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# facts

## Medicaid

Medicaid (also called Title 19) is the federal-state health care program for low-income people and certain people with extremely high medical expenses. Medicaid also pays for services for many residents in Connecticut's nursing homes.

### WHO USES THE MEDICAID PROGRAM?

**More than 399,000 people receive health care coverage through Medicaid in Connecticut.** The major populations served by Medicaid are: children and their parents (usually in HUSKY A); people who are elderly; people with disabilities; people in long-term care (often nursing homes).

Medicaid is a shared federal/state program. To qualify for federal funding, the state is required to cover some categories of people ("mandatory" coverage groups) and can choose to cover other groups ("optional" coverage groups). See attached charts for details.

### WHAT HEALTH CARE SERVICES ARE PROVIDED THROUGH MEDICAID?

Medicaid covers a broad range of health care services. Again, to qualify for federal funding, the state is required to provide some services ("mandatory" services) and can choose to cover other groups ("optional" services). See attached chart for details.

**Note:** Mandatory services to children are more extensive than those required to be provided to adults. Every child participating in Medicaid, including those enrolled in managed care plans, is entitled to services mandated by the **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program**. The EPSDT program must provide:

- a comprehensive health and developmental history including assessment of physical and mental health development and assessment of nutritional status
- a comprehensive, unclothed physical exam
- appropriate immunizations according to age and health history
- laboratory tests (including lead blood level assessments appropriate for age/risk factors)
- health education including anticipatory guidance

- vision, hearing, and dental screenings. Each of these screenings must be provided at intervals which meet reasonable standards of medical and dental practice.

### WHAT DOES MEDICAID COST?

**The Medicaid budget for SFY 2006 is \$3.2 billion and for SFY 2007 is \$3.3 billion.**

For the most part, 50% of Medicaid expenditures are paid by the federal government; 50% are paid by the state of Connecticut. There are some small Medicaid programs in which the federal match is higher than 50%.

**Note:** In 2003, people who are elderly or disabled accounted for about 27% of the State's Medicaid participants. However, spending for their care accounted for about 82% of Connecticut's Medicaid spending.<sup>4</sup>

<sup>1</sup> DSS Active Assistance Units Report for September, 2005 (dated November 9, 2005).

<sup>2-3</sup> From Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July, 2002, as cited in "Federal Proposals to Restructure Medicaid: What could they mean for Connecticut?", the Georgetown University Health Policy Institute, July, 2003.

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“Federal Proposals to Restructure Medicaid: What could they mean for Connecticut?”, the Georgetown University Health Policy Institute, July, 2003, for the Anthem Foundation of Connecticut, Inc., Children’s Health Council and the Connecticut Health Foundation.

Medicaid “Mandatory” and “Optional” Eligible Groups

“Mandatory” Groups	“Optional” Groups
<ul style="list-style-type: none"> <li>•Children under age 6 <math>\leq</math> 133% of Federal Poverty Line (FPL)</li> <li>•Children age 6 and older <math>\leq</math> 100% of FPL</li> <li>•Children in foster care</li> <li>•Pregnant women <math>\leq</math> 133% of FPL</li> <li>•Parents with incomes below state-established minimums*</li> <li>•Elderly and disabled SSI beneficiaries (incomes <math>\leq</math> 74% of FPL)</li> <li>•Low-income Medicare beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>•Children and parents above minimum requirements</li> <li>•Pregnant women <math>&gt;</math> 133% of FPL</li> <li>•Disabled and elderly people <math>&gt;</math> 74% FPL, including those in nursing homes</li> <li>•Disabled and elderly people served under Home and Community Based waivers</li> <li>•Women with breast and cervical cancer</li> <li>•Certain disabled people who are employed and buy into coverage</li> </ul>

“Federal Proposals to Restructure Medicaid: What They Could Mean for Connecticut”, Georgetown University Health Policy Institute, July, 2003, Appendix Table 1, citing Kaiser Commission on Medicaid and the Uninsured, “The Medicaid Resource Book”, July, 2002

\* 100% for Connecticut

# Medicaid Statutory Services

<b><i>Mandatory Services</i></b>		<b><i>Optional Services</i></b>	
<b>Acute Care</b>			
<ul style="list-style-type: none"> <li>- Physician, nurse practitioner and nurse midwife services</li> <li>- Laboratory and x-ray services</li> <li>- Inpatient and outpatient hospital services</li> </ul>	<ul style="list-style-type: none"> <li>- Screening and treatment services for children (EPSDT)</li> <li>- Family planning services</li> <li>- Federally qualified health center (FQHC) and rural health clinic (RHC) services</li> </ul>	<ul style="list-style-type: none"> <li>- Prescribed drugs</li> <li>- Medical care or remedial care furnished by licensed practitioners under state law</li> <li>- Diagnostic, screening, preventive, and rehabilitative services</li> <li>- Clinic services</li> <li>- Dental services, dentures</li> </ul>	<ul style="list-style-type: none"> <li>- Physical therapy and related services</li> <li>- Prosthetic devices</li> <li>- Eyeglasses</li> <li>- TB-related services</li> <li>- Primary care case management services</li> <li>- Other specified medical and remedial care</li> </ul>
<b>Long-term Care</b>			
<ul style="list-style-type: none"> <li>- Nursing facility services for people 21 years of age or older</li> </ul>	<ul style="list-style-type: none"> <li>- Home health care services (for people entitled to nursing facility care)</li> </ul>	<ul style="list-style-type: none"> <li>- Intermediate care facility for people with mental retardation (ICF/MR) services</li> <li>- Inpatient and nursing facility services for people 65 or over in an institution for mental diseases (IMD)</li> <li>- Inpatient psychiatric hospital services for children</li> <li>- Home health care services</li> <li>- Case management services</li> </ul>	<ul style="list-style-type: none"> <li>- Respiratory care services for ventilator-dependent individuals</li> <li>- Personal care services</li> <li>- Private duty nursing services</li> <li>- Hospice care</li> <li>- Services furnished under a "PACE" program</li> <li>- Home and community-based (HCBS) services (under budget neutrality waiver)</li> </ul>

"Federal Proposals to Restructure Medicaid: What They Could Mean for Connecticut", Georgetown University Health Policy Institute, July, 2003, Appendix Table 1, citing Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", July, 2002



## HEALTH CARE

# facts

## HUSKY A

HUSKY A is the Medicaid-funded portion of HUSKY which provides health care coverage to low-income children, their parents and pregnant women. Income eligibility levels are higher for children and pregnant women than for parents, as noted in the chart.

### BENEFITS AND COST SHARING IN HUSKY A

Income Level	HUSKY A Plan Features
At or below 150% Federal Poverty Level (FPL)	Full Medicaid benefit with no premium or co-payments.* Parents, pregnant women, and children under age 19 are eligible.  *2005 legislation authorizes premiums and co-pays for parents in families with incomes over 100% of the federal poverty level. These charges have not yet been imposed.
Over 150% but at or below 185% FPL	Full Medicaid benefit with no premium or co-payments. Only children under age 19 and pregnant women are eligible.

### WHO USES HUSKY A?

HUSKY A covered 212,294 children and 89,654 parents in December of 2005.

### WHAT HEALTH CARE SERVICES ARE PROVIDED THROUGH HUSKY A?

Children in HUSKY A are eligible for the comprehensive Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit package. Adults in HUSKY A receive a less generous benefit package than children but they still have access to many preventive services, including dental care, in-patient hospitalization and prescription drug coverage. The benefits are less generous for adults because adults are not covered by federal EPSDT requirements.

The EPSDT program must provide:

- a comprehensive health and developmental history including assessment of physical and mental health development and assessment of nutritional status
- a comprehensive, unclothed physical exam
- appropriate immunizations according to age and health history
- laboratory tests (including lead blood level assessment appropriate for age/risk factors)
- health education including anticipatory guidance
- vision, hearing, and dental screenings. Each of these screenings must be provided at

intervals which meet reasonable standards of medical and dental practice.

### WHAT DOES HUSKY A COST?

It is difficult to identify the costs of HUSKY A in state budget documents. HUSKY A costs are incorporated in the Medicaid line.

**For SFY 2005, projected HUSKY A costs are \$686.4 million out of a total Medicaid budget of \$2.9 billion. The federal government pays 50% of these costs.<sup>1</sup>**

<sup>1</sup> DSS Division of Financial Management & Analysis Memorandum from Lee Voghel to Sharon Langer, Connecticut Voices for Children, June 14, 2005.



# facts

## HUSKY A Coverage for Parents<sup>1</sup>

HUSKY A is the portion of Connecticut's Medicaid Program that provides health care to children and their parents. In recent years, the extent of coverage for parents in HUSKY A has fluctuated extensively.

### WHO USES HUSKY A FOR PARENTS?

**In December, 2005, the HUSKY A program provided health care coverage to 212,294 children under the age of 19 and 89,654 adults. Most of these adults are parents of children covered by HUSKY A.**

Parents of children in HUSKY A with family incomes up to 150% of the federal poverty level are eligible for HUSKY A coverage. (Coverage for children extends to families with incomes at 185% of the federal poverty level.)

### HISTORY

Income eligibility levels for parental coverage have changed four times over the past seven years in Connecticut.

**1999** - Eligibility for parents of children in HUSKY A extended to families with incomes up to 185% of the federal poverty level (up from 100%) but this expanded eligibility was not effective until July 1, 2000.

**2000** - Increase in income eligibility level for parents reduced to 150% of the federal poverty level and effective date of increase delayed to January 1, 2001.

**2003** - Income eligibility level for parents rolled back to 100% of the federal poverty level, effective April 1, 2003. About 23,000 adults faced loss of health care coverage. A successful lawsuit gained two years of health care coverage under the Transitional or Extended Medicaid Assistance (TMA) program for about 18,000 of these parents who had income from working or child support.

**2005** - Coverage for parents who would have lost TMA coverage in April of 2005 was extended through June 30, 2005, using state funds.

**2005** - Income eligibility level for parents increased to 150% of the federal poverty level, effective July 1, 2005. Co-pays and premiums for parents with incomes between 100% and 150% of the federal poverty level were authorized.

### WHAT DOES HUSKY A FOR PARENTS COST?

In 2005, during the development of the 2006-2007 budget, the Office of Fiscal Analysis, estimated that re-opening HUSKY A enrollment to parents in families with incomes between 100% and 150% of the federal poverty level would cost **\$39 million in SFY 2006 and \$55 million in SFY 2007**. This assumed that by the end of the biennium, 30,000 parents at this income level would be enrolled in HUSKY A. Fifty percent of this cost would be paid by the federal government under the Medicaid program.

<sup>1</sup> For purposes of HUSKY A coverage, caretaker relatives in families are treated in the same manner as parents. When used in this brief, the term "parent" includes parent and caretaker relative.



# facts

## Co-Payments and Premiums in HUSKY A (including update on new federal law)

Since 2003, there have been a variety of plans passed by the legislature which were designed to impose premiums and co-pays on families in HUSKY A. These proposals are not being implemented, in part because they required federally approved waivers which were not applied for and in part because evidence or projections of the impact of the plans led to their repeal.

### HISTORY

In August of 2003, a Medicaid package which required sweeping changes in HUSKY A was passed by the legislature and signed into law. The package included imposition of premiums of:

- \$10 per person, with a maximum of \$25 per family, per month on families with income above 50% of the federal poverty level

- \$20 per person, with a maximum of \$50 per family, per month on families with income at or above 100% of the federal poverty level.

It also imposed co-payments of not more than:

- \$1.50 per prescription drug and
- \$3.00 per medical service.

The same package proposed significant limitations on the benefits provided in HUSKY A.

Co-payment requirements in the amount of \$2.00 per medical service and \$1.50 per prescription drug were imposed for a short time based on these provisions. However, the Department of Social Services determined that higher co-pays could not be charged without obtaining a waiver of federal Medicaid provisions.

These premium and co-payment requirements were repealed in 2004 prior to the submission of a federal waiver request and prior to the imposition of all the changes in the 2003 package. It was estimated that 86,000 children and parents could lose coverage if the proposed premiums were adopted.<sup>1</sup>

In 2005, coverage for HUSKY A parents in families with incomes between 100% and 150% of the federal poverty level was restored, and co-payments and premiums for these parents were authorized. These cost-sharing requirements were premiums of \$25 per person per month and co-payments of \$1 per outpatient visit. The imposition of these provisions also required a waiver of federal Medicaid requirements.

This waiver has not yet been requested and these cost-sharing measures have not yet been imposed. **But see below for changes in federal requirements.**

### NEW FEDERAL MEDICAID REQUIREMENTS

**The Deficit Reduction Act passed on February 1, 2006 gives states substantial new flexibility to impose co-payments and premiums on Medicaid beneficiaries.**

States will now be permitted to vary cost-sharing for different groups of beneficiaries. In addition, states may allow providers to refuse to provide services to beneficiaries who cannot afford to pay required co-payments.

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Co-payments on Services (other than prescription drugs and emergency room use) (effective March 31, 2006):

Due to a serious drafting error, the legislation includes no limits on co-payments for beneficiaries with incomes below the poverty line.

*States are also allowed to:*

- implement co-payments up to 10% of the cost of the service to beneficiaries with incomes between 100 and 150% of the poverty line;
- charge beneficiaries with incomes above 150% of the poverty line with premiums and co-payments up to 20% of the cost of the service.

Cost-sharing for both these groups may not exceed five percent of a family's income over a three-month period.

*Co-payments are not permitted for:*

- services to children under 18 in mandatory coverage groups,
- services to most children in foster care and adoption assistance,
- preventive services to children under 18 regardless of family income,
- pregnancy-related services,
- services for beneficiaries in institutional care,
- emergency services,
- family planning services, and
- services to women receiving treatment for breast and cervical cancer.

#### CO-PAYMENTS ON PRESCRIPTION DRUGS (Effective March 31, 2006):

States can create categories of preferred and non-preferred drugs based primarily on the cost of the drugs.

- Beneficiaries with incomes below 150% of the poverty line, including those that are otherwise exempt from cost-sharing, can be charged "nominal" co-payments for non-preferred drugs.
- Beneficiaries with incomes above 150% of the poverty line can be charged up to 20% of the cost of the non-preferred drug.

The existing "nominal" co-payment charge of \$3 can be raised each year by the percentage increase in the medical care component of the Consumer Price Index, which has been rising twice as fast as general inflation.

#### CO-PAYMENTS FOR NON-EMERGENCY USE OF THE EMERGENCY ROOM (Effective January 1, 2007):

States can allow hospitals to charge beneficiaries for use of the emergency room for non-emergency care. Co-payments can only be charged if it is determined that the individual has access to a non-emergency service provider. Beneficiaries with incomes between 100 and 150% of the poverty line can be charged up to twice the nominal co-payment amount, and

beneficiaries who are otherwise exempt from cost-sharing can be charged up to the nominal amount. There are no limits on the amount of co-payments for use of the emergency room for non-emergency care for beneficiaries with incomes below the poverty line.

#### PREMIUMS

*States are not allowed to charge premiums to:*

- children in mandatory coverage groups (under 6 years old with incomes below 133% of the poverty line and 6 to 18 year olds with incomes above poverty);
- most children in foster care and adoption assistance programs regardless of age;
- pregnant women;
- women eligible because they are receiving treatment for breast and cervical cancer; and
- beneficiaries in institutional care.

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<sup>1</sup>Connecticut Health Foundation Policy Brief, November, 2003; estimate by Georgetown University Health Policy Institute.



# facts

## Transitional Medical Assistance (TMA)

Transitional Medical Assistance (TMA) or extended medical assistance is available to families that lose HUSKY A coverage because their income increases beyond the HUSKY A income limits. Eligible families must have income from employment or child support.

### WHO USES TMA?

Extended health care coverage under TMA is available to families in the “family coverage” group, usually families with incomes up to 150% of the federal poverty level. This extended coverage was instituted to ensure that families do not lose health care coverage immediately upon entering the workforce.

**About 48,000 individuals (usually children and their parents) in Connecticut receive HUSKY A health care coverage through TMA.**

Overall, 301,948 (212,294 children and 89,654 parents) were enrolled in HUSKY A in December of 2005. Until this year, eligible families in Connecticut received

TMA health care coverage for up to two years. In the 2005 legislative session, coverage was reduced to one year. This change will not affect families until SFY 2007.

NOTE: When Connecticut limited coverage for parents in HUSKY A to 100% of the federal poverty level in 2003, families with income from employment or child support who would otherwise have lost health care coverage were able to maintain coverage under TMA for two years.

### WHAT SERVICES ARE OFFERED?

The services offered are the same as those available in HUSKY A. Children in HUSKY A are eligible for the comprehensive Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit package. Adults in HUSKY A receive a less generous benefit package than do children, but they still have access to many preventive services, including dental care, in-patient hospitalization and prescription drug coverage. The benefits are less generous for adults because adults are not covered by federal EPSDT requirements.

### WHAT DOES TMA COST?

The program costs about \$102 million a year. (The entire HUSKY A budget is about \$650 million a year.) The Office of Fiscal Analysis projected a savings of \$13 million in the second year of the biennium as a result of limiting TMA coverage to one year.

Fifty percent of these costs are paid by the federal government through the Medicaid program.

### PAST CHANGES

As noted above, in 2005, TMA coverage was limited to one year. The impact of this change will not be felt until July 2006.



# facts

## Medicaid Fee-For-Service Program

Most people participating in Medicaid in Connecticut are in HUSKY A (about 300,000 of the 400,000 Medicaid participants are in HUSKY A). But there are other routes to eligibility - mostly available to people who are elderly or disabled.

### WHO USES THE MEDICAID FEE-FOR-SERVICE PROGRAM?

There are about 100,000 people who participate in Medicaid in Connecticut and are not in HUSKY A. In most cases, these are **people who are poor and elderly or disabled**. About 65,000 of these elderly or disabled Medicaid participants are also eligible for Medicare (they are referred to as **“dually eligible”**).

Some people who are **“medically needy”** can become eligible for Medicaid by **“spending down”**. This is an option available to people who have high medical costs but whose income is too high to qualify through other eligibility routes. To qualify as “medically needy”, individuals must incur sufficient medical expenses to

reduce their income to the income eligibility levels of the Medicaid program.

People who need **nursing home or long-term home health care** may also be eligible for Medicaid coverage if their income does not cover the cost of medical care and their assets are limited.

People who qualify for Medicaid through the access routes described above are in the **fee-for-service portion of the program**, rather than the managed care portion. Medicaid participants in HUSKY A are in a managed care system.

### WHAT SERVICES ARE OFFERED?

Medicaid covers most health care services including hospital and nursing home care, home care, lab tests, X-rays, medical equipment like wheelchairs, eyeglasses, hearing aids, prescription drugs, some dental care and doctors' care. Medicaid does not cover podiatrists, chiropractors, naturopaths, psychologists or independent physical therapists, audiologists or speech therapists.

### WHAT DOES THE MEDICAID FEE-FOR-SERVICE PROGRAM COST?

It is difficult to identify the costs of different parts of Medicaid in the state budget documents. The total Medicaid budget was \$2.9 billion for SFY 2005. Of this, \$686.4 million is attributed to HUSKY A. The rest of Medicaid costs about \$2.2 billion. Generally, the federal government pays 50% of Medicaid costs.



# facts

## HUSKY B (including HUSKY Plus)

HUSKY B is a companion program to HUSKY A, which provides health care coverage for children in families with incomes over 185% of the federal poverty level.\*

### WHO USES HUSKY B?

The HUSKY B program is for **children only** and is available to uninsured children under age 19 in families with incomes above 185% of the federal poverty level. **In January 2006, 15,163 children were enrolled in HUSKY B** at the following income levels:

- Band 1 (family income over 185%, but at or below 235% FPL) - 9,098
- Band 2 (family income over 235%, but at or below 300% FPL) - 5,374
- Band 3 (family income over 300% FPL) - 691

The cost-sharing requirements in HUSKY B rise as the family's income rises. The chart on the next page outlines these cost-sharing requirements and other features of HUSKY B.

### WHAT SERVICES ARE OFFERED IN HUSKY B?

Children in HUSKY B are eligible for a benefit package that includes a full range of preventive services, including dental services, without any co-payments. Many other services, including inpatient care, prescription drugs, and vision and hearing examinations, are also included in the HUSKY B package.

**The HUSKY Plus** program was designed for children in HUSKY B who have intensive physical health or behavioral health needs. Only children in families with incomes under 300% of the federal poverty level (Bands One and Two) are eligible for HUSKY Plus. The HUSKY Plus Physical program is administered by the Connecticut Children's Medical Center's Center for Children with Special Needs.

Services available include: adaptive and specialty equipment; specialty medical, pharmacy and special nutritional formulas; physical, occupational and speech therapy; specialty dental and/or orthodontic services; medical and surgical supplies; hearing aids; help in

coordinating specialty care and accessing services; advocacy and family support.

The HUSKY Plus Behavioral program was administered through the HUSKY B managed care organizations but has now been incorporated into the new Behavioral Health Carve-Out.

### WHAT DOES HUSKY B COST?

**The HUSKY B budget for SFY 2006 is \$24.25 million and for SFY 2007 is \$27.25 million.**

In SFY 2004, the actual expenditures for the basic HUSKY B program were \$23.6 million; the actual expenditures for HUSKY Plus were \$490,177, for a total cost of \$24.1 million.

HUSKY B is Connecticut's SCHIP (State Children's Health Insurance Program). SCHIP is a federal program adopted in 1997 to encourage coverage of uninsured children. The federal government pays 65% of the costs of state SCHIP programs, with the state paying the remaining 35%.

PAST PROPOSALS FOR CHANGE

BENEFITS AND COST SHARING IN HUSKY B

In 2003 and 2005, the state adopted provisions to

- require that families with incomes between 185% and 235% of the federal poverty level pay premiums of \$30 per month for coverage of one child or \$50 per month for coverage of more than one child and

- increase the premiums for families with incomes between 235% and 300% of the federal poverty level to \$50 per month for coverage of one child or \$75 per month for coverage of more than one child.

In both cases, after it was shown that thousands of children (2,100 in 2005) were about to lose coverage because the premiums had not been paid, these changes were rescinded.

Income Level	HUSKY B Plan Features
Over 185%, but at or below 235% FPL (Band 1)	<b>HUSKY Part B</b> - no premiums; \$5 co-pays for non-preventive visits and \$3 co-pays for generic drugs and \$6 for name brands. Eligible for HUSKY Plus. <b>Only children under age 19 are eligible.</b>
Over 235%, but at or below 300% FPL (Band 2)	<b>HUSKY Part B</b> - monthly premium of \$30 for first child; maximum family premium of \$50; some co-payments. Eligible for HUSKY Plus. <b>Only children under age 19 are eligible.</b>
Over 300% FPL (Band 3; HUSKY Buy-In Program; family pays full cost)	<b>HUSKY Part B</b> - family pays group premium rate (\$158-\$230 per month per enrollee). \$5 co-pays for non-preventive visits; and \$3 for generic drugs and \$6 for name brands. Not eligible for HUSKY Plus. <b>Only children under age 19 are eligible.</b>

\*2006 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$9,800	\$12,250	\$11,270
2	13,200	16,500	15,180
3	16,600	20,750	19,090
4	20,000	25,000	23,000
5	23,400	29,250	26,910
6	26,800	33,500	30,820
7	30,200	37,750	34,730
8	33,600	42,000	38,640
For each additional person, add	3,400	4,250	3,910

SOURCE: Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849



# facts

## HUSKY Enrollment Issues

Making it easy to apply for and stay on HUSKY allows HUSKY families to maintain their health insurance without cycling on and off the program and saves time and money in administering the program. Measures that make it easy for families and DSS include:

- Continuous Eligibility
- Self-Declaration or Double Verification of Income
- Transitional Medical Assistance
- Effective Outreach

### CONTINUOUS ELIGIBILITY

Continuous eligibility helps children stay on HUSKY A for one year regardless of fluctuations in family income. Many low-income families depend on income from jobs where their hours, and therefore their income, change regularly. This creates a “churning effect” with participants cycling on and off the

HUSKY programs monthly. Approximately 6,500 children lose coverage monthly.

Without continuous eligibility, children become uninsured for temporary periods or have gaps in coverage as they move from HUSKY A to HUSKY B and vice versa. Churning also increases paperwork for program administrators and providers. DSS estimates that it costs approximately \$1,000 each time the state has to determine eligibility for a child.

Connecticut eliminated continuous eligibility in 2003.

### SELF-DECLARATION OR ELECTRONIC VERIFICATION OF INCOME (sometimes called “Double Verification” of Income)

This simplified, electronic verification of income avoids unnecessary paperwork in HUSKY. Families sign a statement swearing that the information they have submitted is true under penalty of perjury. HUSKY staff then verify the family’s income through electronic records at the Department of Labor, the Department of Social Services and other agencies. The state is able to check for fraud at the same time that it is verifying income.

This system worked well in Connecticut for four years before being eliminated in July 2005.

### TRANSITIONAL MEDICAL ASSISTANCE (TMA) (see separate section for a fuller explanation of TMA)

TMA helps families stay on HUSKY when their income puts them over the HUSKY A income guidelines of 150% of FPL (\$24,135 for a family of three). TMA used to provide two years of continued HUSKY A coverage. In 2005, TMA was reduced to one year.

### EFFECTIVE OUTREACH

In 2002-04, an estimated 36,000 Connecticut children under 19 who lived in families with income at or below 200% of the federal poverty level were uninsured. Virtually all these children are income-eligible for coverage in the HUSKY Program. <sup>1</sup>

The years 2001 - 2002 saw a spike in enrollment as a direct result of TV, radio and print marketing, consumer hotlines, local outreach grants, Healthy Start outreach, and statewide initiatives.<sup>2</sup>

Funds for HUSKY outreach (including HUSKY Outreach, Healthy Start and

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Children's Health Council) have been cut from \$4.4 million in 2002 to \$2.2 million in 2006.<sup>3</sup>

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<sup>1</sup> *Uninsured Children in Connecticut, 2004*, Connecticut Voices for Children Fact Sheet, available at [www.ctkidslink.org](http://www.ctkidslink.org)

<sup>2</sup> *Uninsured Children in Connecticut, 2003*, Connecticut Voices for Children Fact Sheet, available at [www.ctkidslink.org](http://www.ctkidslink.org)

<sup>3</sup> *The HUSKY Program Budget in Context: An Analysis of the Governor's Proposed FY 07 Budget*, Connecticut Voices for Children, available at [www.ctkidslink.org](http://www.ctkidslink.org).



# facts

## State Administered General Assistance (SAGA) Medical

SAGA (State Administered General Assistance) provides health care to very poor individuals in Connecticut mainly through federally qualified health centers and hospitals. (There is a small cash assistance component of SAGA which serves only about 4,500 people in the state.)

### WHO USES SAGA MEDICAL?

Very poor single individuals who are not eligible for other federal or state health care programs can receive health care through SAGA.

**31,267 individuals participated in the SAGA medical program in January 2006<sup>1</sup>.** Virtually all of SAGA medical participants are single adults. About 40% are women. The age distribution of recipients is approximately as follows:

- 18 - 29 years - 22%
- 30 - 39 years - 24%
- 40 - 49 years - 32%
- 50 - 59 years - 17%
- 60 - 64 years - 4%

### ELIGIBILITY CRITERIA:

**Income limits** vary depending on the region of the state and the number of people in the assistance unit.<sup>2</sup> Examples:

\$476.19/month (\$5,714 per year) for a single individual in the Hartford area

\$574.86/month (\$6,898 per year) for a single individual in Fairfield County

\$150 of earned income per month is disregarded in calculating eligibility for the program.

**Asset limit:** \$1,000 in total assets, except that participants can own a home and a car valued at not more than \$4,500.

### WHAT DOES SAGA COST?

**SFY 06** - approximately \$131 million (the total SAGA budget is \$143.6 million, which includes about \$12 million for the SAGA cash program and \$500,000 for a special pilot project.

**SFY 07** - approximately \$140 million (total SAGA budget is \$152.6 million).

Only state funds are available to pay for the SAGA program; there is no federal program that serves this population.

### WHAT HEALTH CARE SERVICES ARE PROVIDED THROUGH SAGA?

SAGA is supposed to provide a range of medical and specialty services to prevent and treat health care conditions. The services are provided through a managed care program based in federally qualified health centers (FQHCs) and hospitals.

The following services are **no longer** covered by SAGA medical:

- non-emergency medical transportation (eliminated in 2001)
- vision services (2003)
- home health care (2003)
- durable medical equipment (2003)
- podiatry (2003)
- chiropractic (2003)
- naturopathic (2003)
- physical, occupational and speech therapy (2003)

## RECENT CHANGES TO SAGA

In January 2004, the SAGA medical program converted from a fee-for-service program to a managed care program. Most recipients are required to receive their primary and specialty health care through federally qualified health centers (FQHCs). Others get care through private providers if they are unable to access an FQHC. Hospital services are also available to recipients.

As part of the new managed care structure, funding for the program was capped at the amount appropriated in the state budget. Hospitals estimate that they will receive \$20 million less annually in payments to cover the cost of caring for SAGA participants. FQHCs estimate that they will receive \$5 million less in revenues annually under the new SAGA structure.

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<sup>1</sup> DSS Active Assistance Units Report for January, 2006 (dated February 23, 2006).

<sup>2</sup> Virtually all SAGA assistance units consist of one person. In the January 2006 DSS report cited above, there were 31,256 assistance units with 31,267 individual participants in those assistance units.



## HEALTH CARE

# facts

## State Health Care Programs for Legal Immigrants

Connecticut uses state funds to provide health care to about 2,300 recent legal immigrants who are not eligible for federally funded health care programs.

The federal welfare reform act of 1996 barred the use of federal funds to provide benefits to legal immigrants during the first five years of their residence in the country.

### WHO USES THE PROGRAMS?

For legal immigrants residing here less than five years, health care is provided through SAGA medical and through the State Medical Assistance for Non-Citizens program, which mirrors the Medicaid program, for those who would be eligible for Medicaid.

Connecticut also provides home care services to recent legal immigrants through the state-funded portion of the Connecticut Home Care for Elders Program.

### WHAT IS SPONSOR DEEMING?

Federal welfare law does not require, but purports to authorize, sponsor deeming for state-funded benefit programs for immigrants arriving in the U.S. on or after August 22, 1996 if the sponsor has signed a revised Affidavit of Support. Under sponsor deeming requirements, the income of an immigrant's sponsor is deemed to be available to the immigrant and is considered in determining eligibility for a benefit program.

### WHAT DO THESE PROGRAMS COST?

It has been very difficult to determine the costs of these programs. The programs are funded with state funds. The federal budget has barred the use of federal funds for most health care benefits to recent legal immigrants.

### HISTORY OF THESE PROGRAMS

These health care programs for recent legal immigrants were put into place in 1997 with a sunset date of 1999. Until 2003, these benefits were extended each

time the sunset date was reached. On July 1, 2003, the state-funded benefit programs for recent legal immigrants were closed to new applicants. New legislation re-opened these programs on July 1, 2004, without sunset provisions.

The Attorney General has issued an opinion finding that failing to provide benefits to immigrants in the SAGA and state-funded home health care programs constitutes unconstitutional state discrimination against aliens.



# facts

## Primary Care Case Management (PCCM)

**Primary Care Case Management (PCCM) is a way of running Medicaid Managed Care without Health Maintenance Organizations (HMOs).**

**Recipients choose a Primary Care Provider (PCP) who acts as their “medical home”. The PCP is responsible for managing their care including providing preventive health services, coordinating care, and in some states, acting as a gatekeeper to specialty services. PCPs include primary care physicians, clinics, group practices, and nurse practitioners, among others.**

### **WHO WOULD USE PCCM?**

PCCM is an alternative way to deliver services to people currently served by the Medicaid managed care system - families in HUSKY A and children in HUSKY B.

Twenty-nine states use some form of PCCM; the majority have both PCCM and HMO programs, often in the same area of the state. Several states

with both PCCM and HMOs maintain that parallel systems make both programs stronger as well as giving consumers more options. In late 2005, Illinois passed legislation to provide affordable, comprehensive health insurance to every child in the state through a PCCM system.

Providers in PCCM systems feel they have more control over medical decision-making and that their administrative burden is less. Surveys from states with PCCM programs show greater satisfaction among consumers with PCCM. Massachusetts consumers, who have a choice between PCCM and HMOs, overwhelmingly choose PCCM.

### **WHAT SERVICES WOULD BE OFFERED TO PARTICIPANTS?**

The services offered would be the same as those currently offered to participants in the Medicaid HMO program. Primary care providers in a PCCM system must provide 24-hour access to information, emergency treatment and referrals and are expected to provide all routine preventive care.

### **WHAT WOULD PCCM COST?**

The program would be part of the HUSKY A and B program. Providers

would bill the state under a fee-for-service system for the services they provide. PCPs also receive a flat per member per month fee or an increase in their preventive service fees to pay for case management services. Providers bear no financial risk for the services they provide or approve.

States with PCCM programs report savings of between 3% and 20% over fee-for-service spending levels. Connecticut could save \$40 million per year or more with PCCM. States see a decrease in emergency room use, a decrease in specialty services and an increase in the use of preventive care over fee-for-service levels.

Under HUSKY A, the federal government would pay 50% of the costs of the program. Under HUSKY B, the federal government would pay 65% of the costs.

### **HOW WOULD PCCM WORK IN CONNECTICUT?**

States vary in how they manage their provider networks, provider recruitment, data collection and analysis, monitoring, quality improvement, patient education, disease management programs, and enrollment. Some states perform all these functions in-house with state employees; other states contract out

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some or all these functions. Most states monitor client and provider satisfaction annually through surveys.

Under PCCM, the state “owns” the program data and any best practices identified by monitoring. All recipients benefit from effective disease management programs not just those in one HMO. Under PCCM, the state has more control over providers and the quality of services delivered to clients, as the state is paying for them directly.

Participants may not notice much change at all. They now choose a PCP after they choose a health plan, and must get approval from the PCP for referrals. They should notice an increase in the number of available providers, both because more providers may be attracted to the program, and because they can choose any provider who takes Medicaid, not just one from their health plan’s network.

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Adapted from *Facts About PCCM*, Connecticut Health Policy Project Fact Sheet, available at [www.cthealthpolicy.org](http://www.cthealthpolicy.org).



## HEALTH CARE

# facts

## Premium Assistance

The Governor has proposed adoption of a Premium Assistance program for HUSKY A. This would require HUSKY A parents to enroll in health care coverage if it is offered by their employer and is judged to be cost-effective in comparison to HUSKY A.

Under the Governor's proposal, these parents would be reimbursed by the state for the costs of enrollment, including premiums, co-pays and deductibles.

### WHO WOULD USE PREMIUM ASSISTANCE?

The program is targeted to families in HUSKY A who have access to cost-effective employer-sponsored insurance. This is a major obstacle to a successful premium assistance program. States that have tried premium assistance programs have had very low enrollment. Reasons for low enrollment include limited access

by low-wage workers to employer-sponsored health insurance and difficulties in identifying beneficiaries' employers and obtaining information needed to evaluate cost-effectiveness from employers.

### WHAT SERVICES WOULD BE OFFERED?

Participants would have access to the services offered by their employers' health plans. In addition, the Governor proposes that DSS continue to provide "any wraparound coverage needed to ensure [a participant's] medical coverage is *similar* to the existing Medicaid benefit package."<sup>1</sup> (emphasis added)

### WHAT DOES PREMIUM ASSISTANCE COST?

We do not really know the answer to that. Costs would depend on the cost of employer coverage, the amount of wraparound services needed and the cost of those services, and the costs of administering the program.

With the costs of employer sponsored coverage rising and more costs being shifted to employees, it will become increasingly difficult for premium

assistance programs to be cost-effective for the state. In 2001-2002, private insurance premiums rose 12.7% nationally, while Connecticut's per-capita Medicaid expenditures rose only 1.6%.<sup>2</sup>

The administrative burdens can also be considerable. Mechanisms to pay employee premiums without burdening employers or participants must be developed; systems for covering participants' out-of-pocket expenses must be put in place; the cost-effectiveness of employer coverage must be evaluated; and there must be efficient ways to re-enroll participants in HUSKY A if a family loses employer coverage.

Because this would be a program offered to HUSKY A participants, the federal government would pay 50% of the costs, as they do for HUSKY A.

### IMPACT OF PREMIUM ASSISTANCE

Because this is a proposed program, projections of the impact are speculative. Families could lose health care coverage when they lose jobs or when employers cut back on health care coverage. Families might fail to access needed services because wrap-

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around services are not available. The state could lose money, or fail to save money, because of administrative costs, the rising costs of premiums and the costs of wrap around services. Or the system might work for a small number of families.

Rhode Island has a notably successful premium assistance program. But part of the reason that the program works in Rhode Island is that all doctors who accept commercial managed care must also accept Medicaid. In Connecticut, most doctors do not accept HUSKY or Medicaid, so a premium assistance participant might need two doctors: one paid for by the participant's employer-based insurance and one paid by HUSKY.

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<sup>1</sup> FY2006-07 Governor's Midterm Budget Adjustments, p. B-102.

<sup>2</sup> *Premium Assistance: Who Pays and Does It Save Money?*, presentation to Connecticut Health Foundation Forum, January 24, 2006, by Joan Alker, Center for Children and Families, Georgetown University Health Policy Institute.