Connecticut

State Planning Grant to
Develop Coverage Options

ANNUAL PROGRESS:

FINAL REPORT TO THE SECRETARY

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Submitted by:

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EXECUTIVE SUMMARY/ OVERVIEW OF PROJECT PROGRESS

This final report provides an overview of the project work conducted under Connecticut's HRSA State Planning Grant. It describes the results of various data collection efforts including 2004 household and employer surveys and details progress achieved related to the state's coverage expansion policy initiative to utilize premium assistance to increase access to affordable health care coverage in the State.

Connecticut's HRSA grant project has progressed steadily since our initial grant award in March, 2001. Since that time we have fielded and analyzed data from household and employer surveys in 2001 and 2004. Survey data have been instrumental in informing policymakers and agency heads about the characteristics of Connecticut's uninsured and to help frame various policy options available to the state. OHCA was awarded a pilot planning grant in September 2004. Although a pilot program to implement premium assistance for families who might otherwise be eligible for HUSKY, Connecticut's combined Medicaid and SCHIP program adopted by the Connecticut General Assembly, the $3.6M in funding needed for subsidies was not included in the final budget that was enacted. Funding will be requested in the upcoming 2006-2007 budget. The current budget did provide new funding in excess of $39 million in FY 2006 to expand Medicaid eligibility for families with income up to 150 % of the federal poverty level (FPL). By increasing the threshold for HUSKY adults from 100% to 150% FPL is expected to serve an additional 25,000 individuals annually. State Planning grant funds continue to be utilized to study and measure Connecticut's uninsured population and to support the planning and development of several premium assistance policy initiatives to support access to employer sponsored health insurance for working families. Although it has one of the lowest uninsured rates in the nation, Connecticut continues to explore new opportunities to further expand access to coverage, especially for low-income, working uninsured families. In its efforts to develop programs and policies aimed at expansion of access to care, Connecticut continues to take advantage of the experiences of other states and the lessons learned in their coverage expansions. The SPG work group members continue to build on the practical programmatic knowledge obtained from its a site visit to Rhode Island and have contacted Massachusetts, Pennsylvania, and Illinois to discuss their experience with premium assistance programs. A site visit to Massachusetts is planned for early October. Through data collection, analysis and collaboration, OHCA has made significant progress in obtaining the information necessary to advance its coverage initiatives.

SECTION 1 SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The primary source of information provided in this section is the Office of Health Care Access (OHCA) 2004 Household Survey. Comparisons to 2001 Household Survey results are provided where applicable.

Rate of Uninsurance

According to OHCA's 2004 Household Survey, the overall rate of uninsurance in Connecticut is 5.8 percent, or an estimated 196,300 residents who were uninsured at the time of the survey.

This compares to the CPS 3-year average 2002-2004 rate of 10.9%. Approximately 318,300 persons (9.4%) lacked coverage at some point during the preceding year (Spring 2003 to Spring 2004).

Characteristics of the Uninsured

Income/Federal Poverty Level: OHCA's 2004 Household Survey found that nearly 60 percent of Connecticut's uninsured have family incomes of under $35,000, with approximately 37 percent of uninsured residents' family incomes exceeding $35,000. Roughly 43 percent of the state's uninsured residents live in households with family incomes below 185 percent of the federal poverty level (FPL), with an estimated 41 percent of the uninsured living in households with family incomes greater than 185 percent of the FPL.

Family Income and Insurance Status		
Income	**Percent Uninsured within Income Group**	**Percent of All Uninsured**
<$35,000	14%	59%
$35,000+	3%	37%
Don't Know/Refused	3%	4%

Federal Poverty Level (FPL) and Insurance Status		
FPL	**Percent Uninsured within FPL Group**	**Percent of All Uninsured**
<+100%	15%	15%
101% - 185%	16%	28%
186% - 300%	8%	20%
301%	2%	21%
Don't Know/Refused	6%	16%

Comparing 2001 and 2004 Household Survey results finds that today the uninsured have lower family incomes. In 2001, 17 percent of the uninsured had family incomes below $20,000, but in 2004, 27 percent had incomes below $19,000.

Age: The vast majority of uninsured state residents are non-elderly adults between the ages of 19 and 64. Specifically, the highest rate of uninsurance among Connecticut residents is found in adults between the ages of 19 and 29 (17 percent). Since the 2001 Survey, this rate increased from 13 percent to 17 percent. The lowest rate of uninsurance in Connecticut is found among children under age 19 (2 percent). From 2001, the share of uninsured who were children dropped from 12 percent to 10 percent. Due to the low rate of uninsurance among children, children will not be broken out or treated as a separate group in any of the following analysis of the uninsured.

Age and Insurance Status		
Age Category	**Percent Uninsured within Age Group**	**Percent of All Uninsured**
<19	2%	10%
19 – 29	17%	31%

30 – 44	10%	38%
45 - 64	5%	20%
65+	1%	1%

Gender: According to OHCA's 2004 survey, 54 percent of all uninsured are male. The rate of uninsurance among males is 5 percent, versus 4 percent among females.

Gender and Insurance Status		
Gender	**Percent Uninsured within Gender Group**	**Percent of All Uninsured**
Male	5%	54%
Female	4%	46%

Family Composition: Single and married people represent about the same percentage of uninsured. (38 and 39 percent, respectively). Since 2001, the rate of uninsurance for married people increased from 3 percent to 5 percent as did their share of the uninsured (from 32 percent to 39 percent). Uninsurance rates are highest for those residents living with a partner and are lowest for those widowed. Approximately 44 percent of the uninsured were in single or two person families; as compared to 26 percent of insured.

Family Composition and Insurance Status		
Marital Status	**Percent Uninsured within Marital Status Group**	**Percent of All Uninsured**
Single	13%	38%
Married	5%	39%
Living with Partner	21%	14%
Divorced	8%	6%
Separated	14%	2%
Widowed	1%	1%

Employment status (includes seasonal and part-time employment and multiple employers): OHCA's 2004 survey found that the majority of adults in Connecticut, both uninsured (66%) and insured (63%), are employed. These figures remained essentially unchanged since 2001. Approximately 8.4 percent of part-time workers were uninsured and 7.2 percent of full-time workers are uninsured. The self-employed are as likely to be uninsured as the unemployed. One of every four seasonal workers and one of every three temporary workers lacked health coverage. Holding a permanent job was crucial for adult coverage as 95% of those with one were insured. Non-union members were four times as likely to be uninsured than union members. Small firm employees were significantly less likely to be insured than those employed by larger firms. Two-thirds of uninsured workers were employed by firms with fewer than 50 workers.

Employment (age 18+) and Insurance Status		
Employment Status	**Percent Uninsured within Employment Group**	**Percent of All Uninsured**
Self-employed	16%	20%
Work for someone for a wage	6%	46%

Unpaid worker for family firm	0%	0%
Unemployed	16%	27%
Retired	2%	4%
Full-time student	6%	3%

Character of Position for Gainfully Employed, Age 18+		
Position	**Percent Uninsured within Position Group**	**Percent of All Uninsured**
Permanent	5%	64%
Temporary	34%	24%
Seasonal	24%	11%
Don't Know/Refused	25%	1%

Union Membership of Gainfully Employed, Age 18+		
Union Membership	**Percent Uninsured within Union Membership Group**	**Percent of All Uninsured**
Yes	2%	3%
No	8%	93%
Don't Know/Refused	50%	4%

Firm Size of Gainfully Employed, Age 18+		
Firm Size (# of Employees)	**Percent of Firm Size Group**	**Percent of All Uninsured**
1	13%	12%
2 to 10	20%	37%
11 to 50	9%	18%
51 to 100	5%	6%
101 to 500	3%	6%
501+	1%	7%
Don't Know/Refused	18%	15%

Availability of private coverage (including offered but not accepted): Employers offer coverage to 65 percent of residents of all ages and 74 percent of those under the age of 65 years (respondents could report multiple coverages). For the working uninsured, just about 30 percent reported that their employer offers employer sponsored insurance (ESI). For those uninsured working in firms that offer coverage, one-third could not afford ESI, while just under half did not think they were eligible because they did not work enough hours or had just started work with the firm.

Approximately 7 percent of residents of all ages and 6 percent of those under age 65 years purchase their own coverage. Approximately 68 percent of uninsured adults (non-students) cited cost/affordability as the main reason they did not purchase health insurance on their own; 12 percent said either they did not want or need (rarely sick) insurance or that it was too much of a hassle to get; 6 percent reported they did not know how to obtain coverage.

Availability of public coverage: According to OHCA's 2004 Household Survey, approximately 14 percent of Connecticut's residents obtain their health insurance coverage from Medicare, and 10 percent are HUSKY recipients, the state's Medicaid program. Approximately 2 percent of the state's population is on State Administered General Assistance (SAGA) and 1 percent reporting some type of federal coverage such as CHAMPUS/TRICARE/Veteran Health.

Race/ethnicity: Connecticut's population is overwhelmingly white (78 percent non-Hispanic whites - Census 2000), and therefore the majority of the uninsured are non-Hispanic whites (45 percent). However, the Hispanic population has the highest rate of uninsurance (21 percent). For Hispanics, the uninsured rate has nearly doubled since 2001 (11 percent) and their share of the uninsured has tripled. This may in part be related to the sampling design, which included an oversample of four urban areas with large Hispanic populations.

Race/Ethnicity and Insurance Status		
Race/Ethnic Identity	**Percent Uninsured of Racial/Ethnic Identity Group**	**Percent of All Uninsured**
Non-Hispanic		
White	3%	45%
African-American	7%	9%
Asian	7%	2%
Native American	6%	.5%
Biracial	0%	0%
Other	6%	1.5%
Don't Know/Refused	13%	3%
Hispanic	21%	39%

Geographic location: The county rates of uninsured were fairly similar with Litchfield, Windham and Fairfield Counties having the highest rates. Fairfield County has a number of urban areas with high concentrations of poverty and unemployment (Bridgeport, Danbury, Norwalk, and Stamford). Litchfield and Windham are less populated largely rural counties with one urban area having higher poverty and unemployment. Hartford County's lower uninsured rate may be because the general affluence of the county offsets the poverty of the city of Hartford and the town of East Hartford.

As previously mentioned, the survey design included an oversample of four urban areas (Bridgeport, Hartford, New Haven, and Stamford). This was done to ensure a sample of Medicaid recipients sufficient for analysis.

County and Insurance Status		
County	**Percent Uninsured within County**	**Percent of All Uninsured**
Fairfield	8%	35%
Hartford	4%	16%
Litchfield	9%	8%
Middlesex	6%	4%

New Haven	6%	24%
New London	4%	5%
Tolland	2%	1%
Windham	9%	5%

Duration of Uninsurance: For the uninsured as a group, 65 percent were continuously uninsured over the course of the prior year. Half of all uninsured persons who previously had health benefits have been without coverage for two months or less. Half of all insured persons who had been without coverage at some point during the preceding year have been without coverage for 9 months or less prior to obtaining their current health insurance. The distribution of residents by insurance status remains relatively unchanged from the 2001 Household Survey results.

Stability of Insurance Status During the Preceding Year	
Insurance Status	**Share of Residents**
Continuously insured	90.6%
Insured now, but previously uninsured	3.6%
Uninsured now, but previously insured	2%
Continuously uninsured	3.8%

Educational Attainment: In terms of educational attainment, individuals who did not have a high school diploma had the highest rate of uninsurance. In general, increased education was strongly associated with being insured.

Education and Insurance Status, Age 18+		
Education	**Percent Uninsured within Education Group**	**Percent of All Uninsured**
Not high school graduate	17%	23%
High school graduate	9%	46%
Some college/technical school	6%	21%
College graduate	3%	8%
Post-graduate degree	2%	3%
Don't Know/Refused	0%	0%

OHCA's 2004 Household Survey, in combination with other information, revealed several groups that would benefit from targeted coverage expansion options. The agency found that the predominant characteristics of the uninsured were those in families earning 185 percent or less of the federal poverty level, were young working adults, were employed by small firms, were those with temporary or seasonal employment or were of Hispanic origin. As the majority of the uninsured in Connecticut are working, the state has decided to focus its coverage expansion options on working adults and families.

With respect to qualitative research questions, OHCA must rely upon data drawn from its 2001 and 2004 Household Surveys to provide information on the attitudes and decision-making of uninsured individuals. It has not recently conducted any specific qualitative research on these issues. According to OHCA's 2004 Household Survey, for the working uninsured, just about 30 percent reported that their employer offers coverage. For those uninsured working in firms that offer coverage, one-third could not afford ESI, while just under half did not think they were eligible because they did not work enough hours or had just started with the firm.

Approximately 68 percent of uninsured adults (non-students) cited cost/affordability as the main reason they did not purchase health insurance on their own; 12 percent said either they did not want or need (rarely sick) insurance or that it was too much of a hassle to get; 6 percent reported they did not know how to obtain coverage.

In looking at how the uninsured get their medical needs met, according to OHCA's 2004 survey, 65 percent of the uninsured have a usual source of care, versus 95 percent of Connecticut's insured. The uninsured cite *lack of insurance/could not afford it* as the main reason that they do not get need emergency care (91 percent) or treatment for an illness/injury (76 percent). Similarly in explaining why they don't have a regular health care provider, 48 percent of the uninsured state that the main reason is they do not have insurance or cannot afford it; 28 percent say they do not need a doctor – they are rarely sick; and 13 percent say there is no care available/doctor does not accept their insurance.

Utilization of Health Care Services		
Utilization	**Percent of Insured**	**Percent of Uninsured**
Regular Source of Care	95%	65%
Doctors Visits (Avg. last year)	5%	4%
% with no doctor visits	8%	31%
% seeing doctor in last year	73%	36%
Didn't get needed emergency care	1%	11%
Didn't get care for illness/injury	2%	21%

Regular Source of Health Services		
Provider Type	**Percent of Insured**	**Percent of Uninsured**
Doctor's Office	82%	33%
Hospital Outpatient Clinic	6%	9%
Walk-in Center	2%	7%
Hospital ED	1%	6%
Community Health Center	1%	1%
Hospital (Unspecified Department)	1%	4%
Other	2%	5%
None	5%	35%

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, therefore we have not worked under this grant to identify features of a barebones benefit package. 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.

SECTION 2 SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

In an effort to obtain information on how the rising cost of health insurance affects employers and their decisions on offering health insurance coverage to employees, OHCA surveyed 810 Connecticut businesses listed in the Dun and Bradstreet database as of February 2003. The sample frame was designed to include all businesses located in the State of Connecticut with more than two and fewer than 300 employees. Government agencies were excluded. Respondents were asked up to 14 specific questions.

Firm size, annual gross revenue, and the type of business distinguished offer rates within Connecticut's private sector. Smaller firms, those with lower annual gross revenue, and those in the service, retail, agricultural, and gas/sanitation/communication sectors all have lower than average offer rates of ESI. While all three factors influence offer rates, firm size has the strongest effect. When firm size is combined with either economic sector or annual gross revenue, differences in offer rates by size of firm remain clear. For example, the manufacturing sector has a high average offer rate (69%), but less than half of those with fewer than 5 employees offered coverage while all of those surveyed manufacturers with 20 or more employees reported providing health benefits to their workers.

Employer size (# of employees): Similar to the results of OHCA's 2001 survey, OHCA's 2004 Employer Survey found that smaller employers continue to be significantly less likely to offer health care coverage. For example, the offer rate for firms with fewer than five employees was half that of firms with 20 or more workers. The majority of the smallest firms did not offer coverage (59 percent), and accounted for most (nearly 70 percent) of those employers not providing health benefits.

ESI by Firm Size		
Firm Size	**Percent of Firm Size not Offering Coverage**	**Percent of Total Firms not Offering Coverage**
2 – 4	59%	69%
5 – 9	30%	19%
10 - 19	20%	8%
20 - 49	13%	3%
50 - 99	11%	1%
100 - 199	8%	.3%
200 - 299	0%	0%

Industry sector: Manufacturing, construction, wholesale and financial services/insurance/real estate (FIRE) firms had higher than average offer rates. The pervasiveness of coverage among these types of employers may be related to high levels of full-time labor, their need to attract and retain skilled workers, and greater unionization. Conversely, agricultural, retail, gas/sanitation and service firms were less likely to offer ESI. Firms in these economic sectors have a higher proportion of part-time, seasonal, unskilled and non-unionized labor. Over two-thirds of firms that did not offer health benefits were either in the service or retail sectors. Manufacturing, construction, FIRE and wholesale firms were not only more likely to offer health benefits, they

also had broader employee eligibility and elevated take-up rates. Due to these factors, more employees in these sectors had health insurance through their own employer.

ESI by Industry Sector		
Industry Sector	**Percent of Firm Size not Offering Coverage**	**Percent of Total Firms not Offering Coverage**
Agriculture	48%	3%
Construction	32%	9%
Manufacturing	31%	6%
Gas/Sanitation/Communication	45%	4%
Wholesale	32%	5%
Retail	47%	23%
FIRE	38%	9%
Services	39%	42%

Percentage of part-time and seasonal workers: Approximately 31 percent of firms required a 40 hour work week for employees to be eligible for ESI. On average, firms offering ESI required 32 hours of work per week for employees to qualify for health benefits.

Annual Gross Revenue: Annual gross revenue was linked to ESI offer rates as firms with limited financial resources were less likely to offer coverage. As a result, firms with gross revenue below $500,000 (one-third of sample businesses) accounted for nearly half of the employers that did not offer health benefits to their employees.

ESI by Annual Gross Revenue		
Annual Gross Revenue	**Percent Not Offering Coverage**	**Percent of Firms Not Offering**
<$100,000	78%	22%
$100,000 - $500,000	48%	27%
$500,000 - $1 million	27%	9%
$1 million - $10 million	17%	8%
$10 million - $20 million	0%	0%
$20 Million+	0%	0%
Don’t Know/Refused	40%	34%

Firm size, annual gross revenue, and industry sector were combined to identify the types of firms that do not currently offer health coverage. The majority of firms that do not offer coverage are small, lower revenue retail or service sector employers.

Share of firms not offering ESI			
Size (employees)	**Annual Gross Revenue**	**Business Type**	**Share of Firms Not Offering Coverage (percent)**
<5	<$500,000	Services	19

<5	Not available*	Services	11
<5	Not available*	Retail	7
<5	<$500,000	Retail	6
5-19	Not available*	Services	5
<5	<$500,000	Construction	4
<5	<$500,000	Manufacturing	3
<5	<$500,000	FIRE	3
5-19	<$500,000	Retail	3
5-19	<$500,000	Services	2
All other firms not offering coverage			37

*"Not available" refers to firms responding "Don't Know" or refusing to characterize their annual gross revenue.

Cost of Coverage and Employee Contributions: Employers paid most of the premiums for employee only (79 percent) and dependent coverage (64 percent). In fact, many employers reported that they paid the entire employee only and dependent premiums (43 percent and 37 percent, respectively, of firms offering coverage). Naturally, employee only coverage was on average less expensive ($5,052 annually) than dependent coverage ($8,872). Nearly all firms that provided health benefits offered both employee only and dependent coverage (84 percent). In fact, over half (52 percent) of all firms reported that they offered both employee only and dependent coverage.

Average Least Expensive Monthly Premium			
Type of Coverage	**Average Monthly Premium**	**Average Employer Share**	**Average Employee Share**
Employee Only	$421	$333 (79%)	$88 (21%)
Employee plus one or family	$736	$471 (64%)	$265 (36%)

Percentage of employees offered coverage who participate: On average, employers offering ESI reported that 80 percent of their employees were eligible for health benefits, and nearly three-quarters enrolled. Many employers (38 percent) even reported that all of their eligible employees had taken-up their coverage.

Take-up Rates of Eligible Enrollees (Average per firm offering ESI)	
Type of Coverage	**Percent Enrolled**
Any type of coverage	74%
Dependent coverage (Employee plus one or family)	49%

OHCA must rely on the results of its 2004 Small Employer Survey to provide information regarding which factors influence employer decisions on offering health benefits to their employees since we did not conduct specific qualitative research under this grant.

Employer Reasons for Not Offering ESI: The main reason cited by employers electing not to offer health benefits was that they could not afford to. One-third said that their employees do not need health insurance.

Main Reason for Not Offering Health Benefits	
Reason	**Percent of Firms not Offering Coverage**
Can't Afford	34%
Employees don't need health insurance	33%
Part-time/seasonal labor	15%
Too few employees	7%
Other	11%

SECTION 3 SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

As part of its ongoing research of the health care marketplace, OHCA conducted a market assessment of Connecticut Health Plans several years ago as part of its initial state planning efforts. For purposes of this current report, some conclusions from this assessment have been updated below:

Health plan acquisitions, consolidations and closures have significantly reduced the number of vendors with an established presence within Connecticut. As of 2004, there are currently six HMO's licensed to do business in Connecticut. The State currently contracts with three health plans, (Anthem, Oxford and HealthNet) to provide health insurance coverage to its state employee and retiree population. None of the two national health plan vendors (Aetna and CIGNA) currently provide coverage for this population. There are four health plans providing coverage for the state's HUSKY A (Medicaid) population (Anthem BlueCare, Community Health Network, HealthNet and Preferred One) and three plans participating in HUSKY B (SCHIP) (Anthem Blue Care, Community Health Network and Preferred One).

HUSKY provides coverage for children in families of all income levels. Family income determines which part (A or B) of HUSKY will serve the child and whether there is a premium sharing. HUSKY has a comprehensive health care benefit package that includes such benefits as preventive care, inpatient and emergency care and prescription medicines. Enrollment in HUSKY A and HUSKY B reached 302,000 and 16,000 respectively, as of August 1, 2005.

Regarding the prevalence of self insured firms in Connecticut, according to the MEPS in 2003, in Connecticut, about 28 percent (or 23,114) of private-sector firms offering ESI offer at least one self-insured plan. Large firms (50 or more employees) were more likely to offer self-insured plans; 58 percent compared to 10 percent of small firms (less than 50 employees). In 2002 firms in the retail and other services industry were most likely (41 percent) to offer a self-insured plan verses "All Others" in 2003 being most likely to self insure (41 percent). Firms in the mining and manufacturing industry were least likely (20 percent) to self insure in 2002 and 2003. Firms

with fewer full-time employees were less likely (only 17 percent) to offer self-insured plans than firms with more full-time employees, (29 percent) of those offered.

More than half (57 percent) of all enrolled employees are covered by self-insured plans. Large firm employees preferred the self-insured plans offered; 7l percent of enrolled employees in large firms preferred self-insured plans compared to 8 percent in small firms. Six of ten enrolled employees in unincorporated for profit firms but only 57 percent enrolled employees in non-profit firms enrolled in self-insured plans. One-half of enrolled employees of older firms (five or more years) were enrolled in self-insured plans. Close to 62 percent of enrollees in firms where less than one-half of employees were full-time preferred self-insured plans. Over half of enrollees (56 percent) in firms with high proportions of full-time employee took-up self-insured plans.

In its efforts to develop programs and policies aimed at expansion of access to care, Connecticut continues to take advantage of the experiences of other states and the lessons learned in their coverage expansions. SPG work group members conducted a site visit to Rhode Island to discuss that state's experiences with its premium assistance program. Among issues discussed were specific strategies used by Rhode Island used to achieve administrative simplicity and the administrative pros and cons of subsidy payments to employers versus employees, and employer outreach. Rhode Island representatives also reported on the type of actuarial analysis required and explained the state's quantification of the fiscal impact and estimated savings of the subsidy program. In addition, they provided Connecticut with their cost effectiveness methodology and discussed estimating enrollment. Wrap around coverage strategies were examined and finally, program evaluation and ongoing challenges were discussed. We have researched other states such as Illinois, Idaho, Pennsylvania and we are conducting a site visit to Massachusetts in the fall. An issue brief, "Why Premium Assistance Strategies Can Succeed in Connecticut?" was purchased in March to inform our efforts to pursue premium assistance as a health insurance purchasing strategy. In addition, employees from the Department of Social Services attended the premium assistance toolbox workshop to gain knowledge on how to implement Premium Assistance.

SECTION 4 OPTIONS AND PROGRESS IN EXPANDING COVERAGE

Our most recent planning efforts have focused on utilizing premium assistance as a mechanism to expand access to health insurance coverage in Connecticut. In many respects, we plan to use Rhode Island's and Massachusetts' successful premium assistance programs as models in our planning efforts. The budget adopted by the Connecticut General Assembly at the end of the 2003 legislative session included funds for a pilot program to begin premium assistance for families who might otherwise be eligible for HUSKY. Gaining the support of a new Governor and Secretary of the Office of Policy and Management, our initiatives to extend health care coverage to low income workers and implement a premium assistance strategy for HUSKY A families were once again included in 2005's budget proposal. Although current administration supported our initiative the funds were removed during the 2005 session. The Administration still supports our initiative and in the upcoming year we will continue to garner legislative support in hopes that funds will be restored in 2006. Over the years, an increasing number of low-income working families have been forced to decline coverage through their workplace due

to the increase in the employee share, especially the contribution to cover their dependents. Our premise is that by providing assistance with these premiums, the state could reverse the crowd out of private coverage by stabilizing the percentage of low-income working families who are covered primarily through their workplace.

Information analyzing the demographics and characteristics of the uninsured and business ESI offer rates and take up rates has been well received by policy makers and interested constituencies as a means of informing the policy development process.

In our proposed program, eligibility for the HUSKY program would be modified so that families upon their initial application or upon renewal would be asked whether they worked at a job where coverage for themselves and their dependents was available. If they answer "yes," then the state would require them to enroll in that policy as a condition of eligibility. In exchange, the state would pre-pay the amount deducted from their paycheck each month for health insurance directly to the employee. This would minimize the impact on private employers.

The state would have to establish minimum standards for the policies that it participated in and it would need legislation to allow HUSKY clients who received premium assistance to enroll in their employer-sponsored plan at any time during the year (qualifying event legislation).

Connecticut's goals for expanding coverage are:

- To extend employer based coverage to low income workers.
- To maximize the use of Employer Sponsored Insurance (ESI) for families already eligible for HUSKY.
- To maximize the use of unspent funds in the Title XXI annual allotment.
- To reverse the "crowd out" of private insurance by supporting ESI.
- To increase access and promote family coverage.

The following initial assumptions have been made regarding the proposed expansion:

- Eligibility for HUSKY A will be modified to require all families who are eligible for employer-sponsored insurance (ESI) to apply for such coverage through their workplace.

- All HUSKY A recipients who receive Premium Assistance for ESI will receive a full Medicaid benefit wraparound, either through fee-for-service or via enrollment in a designated HUSKY Managed Care Organization (MCO).

- There will be no cost-sharing for HUSKY ESI participants. The Department of Social Services will explore the enrollment of "co-pay only" providers to allow non-Medicaid enrolled ESI providers to bill the department for any beneficiary cost-sharing.

- According to data from the 2005 "One Minute Survey" that OHCA recently completed, of 52% of HUSKY A recipients with at least one parent employed were offered employer sponsored insurance and thirty-nine percent of them did not take the insurance due to cost.

SECTION 5 CONSENSUS BUILDING STRATEGY

The Office of Health Care Access and its interagency partners have worked steadily toward the goal of increasing access to affordable and adequate health insurance coverage since our initial HRSA SPG grant award in 2001. While there is support for addressing the problem of the uninsured, the cost of various coverage expansion options is an important consideration. Since Governor Rell was sworn in last July, OHCA has worked diligently to communicate project goals and objectives to the new administration during the transition period and to gain their support. Since pilot subsidy funding was not included in the final biennial budget for 2006-2007, we have worked to create a new budget option for the next budget to reinstate funding for the pilot. The SPG workgroup continues to meet on a regular basis and will conduct consensus building strategies for premium assistance in the fall prior to next years General Assembly. Recent legislation created a Child Poverty Council in Connecticut charged with creating a plan to reduce child poverty by 50% over the next 10 years. Premium assistance is one strategies that was included in the Council's recommendations to support working poor families. Regional roundtables and public hearings were conducted to solicit input to the plan. This has been a valuable way to efficiently obtain stakeholder input on health care access issues that affect poor families

OHCA continued to serve as the lead agency in accomplishing the program goal by actively engaging in partnerships with other state agencies, members of the executive and legislative branches of state government, and private sector organizations. OHCA's mission is to ensure that the citizens of Connecticut have access to a quality health care delivery system. OHCA's primary agency partners have been the Department of Social Services (the Medicaid and SCHIP agency) and the Office of Policy and Management (the state budget agency). The University of Connecticut (UCONN) has also been a key partner in our SPG planning efforts. The UCONN Center for Survey Research and Analysis and the UCONN Department of Public Policy played significant roles in data collection, research, policy analysis and consensus building.

Consensus building and garnering legislative support were major goals throughout this grant period. Meetings were held and short briefing memos were utilized to communicate information related to the premium assistance pilot initiatives. A fact sheet and several Issue Briefs were published to inform policymakers and the public of our grant activities. DSS also hired two additional staff to work on the premium assistance program. Both staff occupy permanent state funded positions. Presentations on SPG initiatives along with our survey results were delivered to the Medicaid Managed Care Council and the co-chairs of the Insurance Committee. Our data results were also provided to the Children's Healthcare Initiative Committee of the legislature. The survey results have always been received very positively and have been cited by other agencies and legislative committees. OHCA presented a poster, "Connecticut's Household and Employer Insurance Surveys: Informing Policy to Enhance Access to Coverage" at the Academy Health's State Health Research and Policy Interest Group poster session. This past year we changed our web page to include a link devoted to the HRSA project.

We still are receiving support for the premium subsidy initiative and recently had positive feedback from two legislative workgroups. Although our initiatives cannot address all of the uninsured they are being looked at to address the uninsured low-income workers. Once our 2005

survey results are complete we will present those findings to agency and legislative heads, employers and advocacy groups. We will continue to meet with our workgroup to market our initiatives and to better inform key legislators prior to our next legislative session. Since enrollment continues to increase in our HUSKY program and costs and premiums continue to rise and coverage under this public program continues to consume an ever increasing portion of the state budget; it is highly likely that premium assistance will play a role in the upcoming year.

SECTION 6 LESSONS LEARNED AND RECOMMENDATIONS TO STATES

State-specific data collected by OHCA has been extremely helpful to the decision-making process under the State Planning Grant. The 2004 Employer and Household Surveys were critical in informing policy development. The Employer Survey provided data on the number of employers that could be targeted by the state's premium assistance pilot program. It also provided premium information which is being used to estimate the potential cost of the premium for the proposed initiative.

The results of the 2004 Household Survey have been used to gauge the percent of uninsured residents, estimate their numbers, and to develop a demographic profile of them. Specifically for the premium assistance initiative, the survey data have been used to derive the estimated number of uninsured workers, the target of this program.

The 2004 Household Survey design included an oversample of four urban areas (Bridgeport, Hartford, New Haven, and Stamford). This was done to ensure a sub-sample of Medicaid recipients sufficient for study. Estimating the number of Medicaid adults, particularly those who are working, was an essential part of estimating the potential volume and cost of the states' premium assistance pilot program.

In 2004, the survey instruments were refined to focus on information related to the policy options being considered. The Household Survey dropped the SHADAC survey screener concerning general coverage and family information on all household members. This was done with the agreement of our survey vendor, CSRA, because the information it elicited was too general and also less reliable than the information on the survey respondent.

The surveys that are currently taking place in 2005 are more in-depth surveys that will define the target populations and estimate cost and caseloads. The household survey will include working parents of HUSKY children and a matched sample of demographically similar working adults. The employer survey will include top employers of HUSKY parents and a matched sample of employers in similar economic sectors. Because of OHCA's ongoing relationship with CSRA we were able to jointly develop questions that will help appropriately determine the parameters of the initiative going forward.

Since CSRA is in-state and is highly regarded, our data results are utilized by various legislative and agency heads. Recently we were able to rapidly respond to the Office of Policy Management by developing a quick "one minute" survey relating to employer sponsored insurance. Four hundred HUSKY A recipients with at least one parent employed were surveyed by phone.

Our planning efforts continue to work toward the following objectives: 1) identifying the characteristics of the uninsured via household surveys, 2) exploring the feasibility of premium subsidies via employer surveys, and 3) designing specific proposals to provide the uninsured with access to health insurance coverage. A key lesson for other states is to persevere with data collection despite political and economic uncertainty. Ultimately, our data collection and analyses have provided the foundation allowing this initiative to advance. Although the results were widely distributed, presenting the results at forums or focus groups would be even more beneficial. OHCA also recommends establishing an Executive Council with lead agency heads and advocates early in the initiative. In addition, marketing should play a role to seek pubic input in examining the feasibility of implementing a premium subsidy initiative.

SECTION 7 RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

The premium assistance initiatives currently being contemplated and planned for will hopefully be accomplished via Medicaid State Plan Amendments or Medicaid waivers. Support from the Federal Government of initiatives that build on employer sponsored coverage and are tailored to state specific insurance market conditions and business climates is critical. For example, Connecticut is unique in that we are one of the wealthiest states in the country, with some of the poorest cities. Flexibility at the Federal level is needed to tailor our programs effectively and target the populations that would benefit most from our proposed coverage initiatives.

With respect to data needs, the HRSA State Planning Grant has made it possible for us to conduct household and employer surveys that significantly added to our knowledge of the state's uninsured population. Connecticut recommends that the Federal Government continue to support the work of state policy development and data collection on an ongoing basis. Further, additional research should be conducted (either by the federal government, foundations, or other organizations) in order to adequately define and measure affordability of health insurance and define and understand the concept of underinsurance.

Concerning timetables, 1) it would be more efficient for states if the grants were given on a two year basis and 2) there was an option to have funds issued in line with the State Fiscal Year. Although it is standard practice for HRSA to grant one year extensions, additional grantee time is then spent on completing the time extension documents and amendments needed for all existing contracts. This can be a lengthy process and sometimes delays deliverables. Reconciling state fiscal year expenditures against federal Fiscal Year expenditures can sometimes be time consuming and confusing because of the different periods covered.

APPENDIX I: BASELINE INFORMATION

Population:

Year	Resident Population for the State of CT
2004	3,389,483

Source: US Census Bureau, American Community Survey 2004 Multi-Year Profile

Number and percentage of uninsured (current and trend):

Number and percentage of uninsured:

Estimates of CT's Uninsured		
Method	**Rate (%)**	**Population Estimates**
2004 OHCA Household Survey	5.8	196,300
Current Population Survey Continuously Uninsured 2004	11.6	407,000
Behavioral Risk Factor Surveillance Survey Point-in-Time 2004	9.5	322,001

Median age of Connecticut population:
38.9 years (Source: US Census Bureau, American Community Survey 2004.)

Percent of population living in poverty:
7.6 percent (Source: US Census Bureau, American Community Survey 2004)

Primary industries:

CT Business Profile (2004)		
Industry	**Units**	**% of Total**
Agriculture/Forestry/Fishing & Hunting	349	0.3%
Construction/Mining	10,861	9.9%
Manufacturing	5,490	5.0%
Transportation/Warehousing	1,838	1.7%
Information	1,723	1.6%
Utilities	150	0.1%
Retail & Wholesale Trade	22,863	20.9%
Finance/Insurance & Real Estate	10,333	9.5%
Services	51,638	47.3%
Government	3,678	3.4%
Non-classifiable Establishments	331	0.3%
	109,254	100.0%

Source: Published by the Connecticut Department of Labor, Office of Research, September 2004

Number and percent of employers offering coverage:

Number and percent of employers offering coverage: 2003 MEPS Survey for the State of CT

Firm Size	Number of Establishments	State % of Business Establishments Offering Health Insurance
< 10	48,787	46.1%
10 - 24	9,055	88.4%
25 - 99	6,074	84.8%
100 - 999	5,710	99.1%
1000 +	13,518	96.5%
< 50	61,694	54.6%
50 +	21,450	96.2%
Total	**83,144**	**65.3%**

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Finance, Access and Cost Trends. 2002 Medical Expenditure Survey of Private-Sector Business Establishments -Insurance Component

Number and percent of self-insured firms:

Number and percent of employers offering at least one self-insured plan: 2003 MEPS Survey for the State of CT

Firm Size	Number of Establishments Offering Health Coverage	State % of Business Establishments Offering Self-Insured Health Plans
< 50	5,861	9.5%
50 +	12,355	57.6%
Total	**18,216**	**27.8%**

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Finance, Access and Cost Trends. 2002 Medical Expenditure Survey of Private-Sector Business Establishments -Insurance Component.

Payer mix:

Primary Payer Mix for Connecticut's Acute Care Inpatient Charges*, FYs 2002 - 2003

	FY 2003			FY 2004		
Primary Payer	**# of Discharges**	**Total Charge ($)**	**Share of Total (%)**	**# of Discharges**	**Total Charge ($)**	**Share of Total (%)**
Medicare	159,024	3,231,904,003	49	164,563	3,674,434,518	50
Commercial Insurance	167,930	2,207,115,140	34	167,579	2,436,627,940	14
Medicaid	66,184	880,644,100	13	68,425	990,728,456	33
Other	13,657	196,024,096	3	13,680	210,376,822	3
CHAMPUS/Tricare	1.980	20,522,798	0	2,053	21,983,309	0
Total	**408,775**	**6,536,210,137**	**100**	**416,300**	**7,334,151,045**	**100**

* Charges are pre-reimbursements

Source: Hospital Inpatient Discharge Data compiled by the Connecticut Office of Health Care Access

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Links to OHCA's publications and information related to Connecticut's State Planning Grant:

http://www.ohca.state.ct.us/SpecialProjects/hrsa.htm

http://www.ohca.state.ct.us/Publications/survey%20overview%20BRIEF1.pdf

http://www.ct.gov/ohca/lib/ohca/publications/uninsuredestimatesbrieffinalsingle.pdf

http://www.ohca.state.ct.us/Publications/employer04factsheet1.pdf

http://www.ct.gov/ohca/lib/ohca/publications/premium_assistancebrief.pdf

APPENDIX III: SPG SUMMARY OF POLICY OPTIONS

Option considered	Target Population	Estimated Number of People Served	Status of approval (for example waivers submitted or legislation proposed)	Status of implementation (please include date program or initiative began)	If implemented, most recent estimate of number people served. (date and point in time estimate)
1. Health Insurance Subsidy Pilot	Low-income workers with access to employer sponsored coverage	Pilot "expansion program" capped at 3,000 enrollees	Legislation proposed, requires state funding	N/A	N/A
2. Premium Assistance Program for HUSKY	HUSKY A families with access to employer sponsored coverage	Survey data is pending that will be used to estimate target population	Legislation proposed, would result in cost savings	N/A	N/A
3. Small Employer Health Insurance Project	Small low wage employers that cannot afford to offer coverage	Not known	Not currently being pursued	N/A	N/A