver planning and development. In addition, IHPS, our primary contractor for program design and development has produced deliverables providing data and information from other states' experiences. Currently we are most interested in learning from Rhode Island's experience implementing its premium assistance program, RIteShare. Connecticut SPG staff from OHCA, DSS and OPM will be visiting Rhode Island's program office this July to learn more about program operations. The quarterly grantee meetings have provided a useful venue to learn, first hand, strategies that other states are pursuing, and to benefit from "lessons learned" by other states.

Progress on SPG Program Funded Activities

The current request for funds represents a logical progression of Connecticut's State Planning Grant project. Although the project momentum was "derailed" in many aspects due to the severe fiscal constraints imposed over the last few budget years, the state's recently improved budget and economic climate have allowed us to get "back on track". Throughout the economic downturn, the State Budget Secretary Marc Ryan has continued to provide support and encouragement for the initiative and has encouraged OHCA to continue to collect data from employer and household surveys and explore various expansion options. The impact of these data collection and planning activities has sustained our planning efforts during this challenging period. With the 2004 household and employer survey results available this summer we will have timely quantitative data available to inform our policy and planning efforts. The pilot planning and continuation funds will allow us to refine the design of our insurance expansion strategies and to regain much of the momentum needed to refocus our planning efforts and move toward successful implementation of our proposed pilot premium assistance programs. The $3.6M in funds designated for premium subsidies in the SFY 2005 budget signal both political and financial commitment of real budget dollars. These funds are now available to fund this policy initiative on an ongoing basis. OHCA is optimistic that we can succeed in planning an implementation strategy that will expand access to insurance coverage to Connecticut's citizens.

Connecticut's HRSA grant project has progressed steadily toward the goals of studying the uninsured and developing options and plans to expand coverage since March 1, 2001 when an initial $668,110 in grant funds were awarded to the Office of Health Care Access (OHCA). Since that time the SPG Steering Committee has met on a regular basis to discuss strategy and work toward consensus on a variety of coverage options. As previously mentioned, major data collection activities included fielding a 2001 household survey and two consecutive business quarterly surveys. A series of issue briefs was published to disseminate the results to various stakeholders and the public. In addition, the policy analysis and development activities conducted during the first year of the grant culminated in a proposal to pilot a small employer health insurance subsidy initiative. Upon receipt of supplemental funding in 2002, and 2003, the grant period was extended to August 2004 and activities related to the development of the pilot initiative continued. The pilot planning funds currently requested will provide critical support to our planning process.

In March of 2003, the State released a Request for Applications (RFAs) inviting qualified organizations to submit an application for the development and operation of a program to reduce the number of uninsured in Connecticut. As detailed in the RFA, the State proposes to team up with a private-sector partner to develop and operate a program that would use public funds to subsidize employer-based health insurance for low-income uninsured employees and their dependents that work for small firms. When funding for the proposed pilot initiative was not included in the state budget in FY 2004, the RFA was put on hold. During this year's FY 2005 budget process, $3.6 million of pilot funding was restored and activities to secure a private sector partner have resumed.

Design and operational policies for the premium subsidy pilot programs are still under development. The State budget for SFY 2005 will be enacted on time this year. As the economy and budget situation continue to improve, we expect our activities to regain the momentum lost during the recent economic downturn.

To support planning activities, significant data collection activities have been completed or are underway. The 2001 household survey and business surveys are being fielded again in 2004. OHCA continued its relationship with the University of Connecticut's Center for Survey Research and Analysis (CSRA) to field both surveys. As with the previous surveys, a communications plan has been developed and implemented to disseminate the results of the 2004 surveys. Issue briefs related to the SPG project continue to be posted at http://www.ohca.state.ct.us

Throughout the grant period, OHCA, in consultation with the Department of Social Services and the Institute for Health Policy Solutions (IHPS), has continued to explore, model and analyze various policy options related to the design of an employer-based health insurance premium subsidy option in Connecticut. Connecticut's specific planning effort has been directed toward the development of models for subsidy approaches that will allow us to take advantage of the current federal policy environment at CMS and its favorable attitude toward waivers and state flexibility, as articulated in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. We have worked throughout the planning grant process to identify appropriate policy options to increase health care coverage in the state, especially for low-income, working uninsured families. Since 80% of uninsured children live in households where one or both of the adults are working, we believe it is important to make a case to small business on the need to provide health insurance coverage, emphasizing the importance of worker health to business, and its corresponding human capital impact. Connecticut has targeted its current planning efforts on employer sponsored insurance in order to provide a cost-effective way to keep families together in coverage, we want to use our Title XXI funds, we want to reach our families without the stigma of a government program, and to help Connecticut businesses attract and retain employees.

The following pages contain the completed 2001 and 2002 Project Management Matrices that detail the specific tasks undertaken and completed with previous grant funds and the impact of these activities. Remaining tasks to be completed are shown in an updated 2003 Supplemental Funds Matrix, which shows completed activities and revised time frames for completing outstanding activities along with the agencies and individuals responsible for completing these tasks.

2001 Project Management Matrix (Completed)

Project Plan				
Action steps are rolled up for completed tasks	**Time Table**	**Responsible Agency/Person**	**Anticipated Results**	**Evaluation/ Measurement**
Task 1: Project Management	All action steps completed.	OHCA -	Define project deliverables	Completion of deliverables
Task 2*:* Data Collection and Analysis - Conduct and Analyze Household Survey Data	All action steps completed	OHCA CSRA	Develop and finalize survey questions, manage CSRA, analyzed results	Distribution of analysis results.
Task 3: Data Collection and Analysis- Conduct Insurance Market Analysis	All action steps completed	OHCA	Compile data files, summarize findings and communicate to stakeholders.	Findings written and distributed.
Task 4: Policy Development - Identify and Resolve Policy Issues Affecting Program Design	All action steps completed	OHCA IHPS	Identify policy and operational issues and present solutions.	Framework developed that presents solutions to policy concerns.
Task 5: Option Development- Develop Enrollment Structure and Benefit Options	All action steps completed	DSS IHPS	Identify and summarize enrollment options and benefit packages.	White paper on options and benefits best suited for program.
Task 6: Evaluate Planning Initiative	All action steps completed	OHCA IHPS	Review and define action steps compared to anticipated results.	Revised project plans.
Task 7: Prepare Report for Secretary of DHHS	All action steps completed	OHCA	Summarize data collection, coverage options and evaluation.	Secretary receives report.

OHCA = Office of Health Care Access; DSS = Department of Social Services; OPM = Office of Policy and Management; IHPS = Institute for Health Policy Solutions; CSRA = Center for Survey Research and Analysis; SHADAC= State Health Data Assistance Center

2002 Supplemental Activities Project Management Matrix (Completed)

Goal: Refine and implement the selected policy option to expand access to health insurance coverage in Connecticut					
Objective: Complete the planning and administrative tasks required to implement a Small Employer Health Insurance Subsidy Pilot Initiative by July 1, 2003.					
Action steps are rolled up for completed tasks	**How task relates to FY 2001 approved activities**	**Anticipated results of tasks**	**Agencies/individuals responsible for completing tasks**	**Collaboration involved**	**Timetable**
Task 1: Conduct further research on the target market to determine what additional data is needed to support program and waiver development	Builds on coverage option selected, uses previously collected data to support policy option development	Analysis and model of program design, completed reports and issue briefs.	OHCA/DSS/CSRA	OHCA/DSS/CSRA SHADAC	Completed
Task 2: Develop substantive program design for the small employer health insurance subsidy initiative.	Adds needed detail to implement coverage option selected during 2001 activities	Defined process and criteria for eligibility, and reporting	OHCA/DSS/OPM	IHPS/OHCA/DSS/ OPM	Completed
Task 3: Prepare program status report, Report to Secretary of DHHS	Continuation of 2001 activities	All SPG reporting requirements were met.	OHCA	IHPS/CSRA	Completed as specified by HRSA as of 9/30/03
Task 4: Prepare for SFY 2004-05 Biennial Budget Process	Funding requested to operate the subsidy initiative.	Some funding was put into DSS budget for start up costs to operate the subsidy initiative	OHCA/IHPS	DSS	Completed

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2003 Supplemental Activities Project Management Matrix (Updated)

Goal: Refine and implement the selected policy option to expand access to health insurance coverage in Connecticut					
Objective: Complete the planning and administrative tasks required to implement a Small Employer Health Insurance Subsidy Pilot					
	How task relates to FY 2001 approved activities	**Anticipated results of tasks**	**Agencies/individuals responsible for completing tasks**	**Collaboration involved**	**Timetable**
Task 1:**Updated Data Collection and Analysis - Conduct and Analyze 2004 Household Survey and Business Survey**					
Action Step 1: Review and update 2001 household survey questionnaire and make changes as needed to prepare for refielding the survey	Builds on and updates research conducted during 2001 activities	All revisions made.	OHCA- K. Riggott, M. Sabados, CSRA	OHCA/DSS/CSRA /SHADAC	Completed
Action Step 2: Refine and finalize survey instrument to obtain information needed to target expansion efforts	Builds on and updates research conducted during 2001 activities	2003 Household survey instrument finalized.	OHCA – K. Riggott CSRA	OHCA/DSS/CSRA /SHADAC	Completed
Action Step 3: Management and oversight of CSRA data collection (fielding of the actual survey)	Builds on and updates research conducted during 2001 activities	Survey fielded, in accordance with Memorandum of Understanding with CSRA, milestones are met on schedule	OHCA – M.Bonadies	OHCA/DSS/CSRA	70 –75% of interviews as of May 31, 2004
Action Step 4: Management and oversight of CSRA data cleaning and preparation for analysis	Builds on and updates research conducted during 2001 activities	Data tables completed and project milestones are met on schedule	OHCA – K. Riggott	OHCA/CSRA	6/04 – 7/04
Action Step 5: Analyze results for use in planning, compare new 2003 survey results to 2001 Household Survey results	Allows for refinement of expansion strategy	Summary of survey findings compiled into usable format for communication to stakeholders along with comparison to previous survey.	OHCA – K Riggott IHPS	OHCA/CSRA	07/04 – 08/04

	How task relates to FY 2001 approved activities	Anticipated results of tasks	Agencies/individuals responsible for completing tasks	Collaboration involved	Timetable
Action Step 6: Share analysis results with project partners and other stakeholders	Allows for refinement of expansion strategy	Distribution and presentation of analysis results. Conduct presentations of data.	OHCA- M. Bonadies CSRA	OHCA/CSRA/DSS	8/04 – 9/04
Action Step 7: Field 2004 Business Survey	Updates previous research	Updated employer survey data	OHCA- M. Bonadies CSRA	OHCA/CSRA	3/04-7/04 Data collection completed 6/1/04
Task 2: Develop substantive program design for the small employer health insurance subsidy initiative					
Action Step 1: Review all responses to the Request for Applications for a private sector partner(s)	Continuation of 2002 activities	Convene review team, Select applicants that meet bid specifications.	OHCA - D. Longo, DSS - D. Parrella, OPM - S. Netkin evaluation team	OHCA, DSS, OPM evaluation team	Delayed – will restart 7/04
Action Step 2: Evaluate all responses	Continuation of 2002 activities	Follow scoring criteria. Score proposals and select top applicants.	OHCA - D. Longo, DSS - D. Parrella, OPM - S. Netkin evaluation team	OHCA, DSS, OPM evaluation team	Delayed
Action Step 3: Negotiate and complete Memorandum of Agreement with qualified partner	Continuation of 2002 activities	Qualified partner(s) selected.	DSS - K. Brennan	OHCA, DSS, OPM	Delayed
Action Step 4: Develop detailed operational plans for subsidy initiative	Needed to implement selected option	Operational plans specifying eligibility criteria, subsidy structure, enrollment verification, and payment process.	OHCA - M. Bonadies, IHPS	OHCA/DSS/OPM/ IHPS	Ongoing 9/03– 9/04
Action Step 5: Assess administrative and system changes needed to implement the pilot and plan for evaluation of its success	Needed to implement and evaluate coverage expansion strategy	List of administrative systems changes needed. Evaluation Plan.	OHCA - M. Bonadies, DSS - D. Parrella	OHCA/DSS/OPM/ IHPS	Ongoing 9/03-9/04

	How task relates to FY 2001 approved activities	Anticipated results of tasks	Agencies/individuals responsible for completing tasks	Collaboration involved	Timetable
Task 3: Prepare program status report to the Secretary of DHHS					
Action step 1: Meet all SPG reporting requirements as directed by the HRSA Project Officer	Continuation of 2002 activities	Final report to the Secretary of DHHS 30 days after end of new grant project period.	OHCA IHPS/CSRA	Follow reports specified by HRSA	Completed
Action step 2: Attend quarterly grantee meetings	Continuation of 2002 activities	Share lessons learned with other states, communicate successes and challenges.	OHCA DSS/OPM	Attend all quarterly meetings.	As required

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The expected expenditures for CSRA survey deliverables yet to be completed are $100,000 which includes payment for completion of 3,500 household survey interviews, 800 business survey interviews and final payment for completed data sets and documentation. The expected expenditures for IHPS planning deliverables yet to be completed are $60,000 incorporating revisions to the initial draft of substantive program design for the premium assistance projects.

In summary, the pilot planning and continuation funds and the corresponding additional grant extension are important to complete planning for the best health insurance system for Connecticut and these activities cannot be accomplished by reallocating remaining 2003 grant funds. The pilot planning and continuation funds requested will be used specifically to build consensus to support our refined and redirected policy options, to further our data collection activities and for the additional planning, development and preparation needed to implement the selected premium assistance options.

One of the greatest challenges Connecticut faces as it strives to provide access to health insurance coverage for all residents is determining exactly how many people are uninsured. Because the design and methodology of national surveys vary, they produce different estimates of the uninsured. These differences reflect variations in survey estimates and accuracy, especially for some state and sub-state estimates.

Through data collection, analysis, and collaboration, OHCA has obtained a wealth of information necessary to create a solid foundation on which to develop models for providing comprehensive access to health insurance coverage. In-depth interviews of target employers and employees as proposed in this pilot initiative will add to our knowledge base.

Statement of Project Goals

Connecticut is requesting **pilot planning grant** funds to complete planning for two types of coverage expansion initiatives. The first is a premium assistance program targeting decliners (low-income workers in firms that already offer coverage) and the second is a small employer health insurance subsidy pilot initiative that targets small firms who currently do not offer coverage to their employees. The overall goal is to reduce Connecticut's uninsured population by supporting enrollment and retention of employer sponsored health coverage. Additional funds are requested to further data collection efforts already underway. Respondents to our current employer and household surveys will be targeted for in-depth interviews. The employer survey, consisting of 810 businesses was completed in May. The household survey targeting close to 4,000 complete interviews was 70-75% complete as of the end of May. Therefore the timing is extremely favorable to stage follow-up interviews utilizing 2004 SPG funds.

Connecticut's specific objectives regarding the proposed pilot coverage expansions are detailed below. Proposed actions A-D encompass the pilot planning limited competition grant. The proposed action if funds are awarded solely at the **continuation level** is to hire a Durational Project Manager to lead the consensus building and strategic planning process for the premium assistance initiatives as described under Action D below.

Proposed Actions:

A. *Data Collection*

- Move beyond OHCA's current primary data collection efforts by conducting additional in-depth household and employer interviews.
- Utilize both quantitative and qualitative research to better inform planning and design of our proposed coverage expansion.
- Use in-depth interviews to test subsidy program design parameters using a staggered interview approach.

B. *Consensus Building- Involving Stakeholders and the Public*

- Build consensus needed to support the selected coverage options.
- Solicit and collect input from project stakeholder groups.
- Update existing and create new communication strategies to keep people informed and engaged.
- Develop strategy for successful implementation of the planned coverage expansions.

C. *Planning for Premium Subsidy Programs*

- Determine appropriate size and structure of the proposed pilot initiatives.
- Tailor implementation plan to targeted populations
- Demonstrate desirable models for future federal and state subsidy expansions for uninsured workers
- Develop an approach that works for Connecticut and is replicable for other states with public coverage of full time workers (i.e. States with relatively

high Medicaid income standards for adults)

D. Project Management

- Hire a full-time Durational Project Manager to manage and oversee the planning initiative through the implementation phase and build consensus among stakeholder groups including committee members, small business owners, health care vendors, policymakers and advocates.

Connecticut's plans support the overarching SPG Program goal of encouraging states to provide access to affordable health insurance coverage to all citizens by extending employer based coverage for low-income workers and using available private employer coverage dollars. Our overarching goal is to reduce Connecticut's uninsured population. OHCA's 2001 household survey found that 7.3% of working age adults were uninsured and that almost half of workers on HUSKY had employers that offered coverage. Supporting enrollment in and retention of employer-sponsored insurance should help reduce the number of uninsured. Also important, the proposed pilot planning initiatives will use rather than continue to replace private employer coverage dollars and will reduce unnecessary State costs for coverage of HUSKY families eligible for employer coverage as has happened in Rhode Island.

Project Description

A. Detailed project narrative

As part of Connecticut's strategy to maximize health insurance coverage, the requested SPG Pilot Planning funds will be used to further planning and development of employment based premium assistance and subsidy programs that would provide health insurance to low-income uninsured workers and their families.

1. Premium Assistance for Available Employer Coverage

A number of HUSKY families are eligible for employer coverage. Twenty-five percent of near-poor parents on Medicaid nationally are eligible for employer coverage and responses to Connecticut's 2001 household survey indicate about half of workers on HUSKY had employers who offered coverage. Per Rhode Island's experience, where HUSKY families are eligible for "cost-effective" employer coverage, the State can reduce its costs by half or more by paying the worker's share of premium. These are net savings after accounting for premium subsidies, administrative costs and supplemental ("wrap") coverage (including cost-sharing "fill-in") under FFS Medicaid coverage. Where only the children are on HUSKY, State savings are unlikely. But, in some cases, kids-only dollars could make worker share for full family employer coverage affordable for uninsured, low-income parents. Virginia reports success with this option under Medicaid. Connecticut's proposed initiative would also provide a broader premium assistance umbrella within which the small-employer pilot program initiative might operate.

2. Small Employer Health Insurance Subsidy Pilot Project

The proposed small employer pilot project is aimed at expanding work-based coverage by encouraging uninsured small employers with many low-wage workers to begin offering health insurance for their workers, by making it easier for low-wage small employers to offer insurance (through lower employer contribution requirements and use of a purchasing pool), and by providing subsidies for low-income workers to pay their share of the premium. The small employer health insurance subsidy pilot project is not an entitlement program and will operate separately from the HUSKY program. Nevertheless, it may provide coverage for some low-income working parents (and their children) who currently have no insurance and who would otherwise end up on HUSKY. A broader purpose is to build on private employment-based coverage and to help avoid unaffordable shifts from private employer coverage to HUSKY. The small employer health insurance subsidy initiative also provides a unique opportunity to leverage significant tax advantages available only through employer-sponsored insurance.

Relationships and Collaborations

The pilot planning grant will allow us to continue our relationship with the Institute for Health Policy Solutions and the University of Connecticut Center for Survey Research and Analysis and establish a new relationship with the University's Department of Public Policy (DPP). The DPP will assist the Durational Project Manager in the consensus building process. The Institute for Health Policy Solutions is a non-profit organization funded to develop creative and workable solutions to health system problems related to access, cost, and quality. Many of IHPS' projects involve the design of health insurance strategies that both achieve public interest objectives and are viable in the market. One area of particular interest and expertise is developing approaches that coordinate public and private sources for coverage of the uninsured. IHPS is uniquely qualified to assist with the proposed initiatives and IHPS expertise has played a critical role in our planning efforts to date. The UCONN DPP and CSRA will augment this role by serving as a resource for policy analysis, consensus building, and program evaluation while continuing to provide survey research services. Both DPP and CSRA are viewed as non-partisan resources for investigating policy issues facing Connecticut and facilitating creation of viable public policy solutions. This partnership will create synergy needed to advance our planning efforts regarding the small employer subsidy pilot program and the premium subsidy program.

B. Project Management Plan

- Data Collection, Consensus Building and Planning

Specific, proposed 2004 Pilot Planning Initiative tasks are described in the narrative below:

1. Explore whether large health plans/carriers serving Connecticut might be willing to cooperate with the State in a public-private partnership to enroll HUSKY-eligible workers and working parents with HUSKY-eligible children in employment-based

health coverage that is already available to them but in which they have previously not enrolled.

- Investigate potential interest among other States in joining with Connecticut to approach national/regional health plan(s).
- Pursue/arrange high-level meeting(s) with appropriate senior health plan managers to investigate their interest in such an approach.

2. Develop and refine a plan for a premium assistance program structure similar to that in Rhode Island. This plan would address such topics as:

- Identifying who has access to employment-based health insurance;
- Collecting information about and evaluating employer coverage;
- Notification, enrollment and enrollment-verification processes;
- Handling "wrap-around" services and cost-sharing "fill-in";
- Subsidy-payment processes.

3. Research the target small employer market by gathering more data on the characteristics of the employers and employees that are the focus of the coverage-expansion program. Such data would assist in more detailed planning for the expansion program. Data would be gathered through a short, targeted phone survey of employers likely to have a majority of subsidy-eligible workers and a set of in-depth interviews with such employers and subsidy-eligible workers. Tasks include:

- Developing preliminary screening instruments to identify target employer groups and target workers.
- Developing the substantive questions (e.g., characteristics of workforce, use of payroll firm, etc.) to be included in an employer survey instrument, identifying the sample of employers to survey, developing the data analysis strategy, and interpreting and reporting survey findings.
- Developing the substantive questions to be included in in-depth interviews with non-offering employers to test operational details of the subsidy program and communication and outreach strategies, and interpreting and reporting focus group findings.
- Developing the substantive questions to be used for in-depth interviews with subsidy-eligible employees to test operational details of the subsidy program and communication and outreach strategies, and interpreting and reporting focus group findings.
- Determining the characteristics of currently insured firms who are most likely to have a high number of low-income, uninsured workers who declined coverage.

4. Work on Health Plan Issues for the Small-Employer expansion by compiling and developing information and data that could be used to inform private-sector health plans about the potential characteristics and structure of groups likely to participate in

the small-employer coverage expansion program. Such information may include, for example, currently available data pertinent to the overall characteristics and associated risk profiles of populations potentially eligible for subsidies. Tasks include:

- Obtaining and summarizing comparable data on programs similar to this employment-based coverage expansion pilot project.
- Analysis of cost and/or utilization data for current participants in Husky A and B.
- Development and refinement of program rules such as participation rules for subsidized and non-subsidized workers.

5. Continued planning for the various options that might be adopted for the subsidy structure for a small-employer coverage expansion (as may be specified in a waiver application to the federal Centers for Medicare and Medicaid Services) and the eligibility-determination process for public subsidies. This further planning may focus on elements that include, for example:

- The basis for verifying subsidy eligibility (e.g., prior-year income-tax form, employer-reported wage rate, or standard HUSKY-style application, etc.).
- Refinement of the subsidy schedule for eligible workers and families, taking into account characteristics of projected enrollment.
- Criteria to be met by participating, low-wage and/or previously non-offering small businesses (e.g., required employer contribution, participation-rate requirements for subsidized and non-subsidized employees, willingness to allow subsidy-eligibles to enroll immediately upon determination, etc.).
- Criteria and rules that would apply under extenuating circumstances (e.g., whether there should be continued payment of the full subsidy amount for the spouse and children of a subsidy-eligible worker who are receiving continuation coverage because the employee is deceased, etc.)
- Administrative data fields that would need to be created or amended to appropriately account for and report on subsidy-eligible employees and subsidy funds.
- Whether and, if so, how subsidy payments will take into account price differences between competing carriers and between benefit plans.

6. Continued planning for the various options that might be adopted for the subsidy-payment process (as may be specified in a waiver application to the federal Centers for Medicare and Medicaid Services). This further planning may focus on elements that include, for example:

- How and to whom the subsidy will be paid (e.g., by State eligibility contractor directly to individual worker, through payroll firm, etc.) and the processes necessary to permit this. This could include subsidy payment for currently working employees and those receiving continuation coverage.

- The timing of subsidy payments and the processes for making subsidy payments under various scenarios (e.g., full premium due for subsidy-eligible employees is not received, etc.).
- If the subsidy is to be handled through a payroll firm, specification of the necessary processes and (if necessary) assistance in the development and evaluation of an RFP to select the payroll firm.
- Necessary reporting interfaces and data to be shared (regarding enrollment status, payroll deduction amounts, subsidy-eligibility status, etc.) among Private-Sector Partner, DSS (and/or State eligibility contractor), payroll firm (if any), etc.

Project Management Matrices

2004 Pilot Planning Activities Project Management Matrix (NEW)

Goal: Refine and implement the selected pilot planning policy option to expand access to health insurance coverage in Connecticut					
	Timetable	**Responsible agency or person**	**Anticipated results**	**Evaluation/ Measurement**	**How task relates to current or previous activities**
Task 1: Project Management					
Action Step 1: Finalize responsibilities of Durational Project Manager	9/15/04	OHCA/DSS M. Bonadies D. Parrella	Focused position description	Final job specification	Enables consensus building and substantive program design planning activities to continue
Action Step 2: Hire Durational Project Manager.	10/1/04	DSS	Successful recruitment of qualified candidate	Results based performance	Dedicated staff to spearhead consensus building
Task 2: Data Collection – Research Target market population for subsidy/pilot initiatives					
Action Step 1: Target populations for in-depth survey interviews.	10/04	OHCA/CSRA M. Sabados C. Barnes	Gather additional data on employers and employees that are the focus of our pilot coverage expansion programs	In-depth interview target groups selected	Furthers previous research efforts
Action Step 2: Compose in-depth survey questions	11/04	CSRA C. Barnes	Completed instruments, interview guides	Interview Framework	Builds on previous survey findings
Action Step 3: Collect additional quantitative and qualitative data	12/04 – 3/05	CSRA/DPP	Data set for analysis	Analysis files	Builds on previous survey findings

	Timetable	Responsible agency or person	Anticipated results	Evaluation/ Measurement	How task relates to current or previous activities
Action Step 4: Distribute Survey Results	4/05	OHCA K. Riggott D.Longo M. Sabados	Issue Briefs, reports, steering committee presentation	Reports and briefs distributed	Supplements survey issue briefs
Action Step 5: Review results and finalize subsidy initiatives based on findings	5/05	OHCA/DSS/ OPM	Plan for subsidy implementation	White paper to inform subsidy design	Continues planning, design and development
Task 2: Consensus Building – Inform and engage Stakeholders, Public, and key legislators					
Action Step 1: Create new communication strategies for pilot initiatives	10/04-11/04	OHCA/DSS/ DPP/DPM	Communication plan with targeted strategies	Completed plan	Extension of current communication plan
Action Step 2: Plan and hold steering committee and stakeholder meetings	At least quarterly	DPP/ DPM Steering Committee	Stakeholders are kept informed and engaged	Meeting notes	Extension of current activity
Action Step 3: Bring together key opinion leaders	At least quarterly	DPP/DPM Steering Committee	Consensus achieved to implement selected coverage expansion	Meetings Health Care Forum	Enhances current efforts
Task 3: Planning for Premium Subsidy Programs					
Action Step 1: Determine appropriate size and structure of pilot initiatives	Various models will be tested over time	OHCA/DSS/ IHPS	Working model	Briefing Paper	Continues previous activities
Action Step 2: Develop and refine plan for premium assistance program structured similar to Rhode Island's	Complete by 8/05	OHCA/DSS/ OPM/IHPS	Implementation plan for premium assistance program	Written Plan	Builds on previous efforts
Action Step 3: Continued planning for various options for subsidy structure of small employer coverage expansion	Complete by 6/05	OHCA/DSS/ OPM/IHPS	Implementation plan for small employer subsidy pilot initiative	Briefing Paper	Builds on previous efforts

	Timetable	Responsible agency or person	Anticipated results	Evaluation/ Measurement	How task relates to current or previous activities
Action Step 4: Work on health plan issues	9/04 and ongoing	OPM/IHPS P. Potamianos	Agreement from health plans to participate	Plan to address issues	New
Action Step 5: Tailor implementation plan to target populations	9/04 and ongoing	IHPS	Appropriately targeted plan	Detailed operational plans	New
Task 4: Prepare program status report to the Secretary of DHHS					
Action step 1: Meet all SPG reporting requirements as directed by the HRSA Project Officer	As specified 30 days after completion of grant period	OHCA IHPS/CSRA M. Bonadies	Final report to the Secretary of DHHS 30 days after end of new grant project period	Report received by Secretary	Continuation of previous activities
Action step 2: Attend quarterly grantee meetings	As required	OHCA DSS/OPM M.Bonadies D. Parrella	Share lessons learned with other states, communicate successes and challenges.	Attend all quarterly meetings.	Continuation of previous activities

OHCA = Office of Health Care Access; DSS = Department of Social Services; OPM = Office of Policy and Management; IHPS = Institute for Health Policy Solutions; CSRA = Center for Survey Research and Analysis; DPP = Department of Public Policy, DPM=Durational Project Manager

Subsection Describing Proposed Actions - Continuation Grant

Pilot Planning funds are critical to build momentum for the planning of Connecticut's proposed pilot premium subsidy initiatives. If only continuation funds are awarded they will be used to hire a full time Durational Project Manager as described in the matrix that follows. The Durational Project Manager will be responsible for managing the proposed planning initiative and providing leadership in promoting the communications and consensus building needed to advance the premium subsidy initiatives to the point where they can be implemented successfully. Communications will target state and federal officials, employers and employer groups, employees and employee groups, advocates, health plans and consultants.

2004 Continuation Activities Project Management Matrix (NEW)

Goal: Refine and implement the selected pilot planning policy option to expand access to health insurance coverage in Connecticut using Continuation funds only					
	Timetable	**Responsible agency or person**	**Anticipated results**	**Evaluation/ Measure-ment**	**How task relates to current or previous activities**
Task 1: Project Management					
Action Step 1: Finalize responsibilities of Durational Project Manager	9/15/04	OHCA/DSS M. Bonadies D. Parrella	Focused position description	Final job specification	Enables consensus building and substantive program design planning activities to continue
Action Step 2: Hire Durational Project Manager.	10/1/04	DSS	Successful recruitment of qualified candidate	Results based performance	Dedicated staff to spearhead consensus building
Task 4: Prepare program status report to the Secretary of DHHS					
Action step 1: Meet all SPG reporting requirements as directed by the HRSA Project Officer	As specified 30 days after completion of grant period	OHCA IHPS/CSRA	Final report to the Secretary of DHHS 30 days after end of new grant project period	Follow reports specified by HRSA	Builds on previous report
Action step 2: Attend quarterly grantee meetings	As required	OHCA DSS/OPM	Share lessons learned with other states, communicate successes and challenges.	Attend all quarterly meetings.	Continues current attendance

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C. Governance

Structure

As lead agency, OHCA's role is to measure health insurance coverage and explore policy options to expand access to affordable health insurance coverage. OHCA will maintain overall direction of and responsibility for the State Planning Grant project including preparation of all reports to HRSA and the Secretary of Health and Human Services. A variety of management tools will be used to direct the proposed planning and program development activities. Detailed project workplans will be utilized. The Governor will ensure adequate participation of critical players and governance on policy issues and overall project direction will be derived from a Steering Committee comprised of the Commissioners of OHCA and DSS, and the Secretary of OPM. It is expected that the

Steering Committee will meet at least once per quarter. In addition, planning workgroups comprised of project staff and relevant stakeholders will meet on a regular basis and will be facilitated by IHPS and/ or UCONN. Various stakeholders will also serve as technical advisors to the Steering Committee to lend expertise on specific topics or to communicate their unique perspectives on the proposed initiatives.

Project Personnel

Marybeth Bonadies, MBA– Project Director
Director of Research & Planning, Office of Health Care Access
Ms. Bonadies manages and directs projects within the Research and Planning Unit at the Connecticut Office of Health Care Access. She has been with OHCA and its predecessor agency, the Commission on Hospitals and Health Care, since 1987. During this time she has directed a variety of projects related to health policy and finance, including monitoring the financial stability of the state's acute care hospitals and assisting the State in assessment and implementation of policies and strategies to sustain coverage and access to health care services. She currently serves as the Principal Investigator of Connecticut's HRSA State Planning Grant. Ms. Bonadies earned a Bachelor of Science in health services administration at Providence College and a Master of Business Administration with a concentration in health systems management at the University of Connecticut. She will continue to devote 40% of her time to this project.

David Parrella, Ph.D.
Director of Medical Care Administration, Department of Social Services
Mr. Parrella has been employed in the Connecticut Medicaid program since March, 1987. During that time he has served as Policy Analyst, Manager, a Deputy Director, Policy Director and an Acting Deputy Commissioner. He has been in his current position as the Director of Medical Care Administration since February 1997. During his service with the Medicaid program, David has been responsible for a number of different areas including Medical Policy, MMIS, and TPL. He led the development of the states hospital disproportionate share program (DSH), targeted case management (TCM), and other revenue maximization initiatives. He developed the Connecticut AIDS Drug Assistance and the AIDS Insurance Assistance Programs. In 1995 he led the development and implementation of the Connecticut Access Medicaid Managed Care Program, now known as HUSKY Part A. David was a key participant in the design on Connecticut's HUSKY Plan for uninsured children under Title XXI of the Social Security Act.
David is a 1972 graduate of Yale University and completed graduate study in anthropology at the University of Oregon and the University of Connecticut. During his doctoral program David spent four field seasons in Peru working with a health development project sponsored by the United Nations and the Wenner Grenn Foundation for Scientific Research. He is committed to expanding access for the uninsured and improving the health status of low income and minority populations, including Native Americans. Prior to coming to the Medicaid program David served as the Health Director for the Mashantucket Pequot Tribal Nation. He will devote 10% of his time to this project

Paul Potamianos, MPA
Fiscal and Program Policy Section Director, Office of Policy and Management
Mr. Potamianos manages the health and human services section of the Budget and Financial Management Division within the Connecticut Office of Policy and Management. He has been with OPM since 2003. Prior to that, he served as the Chief Fiscal Officer of the Connecticut Department of Children and Families, and as the Budget Director and the Director of Health Care Finance for the Connecticut Department of Mental Health and Addiction Services. He has also served as an Associate Budget Analyst in the Connecticut legislature's Office of Fiscal Analysis, and as a budget analyst in the federal government. His diverse assignments have spanned a full range of public budgeting topics, primarily related to health care financing and policy. Mr. Potamianos earned a Bachelor of Arts in political science and a Master of Public Administration with a concentration in policy analysis, both at the University of Connecticut. He will devote 10% of his time to this project.

Steve Netkin, BS
Principal Budget Specialist, Office of Policy and Management
Mr. Netkin currently serves as a Principal Budget Specialist at the Office of Policy and Management. His career in state service spans twenty-eight years. His primary responsibility includes budget preparation for the Medicaid budget, which accounts for $2.6 billion of the state's budget. On a regular basis he advises the Secretary of OPM and Governor regarding the state's HUSKY A and B program, nursing homes, behavioral health issues for children and adults, elderly community assistance, and hospital disproportionate share. Steve was an active member assisting in developing the state's welfare reform and managed care initiatives. Currently he is a member of the National Association of State Budget Officers and represents OPM on the Connecticut Managed Care Council. Mr. Netkin earned a Bachelor of Science Degree in Business Administration from the American International College in Springfield, Ma. He will devote 20% of his time to this project.

Kaila Riggott, MPA
Research Team Leader, Research and Evaluation Unit, Office of Health Care Access
Ms. Riggott joined the agency in 1996, and has supervised the Research and Evaluation Unit of the Research and Planning Division since 1998. She has overseen a variety of health care research and policy related projects related to State Planning Grant activities, including the publication of a series of issue briefs on the results of the 2001 Household and Employer Surveys, and supervising agency collaboration with the University of Connecticut Center for Survey Research and Analysis. Prior to joining OHCA, Ms. Riggott conducted survey research and analysis at the Connecticut Department of Labor, and implemented quality of care surveys at the Connecticut Department of Mental Retardation. Ms. Riggott holds a Master of Public Affairs from the University of Connecticut, where she also earned a Bachelor of Arts in English. Kaila will devote 40% of her time to this project.

Donna Longo, M.S.
Associate Health Care Analyst, Research & Evaluation Unit, Office of Health Care Access
Ms. Longo has been with the agency since 1999 where she has worked on various healthcare related projects. She was one of the key individuals examining how the state purchases healthcare under the ACHIEVE project, funded by the Robert Wood Johnson Foundation State Coverage Initiatives. She also has been part of the workgroup looking at ways to expand health coverage to uninsured workers. Other responsibilities included participating in State Employee/Retiree Health Care negotiations, developing and providing ongoing monthly and quarterly reports on State Employee/Retiree health data, and assisting in the Health Care Coverage Tax Credit. Ms. Longo worked at Aetna Inc for nine years; five of those years she was a financial consultant for the small business market. She received her M.S. in Health Care Administration at the University of New Haven. Donna will devote 80% of her time to this project.

Michael Sabados, Ph.D.
Associate Research Analyst, Office of Health Care Access

In his capacity as an Associate Research Analyst, Michael Sabados has been responsible for research design, data collection and statistical analysis, authoring publications, and publicly presenting research findings. His agency publications include such topics as CT results from the Medical Panel Expenditure Survey (MEPS), preventable hospitalizations, managed care discount rates, and hospital payer and cost trends. He also authored a series of publications on the results of the 2001 Household and Employer Survey in which he identified characteristics of the state's uninsured. Recently, he worked with the Center for Survey Research and Analysis to modify the Household Survey to provide more policy-relevant information. Michael earned his doctorate from Ohio State University. Michael will devote 50% of his time to this project.

Grant Monitoring Plan and Report to the Department

OHCA will continuously track and measure progress in accomplishing the grant's goals and tasks. OHCA will review the end product of each action step and compare it to anticipated results and will determine and evaluate reasons for these differences. Any necessary adjustments to the project plan will be made based on these findings. This will be accomplished via regular status meetings with project staff and progress reports to the Steering Committee. The Project Director will be responsible for management of the grant funds with assistance from OHCA's Director of Fiscal and Administrative Services. Grant funds will be held in a separate agency account and expenditures will be recorded and tracked accordingly.

As it has over the past several years, Connecticut remains committed to meet the four key program expectations as conditions of the grant award. Specifically, project members will attend regular quarterly grantee meetings in the Washington, D.C., Metropolitan area during the grant; will meet reporting requirements in a format and timeframe as directed by the Project Officer; will cooperate in the preparation of consolidated national reports; and will act as a resource to other grantee States and other interested non-grantee States.

In conclusion, Connecticut is committed to the overarching State Planning Grant goal of providing access to health insurance coverage to all of its citizens. We are both anxious and well positioned to take advantage of the opportunity presented by the SPG Pilot Planning Grant. OHCA and its grant partners already have the technical capacity, manpower and necessary skills to carry out the tasks required to complete the project goals. In addition, we have existing relationships and contracts with consulting entities that are experienced in survey research, market analysis, premium assistance programs and developing expansion options. Furthermore, OHCA continues to upgrade its technical infrastructure. We have more than adequate capability to process and analyze data that will be collected as part of this grant effort and to utilize this data to inform policy and develop options to provide improved access to adequate and affordable health coverage.