The Uninsured in Connecticut: A Supplemental Analysis

EXECUTIVE SUMMARY

The mission of the Office of Health Care Access (OHCA) is to ensure that the citizens of Connecticut have access to a quality health care delivery system. The Agency fulfills its mission by advising policy makers of health care issues; informing the public and the industry of statewide and national trends; and designing and directing health care system development. This report provides estimates on the uninsured population from 1993 to 1997. It is the second in a series that will document OHCA's ongoing study of health insurance coverage in Connecticut.

The methodology used for this report was developed by the State of Florida Agency for Health Care Administration. To estimate the uninsured in Connecticut, OHCA applied Florida's methodology to existing Connecticut hospital discharge data on newborns, and persons hospitalized for appendicitis and heart attacks. This approach provides OHCA with an additional method for estimating the uninsured on an annual basis in a cost-effective manner. **Because this analysis is limited in scope to inpatients, it should be viewed as a useful complement to, not a substitute for, a more comprehensive state-level study.**

This report provides a context for issues related to insurance status, access and the uninsured in Connecticut by examining:

- National estimates of the uninsured;
- Barriers to health insurance enrollment; and
- Efforts to expand health insurance coverage.

In addition, recommendations for further analysis as well as policy questions for consideration are provided.

The following are key findings from this study that are consistent with OHCA's 1995 Connecticut Family Health Care Access survey results and national reports:

- **242,000 Connecticut residents were estimated to be uninsured for 1997;**
- **Individuals in their twenties and thirties represented the greatest percentage of the uninsured;**
- **Males were more likely to be uninsured than females; 20- through 39-year-olds showed the greatest variation between genders.**
- **Newborns and individuals 40 through 64 years of age had the lowest uninsured rates.**

As states continue to maximize enrollment in their Children's Health Insurance Programs (CHIP), and as these programs evolve and expand, adequate data collection and analysis will become even more important. It is OHCA's goal to continue to gather and disseminate such critical health care information in order to assist in shaping health care system development and providing Connecticut's citizens with access to a quality health care delivery system.

INTRODUCTION

Connecticut policymakers continue to be interested in the issue of the uninsured.

Although comprehensive analyses such as OHCA's 1995 baseline survey of more than 2,000 households provide much-needed information, they are costly, labor-intensive and time-consuming to conduct.

The 1995 report revealed that uninsured persons were more likely to delay medical treatments and preventive health care until emergencies arose. As a result, the uninsured were more likely to require a higher and more expensive level of care. The survey also found that the majority of uninsured children were in families where the head of the household was employed. The most frequently cited reason for not enrolling children in insurance programs was cost.

This new report offers 1993 through 1997 uninsured estimates for Connecticut residents from newborn through 64 years of age, using an alternative means of estimation. Since this estimation methodology uses hospital inpatient discharge data regularly collected by OHCA, it provides an additional mechanism for estimating the uninsured on a more frequent and cost-effective basis. **It should be viewed as a useful complement to, not a substitute for, a more comprehensive state-level study.**

The United States Census Bureau estimated 43.4 million people were without health insurance in 1997.[1] This means that 16.1 percent of persons in the United States were faced with difficult decisions of whether or not to forego necessary acute care, seek preventive exams and treatments, pay out-of-pocket, or purchase premiums that could consume a significant percentage of their income.[2]

A key part of OHCA's mission is to advise and inform policy makers, the public and industry of statewide and national health care trends. This report provides a context for policy issues related to insurance status, access and the uninsured in Connecticut. It consists of a review of the United States Census Bureau Current Population Survey (CPS) estimated uninsured rates, a methodology discussion, gives Connecticut estimated uninsured rates and population estimates, identifies barriers to health insurance enrollment, and notes changes in the health care policy arena that affect health insurance enrollment. A discussion about the need for further analysis and a glossary of terms are also included.

This report provides key background information on State policy issues related to insurance status, access and uninsured persons in Connecticut.

[1]The United States Census Bureau estimated 44.3 million people nationwide were uninsured in 1998. Connecticut estimates for 1998 were not included in this report because 1998 hospital inpatient discharge data were not available at time of publication.

[2]U.S. Department of Commerce. Economics and Statistics Administration. Bureau of the Census. *Health Insurance Coverage: 1997*, by Robert L. Bennefield, Current Population Reports, September 1998.

NATIONAL ESTIMATES OF UNINSURED

In 1997, the United States Census Bureau estimated that 12 percent of Connecticut's residents were uninsured. From 1994 through 1997, Connecticut's uninsured rate remained below national and New England region uninsured rates (Figure 1)[3]. Connecticut had the fifteenth lowest uninsured rate in the United States when 1997 census estimated uninsured rates were calculated. Hawaii had the lowest uninsured rate at 7.5 percent; Texas and Arizona had the highest at 24.5 percent.

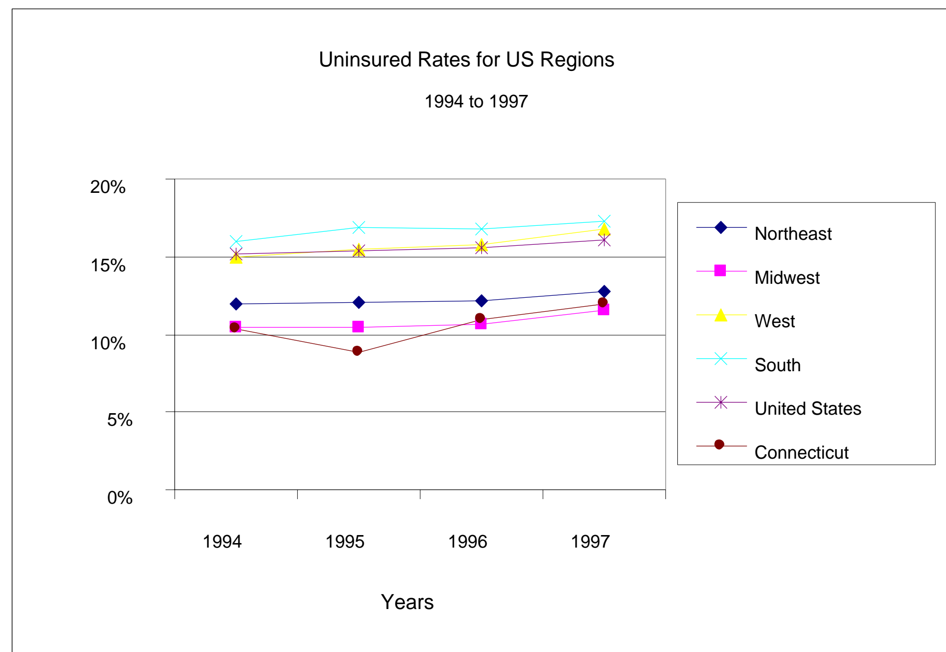
In the United States, many factors appear to increase or decrease the likelihood that individuals will have health insurance coverage. Labor force participation, income, marital status, age and gender are some factors that can play a role in an individual's insurance status. For the full-time workforce and many retirees, employers provide most private insurance.

According to 1997 Current Population Survey estimates, part-time workers had a higher non-coverage rate than full-time workers. Poor people comprised nearly 26 percent of all uninsured.[4] Young adults between the ages of 18 through 24 were more likely than other age groups to lack coverage.

People of Hispanic origin had the highest chance of not having health insurance coverage. The likelihood of being uninsured declined as educational level rose. The foreign born population had a higher proportion of non-coverage than naturalized citizens and U.S. born citizens.[5]

A comprehensive, state-level study would be necessary in order to determine the overall effect of these factors in Connecticut. In the absence of a statewide survey, OHCA has conducted a limited analysis of the uninsured using the following methodology.

Figure 1



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[3] 1993 estimates were not provided because the US. Census Bureau's estimation methodology differed slightly from 1993 to 1994.

[4] Based on U.S. Census Bureau 1995 Federal poverty Guidelines. Federal poverty guidelines are calculated for each year.

[5] United States Bureau of the Census. Health Insurance Coverage: 1997. Current Population Reports, (September 1998).

METHODOLOGY

The estimates in this report were derived using a methodology developed by the Florida Agency for Health Care Administration. The methodology uses hospital inpatient discharge data OHCA has been collecting from hospitals quarterly for more than a decade. While this information has long been used to monitor trends in health services, it also provides a means of estimating the uninsured on a state level.

Based on ICD-9-CM codes[6] for heart attacks, newborns[7] and appendicitis, estimates of uninsured for the age cohorts described below were calculated for 1993 through 1997[8]. The selected diagnosis codes were used because these indicator conditions affect all demographic groups equally, almost always require immediate inpatient medical attention, and are not related to insurance status. While OHCA recognizes that race and ethnicity also play a role in insurance status, the sample size was not adequate to assess these elements with confidence.

Uninsured patients were defined as persons whose primary payer was either self-pay, other, or no charge as defined in OHCA's hospital inpatient discharge database regulations.

Categories Defined

Patients were classified into categories by gender, race and ethnicity, and age. These categories were selected because they match the groups used by the United States Census Bureau. Race and ethnic categories include the following:

- White;
- Black (includes Non-White Non-Hispanic[9]);
- American Indian, Eskimo and Aleut;
- Asian and Hawaiian/Pacific Islander; and
- Hispanic (includes White Hispanic).

Age groups were categorized as follows[10]:

- Newborns;
- 0 through 19 years;
- 20 through 24 years;
- 25 through 39 years; and
- 40 through 64 years.

For purposes of using this methodology, uninsured patients were defined as persons whose primary payer was either self-pay, other, or no charge as defined in OHCA's hospital inpatient discharge database regulations. "No charge" includes hospital charity or free care and individuals qualified under Aunt Millie's law.[11]

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[6] International Classification of Diseases, 9th Revision, Clinical Modification. This coding system is used by hospitals to denote both diagnoses and treatments relevant to a given patient.

[7] It is important to note that "newborn" is a separate indicator condition and category; as a result, newborns are not included in the 0-19 age cohort.

[8] The data were not aggregated into calendar years because the number of discharges for this analysis did not differ significantly between calendar and fiscal years. A Connecticut hospital fiscal year (FY) is from October 1 through September 30.

[9] Non-White is a separate race category in OHCA's hospital discharge database.

[10] The number of cases for each group is provided in Appendix B.

[11] Connecticut General Statute Sec. 19a-673 *Collections from Uninsured Patients* stipulates that no hospital providing health care services to an uninsured patient may collect from the uninsured patient more than the cost of providing services.

Calculations

First, the number of uninsured hospitalizations for each indicator diagnosis for fiscal years 1993 to 1997 was extracted from OHCA's hospital inpatient discharge database. The uninsured hospitalizations were calculated as a percentage of total hospitalizations, producing the unadjusted uninsured rate for each demographic group. The adjusted uninsured rate was then calculated to account for differences in each demographic group's rates. The following steps were performed to calculate the adjusted uninsured rate (Figure 2).

Figure 2: Calculations

1. The unadjusted uninsured rate for each demographic group was calculated as follows:

$$\frac{\textit{Number of Uninsured Hospitalizations for Indicator Condition}}{\textit{Total Number of Hospitalizations for Indicator Condition}}$$

2. The following equation was used to estimate the number of uninsured for each demographic group:

(Unadjusted Uninsured Rate for Each Demographic Group for Year A) **x** ***(US Census Population Estimates for Each Demographic Group Population for Year A)***

3. The adjusted uninsured rate was calculated as follows:

$$\frac{\Sigma\,\textit{Estimated Number of Uninsured for Each Cohort}}{\textit{Total Population Estimate for Year A}}$$

4. The following formula was used to calculate the percent of the total estimated uninsured:

$$\frac{\textit{Estimated Number of Uninsured by Gender and Race/Ethnic Group}}{\textit{Total Estimated Number of Uninsured}}$$

CONSIDERATIONS ABOUT METHODOLOGY

Benefits of Analysis Used

By using existing data on the previously mentioned indicator conditions, the Florida model has several advantages. Because of the time and cost associated with more inclusive statewide surveys, this methodology provides a means of supplementing comprehensive Connecticut survey results with more timely annual uninsured estimates. It has also allowed OHCA to estimate the uninsured for five consecutive years. In addition, it permits state-level comparisons between two different sources, survey responses and hospital data.[12]

Reasons for Using Selected Conditions

As described in this report's methodology, newborns, appendicitis and heart attacks were the indicator conditions used in this analysis.

Two desirable characteristics of indicator conditions, which should be non-discretionary, are: (1) The condition is unrelated to insurance status, and (2) the condition does not vary by ethnic category. "Hospitalization for appendicitis is almost certain and the incidence of appendicitis is generally unrelated to the health and socioeconomic status of the population."[13] Like appendicitis, heart attacks may occur unexpectedly in people who feel healthy prior to the onset.

Limitations

While newborns meet both criteria for indicator conditions, there are several limitations to using appendicitis and heart attacks in this manner.

- Patients can only experience one appendectomy.
- The chance of having an appendectomy decreases as age increases; for this reason, the number of cases is reduced.
- Heart attack warning symptoms or clinical indicators such as high cholesterol levels may encourage at-risk individuals to purchase health insurance. Individuals with a family history of heart disease may also be more likely to invest in health insurance.
- For both conditions, uninsured rates varied. This factor may have resulted in the overestimation or underestimation of the uninsured.
- An uninsured patient may not seek immediate treatment for the chest pain of a "mild" heart attack or the abdominal pain of appendicitis. As a result, uninsured heart attack patients may either avoid hospitalization and survive, or die before reaching the hospital. In addition, some studies indicate uninsured patients are more likely to delay treatment for appendicitis and consequently suffer more from ruptured appendixes.[14]

Newborns, appendicitis and heart attacks were the indicator conditions used in this analysis.

Comparison with the Current Population Survey

Due to differences in methodology, comparisons of this analysis with the United States Current Population Survey (CPS) are limited. While this analysis estimates the number of uninsured at the time of hospitalization, the CPS estimates the number of people who remain uninsured for a full year.[15] In addition, the CPS does not report insurance status by gender or ethnic and age categories at the state level.

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[12] OHCA's 1995 Family Health Care Access Survey estimated there were 240,444 uninsured Connecticut residents in 1995. Using hospital discharge data indicator conditions, OHCA estimated there were 240,000 uninsured Connecticut residents in 1995.

[13] Weissman, JS, Gatsonis C, Epstein AM. Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland. JAMA 1992; 268:2338-94.

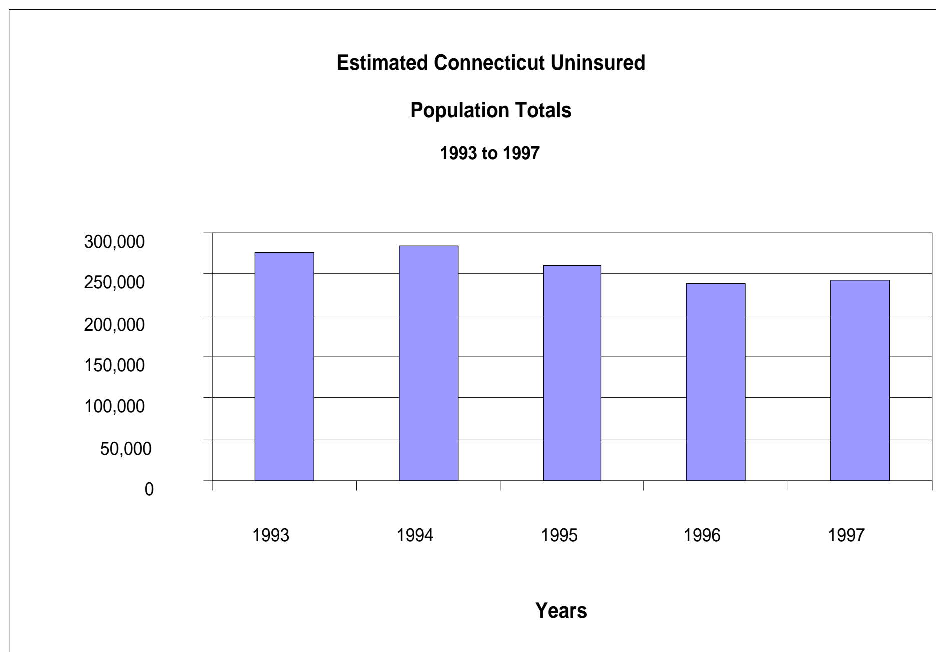
[14] Braverman, P, Schaaf VM, Egerter S., Bennett T, Schecter W. Insurance-related differences in the risk of ruptured appendix. New England Journal of Medicine 1994; 331:441-9.

[15] Some researchers believe that the CPS yields simply a point-in-time estimate of the uninsured given that respondents may be reporting just their current insurance status.

ESTIMATED NUMBER OF UNINSURED

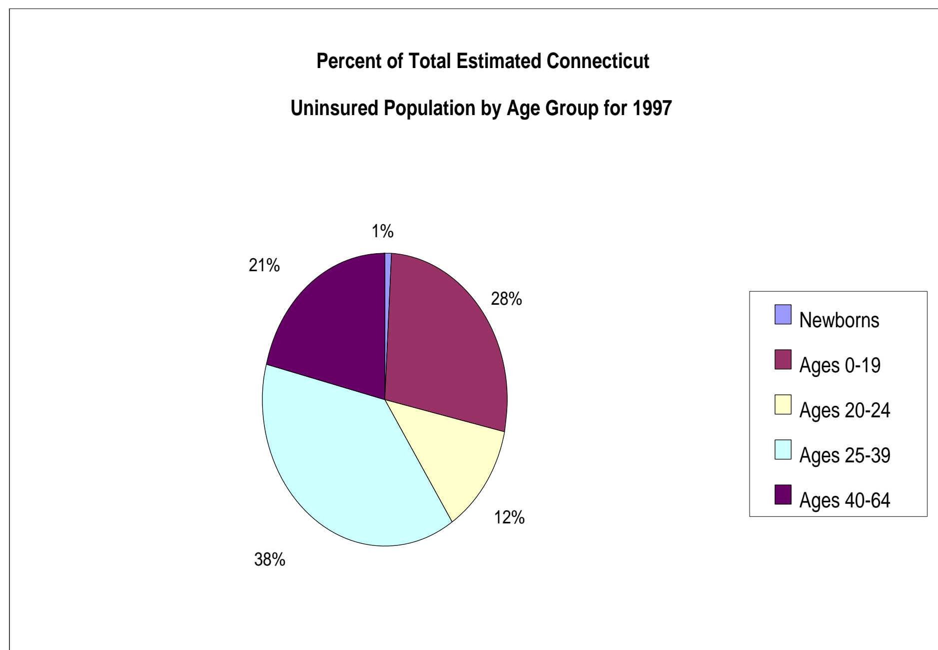
Using the methodology discussed earlier, approximately 242,000 Connecticut residents were uninsured[16] in 1997 (Figure 3). Persons ages 25 through 39 accounted for 38 percent of the total uninsured population.

Figure 3



Residents ages 0 through 19 years comprised 28 percent of the total estimate. Individuals ages 40 through 64 comprised 21 percent; 12 percent of the uninsured were ages 20 through 24, and the final one percent were newborns (Figure 4).

Figure 4



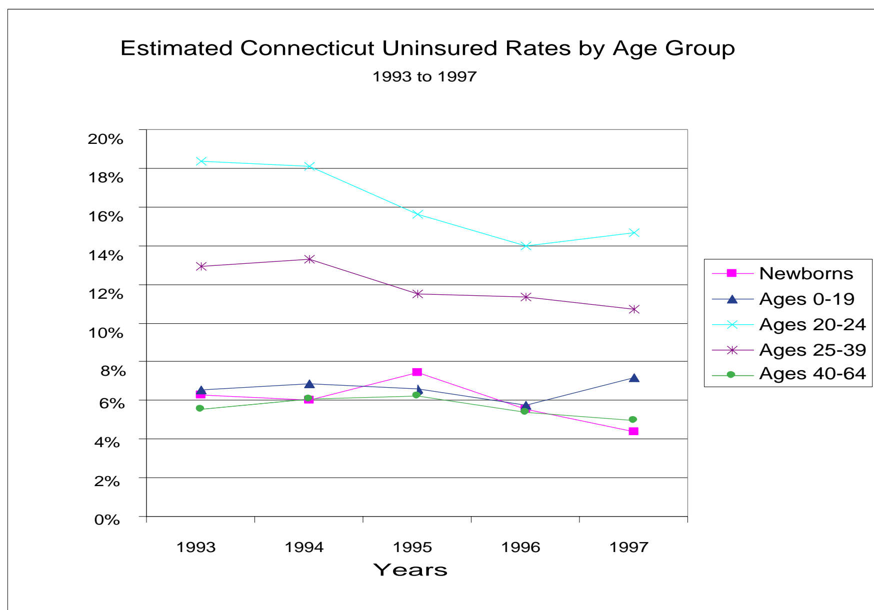
[16] Note that numbers given are estimated values, not actual values, unless indicated otherwise.

Total Number of Uninsured

Newborns comprised the smallest group of uninsured during the five-year study period. Approximately 1,900 newborns were uninsured in 1997; this represents a 35 percent reduction since 1993. Uninsured residents ages 0 through 19 showed a 13 percent increase from 1993 to 1997. In 1997, there were approximately 67,000 uninsured individuals in this age group.

Over the same time period, uninsured 20- through 24-year-olds declined by 33 percent; approximately 30,000 were uninsured in 1997. The number of uninsured persons ages 25 through 39 decreased by 21 percent from 1993 to 1997, with approximately 91,500 uninsured in 1997. The 40 through 64 age group experienced a smaller drop, five percent, between 1993 and 1997. The number of uninsured 40- through 64-year-olds totalled nearly 50,500 in 1997. (Figure 5)

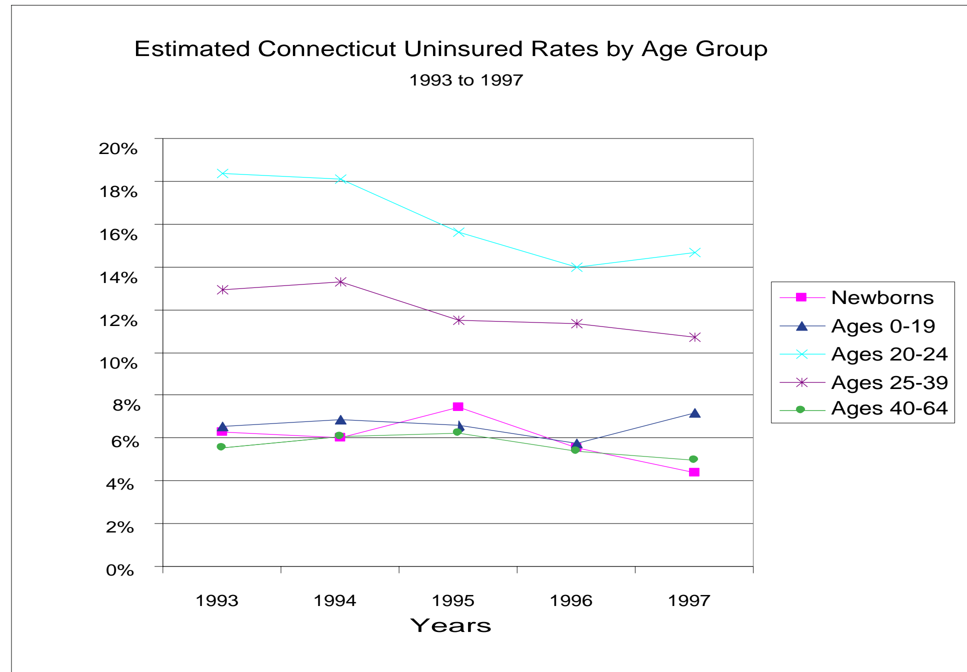
Figure 5



Uninsured Rates Examined by Age Group

The uninsured rate was calculated as the total number of uninsured persons divided by the total age cohort population. With the exception of 0- through 19-year-olds, the uninsured rate for all age groups declined from 1993 to 1997. Connecticut residents ages 20 through 24 had the highest uninsured rate in 1997, at nearly 15 percent. The 25 through 39 age group had the second-highest uninsured rate, at almost 11 percent. Seven percent of individuals ages 0 through 19 were uninsured. Both newborns and those ages 40 through 64 had uninsured rates under five percent (Figure 6).

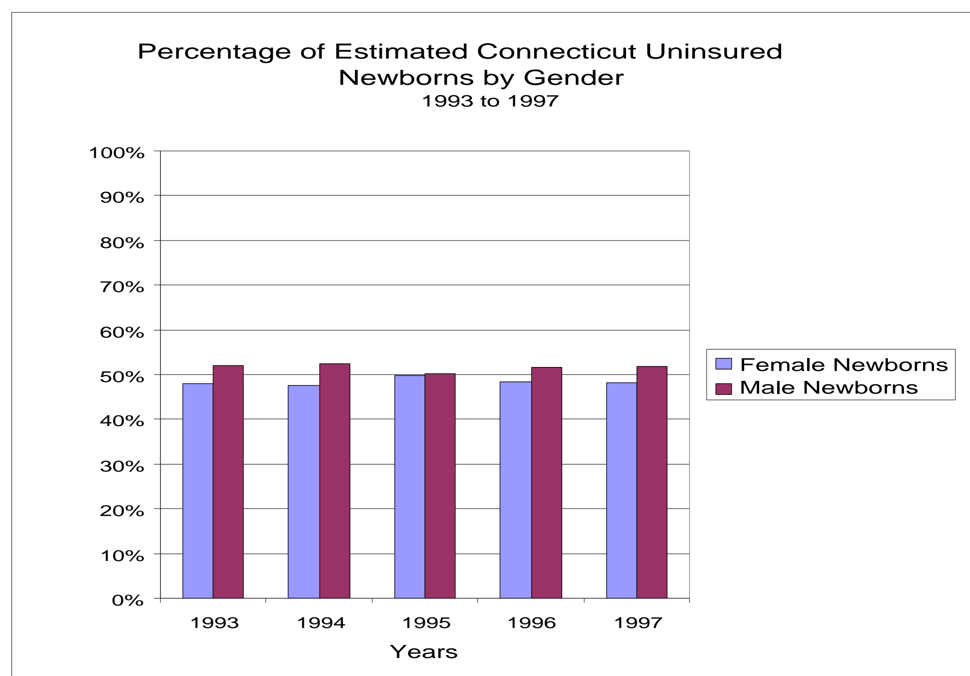
Figure 6



Uninsured Percentages Examined by Age Group and Gender

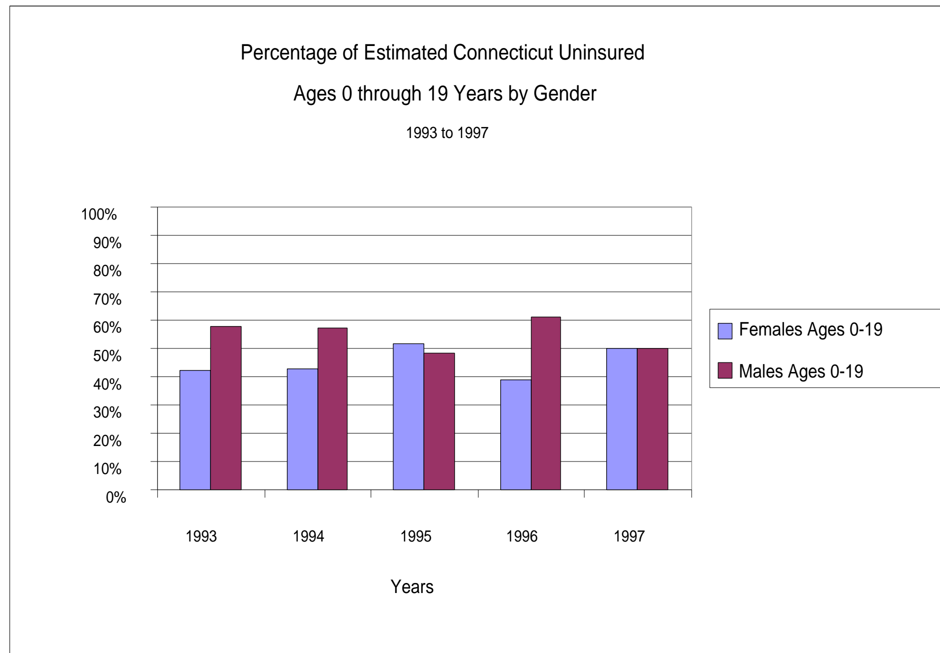
Uninsured percentages reflect the proportion of the total estimated uninsured by gender for each age group. Slightly larger proportions of male newborns versus female newborns were uninsured. This proportion did not exceed a five-percentage point difference during the five-year study period (Figure 7).

Figure 7



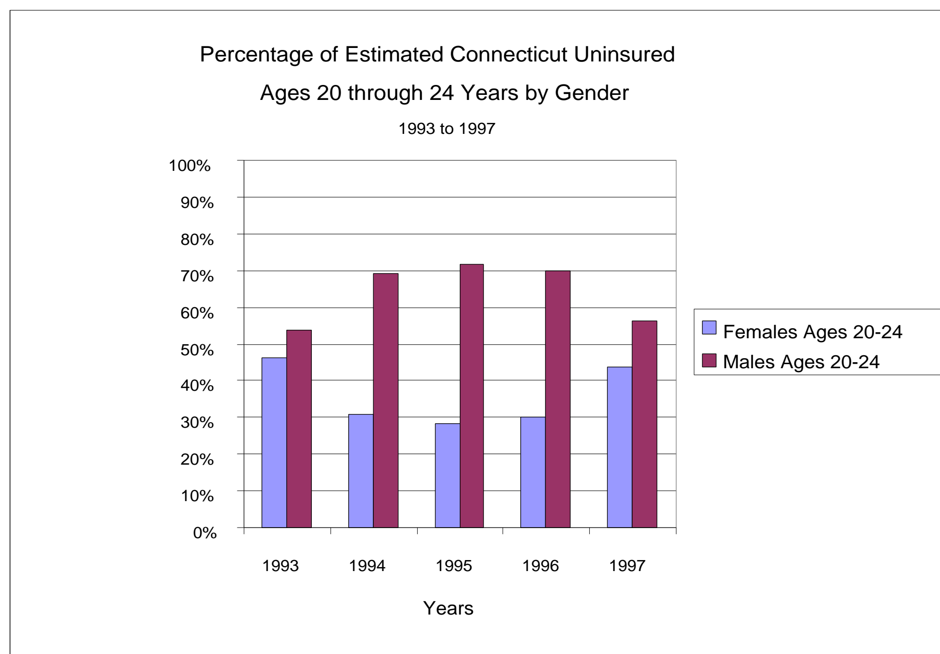
The variation in the proportion of uninsured 0- through 19-year-olds has declined since 1993. In 1993, males and females represented approximately 58 percent and 42 percent, respectively, of the uninsured in this age group. By 1997, males represented only slightly more than females (Figure 8).

Figure 8



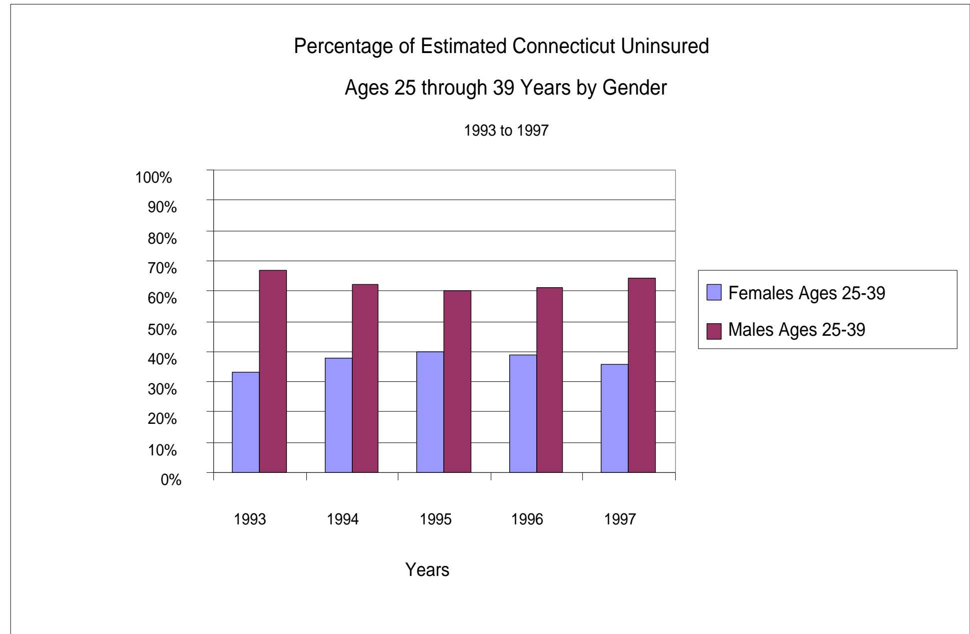
The proportion of males to females in the 20 through 24 age group varied throughout the five years studied. In 1993, males comprised 54 percent of the uninsured in this age group, compared to 46 percent females. However in 1995, males constituted nearly 72 percent of uninsured 20- through 24-year-olds, while females accounted for only 28 percent of the uninsured in this age group. In 1997, 56 percent of the uninsured in this age group were male and 44 percent were female (Figure 9).

Figure 9



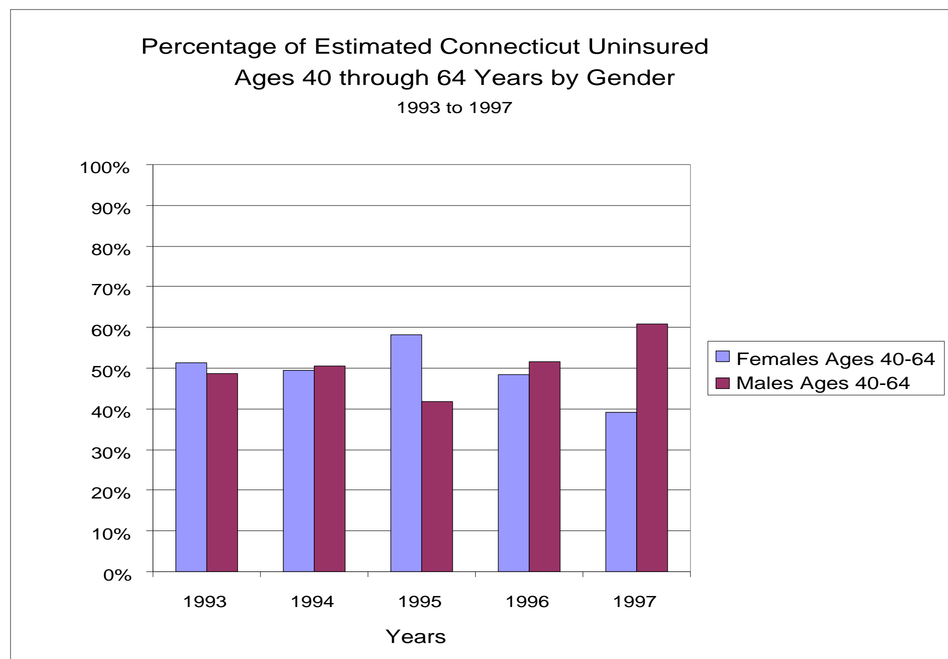
The difference in the proportion of uninsured males and females in the 25 through 39 age group remained relatively constant; it did not increase or decrease by more than four percentage points from year to year. Percentages of uninsured males versus females in this age group for all years in the study period were consistently higher. In 1997, males constituted almost 64 percent of the uninsured population ages 25 through 39, while females accounted for 36 percent (Figure 10).

Figure 10



Residents ages 40 through 64 showed the greatest variation in uninsured percentages between males and females. For years 1993, 1994 and 1996, uninsured males and females did not differ by more than three percentage points. In 1995, females accounted for approximately 58 percent, while males accounted for 42 percent of the uninsured in this age group. 1997 showed the most dramatic difference between genders in this age group. Males accounted for just over 60 percent, while females represented almost 40 percent of the estimated uninsured population (Figure 11).

Figure 11



BARRIERS TO HEALTH INSURANCE ENROLLMENT

There are a variety of reasons why many individuals do not receive care, enroll in insurance plans or apply for public funding for which they are qualified:

- Immigrants may fear that receiving Medicaid, State Children's Health Insurance Plan (CHIP) or other benefits will affect their ability to become a permanent resident or result in deportation.[17]
- Many uninsured can not afford the cost of health insurance. Individual coverage can be prohibitively expensive or may not provide enough coverage for the uninsured to justify the associated expenditure. Health insurance policies may range from $100 a month for very basic coverage to $400-plus a month for benefits similar to employers' packages.[18]
- Employer coverage has decreased due to the rapid rise in health care costs. Seventy percent of the uninsured said they were employed at least part of the time when they were without coverage. More individuals are seeking temporary and part-time work that seldom includes health care coverage.[19]

Insurance undoubtedly plays a significant role within our dynamic health care system. To better understand this role, it is important to review some of the major public policy initiatives and changes that seek to provide more coverage. It is also important to understand the complexity of the uninsured issue within our dynamic political system.

EXPANDING HEALTH INSURANCE COVERAGE

Insurance undoubtedly plays a significant role within our dynamic health care system. To gain a better understanding of this role, it is important to review some of the major public policy initiatives and changes that seek to provide more coverage. It is also important to understand the complexity of the uninsured issue within our dynamic political system.

In 1960, Congress passed the Kerr-Mills bill that provided medical assistance for aged persons who were not receiving public assistance but still needed aid with medical expenses. Comprehensive medical coverage, especially for the elderly, took the forefront on the congressional agenda. In 1965, Congress established Medicare and Medicaid as Title XVIII and Title XIX of the Social Security Act. Medicare was a response to the specific medical care needs of the elderly. Medicaid was established to address the widely perceived inadequacy of "welfare medical care" under public assistance.

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[17] U.S. Department of Health and Human Services. Health Resources and Services Administration. *Clinton Administration Takes Action to Assure Families Access to Health Care and Other Benefits.* Washington: HRSA Press Office, 1999.

[18] Steinhauer, Jennifer, *The Uninsured Get Medical Help in Diverse Ways*, N.Y. TIMES, (March 2, 1999) <http://www.nytimes.com/yr/mo/day/news/national/regional/ny-uninsured.html. >.

[19] Kuttner, Robert. *The American Health Care System: Health Insurance Coverage*. New England Journal of Medicine, (January 14, 1999) < http://www.nehm.org/content/1999/0340/0002/0163.asp>.

In 1977, the Health Care Financing Administration (HCFA) was established under the Department of Health and Human Services to administer the Medicare and Medicaid programs.[20]

The next major attempt to expand health insurance coverage was in the 1990's. Overall, the plans proposed during the 1990's, as well as previous attempts, sought major revisions in a political system that is accustomed to incremental changes. Proposals ranged from simple refundable tax credits for individuals who purchased private health insurance policies to complex managed competition plans which encouraged businesses to include health maintenance organizations in addition to traditional insurance plans.

The various proposals were not approved, for a variety of reasons. Some critics regarded them as excessively complex and too heavily reliant on the alliances between key players both to provide care and to minimize costs. Others felt that universality was too costly and it was not fair to impose costs on employers to provide medical insurance. Still others feared access to care rationing and a decline in overall quality of care.[21]

While national health coverage has not been achieved to date, coverage has been expanded as a result of the federal government increasing states' flexibility and responsibility in implementing federally funded programs. The Health Insurance Portability and Accountability Act of 1996 and the State Children's Health Insurance Program (Title XXI of the Social Security Act) have been crucial in expanding coverage.

While national health coverage has not yet been achieved, coverage has been expanded as a result of the federal government increasing states' flexibility and responsibility in implementing federally funded programs.

The Health Insurance Portability and Accountability Act instituted important protections for an estimated 25 million Americans who change jobs, who are self-employed or who have preexisting medical conditions. Its purpose is to improve the availability of health insurance to working families and their children. The following lists some basic provisions of the Act:

- Guaranteed access to health insurance for small businesses with 50 or fewer employees;
- Guaranteed renewal of insurance regardless of a group member's health status;
- Guaranteed access to health insurance for individuals who lose their coverage because of losing employment or changing jobs to a firm not offering insurance;
- Coverage cannot be denied for more than 12 months due to preexisting medical conditions; and
- Self-employed individuals would qualify for increased tax deductions.[22]

More recently, the establishment of the State Children's Health Insurance Program (CHIP) has resulted in the largest expansion of health insurance in more than three decades.[23] The Balanced Budget Act of 1997 created block grants for states to (1) expand Medicaid eligibility for children, (2) establish a new program to subsidize private insurance for children, or (3) combine the two approaches.

There are three options in expanding Medicaid eligibility. States can establish presumptive eligibility guidelines to cover children temporarily who appear

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[20] Waid, Mary Onnis. *Brief Summaries of Medicare and Medicaid.* Health Care Financing Administration. (June 25, 1998), <http://www.hcfa.gov/medicare/ormedmed.htm>.

[21] Peters, B. Guy. American Public Policy: Promise and Performance 4th Edition. New Jersey: Chatham House, 1996.

[22] Health and Human Services Press Office. *Health Insurance Portability and Accountability Act of 1996.* <http://www.os.dhhs.gov/news/press/1996pres/960821.htm>.

[23] Reschovsky, James D. and Peter J. Cunningham. *CHIPing Away at the Problem of Uninsured Children*. <http://www.hschange.com/issuebriefs/issue14.html>.

eligible for Medicaid but are not yet enrolled. Another option is to guarantee 12 months of coverage to children enrolled in Medicaid regardless of changes in the child's family income. The final option is to accelerate the phase-in of Medicaid coverage for children under age 19 in families with income below 100 percent of the federal poverty level.[24]

Congress committed approximately $40 billion for CHIP programs over the next ten years.[25] To date, all 50 states, five U.S. territories and the District of Columbia have had their CHIP plans approved.[26]

HUSKY – Connecticut's CHIP Program

Connecticut passed its Healthcare for UninSured Kids and Youth (HUSKY) legislation in October 1997; implementation began in June 1998. The HUSKY program combined the two federal approaches to increase health insurance coverage. It increased coverage by expanding Medicaid eligibility for children and creating a new program to subsidize private insurance for children. Basic qualifications for HUSKY require that children are less than 19 years old and Connecticut residents. Family income is also considered. The chart below outlines income qualifications by family size as well as the various plans available.[27]

The basic HUSKY package includes preventive care; outpatient physician visits; prescription medicines; inpatient hospital and physician services; outpatient surgical facility services; mental health and substance abuse services; short term rehabilitation and physical therapy; skilled nursing facility care; home health care and hospice care; diagnostic x-ray and laboratory tests; emergency care; durable medical equipment; eye care and hearing exams; and dental care. More benefits are available depending on the individual HUSKY plan.

Income Range	Family of 2	Family of 3	Family of 4	HUSKY Plan Features
	under $20,469	under $25,686	under $30,903	HUSKY Part A, full Medicaid benefit package with no premiums or co-payments
	$20,469-$26,000	$25,686-$32,627	$30,903-$39,254	HUSKY Part B, with no premiums some co-payments. Eligible for *HUSKY Plus**
	$26001-$33,192	$32,628-$41,652	$39,255-$50,112	HUSKY Part B, with monthly premium of $30 for first child; maximum family premium of $50 regardless of number of children; some co-payments. Eligible for *HUSKY Plus**
	over $33,192	over $41,653	over $50,112	HUSKY Part B, with group premium rate ranging from $113 to $194 monthly; some co-payments

******HUSKY Plus*** **provides supplemental coverage for intensive physical and behavioral health needs.**
SOURCE: Connecticut Department of Social Services

[24] Lewis, Kimball et al. *Counting the Uninsured: A Review of the Literature*. The Urban Institute. (June 1998), <http://newfederalism.urban.org/html/occ8.htm.>.

[25] Balanced Budget Act of 1997, Public Law 105-33.Section 2104 defines the amount of allotments as follows: $4.275 billion for fiscal years 1998-2001; $3.15 billion for fiscal years 2002-2004; $4.05 billion for fiscal years 2005-2006; and $5 billion for fiscal year 2007. For each fiscal year, .25 percent of the total allotment must be allocated to the territories.

[26] U.S. Department of Health and Human Services. *Status of State CHIP Plans.* <http://www.hcfa.gov/init/991101.htm>.

[27] Connecticut Department of Social Services, Pub 98-5[4] , *The Husky Plan: Your Child's New Best Friend in Health Care,* (1999).

NEED FOR FURTHER ANALYSIS

This report demonstrates that the lack of health insurance coverage for Connecticut residents is a chronic issue; it also provides an estimate of the uninsured population. However, this analysis can offer only a snapshot of the larger issue. Each age, gender, race and ethnic group has unique characteristics that make it vulnerable to being underinsured or uninsured[28].

A current, state-level survey would provide a more complete picture of the uninsured and the unique characteristics of this segment of the population. In addition, it would assist OHCA and key policy makers in identifying the specific problems faced by these diverse groups and allow for informed recommendations and decisions to adequately address the complex issue of the uninsured.

OHCA's 1995 survey identified the characteristics of the uninsured, examined factors contributing to underinsurance, and identified barriers to receiving needed care. Since that time, the health care environment has changed markedly, the state's demographic makeup has experienced variations, and the economic climate has shifted. Current, Connecticut-specific survey data would allow OHCA to examine new issues affecting the uninsured as well as to delve further into causes of previously identified areas of concern. In addition to examining current group differences and how they affect strategies and solutions, it would allow policy makers to accurately assess the success level of current insurance expansion programs and implement additional changes and policies as needed.

CONCLUSION

This report demonstrates that data reported by hospitals to OHCA can be useful in monitoring trends in health insurance coverage and can provide an alternative source for a state-level analysis of the uninsured population. While the results presented here should not be solely used for decision-making purposes, they are a valuable complement to existing estimates of the uninsured. Some policy questions for further consideration are:

1. What are the factors that influence the decision to enroll in or purchase insurance plans?
2. How do factors vary between genders, age groups, and races? How can these differences be addressed to expand coverage?
3. What other barriers to care are experienced by the uninsured and underinsured?
4. What do the uninsured know about current programs to assist them in receiving care? What can be done to improve outreach to vulnerable groups?
5. How frequently do the uninsured and underinsured receive medical care?
6. Are there cyclical trends in insurance coverage?
7. What role does the economy play?

These questions will remain at the forefront of policy deliberations for some time. As states strive to maximize CHIP enrollment and as these programs evolve and expand, adequate data collection and analysis will become still more important. It is OHCA's goal to continue to gather and disseminate such critical health care information in order to assist in shaping health care system development and providing Connecticut's citizens with access to a quality health care delivery system.

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[28] Cunningham, Peter J. *Next Steps in Incremental Health Insurance Expansions: Who is Most Deserving?* Center for Studying Health System Change (Number 12, April 1998).

GLOSSARY OF TERMS

Access to Care
A patient's ability to obtain medical care. Ease of access is determined by components such as availability of medical services and their acceptability to the patient, location of health care facilities, transportation, hours of operation and cost of care.

Acute Care
Medical treatment rendered to individuals whose illnesses or health problems are of a short-term or episodic nature. Acute care facilities are those hospitals that primarily serve individuals with short-term health problems.

Charity or Free Care
Services that hospitals provide without cost to patients who cannot afford to pay for care. Charity care may also include a partial-payment option, in which hospitals may provide reduced-cost services to people who can pay some but not all the cost of care. Hospitals do not expect to be reimbursed for free care.

Diagnosis Related Group (DRG)
A classification system for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This classification system is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.

Health Maintenance Organization (HMO)
An entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Internal Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM codes)
A listing of diagnoses and identifying codes used by physicians for reporting diagnoses.

Indicator Conditions
These are non-discretionary health conditions not affected by demographic characteristics such as gender and race/ethnicity. These conditions occur on a frequent basis and hospitalization is usually required.

Traditional Insurance Plans
Fee-for- service reimbursement is a health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.

Indemnity Insurance is an insurance program in which the insured person is reimbursed for covered expenses.

APPENDIX A

Listing of ICD-9-CM Codes by Age Groups

Age Groups	ICD-9-CM Codes	Conditions
Newborns	DRG 385 through 391	Newborn
Ages 0 through 39 Years	DRG 164 through 167	Appendicitis
Age 40 through 64	Principal Diagnosis Codes 410.0 through 410.9 (with 5th digit of 1 indicating first episode)	Heart Attack

APPENDIX B

Total Number of Cases for Each Age Group by Year*

*****_Indicator conditions are shown in the parenthesis._

Year	Newborns (Newborn)	0 through 19 (Appendicitis)	20 through 24 (Appendicitis)	25 through 39 (Appendicitis)	40 through 64 (Heart Attack)
1997	43,454	885	258	808	2,883
1996	44,132	877	221	744	2,970
1995	44,208	837	241	686	2,977
1994	45,645	792	278	726	2,882
1993	46,371	887	287	734	2,535

Source: Connecticut Office of Health Care Access Hospital Inpatient Discharge Database

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