Report on
Connecticut
State Planning Grant to
Develop Coverage Options

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

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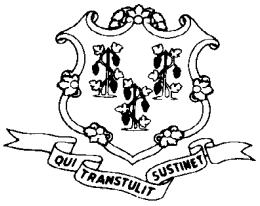
Submitted by:



The State of Connecticut
Office of Health Care Access
Raymond J. Gorman
Commissioner

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EXECUTIVE SUMMARY

This executive summary will provide an overview of the project work conducted under Connecticut's HRSA State Planning Grant to date, including an update of the results of Connecticut's household and employer surveys and a description of policy options currently under consideration to increase access to affordable health care coverage in the State.

Overview of Project Progress

Connecticut's HRSA grant project has progressed steadily since March 1, 2001 when $668,110 in grant funds were awarded to the Office of Health Care Access (OHCA). Major data collection activities have included fielding a household survey and a business survey. In addition, the policy analysis and development activities conducted during the first year of the grant culminated in the inclusion of a proposal to pilot a small employer health insurance subsidy initiative in Governor Rowland's FY 2002 –2003 Midterm Budget Adjustments submitted to Connecticut General Assembly on February 6, 2002, the start of this year's legislative session. This pilot proposal is now working its way through the legislative process. If passed, the pilot could benefit between 3,000 and 5,000 individuals that are now uninsured.

Data Collection Activities

To support planning activities, two significant data collection activities have been completed; a household survey and a business survey. OHCA contracted with the University of Connecticut's Center for Survey Research and Analysis (CSRA) to field a household survey. The OHCA 2001 Household Survey was administered by CSRA between August and October 2001. The data were collected through telephone interviews using a random digit dial (RDD) methodology via the GENESYS Sampling System to generate random samples of telephone households within the state. CSRA used a "list-assisted" method of sample frame enumeration to cross reference data obtained from national telephone exchange records with telephone directory information. The sample for the survey consisted of 14,333 telephone numbers, resulting in 3,985 valid, completed interviews.

In addition, CSRA also added coverage questions related to the planning grant to an existing quarterly business survey for two consecutive quarters in 2001. Throughout the grant period, OHCA, in consultation with the Department of Social Services and the Institute for Health

Policy Solutions (IHPS), has continued to explore and analyze various policy options related to the design of an employer-based health insurance premium subsidy option for the HUSKY health plan in Connecticut.

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

Next Steps

Based upon the planning and policy option development made possible by the State Planning Grant, Governor Rowland has proposed a "Small Employer Health Insurance Subsidy Initiative" that would provide subsidies for a limited number of uninsured workers and their dependents to enroll in employer-sponsored health coverage. This new, non-entitlement program would initially be structured as a pilot program that would be limited to between 3,000 and 5,000 individuals who are eligible for, but do not wish to enroll in, an entitlement program (such as HUSKY A or HUSKY B). Subsidies would be provided to these individuals to help them afford the required contribution towards existing or newly offered small employer coverage. The total amount available for subsidies would be capped at $3.6 million. The proposal is now making its way through the legislative process. The Connecticut General Assembly is scheduled to adjourn on May 8, 2002.

Connecticut has received an extension of its grant to February 28, 2003. During the remainder of our grant period we plan to work to refine our options and models and to conduct additional

program design activities needed to implement a health insurance subsidy initiative in Connecticut and prepare a waiver application for a HIFA demonstration initiative. As we move forward with this challenging endeavor, the State's key recommendation related to Federal action to support State efforts to provide health insurance for the uninsured is that the Federal government provide flexibility to tailor our programs to meet the needs of various populations. Connecticut will continue its efforts to build on the policy analysis and development activities conducted during the first year of the grant and work towards implementation of policy options designed to reduce the number of uninsured in the State.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

More detailed survey findings (reports, spreadsheets, etc.), as well as survey instruments and other descriptions of the research methodology, should be referenced in Appendix II.

*Questions 1.1 through 1.3 focus on the **quantitative** research work conducted by the State. If possible, please use the Current Population Survey definitions and data breaks, even if alternate data sources are used. This will allow comparisons across all states in the summary report*

1.1 What is the overall level of uninsurance in your State?

Under its State Planning Grant to Develop Coverage Options, The Connecticut Office of Health Care Access (OHCA) contracted with the University of Connecticut's Center for Survey Research and Analysis (CSRA) to conduct a statewide survey, which was fielded between August and October 2001. The survey has provided comprehensive data on the state's uninsured population and supports our initiatives to provide the uninsured with access to health care by expanding health insurance coverage to all state residents.

According to the Office of Health Care Access 2001 Household Survey, 5.6%[i] of Connecticut residents were estimated to be uninsured at the time of the survey. Using Census 2000 population figures as a base, this 5.6% translates into 185,201[ii] state residents without health insurance.

An estimated 3.8% (or 124,890 people) were uninsured for the entire twelve-month period preceding the survey. Approximately 4.7% (or 153,606 people) reported being uninsured for part of the previous twelve months (but not necessarily at the time of the survey). It is estimated, therefore, that 8.4% of Connecticut residents (or 278,495 people) were uninsured at some point during the 12-month period.

Table 1.1 provides uninsured rates for specific population groupings using four categories[iii] of uninsured individuals:

- Point in time (uninsured at the time of the survey or for all 12 months prior);
- Whole year (uninsured for all 12 months prior to the survey);
- Part year (either uninsured at the time of the survey but not for all 12 prior months or insured at the time of the survey but not for all 12 prior months); and
- Some point in year (either uninsured for the whole year or part of the year)[iv].

Table 1.1

2001 Connecticut Insurance Rates (%)

	Uninsured				
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**	**Continuously Insured**
State	**5.6**	**3.8**	**4.7**	**8.4**	**91.6**
Family Income					
Under $10,000	16.4	10.7	14.0	24.7	75.3
$10,000 to $19,999	9.9	5.8	7.9	13.6	86.4
$20,000 to $29,999	13.1	10.2	9.4	19.6	80.4
$30,000 to $39,999	7.3	4.1	7.6	11.6	88.4
$40,000 to $49,999	7.5	4.7	6.8	11.4	88.6
$50,000 to $59,999	4.1	1.9	4.6	6.4	93.6
$60,000 t0 $74,999	3.3	2.6	4.2	6.8	93.2
$75,000+	1.7	1.2	1.4	2.6	97.4
Age					
0 to 18	4.0	1.3	5.8	7.1	92.9
19 to 24	14.9	11.8	9.1	20.8	79.2
25 to 34	11.3	6.6	10.8	17.3	82.7
35 to 54	5.4	4.4	3.9	8.3	91.7
55 to 64	4.0	2.4	2.2	4.7	95.3
65+	1.5	1.3	0.7	2.0	98.0
0 to 18	4.0	1.3	5.8	7.1	92.9
19 to 64	7.3	5.2	5.4	10.7	89.3
65+	1.5	1.3	0.7	2.0	98.0
Ethnicity					
Hispanic	9.7	6.5	12.4	19.0	81.0
Non-hispanic	5.3	3.6	4.1	7.7	92.3
Race					
White	4.8	3.3	4.1	7.4	92.6
Black	8.4	5.1	7.0	12.1	87.9
American Indian/Alaska Native	17.9	4.6	14.2	18.7	81.3
Asian	10.8	9.0	1.8	10.8	89.2
Native Hawaiian/Other Pacific Islander	22.6	22.6	-	22.6	77.4
Some Other Race	12.1	8.0	11.6	19.6	80.4

1.2 What are the characteristics of the uninsured?

Table 1.2 shows characteristics of the **uninsured** using the same four categories of uninsured individuals:

- Point in time (uninsured at the time of the survey or for all 12 months prior);
- Whole year (uninsured for all 12 months prior to the survey);
- Part year (either uninsured at the time of the survey but not for all 12 prior months or insured at the time of the survey but not for all 12 prior months); and
- Some point in year (either uninsured for the whole year or part of the year)[v].

Table 1.2

2001 Demographic Characteristics by Insurance Status in Connecticut (%)

	Uninsured					
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**	**Continuously Insured**	**Survery Population**
State	**5.6**	**3.8**	**4.7**	**8.4**	**91.6**	
Family Income						
Under $10,000	8.3	8.3	7.9	8.1	2.3	2.8
$10,000 to $19,999	13.2	11.7	11.7	11.7	6.9	7.3
$20,000 to $29,999	22.0	26.2	17.6	21.2	8.0	9.1
$30,000 to $39,999	12.5	10.6	14.5	12.8	9.0	9.4
$40,000 to $49,999	17.1	16.2	17.0	16.7	11.9	12.3
$50,000 to $59,999	8.7	6.0	10.8	8.8	11.8	11.6
$60,000 t0 $74,999	7.3	8.7	10.3	9.6	12.3	12.1
$75,000+	10.9	12.2	10.1	11.0	37.7	35.5
Age						
0 to 18	13.8	6.9	24.2	16.4	19.7	19.4
19 to 24	16.5	19.3	12.1	15.3	5.4	6.2
25 to 34	24.5	21.1	28.0	24.9	11.0	12.1
35 to 54	32.8	39.6	28.0	33.2	33.9	33.8
55 to 64	7.7	6.8	5.2	5.9	11.2	10.7
65+	4.8	6.3	2.5	4.2	18.9	17.7
0 to 18	13.8	6.9	24.2	16.4	19.7	19.4
19 to 64	81.4	86.8	73.3	79.4	61.4	62.9
65+	4.8	6.3	2.5	4.2	18.9	17.7
Gender						
Male	53.4	52.1	46.3	48.9	47.8	47.9
Female	46.6	47.9	53.7	51.1	52.2	52.1

Table 1.2 (continued)

2001 Demographic Characteristics by Insurance Status in Connecticut (%)

	Uninsured					
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**	**Continuously Insured**	**Survery Population**
Marital Status						
Single	42.5	43.4	32.1	37.7	17.4	19.2
Married	31.4	30.1	39.8	35.0	64.1	61.6
Living with Partner	12.0	11.3	16.1	13.8	4.1	4.9
Divorced/Separated/Widowed	14.1	15.2	11.9	13.5	14.4	14.3
Health Status						
Excellent	29.7	26.8	32.8	30.2	39.7	38.9
Very Good	32.5	30.5	29.0	29.7	30.8	30.8
Good	25.9	30.9	26.5	28.4	19.9	20.6
Fair	9.2	10.8	6.8	8.6	7.7	7.8
Poor	2.8	0.9	4.8	3.1	1.9	2.0
Employment						
Self Employed	13.6	13.6	13.8	13.7	6.2	6.8
Employed by Someone Else	50.3	51.2	56.2	53.7	58.3	57.9
An unpaid worker for family business, farm, or home	1.7	2.4	-	1.2	0.5	0.5
Retired	6.6	5.6	5.9	5.8	23.7	22.1
Unemployed	21.0	19.7	22.0	20.8	7.7	8.8
Full-time Student	6.8	7.5	2.2	4.8	3.7	3.8
Number of Jobs						
Work One Job	82.5	83.8	86.4	85.2	89.7	89.3
Work Multiple Jobs	17.5	16.2	13.6	14.8	10.3	10.7
Hours worked per week						
0 to 10 hours	4.0	0.4	5.2	3.0	1.9	1.9
11 to 20 hours	5.3	5.8	1.8	3.7	5.4	5.2
21 to 30 hours	5.4	5.7	11.2	8.7	6.0	6.2
31 to 40 hours	41.2	36.8	49.9	43.8	49.9	49.4
40+ hours	44.1	51.3	31.8	40.9	36.8	37.2
Type of Job						
Permanent Job	85.4	84.1	92.0	88.3	96.1	95.4
Temporary Job	8.7	9.8	3.2	6.4	2.1	2.5
Seasonal Job	5.9	6.1	4.8	5.4	1.8	2.1

Table 1.2 (continued)

2001 Demographic Characteristics by Insurance Status in Connecticut (%)

	Uninsured					
	Point-in-time	**Whole Year**	**Part Year**	**Some Point in Year**	**Continuously Insured**	**Survery Population**
Size of Employer						
1	17.5	16.7	16.0	16.3	4.7	5.7
2 to 10	30.3	32.5	18.2	25.4	11.6	12.7
11 to 50	20.3	21.6	22.3	22.0	14.9	15.5
51 to 100	5.6	5.2	4.2	4.7	8.3	8.0
101 to 500	10.7	9.5	16.5	13.0	19.8	19.3
501+	15.6	14.5	22.7	18.6	40.7	38.9
Ethnicity						
Hispanic	11.3	11.2	17.4	14.6	5.7	6.5
Non-hispanic	88.7	88.8	82.6	85.4	94.3	93.5
Race						
White	74.4	75.5	76.1	75.8	87.3	86.3
Black	9.4	8.5	9.4	9.0	6.1	6.3
American Indian/Alaska Native	1.7	0.6	1.6	1.2	0.5	0.5
Asian	3.4	4.1	0.7	2.2	1.7	1.8
Native Hawaiian/Other Pacific Islander	0.7	1.0	-	0.5	0.1	0.2
Some Other Race	10.5	10.2	12.2	11.3	4.3	4.9
Educational Attainment						
No Formal Education	-	-	-	-	0.3	0.3
Grade School (1 to 8 years)	3.4	4.8	2.8	3.8	2.1	2.2
Some High School (9 to 11 years)	9.7	10.8	10.2	10.5	4.0	4.6
High School Graduate or GED (received a high school equivalent)	34.5	33.2	33.6	33.4	27.3	27.8
Some College/Technical or Vocational School/Training After High School	27.5	26.5	27.3	26.9	23.3	23.6
College Graduate	19.0	19.4	18.4	18.9	26.2	25.6
Postgraduate Degree/Study	5.9	5.4	7.6	6.5	16.8	15.9

**Characteristics are based on adult responses and the responses of one parent of child respondents.

Uninsured part year distribution is only of those part year uninsured at the time of the survey.

In general, individuals uninsured at the time of the Connecticut's survey (Point-in-time) were more likely to:

- have family incomes under $39,999 -- 56%
- be adults between the ages of 19 and 54 – 73.8%
- be male -- 53.4%
- be single -- 42.5%
- report very good to excellent health status -- 62.2%
- be gainfully employed -- 63.9%
- work only one job -- 82.5%
- work 31 hours or more per week -- 85.3%
- be permanently employed -- 85.4%
- be either self-employed or work for an employer with 50 or fewer employees -- 68.1%
- be Non-Hispanic -- 88.7%
- be white -- 74.4%
- be a high school graduate or its equivalent, or completed some college, technical, vocational or training school after high school -- 62%

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Connecticut has targeted low income working uninsured single adults and families in developing coverage expansion options that focus on public private partnerships for premium assistance.

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?
Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Independent of the State Planning Grant project, to expand enrollment and encourage more parents to take advantage of the opportunities HUSKY offers, the legislative Medicaid Managed Care Council's Consumer Access Subcommittee and the Department of Social Services (DSS) joined to fund and sponsor several focus groups with parents of uninsured children. The focus group asked parents of uninsured children for their attitudes about HUSKY and for their suggestions to improve outreach. The focus groups proved to be very valuable in identifying problems and solutions for HUSKY enrollment. The findings were not surprising. Enrolling children in health coverage is not as simple as sending out brochures and waiting for clients to apply. In many cases, enrollment is a complex process involving information, advocacy, application assistance, follow-up and sometimes persuasion.

METHODOLOGY

Four focus groups were conducted at different locations around Connecticut. Fifty-four adults participated in total, representing 104 children. Ages of the participants ranged from 17 to 59 years. Nineteen each were African American and Hispanic, 15 Caucasian and 1 Asian. Forty-four were women and ten were men. Six participants required translation. Family incomes varied from zero to 346% of the federal poverty level, averaging just below the poverty level (94.5%).

In all but two cases, participants were parents or caretakers of children who were either uninsured or had recently applied or enrolled in HUSKY. The other two participants were 17 years old and applying for themselves. Participants were recruited with the assistance of local community-based organizations - a child-care center, a child advocacy organization, a school resource center and a community health center. Parents in the focus groups identified several barriers to HUSKY enrollment, generally falling into four categories -- lack of information, suspicion and stigma of public programs, cultural barriers, and enrollment problems.

1.6 Why do uninsured individuals and families de-enroll from public programs?
The Children's Health Council and DSS have conducted a series of enrollment studies that track enrollment in HUSKY, survey consumers, and examine the number of uninsured children in the state. The reports can be found at http://www.childrenshealthcouncil.org/outreach/enrollment.htm

1.7 Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.9 How likely are individuals to be influenced by:

Availability of subsidies?:

Tax credits or other incentives?:
Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.10 What other barriers besides affordability prevent the purchase of health insurance?
Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.11 How are the uninsured getting their medical needs met?
Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

1.12 What are the features of an adequate, barebones benefit package?

Connecticut did not address this under the scope of its HRSA grant activities, however Connecticut insurance mandates on what health insurance carriers must cover are among the most comprehensive in the country.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

*Questions within 2.1 focus on the **quantitative** research work conducted by the State:*

Quantitative research conducted by the State to date is included in this report. Combined first and second quarter business survey data is included below.

2.1 Background Information on the Business Survey

Business Quarterly Methodology

Under the State Planning Grant, OHCA contracted with the CSRA to add questions to the Standard Business Quarterly Survey that CSRA currently fields on behalf of the Connecticut Department of Economic and Community Development. Results are based on 805 telephone interviews conducted during two consecutive quarters across the state. The interviews were conducted by trained interviewers from the CSRA research facility in Storrs, Connecticut.

The sample was generated using databases and software from Dunn and Bradstreet. Once selected, each telephone number was contacted a minimum of four times to attempt to reach an eligible respondent. Businesses where a viable contact was made were called additional times.

The sample frame is designed to include all businesses located in the State of Connecticut with two or more employees. The sample frame excludes government agencies and other public facilities such as public schools. The sample is drawn from databases maintained by Dunn and Bradstreet. The sample is disproportionately stratified according to industry clusters as designated by the Department of Economic and Community Development. Final results are weighted to be proportional to the overall population of businesses in the State of Connecticut.

Table 1 lists each industry sector, estimated total number and proportion of businesses in each sector, the expected and actual number of businesses in each industry sector, and the appropriate weight for each industry sector.

Table 1
Population Estimates and Sample Weights
Business Quarterly Survey
Updated, 2001

Industry Sector	Estimated Total Businesses	Percent of Total Businesses	Expected Businesses in Proportional Sample of 805 Interviews	Actual Businesses in Survey	Weight
Financial	4,117	3.04%	24.5	91	0.269075
Health	1,214	0.90%	7.2	92	0.078481
HiTech	3,886	2.87%	23.1	91	0.253978
MFG	3,094	2.29%	18.4	90	0.204462
Telcom	1,889	1.40%	11.23	90	0.124831
Tour/Ent	4,089	3.02%	24.3	90	0.270215
Other	117,062	86.49%	696.2	261	2.667533
	135,351	100%	805	805	

Source: Center for Survey Research and Analysis at the University of Connecticut, Storrs, CT.

What are the characteristics of firms that do not offer coverage, as compared to firms that do? **Please See Tables of Results below**

Survey findings of particular interest:

- 52% of employers said they currently offered health insurance to their employees.
- For employers with 50 or more employees this percentage increased to 94%
- For employers with four or fewer employees this percentage dropped to 26%
- Of those employers that did not offer health insurance 18 % indicated that they can't afford to and, 50% said they have too few employees.
- Employers in Fairfield County represented the highest percentage (68%) to offer insurance to all employees, and also have the highest percentage (46%) of eligible employees taking the insurance offered.

Employer size (including self-employed):
Geographic location:
Other(s):
For those employers offering coverage, please discuss the following:
Cost of policies:
Level of contribution:
Percentage of employees offered coverage who participate:

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Do you currently offer health insurance to ANY of your employees?

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
EC.1. Do you currently offer health insurance to any of your employees?	Yes	52%	18%	40%	79%	89%	26%	77%	88%	94%
	No	44%	74%	56%	21%	11%	70%	21%	10%	1%
	Don't Know	1%	0%	2%			1%	2%		
	Refused	3%	8%	2%			3%	0%	2%	5%
Total	Unweighted Count	805	156	215	119	184	379	148	154	102

Office of Health Care Access Employer Questions Connecticut Business Quarterly Survey
What is the primary reason for electing not to provide coverage?
[Base: Businesses who do not provide coverage]

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
EC.1.a What are the primary reasons for electing not to provide coverage	Can't afford to	18%	10%	21%	16%	39%	18%	17%	20%	
	Too few employees	50%	65%	43%	4%	21%	59%	17%		8%
	Employees don't need health insurance	11%	9%	13%	18%	37%	8%	30%	36%	
	Company just started	1%	2%	0%		2%	0%	7%	2%	
	No employees/ Family run	7%	9%	6%	25%		7%	1%		
	Part-time/ Seasonal/ Independent Contractors	6%	4%	6%	24%	2%	4%	18%	5%	8%
	Other (Specify)	1%	1%	0%	13%		1%	1%	17%	
	Don't know	3%	0%	6%			3%	7%	2%	
	Refused	2%		4%			0%	1%	19%	83%
Total	Unweighted Count	329	124	118	21	12	260	40	14	3

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately what percentage of your employees are currently eligible for health insurance from your business?
[Base: Businesses who provide coverage to some employees]

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
Less than 25%		4%	8%		4%	5%	5%	2%	3%	1%
25% through 49%		3%		3%	4%	2%	2%	7%	3%	0%
50% through 74%		12%	16%	16%	14%	6%	3%	16%	17%	7%
75% through 99%		17%	2%	10%	18%	23%	5%	19%	22%	25%
100%		58%	73%	72%	46%	56%	84%	52%	47%	44%
Don't know		6%	1%	0%	10%	7%	0%	4%	6%	23%
Refused		1%			3%		0%		2%	
Total	Unweighted Count	476	32	97	98	172	119	108	140	99

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately what percentage of eligible employees actually take health insurance from your business?
[Base: Businesses who provide coverage to some employees]

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
Less than 25%		6%	8%	6%	5%	3%	6%	7%	3%	5%
25% through 49%		2%		1%	1%	3%	0%	3%	1%	2%
50% through 74%		17%	8%	27%	20%	13%	11%	27%	16%	8%
75% through 99%		26%	9%	16%	28%	47%	3%	20%	47%	45%
100%		41%	72%	47%	33%	25%	79%	37%	21%	19%
Don't know		8%	3%	3%	10%	9%	1%	7%	11%	21%
Refused		1%			3%				2%	
Total	Unweighted Count	476	32	97	98	172	119	108	140	99

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
What is the monthly premium for the least expensive health insurance plan that you offer?
[Base: Businesses who provide coverage to some employees]

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
Less than $100		8%	0%	12%	4%	14%	6%	7%	7%	23%
$100 through $249		18%	25%	18%	22%	16%	21%	15%	20%	19%
$250 through $499		20%	19%	22%	26%	24%	22%	22%	20%	10%
$500 through $749		7%	0%	12%	2%	10%	6%	9%	8%	0%
$750 and over		8%	18%	3%	8%	6%	12%	9%	5%	7%
Don't know		33%	29%	30%	34%	23%	30%	33%	30%	39%
Refused		6%	9%	3%	4%	7%	3%	5%	9%	2%
Total	Unweighted Count	476	32	97	98	172	119	108	140	99

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately how much of this does your company pay?
[Base: Businesses who provide coverage to some employees]

Banner 1		Total	Gross Revenue Current Calendar Year				Number of Employees			
			Under $100,000	$100,000 to $500,000	$500,000 to $1 Million	$1 Million or more	1 - 4	5 - 9	10 - 49	50 or more
Less than 25%		5%	0%		11%	3%	3%	4%	3%	10%
25% through 49%		2%		1%	0%	5%	0%	0%	3%	9%
50% through 74%		17%	0%	11%	22%	17%	5%	20%	23%	25%
75% through 99%		18%	13%	18%	5%	23%	8%	11%	30%	32%
100%		52%	75%	70%	51%	44%	83%	58%	28%	22%
Refused		7%	11%	0%	10%	8%	0%	7%	13%	3%
Total	Unweighted Count	357	20	80	76	134	98	82	104	68

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Do you currently offer health insurance to ANY of your employees?

Banner 2		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
EC.1. Do you currently offer health insurance to any of your employees?	Yes	52%	47%	61%	48%	48%
	No	44%	49%	35%	49%	49%
	Don't Know	1%	0%	2%	1%	
	Refused	3%	4%	3%	1%	3%
Total	Unweighted Count	805	251	231	222	101

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
What is the primary reason for electing not to provide coverage?
[Base: Businesses who do not provide coverage]

Banner 2		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
EC.1.a What are the primary reasons for electing not to provide coverage?	Can't afford to	18%	14%	18%	20%	25%
	Too few employees	50%	49%	50%	55%	47%
	Employees don't need health insurance	11%	18%	7%	9%	6%
	Company just started	1%	0%		0%	6%
	No employees/ Family run	7%	8%	9%	6%	2%
	Part-time/ Seasonal/ Independent Contractors	6%	7%	7%	1%	12%
	Other (Specify)	1%	1%	1%	3%	1%
	Don't know	3%	0%	8%	3%	1%
	Refused	2%	4%	1%	3%	0%
Total	Unweighted Count	329	113	85	87	44

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately what percentage of your employees are currently eligible for health insurance from your business?
[Base: Businesses who provide coverage to some employees]

Banner 2		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
Less than 25%		4%	2%	7%	0%	1%
25% through 49%		3%	5%	4%	0%	6%
50% through 74%		12%	10%	8%	25%	7%
75% through 99%		17%	9%	19%	23%	18%
100%		58%	68%	55%	48%	60%
Don't know		6%	7%	6%	4%	8%
Refused		1%		2%		0%
Total	Unweighted Count	476	138	146	135	57

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately what percentage of eligible employees actually take health insurance from your business?
[Base: Businesses who provide coverage to some employees]

Banner 2		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
Less than 25%		6%	2%	8%	7%	7%
25% through 49%		2%	3%	1%	1%	7%
50% through 74%		17%	11%	23%	20%	8%
75% through 99%		26%	29%	20%	29%	30%
100%		41%	46%	41%	39%	31%
Don't know		8%	9%	6%	5%	16%
Refused		1%		2%		
Total	Unweighted Count	476	138	146	135	57

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
What is the monthly premium for the least expensive health insurance plan that you offer?
[Base: Businesses who provide coverage to some employees]

Banner 1		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
Less than $100		8%	8%	9%	7%	8%
$100 through $249		18%	15%	13%	28%	27%
$250 through $499		20%	21%	19%	22%	12%
$500 through $749		7%	11%	3%	10%	1%
$750 and over		8%	3%	13%	7%	8%
Don't know		33%	37%	33%	24%	39%
Refused		6%	4%	10%	1%	6%
Total	Unweighted Count	476	138	146	135	57

Office of Health Care Access Employer Questions
Connecticut Business Quarterly Survey
Approximately how much of this does your company pay?
[Base: Businesses who provide coverage to some employees]

Banner 2		Total	Fairfield County	Hartford/Litchfield Counties	New Haven/Middlesex Counties	East of River
Less than 25%		5%	0%	10%	4%	
25% through 49%		2%	4%	3%	0%	
50% through 74%		17%	16%	17%	19%	5%
75% through 99%		18%	19%	16%	16%	31%
100%		52%	54%	46%	57%	52%
Refused		7%	7%	8%	4%	12%
Total	Unweighted Count	357	97	110	113	37

Independent of the Connecticut State Planning Grant, the Center for Survey Research and Analysis at the University of Connecticut conducted a survey in December, 2001 at CBIA's request, to determine the current health benefits climate in the state. This Connecticut-specific, comprehensive survey of health care benefit costs, included the experiences of both self-insured and fully insured companies. The findings of this survey were excerpted from *CBIA News*, February 2002. The survey report can be found on the web at http://www.cbia.com/BusEcon/SrvPub/Other%20Surveys/UConnsurvey1-17-02.PDF
The CBIA commissioned survey had 405 responding companies, each with 50 or more employees, covering a total of 120,000 employees. This survey added to the quantitative

research findings available to the state during the planning process. Significant findings are bulleted below:

- Health benefit cost increases are happening across the board. Fully insured companies, companies that self-insure, and small, midsize and large companies all reported similar patterns of cost increases.

- On average, Connecticut employers experienced overall health benefit cost increases of 15% in 2001. The average increases for specific types of health plans were as follows:
  – Indemnity plans,17%;
  – HMO plans,14%;
  – Point-of-Service (POS) plans,14%; and
  – Preferred Provider Organization (PPO) plans,17%.

- Connecticut employers predict comparable double-digit cost increases for 2002 — on average, an overall increase of 13%. For specific types of plans, employers predicted the following increases for 2002:
  – Indemnity plans, 12%;
  – HMO plans, 13%;
  – POS plans, 14%; and
  – PPO plans, 14%.

- Employers pay the vast majority of employee health benefit costs — 73%, on average — while employees' average share is 27%.

- Despite double-digit cost increases, most employers still intend to continue providing health benefits for their employees. Only 2% said they are eliminating coverage because of cost increases.

- Most employers (51%) said they will absorb some or all of the cost increase. However, an even larger percentage of employers will also ask employees to shoulder some of the increase.
  – 70% said they will ask employees to pay a greater share of premium or plan costs.
  – 67% said they will increase employees' deductibles or co-pays.
- All the employers surveyed offer employee health benefits, and nearly all (97%) offer health care benefits for employee spouses and dependents. But not all employees take up their employers on the offer:
  – 15% of employees decline coverage for themselves, and
  – 25% decline spouse and dependent coverage.

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

According to the OHCA commissioned survey, of businesses that do not provide coverage, half said that the reason they did not, was because they had too few employees.

2.3 How do employers make decisions about the health insurance they will offer to their employees? What factors go into their decisions regarding premium contributions, benefit package, and other features of the coverage?

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

According to the CBIA commissioned survey, when asked what they would do if their health care costs rise, slightly more than half of the employers said they would absorb at least some of the increase. But 70% said they would consider increasing employees' share of the cost, and 67% might raise employees' co-pays or deductibles.

2.5 What employer and employee groups are most susceptible to crowd-out?
This was not addressed under the scope of this project.

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?:

Individual or employer subsidies?:

Additional tax incentives?:

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

This was not addressed under the scope of this project.

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate? Suitable for what is required.

RPM Health Management performed a market assessment of Connecticut Health Plans in October, 2000 as part of OHCA's ACHIEVE health purchasing initiative. Conclusions from this assessment were as follows:

- Health plan acquisitions, consolidations and closures have significantly reduced the number of vendors with an established presence within Connecticut.
- There are currently 10 HMO's licensed to do business in the Connecticut.
- The State currently contracts with three health plans. (Anthem, ConnectiCare, HealthNet) to provide health insurance coverage to its employee and retiree population. None of the three national health plan vendors (Aetna, CIGNA and United Healthcare) provide coverage for this population.
- There are four health plans providing coverage to the Medicaid population (Anthem, Community Health Network, Preferred One -First Choice, and HealthNet) . The issue of how other vendors with a Connecticut presence can be encouraged to compete for the HUSKY business must be addressed.
- There are a sufficient number of viable health plans in Connecticut to support a competitive joint procurement process for the State.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans? Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace? Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

The state is large purchaser of health care. The State of Connecticut covers 179,000 State employee/retirees lives and 273,000 HUSKY lives. Spending by the State is $540 million for employees/retirees and $512 million for the HUSKY program.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

Connecticut will consult with its Department of Insurance to assess the impact of the proposed pilot program and an update will be included in our next Report to the Secretary.

3.6 How would universal coverage affect the financial status of health plans and providers?

Connecticut did not specifically address this question in its data collection efforts under the State Planning Grant.

3.7 How did the planning process take safety net providers into account?

The medical safety net in Connecticut provides services to the poor, the uninsured and those with special needs. Safety net providers are often located in inner cities or rural areas where there are shortages of health care professionals. Many of their clients are insured but use safety net providers because they represent one among a limited source of medical care providers in the community.

3.8 How would utilization change with universal coverage?

This question was not addressed under the scope of the State Planning Grant.

3.9 Did you consider the experience of other States with regard to:
Expansions of public coverage?:
Public/private partnerships?:
Incentives for employers to offer coverage?:
Regulation of the marketplace?:

Connecticut staff members attend State Planning Grant Meetings. At these meetings, several states, including Massachusetts, Wisconsin and Oregon, have shared and discussed their experiences in financing the expansion of health care for the uninsured in their state. IHPS has expertise in assisting states in developing public-private partnerships and has shared information with Connecticut during our policy development process. In addition, the March 2001 SCI Issue Brief *Employer Buy-in Programs: How Four States Subsidize Employer Sponsored Insurance* was used as a reference.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The purpose of this section is to provide specific details about the policy options selected by the State. A number of States have not reached a consensus on a coverage expansion strategy and are not yet in a position to answer the questions included in this section. These States should answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g. coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The proposed expansion initiative would provide subsidies for a limited number of uninsured workers and their dependents to enroll in employer-sponsored health coverage. This new, non-entitlement program would initially be structured as a pilot program that would be limited to between 3,000 and 5,000 individuals who are eligible for but do not wish to enroll in Husky A or Husky B. Subsidies would be provided to these individuals to help them afford the required contribution towards existing or newly offered small employer coverage. The total amount available for subsidies would be capped at $3.6 million. In order to implement the proposed health insurance subsidy initiative the State will need to apply for and be granted Health Insurance Flexibility and Accountability (HIFA) demonstration waiver.

For each option identified, complete questions 4.2 through 4.15 (if relevant to your State's planning process):
Questions 4.2 through 4.15 will be fully addressed during the operational planning and waiver development process and included in our next report to the Secretary.

4.2 What is the target eligibility group under the expansion?
4.3 How will the program be administered?
4.4 How will outreach and enrollment be conducted?
4.5 What will the enrollee (and/or employer) premium-sharing requirements be?
4.6 What will the benefits structure be (including co-payments and other cost-sharing)?
4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)
4.8 How will the program be financed?
4.9 What strategies to contain costs will be used?
4.10 How will services be delivered under the expansion?
4.11 What methods for ensuring quality will be used?
4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?
4.13 How will crowd-out will be avoided and monitored?
4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?
4.15 How (and how often) will the program will be evaluated?

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

Participants in the planning meetings assessed implications of and refined ideas for four different options presented by IHPS for expanding coverage to uninsured low-income individuals working for small employers in Connecticut. These options varied based on the eligibility process used and the process for applying the subsidy. The proposed pilot initiative was an outgrowth of the premium subsidy options discussed during the option development phase of the State Planning Grant and was refined during preparation for the Governor's Midterm Budget Adjustments for FY 2002-2003.

For background purposes the options as originally formulated and included in our October 2001 Interim Report are described below:

Option 1: Under the first option, an eligible individual would go through the normal DSS eligibility process, and if determined eligible and subsequently enrolled in his or her employer plan, would receive a direct subsidy to offset the amount he or she contributes to health coverage. The employer would treat the employee like any other, would receive a bill for the full premium from the purchasing cooperative, and would deduct the necessary employee-contribution amount from the employee's paycheck. The subsidy payment would be sent from the DSS or its appropriate vendor to the employee, and the purchasing cooperative would notify the DSS or its vendor of the continued enrollment of subsidy-eligible individuals.

Option 2: Under the second option, an individual would go through the normal DSS eligibility process, and if determined eligible and subsequently enrolled in his or her employer plan, the appropriate subsidy amount would be transferred from the DSS or its vendor directly to the purchasing cooperative. The purchasing cooperative would send the employer a premium bill that specifies, for each worker, the employer's share and the worker's share of premium based on the employer's contribution policy. For workers eligible for a subsidy, the worker's share would be shown net of the subsidy amount payable. The purchasing cooperative would notify the DSS or its vendor of the continued enrollment of subsidy-eligible individuals and would transfer the subsidies it receives from the DSS with the employer and employee payments as payment in full to the health plans.

Option 3: Under the third option, an employee would not complete a formal application to DSS for a subsidy but instead would be able to "self-declare" their eligibility for a subsidy (with some form of employer wage verification) based on information regarding the maximum family income limits for subsidy eligibility. The subsidy could be recouped from the individual at a later date if family income is found, through a reconciliation process based on the worker's tax return, to have exceeded the specified limits by more than some pre-set amount. Instead of receiving a direct subsidy payment from the state, the employee's tax withholding would be reduced to offset the employer's health insurance payroll deduction. Other than potentially changing the employee's tax withholding, the employer would treat the employee like any other and would receive a

bill for the full premium from the purchasing cooperative and would deduct the necessary employee-contribution amount from the employee's paycheck. Since no funds would be sent to the employee, the purchasing cooperative would only have to notify the appropriate state agency of the number of months an employee received health coverage.

Option 4: This option would combine options two and three. The employee would self-declare his or her eligibility for a subsidy but instead of the employee's tax withholding being altered, the employer would receive a bill from the purchasing cooperative that specifies, for each worker, the employer's share and the worker's share of premium based on the employer's contribution policy. For workers who self-declare for a subsidy, the worker's share would be shown net of the subsidy amount payable. The DSS or its vendor would transfer the appropriate subsidy amounts to the purchasing cooperative, which would then combine them with the employer and employee payments received as payment in full to the health plans. Since the purchasing cooperative would notify DSS or its vendor of the continued enrollment of self-declared individuals, DSS or its vendor would notify the appropriate state agency of the number of months an employee received health coverage and this agency would recoup any funds if necessary based upon the employee's tax return.

In terms of policy considerations, discussions have addressed several different dimensions. Option one would require the least changes in the activities and roles of the purchasing cooperative or participating employers and would also have the advantages of the employer possibly not knowing that an employee is receiving a subsidy (if no special qualifying event occurs or the employee is not the recipient of supplemental coverage), thereby reducing employee equity concerns and the possibility of employer crowd out. The disadvantages of this option are that the subsidy-recipient may have cash-flow problems unless the subsidy is paid prospectively or may not be eligible for coverage without a special qualifying event. In addition, because the employer is not aware of the existence of subsidized coverage, this option may only succeed in enrolling individuals who declined existing employer coverage and not encourage many uninsured small firms to begin offering coverage to subsidy-eligible individuals.

Option two, on the other hand, may have a better chance of encouraging uninsured small employers to begin offering coverage because the direct benefit of the subsidy would be known. However, employee confidentiality may suffer since the employer would know who was receiving a subsidy, and, depending on the size of the firm, every employee would know as well, thereby potentially causing employee equity concerns. In addition, because the employer would know the amount of the subsidy received by each employee, with respect to coverage of decliners in already insured firms, the possibility of crowd-out of employer contributions would be much greater. Another significant policy issue concerning this option is that the purchasing cooperative would become an agent of the state with regard to the receipt and accounting for subsidy dollars received

The policy issues for option three would be very similar to option two if the employer must certify that an employee's wage would make the employee potentially available for a tax credit/subsidy. The employer would know that an employee is eligible for a subsidy and since the employer would potentially alter the employee's tax withholding, could determine the relative amount of the subsidy received (and thus could increase the potential for crowd out). However, because the bill would be for the full premium

amount due, the potential for equity concerns among employees would be reduced. In addition, this option would preclude the purchasing cooperative handling any subsidy funds, but may only succeed best at enrolling subsidy-eligible individuals who declined existing employer coverage. Also, options three and four would have to rely on requesting copies of federal tax returns since individuals earning less than $25,000 in total family income are not required to file returns in Connecticut.

The policy issues for option four would be almost identical to those for option two. However, given the nature of employee self-declaration for subsidy eligibility, this option could raise other policy issues for both the State and the purchasing cooperative if either a large number of self-declared individuals are subsequently found to be ineligible or if newly enrolled groups are found to have a large number of ineligible self-declared individuals.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Legislation has been introduced to implement a selected policy option. The legislative session is scheduled to adjourn no later than May 8, 2002. The text of the proposed legislation is provided below.

Legislation under **House Bill 5023 An Act Concerning Implementing the Governor's Budget Regarding the Department of Social Services** has been proposed to implement the Governor's budget recommendations. Section 4 reads as follows:
Sec. 4. (NEW) (*Effective July 1, 2002*) (a) The Commissioner of Social Services may seek a federal waiver to (1) implement a pilot program to provide subsidies toward employee premium costs that are required for participation in an employer-sponsored health care plan for (A) parents or needy caretaker relatives of children under nineteen years of age, and (B) adults who have no children, and (2) upon implementation of the waiver, provide coverage under HUSKY Plan, Part B to parents or needy caretaker relatives of children under nineteen years of age whose income is under one hundred fifty per cent of the federal poverty level.
(b) Participation in the subsidized employee premium pursuant to the waiver shall be limited to applicants who have household incomes below one hundred eighty-five per cent of the federal poverty level. The waiver may include, but shall not be limited to, the following components: (1) A subsidy that pays (A) no more than sixty dollars a month for a premium that an employee with no children is required to pay to participate in an employer-sponsored health care plan, and (B) no more than one hundred dollars a month for each family member for families that consist of parents or needy caretaker relatives with children under nineteen years of age for a premium that such family is required to pay to participate in an employer-sponsored health care plan; (2) an identification of the minimum benefits standard that an employer-sponsored health plan is required to meet to qualify for participation in the pilot program; (3) a limitation on the number of pilot program participants to assure the program is operated within available appropriations; (4) an option for the commissioner to contract with a private entity to administer the pilot program; and (5) a plan for the evaluation of the cost effectiveness and client satisfaction for persons enrolled in the subsidized employee premium pilot program.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

Options related to tax credits were not considered viable at this time. Based on the current economic and political environment it was determined that the most prudent choice was to pursue a pilot approach for a health insurance subsidy initiative. Significant operational and pilot initiative design activities are currently underway to refine the selected approach.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

The State has made a conscious decision to pursue a private rather than a public approach to reaching individuals who are eligible but not enrolled in existing programs. It is the State's hope that under the pilot initiative, employer-based coverage can be extended to individuals who otherwise might not ever enroll in a public program either because they do not consider themselves eligible or do not want to be associated with public coverage for whatever reason.

In addition, although this approach may not result in reaching all individuals who are eligible but not enrolled in existing programs, the State believes it will generate many additional benefits. For one, this approach would extend the reach of state and federal funding by including private employer contributions towards coverage and may further reduce the number of uninsured by making employer group coverage, and employer contributions, available to uninsured workers who are not eligible for public programs. In addition, this approach may have positive effects on the labor market by reinforcing the value and benefits of employment for eligible individuals and may benefit Connecticut small employers by stabilizing an aspect of their work force that normally may be subject to significant turnover. Finally, by increasing the prevalence of coverage among small employers and committing private employer contributions towards coverage, the State may be able to better weather reductions in state and federal outlays for coverage through public programs.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

At the outset of grant period, a workgroup was formed to explore the potential for a partnership between the Department of Social Services (DSS) and a private sector purchasing cooperative. The purpose of the group was to identify subsidy process options for job-based healthcare coverage for the uninsured population of Connecticut. Several consultants from the Institute for Health Policy Solutions were contracted to assist OHCA staff with the following: 1) Conduct policy development and analysis to explore the possibilities related to the design of an employer-based subsidy options for the HUSKY plan in Connecticut, 2) Provide overall guidance and facilitate discussion with the purchasing cooperative related to their potential role in an employer subsidy option, 3) Identify key policy and operational issues that are known or suspected barriers to optimal program implementation and results, 4) Using data analysis, prepare benefit package options which describe the basic options of each benefit package and assist OHCA in report creation, preparation and publication of the final report to the U.S. Secretary of Health and Human Services. The consultants and the OHCA staff make up the remainder of the membership of the workgroup. The group met on a regular basis from May to November 2001 and completed the preliminary planning/expansion option activities. The minutes of each meeting are included in the Appendices. As the Governor prepared his midterm budget adjustments meetings were held with key officials within the Office of Policy and Management and DSS during the months of December and January.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

The proposed pilot initiative is winding its way through the General Assembly, this process of course, provides opportunity for public comment. A public hearing on the proposed legislation was held on March 7, 2002.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

The planning grant team meets regularly with OHCA's Director of Public and Government Relations to develop a communications plan and discuss opportunities to educate legislators on State Planning Grant Activities. The Project Director attended and presented Connecticut Planning Grant Activities Update at the Council of State Governments' Eastern Regional Conference. The Project Director has also met with advocacy organizations, including the Health Care for all Coalition and its member organizations and the CT Health Policy Project Director.

The Office of Health Care Access has published several issue briefs that have been mailed to other state agencies, state senators and representatives and other interested stakeholders. These issues briefs are included in the appendix section of the report under Household Survey Tool and Attachments. During the grant extension period, OHCA intends to produce a final household survey report and several additional issue briefs utilizing the both the household survey and employer survey data.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The current policy environment in the State can be described as cautiously optimistic. The challenge of declining state revenues and a budget deficit, along with significant health insurance premium increases have had an impact on the type and scope of expansion option selected and will continue to present a challenge as we work toward implementation. However, the inclusion of the pilot coverage expansion proposal in the Governor's budget demonstrates Connecticut's ongoing commitment to covering the uninsured.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

Both the household survey and the employer survey data was used to inform the policy development process and to model policy options. This data helped us better understand current health insurance coverage issues in Connecticut.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

Adding questions to an existing quarterly business survey fielded by CSRA on behalf of the Department of Economic and Community Development was extremely cost effective and also improved response rates in comparison to previously attempted business surveys conducted on a stand alone basis.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)? Not applicable, our data collection efforts are ongoing at this time.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

Contracting with the University of Connecticut as a partner in our data collection activities was very effective in improving data collection in terms of timely receipt of data files, quick turn-around on questions and transfer of knowledge to state data analysts. In addition, an insurance status verification question was included in the survey, this improved our confidence in our estimates of the uninsured.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

More research is needed in order to adequately define and measure affordability of health insurance and the concept of underinsurance.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

Our State Planning Grant efforts were organized around a core team of individuals from OHCA, DSS,(the Medicaid agency), OPM, (the budget agency), IHPS and CSRA. Use of email and teleconferencing as well as face-to-face meetings contributed to the success of our planning efforts. We also held a series of working meetings with the Connecticut

Business and Industry Association that provided valuable information for our policy option development process.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Our planning efforts are continuing in this area. Connecticut has specifically engaged in dialogue with private sector partners to provide information needed to develop policy options related to health insurance premium subsidies for low-wage workers.

6.8.1 What are the key recommendations that your State can provide other States regarding the policy planning process?

The value of having current state specific data to inform policy decisions cannot be overstated. In addition, effective interagency communications, engaging private sector partners in policy development and providing sufficient time to brainstorm creative new approaches contributed to the success of our policy planning process

6.9 How did your State's political and economic environment change during the course of your grant?

The Governor's proposed budget for the next fiscal year beginning July 1, 2002 had to cover a gap of about $630 million that emerged because of the recession. Connecticut lost 22,300 jobs between May 2002 and December 2001, however the economy looks better today than we might have imagined several months ago and there are signs that a recovery is imminent and that Connecticut may emerge from this recession in the Spring of 2002.

6.10 How did your project goals change during the grant period?
The overall goals of the project did not change during the grant period, however, the impact of September 11, 2001 and the corresponding economic downturn, led to changes in the potential size and scope of our proposed expansion options.

6.11 What will be the next steps of this effort once the grant comes to a close?

Connecticut was granted a one year extension to its State Planning Grant to February 28, 2003. The grant extension will be used to complete current grant activities and other related activities necessary to develop and implement a plan to expand access to health insurance coverage in Connecticut as follows:

- continued policy option development,
- design and modeling of the proposed health insurance subsidy initiative
- publication of a household survey report
- issue brief preparation and publication,
- preparation of final report to the Secretary,
- travel to participate in HRSA SPG follow-up meetings,
- interagency planning meetings, continued development/implementation of communications strategy.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

The private market expansion option selected by Connecticut to provide subsidies to low-income, working uninsured to purchase private coverage through their employer requires a Federal HIFA demonstration initiative waiver.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

Tax credit options were not selected at his time. These would most likely require changes in Federal law.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

Under the HRSA State Planning Grant Connecticut conducted surveys that added to its 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.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

More research is needed in order to adequately define and measure affordability of health insurance and the concept of underinsurance.

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[i] Percentages/numbers may not add up exactly due to rounding
[ii] Represents civilian, noninstitutionalzed population
[iii] Not mutually exclusive
[iv] The sum of Whole Year and Part Year equals Some Point in Year
[v] The sum of Whole Year and Part Year equals Some Point in Year; may not add up exactly due to rounding

APPENDIX I: BASELINE INFORMATION

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population:

Year	Resident Population for the State of CT
2000	3,405,565
1990	3,287,116

Source: US Census Bureau, Census 2000.

Number and percentage of uninsured (1999):

Methods for Estimating Connecticut's Uninsured		
Method	**Percent**	**Numbers**
Current Population Survey	9.0	295,383
Behavioral Risk Factor Surveillance Survey	10.1	331,485
Inpatient Adjusted Estimates	8.4	275,389

Source: ACHIEVE Issue Brief, Estimates of Connecticut's Uninsured Using Different Methods, April 2001.

Median age of Connecticut population: 37.4 years (Source: US Census Bureau, Census 2000.)

Percent of population living in poverty (<100% FPL):
According to the US Census Bureau figures, 8.4% of Connecticut's population has incomes below the poverty level. This figure is a three year average based on data from the Current Population Survey from March 1998, 1999 and 2000.

Primary industries:

Business Profile (1997)		
Sector	**Firms**	**% of Total**
Agriculture	3,840	2%
Construction and Mining	26,840	16%
Manufacturing	9,554	6%
Transportation and utilities	5,316	3%
Trade	38,843	23%
Finance, Insurance and Real Estate	13,426	8%
Services	67,707	40%
Government	1,706	1%
Total	**167,232**	**100%**

Source: The Connecticut Department of Economic and Community Development 1997 Business Profile.

Number and percent of employers offering coverage: 1998 MEPS Survey for the State of CT

Firm Size	Number of Establishments	State % of Business Establishments Offering Health Insurance
< 10	50,351	47.9%
10 - 24	10,586	75.1%
25 - 99	5,789	90.5%
100 - 999	5,368	97.3%
1000 +	8,527	98.9%
< 50	64,220	54.4%
50 +	16,400	97.9%
Total	**80,621**	**63.2%**

Source: 1998 MEPS Survey of Private-Sector Business Establishments for AHRQ

Number and percent of self-insured firms:

Does the company contract directly? (weighted responses)

State of Connecticut

Response	Frequency	Percent	Cumulative Percent
N/A, not self-insured, single svc plan, or state/federal government	92,885	87.6	87.6
Not ascertained	1,309	1.2	88.8
Refused	82	0.1	88.9
Don't know	505	0.5	89.4
Yes	3,314	3.1	92.5
No	7,973	7.5	**100%**
Total	**106,069**	**100%**	

Does the company contract directly? (unweighted responses)

State of Connecticut

Response	Frequency	Percent	Cumulative Percent
N/A, not self-insured, single svc plan, or state/federal government	1,798	91.3	91.3
Not ascertained	29	1.5	92.8
Refused	1	0.1	92.8
Don't know	10	0.5	93.3
Yes	48	2.4	95.8
No	83	4.2	**100%**
Total	**1,969**	**100%**	

Source: 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey completed by the Rand Corporation

Payer mix:

Primary Payer Mix for Connecticut's Acute Care Inpatient Charges*, FYs 1998 - 1999

	FY 1999			FY 1998		
Primary Payer	# of Discharges	Total Charges ($)	Share of Total (%)	# of Discharges	Total Charges ($)	Share of Total (%)
Medicare	140,035	2,186,362,522	50	144,626	2,195,204,455	52
Medicaid	54,127	517,937,130	12	54,074	490,431,297	12
Commercial Insurance	34,095	346,374,876	8	36,887	360,411,796	9
CHAMPUS	1,692	11,235,561	0	1,554	10,112,660	0
Other	140,944	1,318,389,165	30	132,329	1,164,021,037	28
Total	370,893	4,380,299,254	100	369,470	4,220,181,245	100

*** Charges are pre-reimbursements**

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

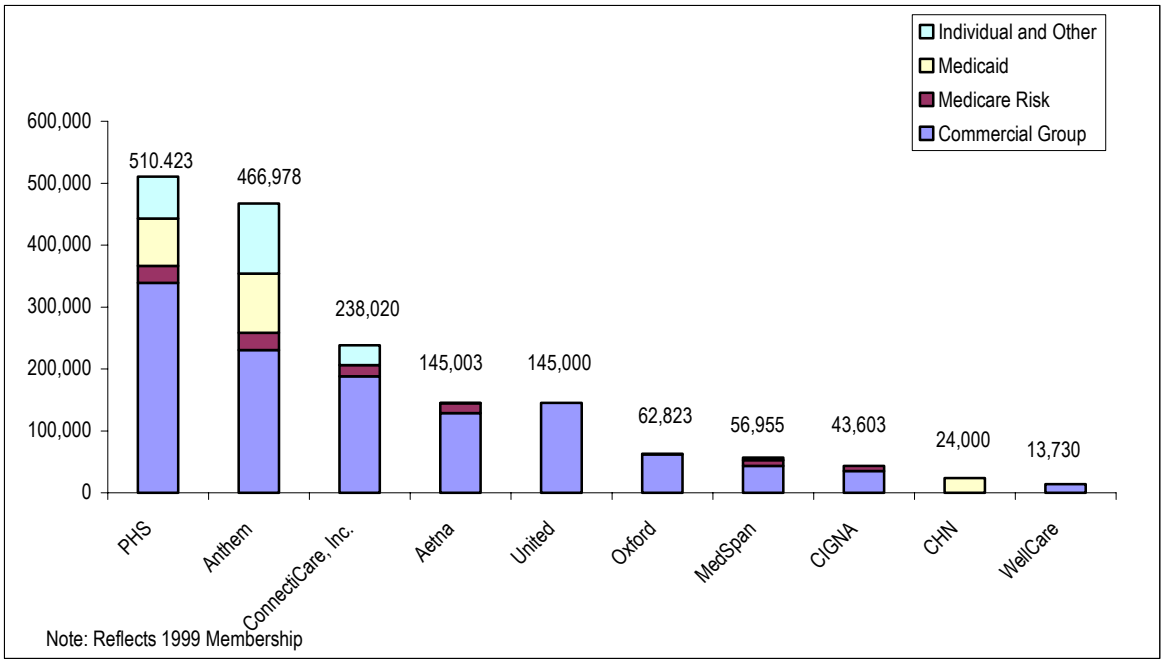
Provider competition:

Product Capability of Connecticut Health Plans

Source: RPM Health, Market Assessment of Connecticut Health Plans, October 23, 2000

	Indemnity	HMO	POS	PPO	Medicare Risk	Medicare Supp.
Aetna US Healthcare Inc.	*	*	*	*	*	
Anthem Health Plans, Inc.		*	*	*	*	*
CIGNA Healthcare of CT	*	*	*	*	*	
Community Health Network						
ConnectiCare, Inc.		*	*		*	
MedSpan Health Options, Inc.		*	*	*	*	
Oxford Health Plans, Inc.		*	*		*	
PHS of CT, Inc.		*	*		*	
United Healthcare	*	(EPO only)	*	*		
WellCare of CT, Inc.			*			
Note: Reflects 1999 product offerings.						
Aetna US Healthcare Inc., Anthem Health Plans, Inc., and CIGNA will not be offering Medicare Risk products 1/1/2001						

Membership for Competing Providers



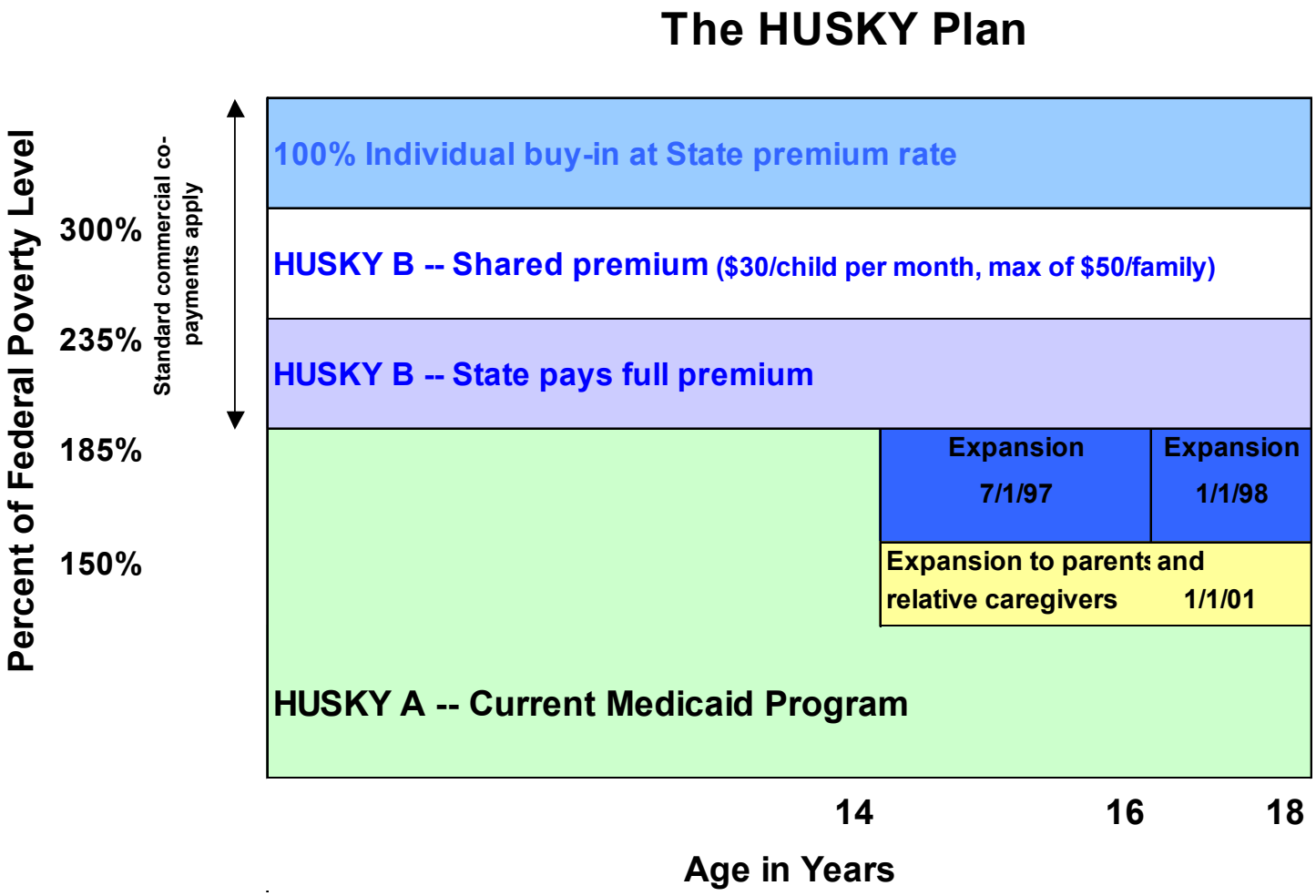
Source: RPM Health, Market Assessment of Connecticut Health Plans, October 23, 2000.

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

Connecticut has significantly increased the number of children with health insurance through implementation of its Title XXI SCHIP program by expanding Medicaid coverage to children (now known as HUSKY part A) and creating a new health insurance program for previously uninsured children (HUSKY part B). HUSKY A is a Medicaid expansion program that includes all children up to age 19 from families with incomes up to and including 185% of the FPL. HUSKY B, a separate insurance program, covers children up to age 19 with a family income of up to 300% of the FPL. HUSKY B also includes an unsubsidized buy-in opportunity for uninsured children in families with income over 300% of the FPL. As of June 1, 2000, 176,376 children and 57,370 eligible adults were enrolled in HUSKY A and 5,761 children were enrolled in HUSKY B. Children enrolled in HUSKY represent about 20% of all children in the state. In addition, expansion of HUSKY A health care benefits to parents and caretaker relatives with incomes under 150% of the FPL was implemented in January 2001.

HUSKY Family Income Guidelines (See link below)

Family of 2	Family of 3	Family of 4	HUSKY Plan features
under $17,416	under $21,946	under $26,475	**HUSKY Part A for parents or a relative caregiver** who live with a child. Full health benefit package; free
under 21,479	under $27,066	under $32,653	**HUSKY Part A for children under 19; and pregnant women** (note: for eligibility of pregnant women, unborn child is also counted as a family member). Full health benefit package; free
from $21,479 to $27,283	from $27,066 to $34,380	from $32,653 to $41,477	**HUSKY Part B for children under 19.** Full health benefit package, with no premiums; some co-payments. Eligible for HUSKY Plus.*
from $27,284 to $34,830	from $34,381 to $43,890	from $41,478 to $52,950	**HUSKY Part B** for children under 19. Full health benefit package, with monthly premium of $30 for first child; maximum monthly premium of $50, regardless of number of children; some co-payments. Eligible for HUSKY Plus.*
Over $34,830	over $43,890	over $52,950	**HUSKY Part B for children under 19**. Full health benefit package. Group premium rate, currently ranging from $137 to $200 monthly per child; some co-payments.



Use of Federal Waivers:
The Department of Social Services has obtained a 1915B waiver in reference to Children and Family Services. The waiver overrides a client's choice in Medicaid programs and requires mandatory enrollment in a managed care Medicaid program.

APPENDIX II: LINKS TO RESEARCH FINDINGS AND METHODOLOGIES

Indicate the Web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

See attachments for additional documents listed in the Table of Contents.

Links The following are useful weblinks:

CBIA	http://www.cbia.com/busecon/srvpub/default.htm
HUSKY	http://www.huskyhealth.com/about.htm
Childrens Health Council	http://www.childrenshealthcouncil.org/resources/publications.hrtml
State Coverage Initiatives	http://www.statecoverage.net/statereports/index.htm#ct
OHCA	http://www.state.ct.us/ohca

August 2001

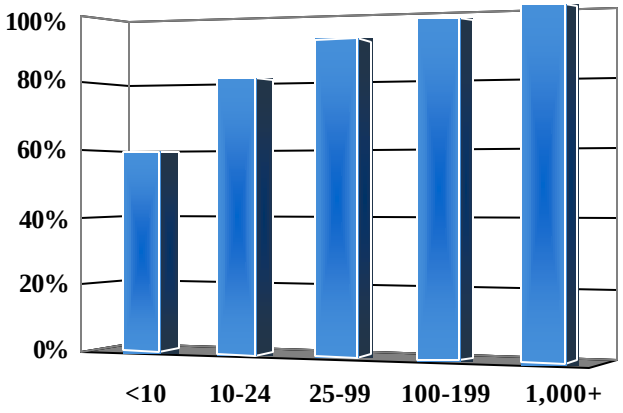
Employer-Sponsored Health Insurance

Although Connecticut has one of the lowest uninsured rates for health insurance, it is still good policy to seeks ways to expand health insurance coverage. Research has shown that people with health insurance are more likely to get preventive care and timely treatment for medical conditions,[1] reducing the costs of illnesses through appropriate treatment and a reduction of lost work time.

Estimates of the rate of people in Connecticut with health insurance are between 90 and 92 percent.[2] Most workers (60%) receive health insurance through their workplace; some of these policies also cover family members.[3] Firms with larger numbers of employees are more likely to offer this benefit. For example, nearly all (99.9%) of the largest firms in Connecticut, those with over 1,000 employees, offer health insurance. In contrast, less than two-thirds (60%) of firms with less than ten employees offer it.

Figure 1:

Larger Firms Are More Likely to Offer Insurance Than Smaller Firms

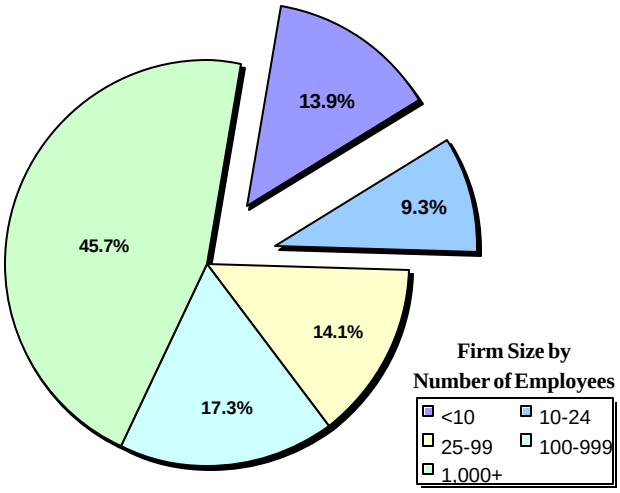


Size of Firm by Number of Employees

These smaller firms are significant, because nearly one-quarter (23 %) of Connecticut workers are employed in firms with fewer than 24 employees.

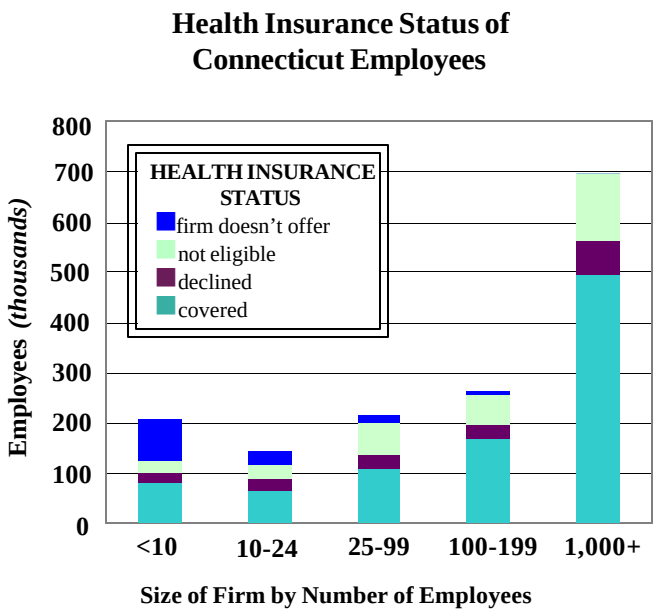
Figure 2:

One-Quarter of Employees Work at Firms with Less than 24 Employees



Even though the majority of small firms offer health insurance, some of their employees are not enrolled for two main reasons. Either the employee is not eligible for the benefit (usually because only full- time workers are offered insurance and many workers in small firms are part-time employees), or the employee declines the coverage, usually due to the high cost of his or her share of the insurance premium. The average monthly employee's contribution for employer-sponsored health insurance is $30 for single coverage or $111 for family coverage.[4] *(see Figure 3)*

Figure 3:



The status of employee-sponsored health insurance during the next few years, and its effect on health insurance coverage in the state, is uncertain.

Decreased economic growth or increased health insurance premiums will make it more difficult for employers to carry the expense of this benefit. Some employers will respond to these conditions by increasing the premium portion paid by employees or eliminating the health plan entirely, either of which will erode the rate of health insurance coverage.

On the other hand, competition for workers resulting from Connecticut's continuing low unemployment rate makes it difficult for employers to reduce this popular benefit. About one-quarter of employers nationally responding to a survey stated that they are very concerned that health insurance costs will increase faster than they can afford (23%) or cause them to switch plans (28%).[5]

The Office of Health Care Access recently received a one-year State Planning Grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration. The purpose of the grant is to explore ways to expand health coverage to Connecticut citizens by lowering barriers to employee-sponsored health insurance.

A survey of Connecticut households will be done to provide a more recent description of those who are without health insurance and to better understand their usual sources of health care. A second survey of Connecticut businesses will ascertain if changes in the workforce structure or the increasing cost for insurance premiums has changed the rate at which businesses offer and employees enroll in employment sponsored health insurance. Results from these surveys will be available in future ACHIEVE Issue Briefs.

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[1] Kaiser Commission on Medicaid and the Uninsured, *Uninsured in America: A Chart Book.* Washington, D.C: Kaiser Commission on Medicaid and the Uninsured, 1998.

[2] See ACHIEVE Issue Brief, April 2001, "Estimating Connecticut's Uninsured Using Different Methods."

[3] Unless otherwise noted, all data is from the 1998 Medical Expenditure Panel Survey, Agency for Health Research and Quality, Department of Health and Human Services.

[4] Kaiser Family Foundation and Health Research and Education Trust. Employer Health Benefits 2000 Annual Survey, page 76. Menlo Park CA: Kaiser Family Foundation, 2000.

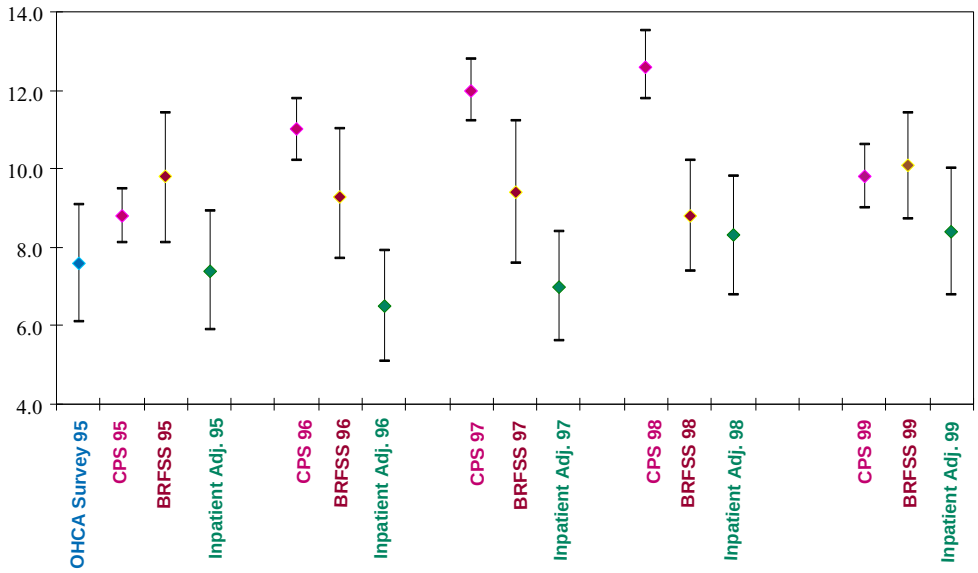
[5] Ibid. Pages 157-158.

ACHIEVE Issue Brief

April 2001 STATE OF CONNECTICUT ❖ OFFICE OF HEALTH CARE ACCESS

Estimates of Connecticut's Uninsured Using Different Methods

Comparison of Current Population Survey (CPS) and Benchmark Estimates of Connecticut's Uninsured, FY 1995 - FY 1999



The Office of Health Care Access Health (OHCA) has undertaken a mission to ensure that the citizens of Connecticut have access to quality health care. In order to achieve this goal, OHCA monitors and provides information on the rate of uninsured in the state, the variation in the rate over time, the cause of these changes, and the distribution across specific demographic groups to facilitate policy formulation. The purpose of this brief is to examine and describe several different methods of estimating the uninsured. The chart shows sets of estimates of Connecticut's uninsured derived by different sources for fiscal years 1995 through 1999. In the chart, the point estimates are in bold, and the upper and lower limits of the estimates are presented as lines. Interval estimates give a more accurate measure since they provide a range within which the true point lies. The four different methods used to estimate uninsurance rates are described here.

Office of Health Care Access (OHCA) Survey 1995

http://www.state.ct.us/ohca

The OHCA survey, "A Connecticut Family Health Care Access Survey" was fielded in 1995, the year Medicaid Managed Care went into effect but prior to the passage of the State Children's Health Insurance Program (SCHIP) known as the HUSKY Plan (**H**ealthcare for **U**nin**S**ured **K**ids and **Y**outh). OHCA expects to re-administer the survey in 2001 and is cooperating with other states fielding similar surveys to ensure comparability of results.

Current Population Survey (CPS)

http://www.census.gov/

The second set of estimates is from the U.S. Census Bureau's March CPS Annual Demographic Supplement, which includes insurance coverage questions. Individuals who did not report coverage under three major categories - private insurance, Medicaid or other coverage- are considered uninsured. The CPS interprets these uninsured to have lacked coverage for the entire prior year.

Behavioral Risk Factor Surveillance Survey (BRFSS)

http://www.cdc.gov/nccdphp/brfss/

The third set is from the monthly BRFSS conducted by the Centers for Disease Control and Prevention (CDC). BRFSS tracks preventative health practices and health risk behaviors of the adult population in the United States and its territories. It provides state-specific data to state health agencies that play the crucial role of developing measures for reducing these behavioral risks and their consequent illnesses. The CDC adjusts the responses to a question on

ACHIEVE is a grant initiative funded by the Robert Wood Johnson Foundation State Coverage Initiatives Program. The Office of Health Care Access functions as the lead agency for the grant.

health care coverage according to population demographics and uses this as its estimate of the uninsured.

Inpatient-Adjusted Estimates

Unlike the others, the inpatient-adjusted estimates are not based on survey methods. They were derived using OHCA's hospital discharge database. Newborns, appendectomies, and heart attacks were the conditions used to estimate the number of residents without insurance coverage. These conditions were selected because they require hospitalization regardless of insurance coverage status. The derived percentages were adjusted to reflect age, gender, race and ethnic composition of the state's population.

Observations

Several observations can be made about the different estimates. First, aside from 1995 and 1999 when each of the methods yielded estimates of approximately 10%, the trends from the different approaches displayed varying characteristics. Second, the BRFSS estimates were the most consistent over the years while the CPS estimates experienced the largest changes; the latter showed a 25% increase (the highest) from 8.8% in FY 1995 to 11.0% in 1996, with a peak at 11.8% in 1998. Third, for each year, the inpatient-adjusted methodology estimated the lowest percentages of uninsured in the state while the CPS showed the highest for three years in a row. Remarkably, although the BRFSS and inpatient methods did not always yield similar estimates, the results were lower than the CPS and the two moved in unison, except in 1998 - when there was no statistically significant difference between the two estimates.

		Uninsured	
State's Pop.	Method	Percent	Numbers
3,282,031	CPS	9.0	295,383
	BRFSS	10.1	331,485
	Inpatient-Adjusted	8.4	275,389

Analyses

The reasons for these differences are related to the various methods of estimation. While the CPS used a 90% level of accuracy, the OHCA survey, BRFSS and inpatient-adjusted interval estimates were derived using a 95% level. Due to the lower level of accuracy, the spread for the CPS interval estimates are the smallest. The width of the inpatient-adjusted interval estimates was additionally affected by racial differences in insurance coverage; Whites (3.4%) and Native Americans (4.1%) had relatively lower uninsured rates compared with Blacks (5.9%) and Hispanics (6.6%).

One of the possible causes of the CPS over-estimation of the uninsured is its restricted size; for each year, there were only 630 respondents, so demographic groups were inadequately represented and some were not represented at all. Generally, in estimating population percentages, increasing the samples increases precision, and adjusting for demographic characteristics improves the inferences to be made about the population. BRFSS uses a minimum of 1,829 respondents and the inpatient-adjusted method utilizes an average of 52,800 discharges each year; each of these samples truly reflect the state's demographic composition. Recognizing that having a larger sample will enhance precision, CPS has increased its sample to 1,800 effective December 2000.

Some researchers believe that some CPS respondents may have reported their insurance coverage at time of the interview rather than the prior year, leading to data inconsistencies. In addition, the CPS data has been noted to underreport the number of individuals receiving Medicaid compared with participation data reported to Health and Financing Administration (HCFA) by the states. Majority of the states have a different name for the Medicaid State Children's Health Insurance Program (S-CHIP) program therefore CPS may have wrongly labeled participating residents of such states as uninsured.

Conclusions

Most deliberations concerning the extension of health insurance coverage and measures on the level of success utilize the CPS estimates. The CPS was intended to serve as an estimate of the overall nation's benchmark of various issues, for instance the allocation of funding for the S-CHIP. Uninsured rates vary widely across states and demographic groups, but the CPS does not report insurance status by demographic characteristics. Furthermore, the lower estimates yielded by the other three methods illustrate how the CPS tends to over-estimates the level of uninsured in a state. National estimates of the uninsured available to state policymakers are inadequate for precise statewide or local strategies and this affirms the need for additional reliable sources of data. OHCA is currently considering use of a coordinated state household survey instrument that, if adopted by a number of states, would provide an opportunity for cross state comparisons and greatly enhance our ability to estimate the uninsured in Connecticut.

This information is presented by OHCA to inform policy makers, the public and the health care industry. For further details, please call (860) 418-7028.

OHCA
OFFICE OF HEALTH CARE ACCESS
Planning tomorrow's health care system today.

June 2001

Who Were the Primary Payers of Inpatient Acute Care Hospital Charges, FYs 1991 to 1999?

This is the third report in a series that explores recent trends shaping Connecticut's hospitals. The first report detailed changes in the delivery of care that followed the 1994 deregulation of the hospital industry and the subsequent development of a more competitive health services market. Specifically, care was increasingly shifted to outpatient settings, as the number of outpatient visits leapt by 19% and inpatient discharges fell by over 5%. In addition, the average hospital stay fell from seven days to five days.

The second report in this series revealed that despite the drop in the number of inpatients, total inpatient charges rose from $3.4 billion in FY 1991 to $4.4 billion in FY 1999 (the hospital fiscal year runs from October 1st through September 30th). During this time, the median patient charge expanded from nearly $5,000 to $7,000. Hospital charges grew due to a number of factors including an increase in the severity of inpatient illnesses, an aging patient population, the burgeoning cost of medical technology, inflation and other factors. Net operating expenses for all of Connecticut's acute care hospitals climbed from $3.3 billion in FY 1992 to $3.9 billion in FY 1999. During this period, hospitals' net revenue barely kept pace with costs, rising from $3.4 billion to $3.9 billion.

This report identifies the primary payers of inpatient charges and examines the changing patterns of hospital reimbursements. Although there may be several payers responsible for a patient's total charges, the primary payer is the one expected to reimburse the largest share of those charges. The Office of Health Care Access' (OHCA) inpatient database records the top three payers for every discharge and ranks their relative importance. It does not, however, record the payers' shares of each discharge's total charges. In FY 1991, about one in every three hospital discharges had a secondary payer but by FY 1999 this had grown to one in every two. During that time frame, the proportion of those with a third payer leapt from a mere 3% to 22%.

Significant Primary Payers of Inpatient Hospital Charges*

Medicare (Title II of the Social Security Act): Established in 1965 to provide health insurance coverage to those 65 years and

* For more information, see OHCA's *The Health of Connecticut's Hospitals*.)

older as well as the disabled, Medicare is the nation's largest payer of inpatient charges. Hospital Insurance (Part A) covers inpatient care and for Connecticut's hospitals in FY 1998, Medicare gross revenue was $3 billion, just less than half of their total gross revenue. In 1983, Medicare moved from reimbursements based upon fee-for-service to the Prospective Payment System (PPS).

Under the PPS, hospitals are reimbursed a fixed, predetermined amount based upon a patient's diagnosis using the Diagnosis Related Group classification system. These reimbursements are adjusted to account for local wages, urban versus rural location, and whether or not the hospital is a teaching hospital. In FY 1996, Connecticut introduced Medicare Managed Care. However, its development has been slow and only 11% of hospitals' Medicare revenues (FY 1998) were from its managed care component.

Medicaid (Title XIX of the Social Security Act): Within federal guidelines, states administer their own Medicaid programs, which provide health insurance coverage for low-income families and the disabled. In FY 1998, Medicaid payments to hospitals represented 10% of Connecticut hospitals' gross revenue ($792 million). Connecticut's reimbursement rate relative to costs is 71% -- the nation's third lowest.

The state also pays 50% of its Medicaid program's total costs, the largest share that any state is required to contribute.

Connecticut introduced Medicaid Managed Care in FY 1995. As of mid-1999, 71% of enrollees were in managed care, however, 60% of the program's costs were in its fee-for-service portion.

HMO/PPO: Managed care rapidly expanded in Connecticut following the establishment of the competitive health care market in the mid-1990s. From the early 1990s to the decade's end, HMO enrollment grew from 24% to 43% of the state's population. Managed care is a broad term encompassing many types of plans, but is generally characterized by a network of providers and financial incentives for enrollees to stay within this network.

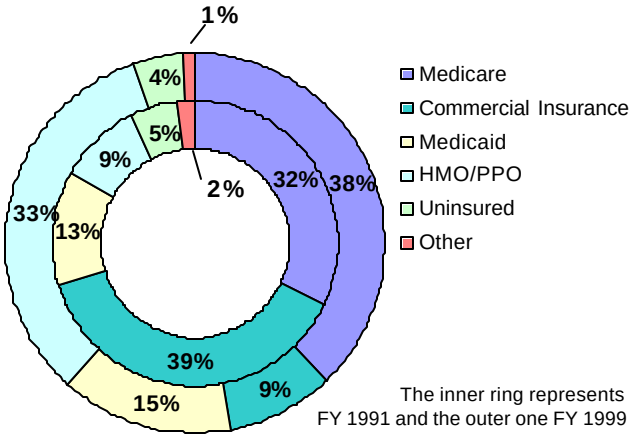
Managed care organizations seek to limit their costs through gatekeepers, utilization reviews, and practice protocols. They reimburse hospitals upon the basis of negotiated fee schedules (predetermined amounts based upon diagnoses), or capitated rates. From FY 1994 to FY 1998, aggregate managed care discounts for all of Connecticut's acute care hospitals grew from 9% to 30% of all charges, or $2.25 billion.

Commercial/Indemnity Insurance: Traditional fee-for-service reimbursement has increasingly been discarded over the last decades of the 20th century. Commercial insurers have for the most part adopted managed care practices. As a result the distinction between commercial insurers and managed care organizations has been largely eroded.

Other Payers: These include Title V, the Maternal and Child Health Block Grant; the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Worker's Compensation; and Other Federal Programs.

Uninsured: This refers to those whose payer categories were either "Self-pay," "Other," or "No charge." The number of uninsured may be under-counted because hospitals may retroactively enroll in the Medicaid program those without health insurance coverage who qualify.

Fig 1: Primary Payers' Share of Total Discharges, FYs 1991 to 1999



In Figure 1, the varying sizes of the color bands on the inner (FY 1991) and outer (FY 1999) rings illustrate changes in the primary payers' share of discharges. The most striking change has been the growth of HMO/PPOs (from 9% to 33%) and the precipitous decline of commercial/indemnity insurance (from 39% to 9%). In FY 1991, Blue Cross/Blue Shield of Connecticut was a mutual insurance company but in FY 1997, Anthem Inc., an HMO, acquired it.

The graph understates the extent of managed care, because the differences between traditional commercial insurers and HMOs vanished as commercial insurers adopted managed care practices. Furthermore, by FY 1999, 71% of Medicaid enrollees were in managed care plans, as were increasing numbers of Medicare recipients. The proportions of Medicare and Medicaid patients increased slightly so that by FY 1999, public programs were the primary payers for over half of all inpatient discharges.

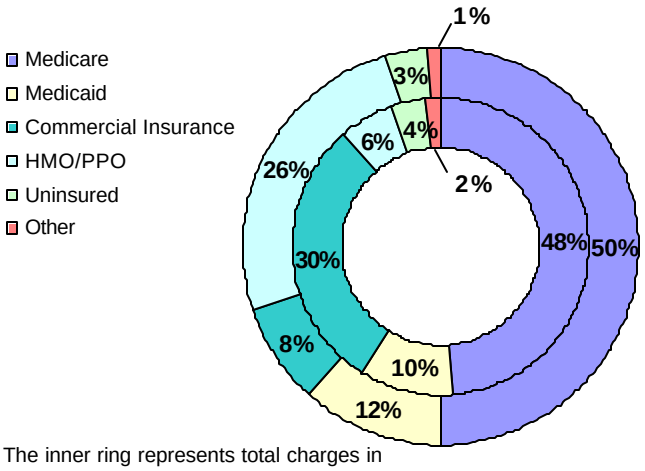
Primary Payers' Share of Total Charges

Charges are the amounts that hospitals billed payers, whether HMOs, the government, or individual patients. They are not, however, identical with either the hospitals' actual cost of care or the reimbursements that they collected. Discounts to public and private payers reduce reimbursements.

OHCA's inpatient database records up to three payers for each discharge and identifies the primary payer. It does not record the proportion of a patient's charges that each payer was responsible for.

For the following analysis of total charges by primary payer, the patient's entire charge was imputed to the primary payer. For example, if a patient's charges totaled $10,000 and an HMO was the primary payer but there was also a secondary payer, the HMO was considered the sole payer for the entire $10,000. In FY 1999, 47% of all discharges had a secondary payer and 22% had a tertiary payer.

Fig 2: Total Inpatient Charges by Primary Payer, FYs 1991 and 1999



The inner ring represents total charges in FY 1991 and the outer ring represents those in FY 1999

In Figure 2, the changes in total charges by primary payer from FY 1991 (inner ring) to FY 1999 (outer ring) reflect those for total discharges, namely the dramatic expansion of HMO/PPOs and the concurrent decline of commercial insurance. It also reflects the dominance of public programs as primary payers for inpatient care.

Comparing Figures 1 and 2, Medicare and Medicaid were the primary payers for *half of all discharges* in FY 1999, but were the primary payer for *two-thirds of total charges*. These programs cover the elderly and the disabled who are more likely to have higher average charges than other types of patients (See OHCA's *Rising Acute Care Inpatient Hospital Charges, FYs 1991 to 1999*). In contrast, HMO/PPOs were the primary payers for 33% of all discharges but only 26% of total charges.

Conclusion

From FY 1991 to FY 1999, the number of acute care hospital patients whose primary payer was an HMO or PPO swelled significantly as traditional indemnity insurance coverage evaporated. During this time, public payers such as Medicare and Medicaid became the primary payers for the majority of inpatient care. The spread of managed care includes the establishment of Medicaid and Medicare managed care in the mid-1990s and the commercial insurers' adoption of managed care practices.

In one form or another, most Connecticut residents are covered by managed care as public and private payers have sought to limit their costs. Since the mid-1990s, average annual growth for inpatient charges was less than 2% and net revenue averaged 1%, while hospital net operating expenses grew at an average of 3%.

OHCA SURVEY QUESTION LIST (INVISIBLE AND DUMMY VARIABLES LEFT OUT)					
SECTION 1: HOUSEHOLD LEVEL INFORMATION					
INT1	Hello, my is $I, calling from the University of Connecticut on behalf of the State of Connecticut…				
INT2	We will gather some general information about the health insurance status of everyone…				
S6	How many people currently live or stay in this house, apartment, or mobile home?				
AGE01	What is your age as of your last birthday?				
SEX01	(DO NOT ASK - RECORD GENDER)				
AGE02	And the next person's age?				
SEX02	Is this person male or female?				
AGE03	And the next person's age?				
SEX03	Is this person male or female?				
AGE04	And the next person's age?				
SEX04	Is this person male or female?				
AGE05	And the next person's age?				
SEX05	Is this person male or female?				
AGE06	And the next person's age?				
SEX06	Is this person male or female?				
AGE07	And the next person's age?				
SEX07	Is this person male or female?				
AGE08	And the next person's age?				
SEX08	Is this person male or female?				
AGE09	And the next person's age?				
SEX09	Is this person male or female?				
AGE10	And the next person's age?				
SEX10	Is this person male or female?				
AGE11	And the next person's age?				
SEX11	Is this person male or female?				
AGE12	And the next person's age?				
SEX12	Is this person male or female?				
SEL	The program has randomly selected the <age> year old <sex> as the person I will need to get more detailed information about.				
STUD	Are you (Is <TARGE>) currently a full-time student?				
REL1	Now I need to know each person's relationship to the person selected. What is your relationship to <TARGE>?				
REL2	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL3	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL4	What is the <age> year old <sex>'s relationship to <TARGE>?				

REL5	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL6	What is the <age> year old <sex>'s relationship to <TARGE>?	GROUP	GROUP	ON/Group	ON/Group
REL7	What is the <age> year old <sex>'s relationship to <TARGE>?	adult non-student	minor or student	adult non-student	minor or student
REL8	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL9	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL10	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL11	What is the <age> year old <sex>'s relationship to <TARGE>?				
REL12	What is the <age> year old <sex>'s relationship to <TARGE>?				
ISTA1	The next questions are about the health insurance that people in your household may have at this time.				
STAT1	Do you currently have health insurance?				
TYPE1	What type of insurance are you covered by?				
STAT2	Does the <age> year old <sex> currently have health insurance?				
TYPE2	What type of insurance is this person covered by?				
STAT3	Does the <age> year old <sex> currently have health insurance?				
TYPE3	What type of insurance is this person covered by?				
STAT4	Does the <age> year old <sex> currently have health insurance?				
TYPE4	What type of insurance is this person covered by?				
STAT5	Does the <age> year old <sex> currently have health insurance?				
TYPE5	What type of insurance is this person covered by?				
STAT6	Does the <age> year old <sex> currently have health insurance?				
TYPE6	What type of insurance is this person covered by?				
STAT7	Does the <age> year old <sex> currently have health insurance?				
TYPE7	What type of insurance is this person covered by?				
STAT8	Does the <age> year old <sex> currently have health insurance?				
TYPE8	What type of insurance is this person covered by?				
STAT9	Does the <age> year old <sex> currently have health insurance?				
TYPE9	What type of insurance is this person covered by?				
STAT10	Does the <age> year old <sex> currently have health insurance?				
TYPE10	What type of insurance is this person covered by?				
STAT11	Does the <age> year old <sex> currently have health insurance?				
TYPE11	What type of insurance is this person covered by?				
STAT12	Does the <age> year old <sex> currently have health insurance?				
TYPE12	What type of insurance is this person covered by?				
IVER1	According to the information you have provided, the following do NOT currently have health care coverage:				
VER1	The <age> year old <sex>. Is this correct?				
VER2	The <age> year old <sex>. Is this correct?				
VER3	The <age> year old <sex>. Is this correct?				

VER4	The <age> year old <sex>. Is this correct?				
VER5	The <age> year old <sex>. Is this correct?				
VER6	The <age> year old <sex>. Is this correct?				
VER7	The <age> year old <sex>. Is this correct?				
VER8	The <age> year old <sex>. Is this correct?				
VER9	The <age> year old <sex>. Is this correct?				
VER10	The <age> year old <sex>. Is this correct?				
VER11	The <age> year old <sex>. Is this correct?				
VER12	The <age> year old <sex>. Is this correct?				
SECTION 2: FIGURING OUT WHAT KIND OF INSURANCE TARGET HAS (IN DETAIL)					
X1	INTERVIEWER: PLEASE INDICATE WHO YOU ARE SPEAKING WITH				
X2	Are you familiar with the health care and insurance coverage of the <age> year old <sex>?				
X3	May I please speak with an adult who is familiar with the health care and insurance coverage of the <age> year old <sex>?				
XX1	Now I need to ask some more detailed questions about <TARGE >'s health insurance coverage. May I speak				
XX2	Are you familiar with the health care and insurance coverage of the <age> year old <sex>?				
XX3	May I please speak with an adult who is familiar with the health care and insurance coverage of the <age> year old <sex>?				
IH1	I am going to read you a list of different types of health insurance. Please tell me if you (<TARGE) CURRENTLY have/has any of the following. Answer for each type that ap				
H1	Do you (Does <TARGE>) currently have Medicare?				
H1A	Do you (Does <TARGE>) have additional insurance to supplement Medicare, such as a self-purchased Medigap policy, or a retiree benefit?				
H1B	Do you (Does <TARGE>) have insurance that pays for prescription drugs?				
H1P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H2	A Railroad Retirement plan?				
H2P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H3	CHAMPUS, Veteran's Affairs service connected to a disability, or military health care?				
H3P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H4	Indian Health Service?				
H4P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H5	Medical Assistance or Medicaid?				
H5P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H6A	A health insurance plan for children and families called Husky?				
H6P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H9	Health insurance through your (<TARGE>'s) work or union?				
H9P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H10	Health insurance through someone else's work or union?				
H10P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				

H11	Health insurance bought directly by you (<TARGE>)?				
H11P	Besides this, do you (does <TARGE>) have any other type of health insurance coverage?				
H12	Health insurance bought directly by someone else?				
IPOL	You have indicated that you have (<TARGE> has) health insurance you (he/she) purchased and insurance purchased by someone else…				
POLIC	Is the purchased health insurance an individual or family policy?				
PREM1	Do you (Does <TARGE>) pay the health insurance premium weekly, biweekly, monthly, quarterly, semi-annually, or annually?				
PREM2	How much do you (does <TARGE>) pay <PREM1> for the health insurance premium?				
DED1	Does your (<TARGE>'s) health insurance include a deductible?				
DED2	How much is that NOT INCLUDING PREMIUM EXPENSES?				
DRUG	Do you (Does <TARGE>) have insurance that pays for prescription drugs?				
H12A	Other than the types of health insurance I've just mentioned, what types of health insurance do you have?				
H13	According to the information you have provided, you do (<TARGE> does) not have health insurance coverage. Does anyone else pay for your (his/her) bills when you go (he				
H13A	You've just told me you receive (<TARGE> receives) services through the Indian Health Service but do (does) not have health INSURANCE. Does anyone else pay for your				
H14	And who is that?				
H14A	For the purposes of this survey, we'll assume you do (<TARGE>) does not have insurance.				
H15	Have you (Has <TARGE>) had insurance coverage for all of the past 12 months?				
H18	Was there anytime IN THE PAST 12 MONTHS that you were (<TARGE > was) not covered by insurance?				
H19	Have you (Has <TARGE>) been covered by any health insurance IN THE PAST 12 MONTHS?				
SECTION 3: THE CATEGORIES TARGET CAN BE PLACED IN (THIS HAPPENS BEHIND THE SCENES)					
SORT1	GROUP: Has had insurance for the last 12 months through own work or union and/or someone else's work or union.				
SORT2	ON/GROUP: Currently has, but has not had for entire last 12 months, insurance through own work and/or someone else's work or union.				
SORT4	ON/Individual: Currently has, but has not had for entire last 12 months, insurance they purchased and/or someone else purchased				
SORT5	Individual: Has had insurance for the last 12 months through plan they purchased and/or someone else purchased.				
SORT3	ON/ELSE: Currently has, but has not had for entire last 12 months, some type of insurance other than purchases or through work.				
SOR3A	ELSE: Has had insurance for the last 12 months that is a type other than purchased or through work.				
SORT6	SCREEN: Listed "Other" insurance to question H14 or H12A but had none of the insurance types we specifically asked about.				
SORT7	UNINSURED: Currently has no insurance and has not had any during last 12 months.				
SORT8	OFF: Currently has no insurance, but had some type of insurance in the last 12 months.				
SORT9	SCREEN: Refused to say or didn't know whether or not they have had insurance over the last 12 months (H18 or H19)				
SECTION 3: INSURANCE ACCESS QUESTIONS (x means a person in the category could NEVER get the particular question and P means it is possible that they can get the question					
		GROUP	GROUP	ON/Group	ON/Group
		adult non-student	minor or student	adult non-student	minor or student
IPATU	The next set of questions is about your (<TARGE>') history of insurance coverage over the past 12	x	x	P	P

PATHU	You have just explained that you are not covered by health insurance but were covered at some pc	x	x	x	x
PROB	Can you please briefly describe your (<TARGE>'s) current health insurance situation and what this	x	x	x	x
UNIN1	What type of insurance were you covered by most recently? Was it…	x	x	x	x
UIN1A	How many months ago did that coverage end?	x	x	x	x
UNIN2	And what is the main reason your coverage ended?	x	x	x	x
YOUNG	Was this insurance coverage through your (<TARGE>'s) parents' or guardians' plan?	x	x	x	x
UNIN3	Did you (<TARGE>) get this insurance coverage less than 12 months ago?	x	x	x	x
UNIN4	What was the main reason you (<TARGE> got this insurance coverage?	x	x	x	x
UNIN5	Was there another period of time WITHIN THE PAST 12 MONTHS before you (<TARGE>) had the	x	x	x	x
PATHI	You have just explained to me that currently you are (<TARGE> is) covered by health insurance bu	x	x	P	P
PROB2	Can you please briefly describe your (<TARGE>'s) current health insurance situation and what this	x	x	P	P
INSD1	Was there more than one period of time you were (<TARGE> was) not covered by insurance in the	x	x	P	P
INSD2	Thinking back to the time you (<TARGE>) got your (his/her) current form of insurance, what is the r	x	x	P	P
YOUN2	Was this insurance coverage through your (<TARGE>'s) parents' or guardians' plan?	x	x	P	P
INSD3	Before you (<TARGE>) got your (his/her) current coverage, did you (he/she) go with NO insurance	x	x	P	P
ISD3A	How many years?	x	x	P	P
ISD3B	How many months?	x	x	P	P
ICOV1	Now I'd like to ask a few questions about your (<TARGE>'s) access to insurance.	P	x	P	x
COV1	Does your (<TARGE>'s) spouse or partner have insurance through their work or union?	P	x	P	x
COV2	Could this insurance policy be extended to cover you (<TARGE>)?	P	x	P	x
COV3	Is your spouse or partner ELIGIBLE for health insurance through their work or union, but chosen nc	P	x	P	x
COV4	If that family member were to sign up for that health insurance, could the policy be extended to cov	P	x	P	x
COV5	What is the main reason you do (<TARGE> does) not get insurance through that family member?	P	x	P	x
OWNCO	What is the main reason you have not bought health insurance on your own?	x	x	x	x
EMCO1	Does the firm you work for offer health insurance as a benefit to any of its employees?	x	x	x	x
IEMC2	You have explained to me that you get (<TARGE gets) insurance through your (his/her) own emplc	P	x	P	x
EMCO2	Can your (<TARGE>'s) employer coverage be extended to cover dependents?	P	x	P	x
EMCO3	Does your (<TARGE>'s) employer contribute to health insurance costs for those employees covere	P	x	P	x
EMCO4	Why aren't you (isn't <TARGE>) included in your (his/her) employer's group health insurance plan?	P	x	P	x
IUIO	Now I'd like to ask a few questions about <TARGE>'s access to insurance through a parent or gua	x	P	x	P
PACO1	Does the firm <TARGE>'s parent or guardian works for offer health insurance as a benefit to any o	x	P	x	P
PACO2	Does this employer contribute to health insurance costs for those employees covered by this benef	x	P	x	P
PACO3	Is <TARGE> covered under this plan?	x	P	x	P
PACO4	Can this coverage be extended to cover dependents?	x	P	x	P
PACO5	What is the main reason <TARGE> is not included in this employer's health insurance plan as a de	x	P	x	P
OWNCO2	What is the main reason <TARGE>'s parents or guardian have not bought health insurance for tarc	x	x	x	x

SECTION 4: HEALTH CARE QUESTIONS (EVERYONE ENDS UP HERE)					
Q31	Next, I'd like to talk about your (<TARGE>'s) health care. Is there a doctor's office, health maintenance organization, hospital or some other place you (they) usually go to if y				
Q32	What kind of place is that?				
Q34	What is the MAIN reason you don't (<TARGE> doesn't) have a usual source of medical care?				
Q35	During the past year, was there any time when <TARGE> needed emergency medical care but did not get it?				
Q36	Why didn't <TARGE> receive emergency medical care?				
Q37	What is the MAIN reason <TARGE> did not receive emergency medical care?				
Q38	During the past year, was there any time that you <TARGE> needed a doctor or other health care provider because of illness or injury other than an emergency, but did not g				
Q39	Why didn't <TARGE> receive (non-emergency) medical care from a doctor or other health care provider?				
Q310	What is the MAIN reason you <TARGE> did not receive (non-emergency) medical care?				
DENT	Do you (Does <TARGE>) currently have insurance that pays for dental care.				
HSTAT	Would you say your (<TARGE>'s) health, in general, is excellent, very good, good, fair, or poor?				
SECTION 5: DEMOGRAPHICS (EVERYONE GETS THESE)					
IRACE	The following questions are for classification purposes only.				
RACE1	Are you (Is <TARGE>) Mexican, Puerto Rican, Cuban or another Hispanic or Latino group?				
RACE2	Now choose one or more races for yourself (<TARGE>). Which race or races do you consider yourself (him/her) to be?				
MSTAT	Are you (Is <TARGE>) currently single, married, living with a partner, divorced, separated or widowed?				
EDUC	What is the highest level of education you have (<TARGE> has) completed?				
VSTAT	Have you (Has <TARGE>) ever served on active duty in the U.S. Armed Forces…				
EST1	Are you (Is <TARGE>) currently self-employed or own your (their) own business…				
EST2	Do you (Does <TARGE>) have more than one paying job?				
HOURS	What is the total number of hours worked per week?				
EMHRS	For the job you work (<TARGE> works) at the most hours, what is the total number of hours usually worked per week?				
EPERM	Is this a permanent, temporary or seasonal job?				
ALLS	Thinking about the employer you work (<TARGE> works) for, about how many people are employed there?				
IMI	Now I'd like to ask a few questions about the person this child gets their insurance benefits through.				
CHARG	Now I'd like to ask a few questions about the PRIMARY WAGE EARNER in the household…				
YOUAGE	What is your age?				
YOUS	(RECORD GENDER)				
ELAG	What is their age?				
ELSEX	And is this person male or female?				
HHR1	Are you (Is <TARGE>) Mexican, Puerto Rican, Cuban or another Hispanic or Latino group?				
HHR2	Now choose one or more races for yourself (<TARGE>). Which race or races do you consider yourself (him/her) to be?				
HHMAR	Is this person (Are you) currently single, married, living with a partner, divorced, separated or widowed?				

HHED	What is the highest level of education this person has (you have) completed?				
HHVA	Has this person (have you) ever served on active duty in the U.S. Armed Forces…				
HHEM1	Is this person (Are you) currently self-employed or own (their) your own business…				
HHEM2	Does this person (Do you) have more than one paying job?				
HHRS	What is the total number of hours worked per week?				
HEM2B	For the job this person works (you work) at the most hours, what is the total number of hours usually worked per week?				
HPERM	Is this a permanent, temporary or seasonal job?				
HSITE	Thinking about the employer this person works (you work) for, about how many people are employed there?				
PH1	Besides this phone number, do you have other telephone numbers in your household, such as fax or data lines, a children's or business line? Do not include cell phones.				
PH2	How many of these telephone numbers are connected to phones that can be answered by a person?				
PH3	During the past 12 months, has your household ever been without telephone service for more than 24 hours?				
PH4A	Over the past year, was your household ever telephone service for days, weeks, or months?				
PH4B	Over the past year, what was the total number of <PH4A> your household was without telephone service?				
ICOUN	Now I am going to ask some questions about your household income. This income information is important…				
COUNT	How many people live on you or your family's income who CURRENTLY LIVE in the household?				
KIDS	How many of these people are children under the age of 21?				
INCM1	For classification purposes only, is the total yearly income of all of the members of your family now living at home…				
INCM2	And is that…				
INCM3	And is that…				
GOVP	Do you or your family (Does <TARGE> or his/her family) currently receive any of the following:				
THAN2	Thank you for your contribution to this important research.				

ELSE	ELSE	ON/Else	ON/Else	Individual	Individual	ON/Individual	ON/Individual	UNINSURED	UNINSURED
adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student

plies.

/she goes) to a doctor or hospital?									
(his/her) bills when you go (he/she goes) to a doctor or hospital?									
depending on how they answer others)									
ELSE	ELSE	ON/Else	ON/Else	Individual	Individual	ON/Individual	ON/Individual	UNINSURED	UNINSURED
adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student	adult non-student	minor or student
x	x	P	P	x	x	P	P	x	x

x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	x	x	x	x	x	x	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
x	x	P	P	x	x	P	P	x	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
x	x	x	x	x	x	x	x	P	x
P	x	P	x	P	x	P	x	P	x
x	x	x	x	x	x	x	x	x	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
P	x	P	x	P	x	P	x	P	x
x	P	x	P	x	P	x	P	x	P
x	P	x	P	x	P	x	P	x	P
x	P	x	P	x	P	x	P	x	P
x	P	x	P	x	P	x	P	x	P
x	P	x	P	x	P	x	P	x	P
x	P	x	P	x	P	x	P	x	P
x	x	x	x	x	x	x	x	x	P

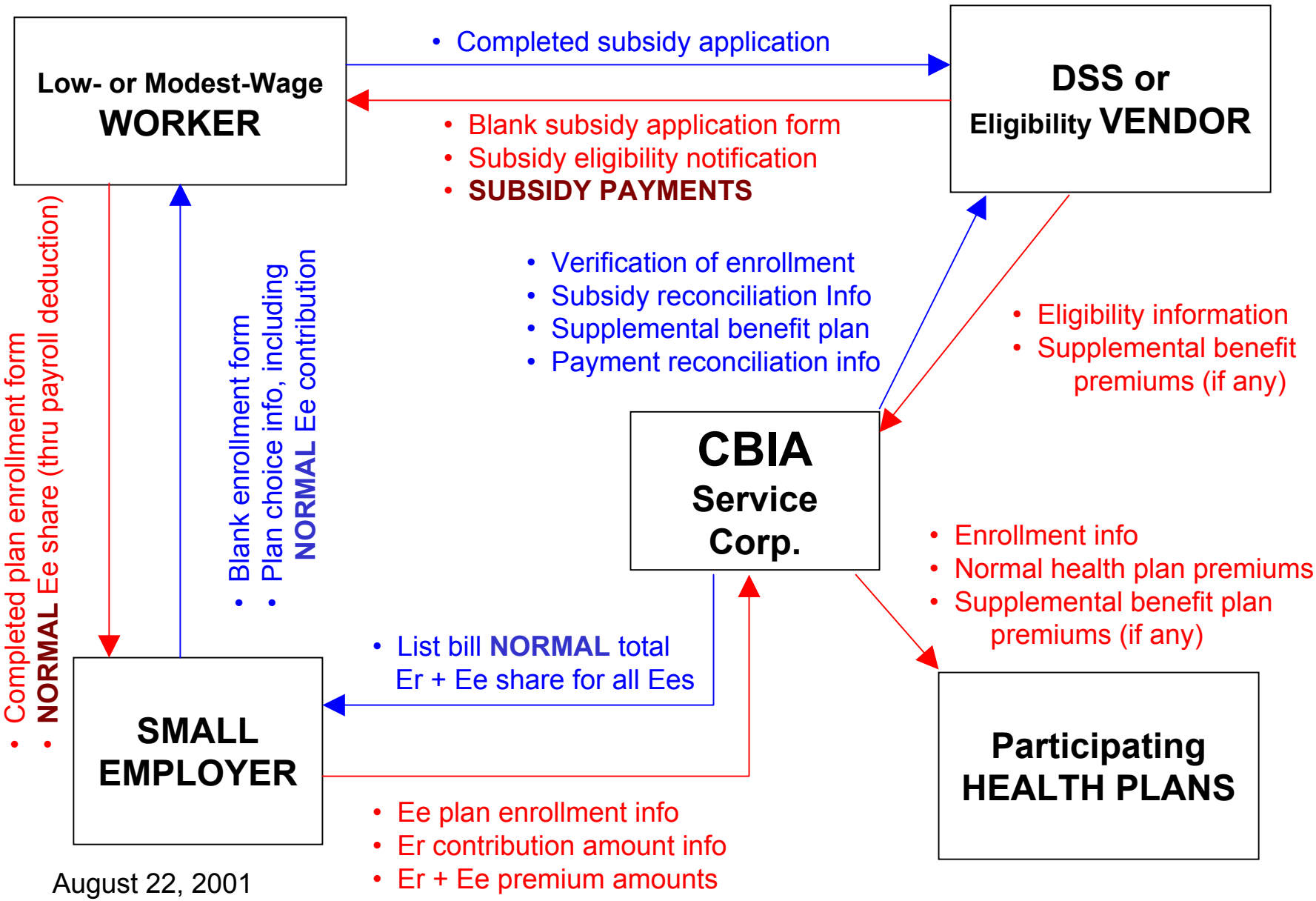
ou (they) are sick or need advice about your (their) health?									
et it?									

OFF	OFF	SCREEN
adult non-student	minor or student	

OFF	OFF	SCREEN
adult non-student	minor or student	
P	P	x

P	P	x
P	P	x
P	P	x
P	P	x
P	P	x
P	P	x
P	P	x
P	P	x
P	P	x
x	x	x
x	x	x
x	x	x
x	x	x
x	x	x
x	x	x
x	x	x
x	x	x
x	x	x
P	x	x
P	x	x
P	x	x
P	x	x
P	x	x
P	x	x
P	x	x
P	x	x
x	x	x
P	x	x
P	x	x
P	x	x
x	P	x
x	P	x
x	P	x
x	P	x
x	P	x
x	P	x
x	P	x

SUBSIDY OPTION 1: REIMBURSE WORKER DIRECTLY



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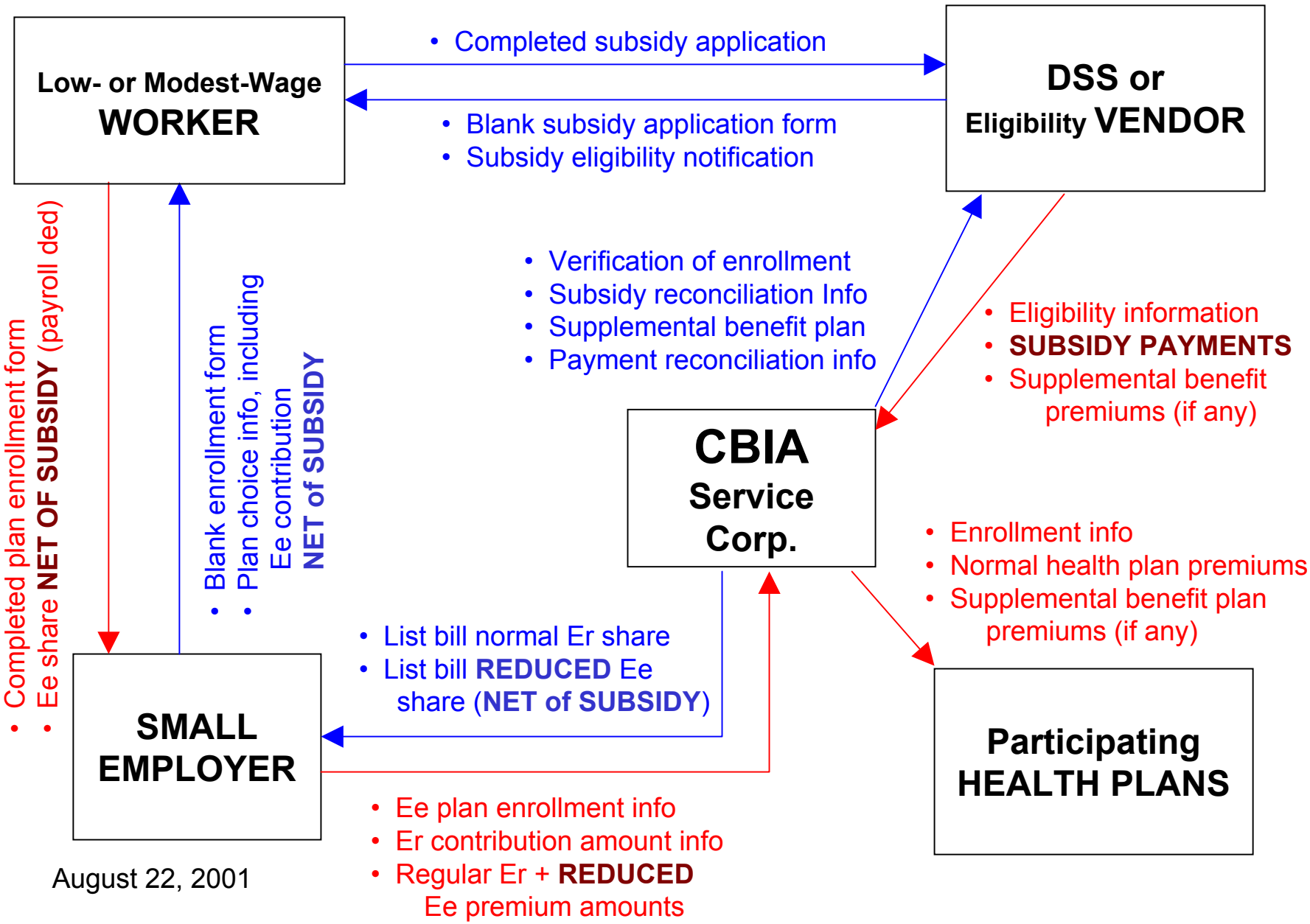
SUBSIDY OPTION 2: OFFSET PAYROLL DEDUCTION



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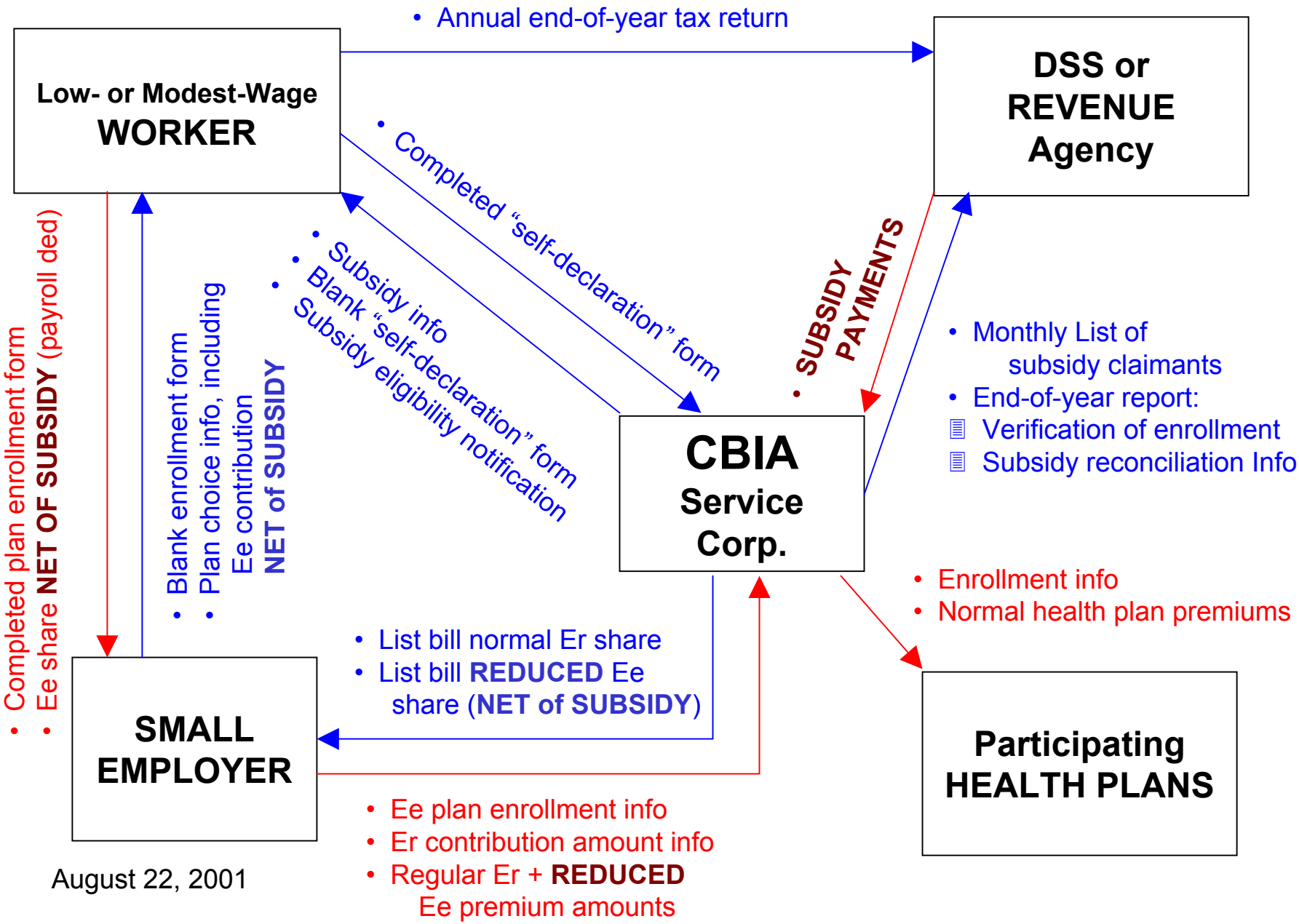
SUBSIDY OPTION 3: WAGE-BASED PRESUMPTIVE ELIGIBILITY



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