CONNECTICUT
Pilot State Planning Grant

HRSA PILOT PLANNING GRANT
FINAL ANNUAL REPORT

September 2006

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

Submitted by:

The State of Connecticut
Office of Health Care Access
Cristine A. Vogel
Commissioner

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A. Executive Summary

In September 2004, OHCA was awarded a Pilot State Planning Grant (SPG) from the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA). This report summarizes the achievements under Connecticut's Pilot State Planning Grant during its most recent grant period. Beginning with its initial 2001 SPG grant application, the state identified goals of (1) exploring the feasibility of health insurance premium subsidies for employer sponsored insurance coverage, building, in part, on the previous Robert Wood Johnson Foundation's State Coverage Initiatives grant and (2) using state-specific data collection to initiate a process to identify and prioritize coverage strategies and target available resources. Connecticut's goals for expanding coverage under the pilot grant were to extend employer based coverage to low income workers, maximize the use of employer-sponsored insurance (ESI), promote family coverage and to reverse the "crowd-out" of private insurance with public coverage by supporting employer-sponsored coverage.

Survey data collected via the initial SPG grants revealed that nearly three of every five uninsured Connecticut residents are working adults. Two thirds of the uninsured are between the ages of 19 and 44 and the majority of the uninsured in Connecticut are in working families. Therefore, the coverage options put forth by the administration since the inception of the SPGs have focused on low-income working families**.**

Connecticut's uninsured rate has been relatively stable and private insurance is still the primary source of health insurance coverage for most individuals in Connecticut. Reversing a trend since OHCA's first Household Survey in 2001, the share of Connecticut residents with employment-based insurance coverage increased from 64 percent in 2004 to 66 percent in 2006.

Despite the increase of employment based coverage among the state's general population, it is interesting to observe that the share of Connecticut's uninsured that are working people increased from 58% to 62% between 2004 and 2006. Uninsured workers share a number of characteristics that limit their access to receiving health benefits from their employers; they are less likely than insured workers to hold permanent full-time positions and to have been with their current employer for longer periods. The majority of uninsured workers are also employed by firms that are less likely to offer health benefits, such as service and retail establishments and small companies (20 or fewer employees). Uninsured workers with access to employment based coverage still may face financial barriers to enrollment as nearly two-thirds of them earn less than 300 percent of FPL. This is in sharp contrast to insured workers, 69 percent who earn above 300 percent of FPL.

Connecticut's SPG policy focus continues to center on maintaining and supporting access to employment-based coverage. The Pilot SPG was utilized to support planning for a pilot premium subsidy program that subsidized work-based coverage for low-income workers and their families. The goal of the pilot SPG initiative was to 1) extend employer based coverage to low income workers, and 2) maximize the use of Employer Sponsored Insurance (ESI) for families already eligible for HUSKY coverage. Since many HUSKY households have members who are gainfully employed but cannot afford to take up employer sponsored coverage offered to them, providing premium assistance was identified as a viable strategy to not only stretch state

Medicaid dollars but to support and facilitate access for working families to employment based health insurance coverage.

During the past two years, numerous data collection, analysis and planning activities were completed under the Pilot Planning Grant, mostly building on previous SPG efforts. During the initial year of the Pilot Grant an Employer Survey was conducted that targeted two categories of businesses – those with employees whose families used HUSKY insurance and businesses within the same Standard Industry Classification/North American Industry Classification System (SIC/NAICS) categories. In addition, a Household Survey was conducted that was directed at two categories of households – HUSKY recipients with someone in the household employed and low income workers not on HUSKY. Survey results from these paired samples yielded additional information and explored these families' access to employment-based coverage, the particular barriers faced in obtaining coverage, as well as the challenges their employers encountered in providing health benefits. These studies supported our SPG pilot initiative for state subsidy expansions for low income workers and their families. The Institute for Health Policy Solutions (IHPS), one of OHCA's consultants, then used the survey data to model various subsidy options.

Our 2004 Household survey revealed that in Connecticut, low income families, Hispanics, and young adults were most likely to be uninsured. During the second year of the pilot these groups were targeted for further study and the following surveys were conducted:

- Young Adult Household Surveys – 568 completed 10-minute surveys of those aged 19-29 years.

- Hispanic Household Surveys – 1,000 completed 10-minute surveys of the Hispanic population.

- Surveys of People Transitioning Off Medicaid – 600 completed 10-minute surveys of individuals from a listed sample provided by the Medicaid agency.

In addition, in-depth interviews with not-for-profit community service providers were conducted with executives from six Visiting Nurse Associations throughout Connecticut to frame out a possible future policy option to expand access to coverage to certain low-wage health professionals.

The IHPS conducted surveys with other states with successful premium assistance programs. This information was shared with the Office of Policy Management, Department of Social Services, and the Governor's office to educate key policy makers on the various other states' programs and to help estimate Connecticut's potential cost savings under similar programs.

B. Background and Previous HRSA SPG Accomplishments

Prior efforts to address the uninsured and Connecticut's policy environment

The starting point for Connecticut's HRSA Pilot project was its initial HRSA SPG received in 2001. The SPG, along with subsequent continuation grants, was used to support ongoing data collection and planning efforts to enhance access to affordable health insurance coverage. Since Connecticut already had high levels of coverage relative to other states, incremental approaches

to expanding coverage were of the greatest interest. Additionally, survey data collected under the SPG showed that Connecticut's uninsured population was diverse and that many of its uninsured are in working families. Therefore, the state adopted premium assistance as a policy option to address the needs of these low-income working families. In addition, state budget constraints dictated that any options considered include cost savings. Fortunately, despite these budgetary constraints, HRSA grant funds enabled policy option development and continued study.

State funding was designated for an employer subsidy pilot program in each budget proposed by the Governor for three consecutive years. Unfortunately, final funding for the pilot subsidies was never approved by the legislature. However, OHCA has continued its study of key coverage groups, and the data collected continues to support many of the policy initiatives identified under the SPG program. Interest in utilizing premium assistance as a mechanism to expand access to affordable coverage continues to be strong and has been a part of campaign efforts of candidates vying for Governor in the upcoming 2006 elections. This summer Governor Rell convened a State Health Insurance Task Force comprised of state agency and business leaders that has utilized much of the data and information collected under the SPG to look at options to increase coverage at an acceptable cost. Governor Rell continues to be concerned about coverage for children and recently announced $1 million in new funding for community outreach and public information aimed at boosting the number of children and teenagers enrolled in Connecticut's HUSKY healthcare program.

Involvement of key policy makers

OHCA served as the lead agency in advancing the SPG pilot planning project goals 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 key project partners were the Department of Social Services (the state Medicaid agency) and the Office of Policy and Management (the state budget agency). Consensus building occurred in a variety of settings and meetings were held regularly to discuss survey instruments, data analyses and policy direction. OHCA continues to participate in and share data with several executive and legislative branch task forces and committees, including the Healthy Kids Committee, the Medicaid Managed Care Council and the Child Poverty Prevention Council.

The University of Connecticut (UCONN) Department of Public Policy (DPP) and the Center for Survey Research and Analysis, (CSRA), a key partner in our SPG planning efforts, played a significant role in data collection, research and policy analysis. The IHPS also contributed expertise in the design and modeling of health insurance strategies that achieve public interest objectives, are viable in the market, and coordinate public and private sources for coverage of the uninsured.

Accomplishments under prior SPGs

Under its SPGs, the state conducted in-depth studies of several insurance expansion options. Connecticut's planning efforts have consistently targeted the development of models for premium subsidy approaches that would have allowed us to take advantage of waivers and state flexibility articulated in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.

Since Connecticut received its first SPG grant in 2001, the main impediment to coverage expansions has been economic. Similar to most other states, Connecticut implemented measures to contain costs in its Medicaid and SCHIP programs in response to budget deficits, many of which have been restored as the state's fiscal health improved in recent years. Politically, there are ongoing philosophical differences between the Republican administration and the Democrat-controlled legislature on how the Medicaid program, HUSKY and any coverage expansions under these programs should be shaped.

Accomplishments associated with previous funding include significant data collection efforts to measure health insurance coverage rates and the characteristics of the uninsured via household surveys fielded in 2001, 2004 and 2006 as well as measurement of offer rates and take-up rates of employer-sponsored coverage via employer surveys in 2001 and 2004 and 2006. These surveys have been utilized to identify the uninsured and monitor state trends to develop expansion options that are appropriate for Connecticut.

Connecticut has focused on options and strategies that build on the existing employer-sponsored insurance market to cover lower income groups, build existing public coverage programs to cover higher income groups or new populations, or link the public and private sectors. Three main options were considered over the course of the planning grant period.

- A Health Insurance Subsidy Pilot
- A Premium Assistance Program for HUSKY A recipients
- A Small Employer Health Insurance Project

The Health Insurance Subsidy Pilot legislation, with an expansion capped at 3,000 enrollees was never implemented. The Premium Assistance Program for HUSKY A recipients targeted approximately 23,000 HUSKY workers who have family members enrolled in HUSKY, but indicated that they have access to employer-sponsored insurance. This program was eliminated from the final budget last year. The Small Employer Health Insurance Project targeted small businesses that do not currently offer coverage. This option was pursued in partnership with the Connecticut Business and Industry Association (CBIA) in 2001-2002 but momentum ceased when the state economy deteriorated.

C. Pilot Grant Activities

The pilot planning grant funds allowed Connecticut to refine the design of its insurance expansion strategies and to regain momentum needed to refocus planning efforts and move toward successful implementation of pilot premium assistance programs. The bulk of the funds in the pilot project grant were designated for data collection and analysis, consensus building and planning for a premium subsidy pilot program.

As part of the strategy to maximize health insurance coverage, Connecticut focused on two coverage expansion initiatives for its Pilot grant. As mentioned above, the first was a Premium Assistance Program targeting HUSKY A families utilizing Medicaid funds to help them purchase health insurance from their employers. A full "wrap-around" program for HUSKY A families would be included to ensure no loss of benefit between Medicaid and private insurance

while utilizing employer's health insurance policies. The second was a Premium Assistance Pilot Program to expand HUSKY to make employer-sponsored health insurance accessible to low-income workers currently not eligible for Medicaid. The pilot would be capped at up to 3,000 enrollees. The IHPS provided policy analysis, option development, planning and modeling deliverables as OHCA worked with DSS and OPM to frame out these coverage options.

In May of 2005, OHCA utilized the pilot grant to conduct a "one minute survey" at the end of the legislative session to learn more about the employed HUSKY population and its access to employer sponsored coverage. Four hundred phone interviews were completed consisting of questions asked of HUSKY A recipients in households with known employers. Results showed fifty-two percent of households were offered employer sponsored insurance and that fifty-five percent of those individuals took the insurance offered by their employer. The thirty-nine percent that did not take-up offered ESI stated it was due to cost. Documentation was presented to OPM and DSS regarding the survey results. Results are attached in Appendix 3. OHCA then worked to quantify the population that would be potentially eligible for premium subsidies. Subsequently, in 2005, CSRA fielded surveys of HUSKY households and HUSKY employers as well as other similarly situated low wage workers and employers. The employer survey was directed at two categories of businesses – employers of HUSKY recipients and a matched sample of employers within the same SIC/NAICS categories. The household survey was directed at two categories of households – HUSKY recipients with someone in the household who was employed and offered ESI and a sub-population of low income workers who were not on HUSKY. Survey results are referenced in Appendix 3.

The *Working HUSKY Family and HUSKY Employer Surveys* were fielded between August and October 2005 by the CSRA. The *Family* survey consisted of 1,004 completed telephone interviews, of which 760 were of currently employed adults. The *Employer* survey included 402 businesses with employees whose families use HUSKY insurance. According to the *2005 Working HUSKY Family Survey*, the majority of families with some members receiving Medicaid (HUSKY) benefits and headed by a working adult had access to employment-based health coverage. Still, these heads of working HUSKY families were less likely to have employer health benefits than other working adults and were more apt to be uninsured than others in the labor force. The analysis focused on working HUSKY families and the barriers they face to access ESI coverage. Key findings from the survey indicate that over half were employed in service and retail sector jobs, many held permanent positions working twenty or more hours a week and over half worked at the same job for two or more years. Survey results show that affordability was the main barrier to take-up of employer-sponsored coverage rather than the commonly held assumptions that access to ESI is related to employment tenure, or part-time status.

In addition to the HUSKY Family and Employer Surveys, OHCA sponsored two additional surveys fielded at the same time. These additional surveys were "paired" with each of the HUSKY surveys. The first paired survey, the *Non-HUSKY Working Family Control Group Survey*, targeted families that earned below 300 percent of the Federal Poverty Level and were thus eligible for either HUSKY A (below 185 percent) or HUSKY B (186 percent to 300 percent) but were not enrolled. It was difficult to populate this sample with 400 families who were within the appropriate income range yet had no family members enrolled in HUSKY. Of these 400 families, 172 were employed at the time of the survey. This group was used as a

comparison group for the working heads of HUSKY families. The difficulty of building a sufficient sample of non-HUSKY lower income working people suggests that the HUSKY program has been fairly successful in enrolling eligible children and families.

The second paired survey, the *HUSKY Employer Control Group Survey,* was a sample of businesses similar to the types of firms that employed the heads of families with some member currently covered by HUSKY insurance. These 401 businesses were predominantly in the service and retail sectors. Although the initial assumption was that the comparative employer surveys would yield different results; the groups were found to be quite similar in that employees are often eligible for and offered ESI, employers continue to contribute substantially to that coverage, and frequently provide the option of family coverage. For employers not offering coverage, cost was cited as the main reason.

In addition to using the paired surveys to make comparisons with the HUSKY results, this study also utilized the findings of OHCA's 2004 Household and Employer Surveys along with results from the Agency for Health Care Research and Quality's 2003 Medical Expenditure Panel Survey (MEPS). These more general studies of insurance coverage in Connecticut were used to place the HUSKY Survey results into a broader context. They also highlight the unique socio-demographic characteristics of working heads of HUSKY families and their employers that influence the availability of and enrollment in employment-based health coverage.

Over the past two years, OHCA continued to work with IHPS, DSS and OPM to model various options and look at the need for federal waivers or Medicaid State plan amendments and to identify implementation tasks and options.

OHCA and its project partners also visited and met with program staff in our neighboring states, Rhode Island and Massachusetts to learn from their experiences implementing and operating a successful premium assistance programs. Rhode Island's experience shows that $1 million is saved for every 1,000 full year enrollees and Massachusetts projects yearly savings of $32 million in their premium assistance program. In addition to visiting our neighbor states, OHCA's policy staff had numerous phone discussions with New Jersey, New Mexico, Illinois, and Idaho on their existing premium assistance programs. The IHPS completed a deliverable summarizing aspects of premium assistance programs in six States: Illinois, Maryland, Massachusetts, Pennsylvania, Rhode Island and Wisconsin. Excerpts from this deliverable are included in Appendix 3. This information was extremely helpful in educating Connecticut's policy makers on states with successful premium assistance programs and how those programs were implemented. A premium assistance brochure was created to educate policymakers other state's practices, and Connecticut's potential benefit from premium assistance. The brochure is included in a separate pdf document and attached to this electronic submission.

OHCA's grant activities provided useful data on coverage trends and the characteristics of the uninsured which have been used to inform Connecticut's policy and planning efforts. Data collected as a result of the grant funding have been disseminated widely and are used regularly by OPM, DSS and community service providers. Data collection and analysis and reporting activities have sustained our planning efforts despite budgetary setbacks.

Throughout the grant period, presentations were prepared and delivered to the Medicaid Managed Care Council and the co-chairs of the Insurance Committee detailing the premium assistance proposals and conveying the results of our 2004 Household and Employer Surveys. Publications detailing the results of our surveys and describing premium subsidy options were widely distributed. The Department of Social Services hired two additional staff to work on the premium assistance program. Both staff occupy permanent state funded positions. OHCA's Commissioner, the Director of Research and Planning and research staff presented results to various interested parties and legislative committees throughout the year.

A number of activities were completed during year two of Connecticut's Pilot planning grant. Many of the activities related to the collection and analysis of data related to earlier planning grant findings. Prior surveys revealed that low income families, Hispanics and young adults have a greater chance of being uninsured than others. Our most recent pilot data collection efforts have targeted these groups for more in-depth study and future policy development.

- Hispanic Household Survey - According to OHCA's 2004 Household survey, more than one-fifth of Hispanics were uninsured and were 5.5 times more likely to be uninsured than persons from all other racial/ethnic groups together. Hispanics are 10 percent of Connecticut's population, but represented 40% of the uninsured. They were more likely to be lower income, with a higher likelihood of being uninsured. They were less likely to be in permanent, full-time positions and therefore less likely to be eligible for employment sponsored insurance. They were also less likely to work for an employer who offered health benefits. CSRA completed 724 10-minute surveys of Hispanic households.
- Young Adult Household Survey – According to OHCA's 2004 household survey, young adults (ages 19-29) had the highest likelihood of being uninsured. The represent nearly one-third of Connecticut's uninsured. Young adults were found to be less likely than other working adults to have permanent, full-time employment job (which affects eligibility for coverage) and more likely to be single with less likelihood of spousal coverage. CSRA completed close to 600 10-minute surveys of young adults.
- Surveys of People Transitioning Off Medicaid – Recent changes in length of eligibility for Transitional Medical Assistance (TMA) and declines in HUSKY enrollment have prompted questions from OPM and DSS regarding whether former TMA clients are uninsured, cycling back on to Medicaid or obtaining job-based coverage. CSRA completed 598 10-minute surveys of individuals.
- In-Depth Executive Interviews with Not-for-Profit Community Service Providers (Visiting Nurse Associations) CSRA conducted six interviews with providers to gather data to frame out a possible future policy option to expand access to coverage to certain low-wage health professionals. CSRA completed six executive interviews.

D. Implementation Status

During the past year, a significant amount of effort was devoted to preparing the Governor's SFY06-07 biennial budget adjustment proposal to implement a premium assistance strategy for HUSKY A families. The proposal was to expand the Medicaid program to make employer sponsored health insurance accessible to low-income workers through a pilot premium subsidy

program. Although the premium subsidy initiatives had support, the funding was not included in the final budget that was enacted July 1, 2006. Budget option proposals are currently being developed for the upcoming biennial budget at this time. Planning efforts continue and we expect that our recent survey results will further inform these efforts and result in viable coverage options.

E. Recommendations to the Federal Government and HRSA

Support from the Federal Government for initiatives that build on employer sponsored coverage and are tailored to state specific insurance market conditions and business climates is critical. Connecticut is unique in that although we are one of the wealthiest states in the country, we have 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 OHCA to conduct household and employer surveys that significantly add to our knowledge of the state's uninsured population. OHCA has become a recognized authoritative source of information regarding health insurance coverage in the state of Connecticut. OHCA regularly receives requests from legislators, healthcare advocates, municipal governments, health care providers, business executives and other stakeholders for timely information to inform their planning and policy making efforts. Connecticut strongly 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.

F. Appendix 1: Summary of Policy Options

Option considered	Target Population	Estimated Number of People Served	Status of approval	Status of implementation	If implemented, most recent estimate of number people served.
1. Health Insurance Subsidy Pilot	Low-income workers with access to employer sponsored coverage	Pilot "expansion program" capped at 3,000 enrollees	Legislation proposed, never approved	Not implemented	N/A
2. Premium Assistance Program for HUSKY	HUSKY A families with access to employer sponsored coverage	Approximately 23,000	Legislation proposed and included several Governor's Budget Proposals. Never approved.	Not implemented	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

G. Appendix 2: Project Management Matrix

2005 Pilot Planning Activities Project Management Matrix (Updated)

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**	**Current Status**
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	**Complete**
Action Step 2: Hire Durational Project Manager.	10/1/04	DSS	Successful recruitment of qualified candidate	Results based performance	**Complete DSS hired 2 permanent positions in lieu of a DPM**
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	**Complete** Defined at 10/27/04 meeting with C. Barnes of CSRA.
Action Step 2: Compose in-depth survey questions	11/04 Revised to 12/04 Completed 5/05	CSRA OHCA C. Barnes	Completed instruments, interview guides	Interview Framework	**Complete** All questions are finalized and surveys went out in the field at end of August.
Action Step 3: Collect additional quantitative and qualitative data	6/05 – 8/05	CSRA/DPP	Data set for analysis	Analysis files	**Complete.**
Action Step 4: Distribute Survey Results	4/05 Revised 09/05 – 10/05	OHCA K. Riggott D.Longo M. Sabados	Issue Briefs, reports, steering committee presentation	Reports and briefs distributed	**Complete Databook and Summary Briefing**
Action Step 5: Review results and finalize subsidy initiatives based on findings	10/05	OHCA/DSS/ OPM	Plan for subsidy implementation	White paper to inform subsidy design	**Complete Findings sent to DSS and OPM.**
Task 3 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	**Complete**
Action Step 2: Plan and hold steering committee and	At least quarterly	DPP/ DSS Steering Committee	Stakeholders are kept informed and engaged	Meeting notes	**Complete** Meet with OPM and DSS members on a monthly basis.

stakeholder meetings					
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	**Complete Deliverables A,B, C and D. received from IHPS**
Task 4: 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	**Complete Deliverables A,B, C, D and E. received from IHPS.**
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	**Not applicable at this time**.
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	**Not applicable at this time**.
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	**All surveys completed by August 31, 2006.**
Action Step 5: Tailor implementation plan to target populations	9/04 and ongoing	IHPS	Appropriately targeted plan	Detailed operational plans	**Surveys completed August 31, 2006 for the following target populations: Hispanics, young adults, TMAs and VNAs.**
Task 5: Prepare program status report to the Secretary of DHHS					
	Timetable	**Responsible agency or person**	**Anticipated results**	**Evaluation/ Measurement**	**Status**
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	**Qtr 1, Qtr 2, and Qtr 3 and Annual reports complete.**
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	Attend all quarterly meetings.	**M. Sabados and D. Longo attended QTR 1 Mtg - presented Pilot overview. M.**

			challenges.		**Bonadies and D. Longo attended Qtr 2 Mtg. P. O'Hagan from DSS and D. Longo attended QTR 3 and Presented Pilot Update. M. Bonadies and D. Longo attended SCI Workshop 8/06**

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

H. Appendix 3: Completed Reports and Products Supported by HRSA Pilot Project Planning Grant

Frequency Tables One Minute Survey- June 2005

SNC1. How many people currently live or stay in this house, apartment or mobile home? (PROBE: Include children, foster children, roomers, housemates not related to you, or college students living away while attending college.) (ENTER NUMBER 1-12)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	1	.3	.3	.3
	2.00	57	14.3	14.3	14.5
	3.00	93	23.3	23.3	37.8
	4.00	126	31.6	31.6	69.4
	5.00	82	20.6	20.6	90.0
	6.00	25	6.3	6.3	96.2
	7.00	8	2.0	2.0	98.2
	8.00	2	.5	.5	98.7
	9.00	4	1.0	1.0	99.7
	10.00	1	.3	.3	100.0
	Total	399	100.0	100.0	

SCN2. How many of these people are children under age 19? (ENTER NUMBER 0-12) (NOTE: SKIPS TO END/ TERMINATES IF 0 CHILDREN OR ANSWER DK/REFUSED 98/99. IF SKIP TO END, SAY THANK YOU VERY MUCH, THOSE ARE ALL THE QUESTIONS WE HAVE FOR YOUR TODAY.)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	148	37.1	37.1	37.1
	2.00	136	34.1	34.1	71.2
	3.00	83	20.8	20.8	92.0
	4.00	23	5.8	5.8	97.7
	5.00	4	1.0	1.0	98.7
	6.00	4	1.0	1.0	99.7
	7.00	1	.3	.3	100.0
	Total	399	100.0	100.0	

Q1. Does your employer or the employer of other family members in your household offer health insurance to any or all of its employees? (PROBE: ANSWER FOR THE JOB YOU WORK AT THE MOST HOURS)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	208	52.1	52.5	52.5
	No	180	45.1	45.5	98.0
	Don't Know	8	2.0	2.0	100.0
	Total	396	99.2	100.0	
Missing	-9998.00	3	.8		
Total		399	100.0		

Q2. Does anyone in your household have health insurance through this employer?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	118	29.6	55.9	55.9
	No	93	23.3	44.1	100.0
	Total	211	52.9	100.0	
Missing	-9998.00	188	47.1		
Total		399	100.0		

Q3. Does anyone in your household have health insurance through a union, through Medicare, through Medicaid, or in some way other than through an employer? (ACCEPT UP TO 4 RESPONSES)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Union	8	2.0	2.0	2.0
	Medicare	23	5.8	5.8	7.8
	Medicaid	68	17.0	17.0	24.8
	In some other way other than employer (Please specify)	173	43.4	43.4	68.2
	Employer only (VOL)	45	11.3	11.3	79.4
	No health Insurance coverage (VOL)	62	15.5	15.5	95.0
	Don't Know	17	4.3	4.3	99.2
	Refused	3	.8	.8	100.0
	Total	399	100.0	100.0	

Q3. Does anyone in your household have health insurance through a union, through Medicare, through Medicaid, or in some way other than through an employer? (ACCEPT UP TO 4 RESPONSES)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Union	2	.5	12.5	12.5
	Medicare	1	.3	6.3	18.8
	Medicaid	2	.5	12.5	31.3
	In some other way other than employer (Please specify)	9	2.3	56.3	87.5
	Employer only (VOL)	2	.5	12.5	100.0
	Total	16	4.0	100.0	
Missing	-9998.00	383	96.0		
Total		399	100.0		

Q3. Does anyone in your household have health insurance through a union, through Medicare, through Medicaid, or in some way other than through an employer? (ACCEPT UP TO 4 RESPONSES)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In some other way other than employer (Please specify)	1	.3	100.0	100.0
Missing	-9998.00	398	99.7		
Total		399	100.0		

Q4. You mentioned that your employer or the employer of someone in your household offers health insurance, but that you do NOT have health insurance through this employer. Why don't you get insurance through this employer? (ASK OPEN-ENDED, CODE INTO CATEG

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Could not afford/Too expensive	36	9.0	38.7	38.7
	Do not need any health insurance	1	.3	1.1	39.8
	Do not want any health insurance	1	.3	1.1	40.9
	DO NOT work enough hours in a week	6	1.5	6.5	47.3
	Have NOT worked there long enough	11	2.8	11.8	59.1
	Benefit package didn't meet needs	1	.3	1.1	60.2
	Has other coverage	7	1.8	7.5	67.7
	Are part-time or seasonal	7	1.8	7.5	75.3
	Other (specify)	16	4.0	17.2	92.5
	Don't Know	6	1.5	6.5	98.9
	Refused	1	.3	1.1	100.0
	Total	93	23.3	100.0	
Missing	-9998.00	306	76.7		
Total		399	100.0		

Appendix 3 Links to 2005-2006 Publications:

2005 DATABOOK-Working HUSKY Families and Employers

http://www.ct.gov/ohca/lib/ohca/husky_databook_final.pdf

Summary Briefing Paper

http://www.ct.gov/ohca/lib/ohca/summary_briefing_paper_final.pdf

Eroding Private Sector Health Insurance Coverage and Rising Costs: 2003 Medical Expenditure Panel (MEPS) Results

http://www.ct.gov/ohca/lib/ohca/publications/newmeps05_letterhead_sp.pdf

Appendix 3

Excerpts from Institute for Health Policy Solutions Deliverable: Premium Assistance Experience in Six States

At the request of OHCA project managers, IHPS gathered current information about premium assistance programs in six States: Illinois, Maryland, Massachusetts, Pennsylvania, Rhode Island and Wisconsin. These States were chosen to include both more successful (IL, MA, PA, RI) and less successful (WI) or failed (MD) programs. They also represent a range of program designs. For example, one serves only Medicaid clients (PA), three serve only S-CHIP enrollees (IL, MD, WI) and two serve both Medicaid and S-CHIP (MA, RI). Two operate entirely without waivers (MD, PA), two required 1115 waivers (IL, MA), and two operate in an 1115-waiver environment, although the waiver does not directly affect the operation of the premium assistance program (RI, WI).

After these six States were identified in consultation with OHCA, IHPS prepared a draft questionnaire to solicit the information OHCA was most interested in having updated. This draft was shared with OHCA project managers before being used. IHPS then pre-filled parts of the questionnaire for each State based on information already available to IHPS from our own prior work and other sources. The partially pre-filled questionnaire was e-mailed to State staff in charge of premium assistance in each of the six States, with a request to arrange a telephone interview to complete the rest of the information. (We felt a telephone interview would be more efficient and effective at eliciting the desired information, as well as less burdensome for State respondents than actually filling out and returning a formal questionnaire.) Telephone interviews were carried out in December 2005 and early January 2006. In several cases, respondents also made available written documents, such as formal evaluations or savings estimates. IHPS used the results of the telephone interviews and written documents to complete the questionnaires, which were submitted to OHCA between January 11 and January 17, 2006. (The completed questionnaires and supporting documents are available upon request. Some of the supporting documents are not public and can be made available only to Connecticut staff.)

We summarize the information gathered through this process in the following tables, with additional commentary only where it seems helpful.

Basics

The first table names the State programs and shows how long they have been operating under which federal statutory authority.

State	Program Name	Year Begun	Waiver? (SSA section)	Notes
Illinois	KidCare Rebate	1998 (state-only) 2002 (federal match)	Yes (1115)	
Maryland	(MCHP) Premium Private Option	July 2001	No. S-CHIP (Title XXI)	Terminated July 2003
Massachusetts	Medicaid HIPP*	1997	No (1906)	
	Family Assistance	1998	Yes (1115)	
	Insurance Partnership	1999	Yes (1115)	
Pennsylvania	Medicaid HIPP*	1994	No (1906)	
Rhode Island	RIte Share	February 2001	No (1906)	Operates in context of 1115 waiver
Wisconsin	BadgerCare HIPP*	1999	Yes (1115)	Operates like Medicaid 1906, but for S-CHIP

* "HIPP" means "Health Insurance Premium Payment."

Populations Covered

The second table shows which populations the premium assistance programs serve, and whether or not participation in premium assistance is required, when found to be cost-effective. (Note that, because children cannot be sanctioned for a parent's failure to comply with program rules, premium assistance can never be absolutely required for children.)

State	Medicaid or S-CHIP	Populations Covered	Mandatory or Voluntary	Notes
Illinois	S-CHIP	Children and parents	Voluntary	Coverage of parents began 1 Jan 2006.
Maryland	S-CHIP	Children	Voluntary	
Massachusetts Medicaid HIPP	Medicaid	Parents, children and disabled	Mandatory for parents. Voluntary for disabled.	Children *de facto* voluntary.
Family Assistance	S-CHIP plus 1115 expansion	Children	Voluntary (*de facto*).	Parents not eligible for direct coverage.
Insurance Partnership	Both plus 1115 expansion	Parents, children and childless adults	Mandatory	Only premium assistance is available under this program.
Pennsylvania	Medicaid only	All (including SSI-related)	Mandatory	
Rhode Island	Both (combined program)	Parents and children	Mandatory	
Wisconsin	S-CHIP/1115	Parents and children	Mandatory	If children are Medicaid-eligible, parents cannot get HIPP.

Some States make their Medicaid HIPP programs available *only* to eligibles with known high-cost conditions, and screen only persons with such conditions for possible premium assistance. All of the States discussed here, however, review *all* eligibles (applicants/ recipients) to determine if they have access to employer coverage and, if so, whether the coverage is cost-effective for premium assistance purposes.

Some of our States do use the presence of high-cost conditions as a factor in determining workload priorities, however. Workload constraints in Pennsylvania, for example, mean that referrals must be prioritized for follow-up. One of the criteria used for prioritizing referrals is the presence of a pregnancy or a medical condition. Massachusetts has an "Enhanced COB" unit, whose staffers visit hospitals and review high-cost cases for possible availability of employer coverage or COBRA. But being a high-cost case is not a precondition for qualifying for premium assistance in Massachusetts.

Applicable Income Levels and Premiums Charged

This table shows the income ranges in which people are eligible for premium assistance (and for the underlying direct-public-coverage program, except where noted.) It also shows the premiums that people are charged for this coverage. Except where noted, these premiums apply *both* for premium assistance *and* for direct public coverage.

State	Income Range (%FPL) Eligible for Premium Assistance	Premiums Charged	Notes
Illinois	133% - 200% (kids) 133% - 185% (parents)	Above 150% FPL, premiums are charged for direct coverage, but <u>not</u> for premium assistance.	Parents are covered by S-CHIP, under 1115 waiver.
Maryland	200% - 300%	< 250%, $40/family/month > 250%, $50/family/month	
Massachusetts Medicaid HIPP	< 150% (children) <133% (parents)	> 133%, $12/month for 1 child $15/month for 2+ children	Infants and pregnant women eligible to 200% FPL
Family Assistance	150% - 200% (kids) (parents indirect)	$12/child/month $36 maximum/family	
Insurance Partnership	< 200% FPL	$27/month/adult plus FA kids $ only > 100% for childless, > 150% for families.	Premium assistance *only*, no direct coverage.
Pennsylvania	Medicaid mandatory levels for children; cash assistance stnd of need for parents	None.	Infants eligible to 185% FPL
Rhode Island	< 250% (children) < 185% (parents)	150% - 185%, $61/family/month 185% - 200%, $77/family/month 200% - 350%, $92/family/month	No premiums for infants or pregnant women
Wisconsin	Above Medicaid and < 185% (applicants) < 200% (recipients)	> 150%, 5% of income	Medicaid = federal mandates plus infants to 185%

Current Enrollment

This table shows current enrollment in premium assistance programs, as of the date noted. States were often unable to provide separate counts for adults and children.

State	Date	Cases	People	Non-Disabled Adults	Non-Disabled Children	Disabled
Illinois	12/31/05	n/r	5,238	-0-†	5,238	n/a
Maryland	July 2003 (maximum)	n/r	194	n/a	194	n/a
Massachusetts Medicaid HIPP	Sept 2005	2,743	8,036	7,217		819
Family Assistance	Sept 2005	1,950	6,920	n/r	n/r	n/a
Insurance Partnership	Sept 2005	5,955	13,394	n/r	n/r	n/a
Other Programs*	Sept 2005	1,197	3,935	n/r	n/r	n/r
Pennsylvania	Jan 2006	10,911	23,891	~ 74%		~ 26%
Rhode Island	1/31/06	2,104 (est'd)	5,462	n/r	n/r	n/a
Wisconsin	11/30/05	344	1,363	534	829	n/a

n/a = not applicable. People in this category are not eligible for premium assistance.

n/r = not reported.

† Enrollment of adults in Illinois' premium assistance program began in January 2006.

* "Other (Premium Assistance) Programs in Massachusetts include CommonHealth, MassHealth Essential, and HIV Premium Assistance. Almost all of the enrollment cited here is in CommonHealth, with less than 200 individuals in the other programs.

Benchmark Requirements and Supplemental ("Wrap-around") Coverage

This table addresses whether the State uses a pre-determined "benchmark" that employment-based health insurance must meet in order to qualify for premium assistance (such as the "benchmarks" established for the S-CHIP program). It also shows whether and, if so, how the State provides supplemental or "wrap-around" coverage for (a) services not covered by the enrollee's employer coverage that are covered by the underlying public program (Medicaid or S-CHIP) and (b) patient cost-sharing charged by the enrollee's employer coverage that exceeds amounts allowable under the underlying public program.

State	Benchmark?	Supplemental Services?	Patient Cost-Sharing?	Notes
Illinois	No. Employer plan need only cover physicians' services and inpatient hospital.	Not provided (1115 waiver)	Not provided (1115 waiver)	Waiver requires coverage of immunizations for previously uninsured kids.
Maryland	Yes. Must be equivalent to "Comprehensive Standard Health Benefits Plan for Small Employers."	Only for services paid on FFS basis in underlying MCHP Program.	Yes. Special ID card given (NOT Medicaid FFS card).	
Massachusetts Medicaid HIPP	None.	Yes. Medicaid FFS card.	Yes. Medicaid FFS card.	
Family Assistance	MassHealth basic benefit level = commercial small-group market standard	No.	Only for kids. Separate manual system. "Shoebox" for 5% limit.	
Insurance Partnership	Commercial small-group market standard	No.	Only for kids (assumed).	
Pennsylvania	Generally look for HMO or major medical plan.	Yes. Medicaid FFS card.	Yes. Medicaid FFS card.	
Rhode Island	No benchmark *per se*. But plans need to be "fairly comprehensive" to be cost-effective.	Yes. Medicaid FFS card.	Yes. Medicaid FFS card.	Pays full copay or coinsurance and allows "copayment -only" providers.
Wisconsin	Must be HMO or major medical plan and cover physicians' visits and hospital services.	Yes. Medicaid FFS card.	Yes. Medicaid FFS card.	

Data Related to Cost-Effectiveness Test

This table provides information related to the standards States use to determine whether premium assistance is cost-effective. Because the cost-effectiveness determination process is often computerized or automated, and because the relevant comparison costs often vary by category of eligibility, other demographic characteristics, and geographic region within the State, it is not possible to give definitive data in most cases.

State	Data	Description	Notes
Illinois	$75 pmpm	Maximum premium assistance amount payable.	Has not been updated since beginning of program in 1998.
Maryland	$125 pmpm	Cost of underlying MCHP program.	Includes both capitated and non-capitated services.
Massachusetts Medicaid HIPP	$160 pmpm	Current cost-effectiveness standard in use.	Has not been updated recently.
Family Assistance	$150 pmpm	Standard in use.	Has not been updated recently.
Insurance Partnership	$150 pmpm	Standard in use.	Has not been updated recently.
Pennsylvania	Philadelphia: $350 pmpm PH, $125 pmpm BH. Allegheny County: $300 pmpm PH, $90 pmpm BH.	Costs in underlying program vary widely by geographic region. Two major urban areas shown.	PH = physical health. BH = behavioral health. Applicable population or categories of eligibility not clear.
Rhode Island	$186.10 pmpm	Estimated expenditures avoided in underlying RIteCare program.	Partial data for SFY2005 (7/1/04 – 2/28/05).
Wisconsin	$126.57 pmpm $158.99 pmpm	Range of "blended" capitation rates used for cost-effectiveness test in 2004.	Underlying program has 14 separate HMO rate regions.

Note that Rhode Island calculates a separate cost-effectiveness threshold for every plan offered in the State. Currently, the cost-effectiveness determination process is a manual look-up, but the State is planning to automate it.

Pennsylvania's cost-effectiveness determination process is automated.

Savings Estimates

This table gives the States' most recent estimates of savings from their premium assistance programs, where available. Methodologies differ greatly. Administrative costs are often not included.

State	Aggregate Annual Savings Estimate	PMPM Equivalent	Comments
Illinois	No estimate made.		Program designed as "break-even" from the outset.
Maryland	Net cost	($22.14) "optimistic projection" State share only	Formal evaluation found program not cost-effective due to very high administrative costs. (Separate contractor hired to contact many employers up front.)
Massachusetts Medicaid HIPP	$19,000,000	~ $180	FY06 projection. Savings equal 63.3% of underlying program costs. Includes disabled. Administrative costs not included.
Family Assistance	$16,000,000	~ $104	FY06 projection. Savings equal 62.5% of underlying program costs. Administrative costs uncertain.
Insurance Partnership	$14,000,000	~ $85	FY06 projection. Not clear if estimate includes payments to employers, or what "cost avoidance" means in context of this program.
Other Programs*	$10,275,000	~ $203	FY06 projection. High proportion of disabled in these programs.
Pennsylvania	$88,360,000	$308.44	CY06 projection. No details of methodology available.
Rhode Island	$4,800,000	$79.86	SFY04 results before administrative costs. Estimate provided only for State share of administrative costs: $539,000. Net State-share savings were $1,150,000 or $19 pmpm.
Wisconsin	$217,722	~ $58	SFY04 results before administrative costs.

* "Other (Premium Assistance) Programs in Massachusetts include CommonHealth, MassHealth Essential, and HIV Premium Assistance.

Administrative Issues

This table addresses several issues affecting program administration, including to whom premium assistance payments are actually made, whether key program functions are carried out by contractors or direct State staff, and how many staff are devoted to administering premium assistance functions. The staff estimates *exclude* up-front work performed by eligibility staff in local service offices, who gather some very basic information as part of the regular application-and-eligibility-determination process.

State	Premium Assistance Payment Goes to—	Dedicated Premium Assistance Staff are Employed by—	Number of FTEs
Illinois	The policy holder, always. (Can be absent parent.)	State. But premium assistance functions are integrated with overall KidCare program functions.	No staff dedicated solely to premium assistance. 29 caseworkers for entire KidCare caseload (~24,000).
Maryland	Family (believed to be always).	Mostly contractor. Some State.	Contractor (2-3 FTEs) investigated employer plans and paid cost-sharing "wrap." State paid premium assistance subsidies and collected premiums for underlying program.
Massachusetts Medicaid HIPP and Family Assistance	Family, 99% of the time.	Contractor (formerly direct State staff) and subcontractors. Major subcontractor handles employer plan investigation and data entry. State Comptroller issues checks.	Prime contractor is Univ of Massachusetts with 15 FTEs (former State staff were transferred here). Major subcontractor is paid ~$984,000 per year. No FTE data available.
Insurance Partnership	Employer or "billing and enrollment intermediary (BEI)"	Separate subcontractor handles marketing, subsidy payments to small employers. Also 3 BEIs for subsidies only.	Total value of 4 subcontracts about $4 million per year.
Pennsylvania	Employer, about 2/3s of the time. Family less than 10%.	State staff only.	50 FTEs. Central office plus 5 regional offices.
Rhode Island	Family, most of the time. Employer, rarely.	Contractor.	~6.5 FTEs in "employer contract unit." Also contracted actuarial support.
Wisconsin	Family, 85-90%. Employer, 10-15%.	Part of overall MMIS contract.	~2-3 FTEs, spread across multiple staff.