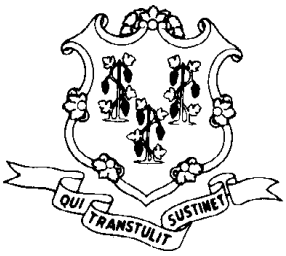
STATE OF CONNECTICUT ■ OFFICE OF HEALTH CARE ACCESS

Report on Connecticut s Insured and Uninsured

APRIL 1998



John G. Rowland, Governor
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THE CONNECTICUT FAMILY HEALTH CARE ACCESS SURVEY

Baseline Results

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The Office of Health Care Access (OHCA) provides independent oversight of Connecticut's health care delivery system to ensure that access to quality care is made available in a fiscally prudent fashion. OHCA's role includes not only the monitoring and oversight of the state's health care delivery system, but also defining, informing and shaping the evolving health care environment. OHCA's Policy, Planning and Research Unit, producer of this report, provides and uses information for data-driven, prospective decision-making and policy development. This unit generates reports and publications on the impact of changes to the health care delivery system and evolving health care issues and trends.

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EXECUTIVE SUMMARY

The Office of Health Care Access (OHCA) has, since its inception, been concerned about access to health care for all Connecticut citizens. Although improving access to health care is not OHCA's only focus, it is a primary agency goal. To better understand the nature of the uninsured population, OHCA has been gathering data and monitoring insurance status for several years. In an effort to provide important baseline data for use by this office and other agencies and organizations in policy formulation and outreach, OHCA has decided to more broadly distribute this information. This decision is based, in part, on the recent emergence of new insurance programs within the state such as Medicaid Managed Care and the HUSKY (Health Care for UninSured Kids and Youth) Plan.

This report focuses on the uninsured population as a whole, uninsured children, private insurance and access issues. It is based on an analysis of OHCA's 1995 Connecticut Family Health Care Access Survey. OHCA will readminister this survey in 1999 and in subsequent years. The data analyzed in this report were collected before Medicaid Managed Care was implemented and prior to the passage of the HUSKY Children's Health Initiative, and thus will serve as baseline data. The 1999 survey will allow OHCA to track the impact of these programs on health insurance coverage. In addition, OHCA has and will continue to monitor economic changes and trends that have the potential to affect insurance status. When the next survey is conducted, OHCA will examine if and how insurance status has changed as the state's economy has improved and its basic economic structure has evolved. Finally, subsequent surveys will examine whether or not national efforts, such as the Health Insurance Portability and Accountability Act, have affected health insurance status in Connecticut.

This publication is therefore the first in a series that will report on OHCA's ongoing study of health insurance coverage in Connecticut. OHCA's survey, while varying somewhat in methodology from the Current Population Survey and the Medical Expenditure Panel Survey which also measure health insurance coverage and access to care, has yielded results similar to those documented in these national surveys. Key survey findings include:

- Almost 70 percent of Connecticut residents reported having private insurance. Nearly 25 percent were covered by Medicaid or Medicare. However, over 7 percent of Connecticut's residents said they had no health insurance coverage.

- Employer-based health insurance coverage was the most common source of coverage for most insured Connecticut residents. Almost 90 percent of insured Connecticut residents were insured through their (or their family members') current employer or union.

- While the state's unemployed residents were more likely to lack health insurance, a significant percentage of working adults, 8.3 percent, also lacked insurance coverage. Moreover, 60.7 percent of adults who were uninsured at the time of the survey were employed.

- Young adults age 19 to 24 were more likely than any other age group to lack insurance coverage.

- Lack of insurance appears to have been more than just a short-term problem for most uninsured Connecticut residents. The majority (68.7 percent) of state residents who were uninsured at the time of the survey were uninsured for the entire prior 12 months as well.

- More than 90 percent of the state's children age 18 and under were insured, either privately or publicly, but 5.7 percent of children did not have any health insurance coverage. Almost 25 percent of all children were insured by government insurance, with 23 percent covered by Medicaid. Over 70 percent of Connecticut's children were covered by private insurance.

- Approximately 72 percent of uninsured children in Connecticut were in employed families -- where the head of household was employed.

- The reason most frequently cited by uninsured children's parents who were offered insurance by an employer or union but did not enroll was that it cost too much.

- In Connecticut, uninsured adults were almost three times as likely as the insured to have no usual source of care other than the emergency room. Uninsured children were almost four times as likely as insured children to have no usual source of care.

- Uninsured adults were nearly seven times more likely than the insured to report an episode of needing but not getting emergency medical care.

- Almost 20 percent of the state's uninsured were middle income or higher, with family incomes over 300 percent of the Federal Poverty Level.

HEALTH INSURANCE: EVERYONE'S CONCERN

In today's society, it is generally believed that the availability of health insurance allows individuals to avoid unnecessary pain and suffering and thus improves the quality of life. People without health insurance are less likely to receive the basic health care services that the insured receive. The collective health status of the population is lowered and individuals' overall productivity is negatively impacted if large numbers of people are uninsured.

Regardless of their lack of insurance coverage, uninsured individuals will no doubt require medical care at some point in time. The uninsured are more likely to delay medical treatment and preventive health care until an emergency arises and subsequently require a higher and more expensive level of care. When they do finally obtain needed medical services, their condition may be significantly worse than if it had been treated at an earlier stage.

Furthermore, the uninsured will probably use the emergency room, one of the most expensive sources of care, for such services.[1] Such a level of care is often provided without payment, which often results in a shift of costs to other payers. Cost shifting can translate into higher health insurance premiums for the insured or higher taxes to finance care provided in public hospitals. Such shifts also raise the cost of fringe benefits some employers provide. Uncompensated care (for which no payment or government subsidy is received) is shouldered by all payers in the health care delivery system.

The uninsured are more likely to delay medical treatment and preventive health care until an emergency arises and subsequently require a higher and more expensive level of care.

The costs associated with the uninsured are compounded when significant numbers of young, healthy adults opt to forego health insurance coverage. The absence of these individuals in risk pools eliminates cross subsidies they would normally pay, raising premiums for the insured.

Also, states with high levels of uninsured are more costly for private employers, causing them to relocate firms and associated jobs to states with higher insurance coverage rates.[2] All of us, in one way or another, pay indirectly for the uninsured population.

THE CONNECTICUT FAMILY HEALTH CARE ACCESS SURVEY

This report, prepared by the Connecticut Office of Health Care Access (OHCA), presents results of a survey of Connecticut residents on the issue of health insurance coverage. The survey was conducted by Mathematica Policy Research, Inc., (MPRI) for OHCA. It focused on insurance coverage at the time of the survey and the 12 months prior to the interview period of June through October 1995. Core contents of the survey included:

- current and prior 12-month health insurance coverage;
- use of health care;
- health status;
- access;
- satisfaction with the health care system;
- family composition;
- demographic data;
- employment characteristics; and
- family income.

MPRI completed a total of 2,079 interviews, with 2,026 by telephone and 53 in person. The survey consisted of 170 questions and each interview averaged 25 minutes. Information was obtained for all persons age 18 and over within a family and for one randomly-selected family member under age 18, if a family included any members less than 18 years of age.

The survey results are meant to provide an overview of the state's health insurance system, describe problems in the current system, aid in conducting policy analysis and provide a baseline for evaluating the effects of future changes in the insurance system. The survey also provides a standard instrument for subsequent surveys on health insurance.

OHCA plans to readminister the survey in 1999, in part, to aid in tracking enrollment and outreach efforts associated with the HUSKY (Health Care for UninSured Kids and Youth) Plan, a health insurance program created to help Connecticut families obtain and afford coverage for their uninsured children.

The plan, which is administered by the Connecticut Department of Social Services, is subsidized by federal State Children's Health Insurance Program (S-CHIP) Title XXI funds. These funds, along with state dollars, will provide health insurance coverage for children age 18 and under in families with incomes too high to qualify for Medicaid but too low to afford private health insurance.

Connecticut will be eligible for federal matching funds to provide health insurance to uninsured children. HUSKY Part A will reach out to children who are eligible for Medicaid but are not currently enrolled, while HUSKY Part B will provide health insurance to children in working families who now cannot obtain or afford health insurance.

The HUSKY Part B benefit package will mirror state employees' health insurance. A supplemental package, called HUSKY Plus, will cover intensive physical and behavioral health needs. For families with incomes under 300 percent of the Federal Poverty Level (FPL), the insurance will be free or carry premiums of up to $50 per month per family, depending on family income and size. Families with incomes over 300 percent of the FPL can buy into the HUSKY Plan at a group premium rate.

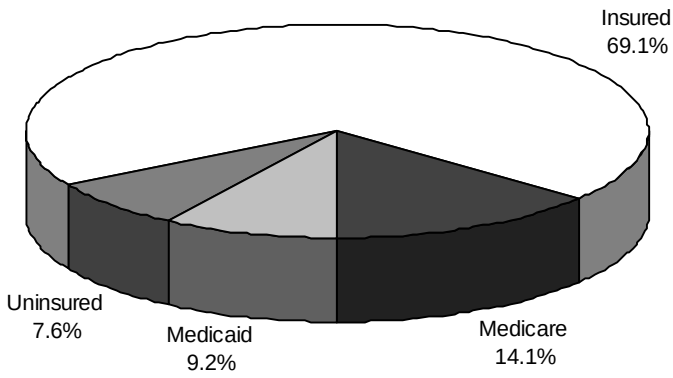
To facilitate comparisons between the baseline survey and future studies, the following report categorizes children as those individuals age 18 and under. It also uses Federal Poverty Level breakdowns that correspond to HUSKY Plan income levels.

AN OVERVIEW OF HEALTH INSURANCE COVERAGE FOR CONNECTICUT RESIDENTS

Health Insurance Coverage

The majority of Connecticut residents were insured, either by private or government insurance at the time of the survey. Almost 70 percent of Connecticut residents reported having private insurance. Nearly 25 percent of the state's population was covered by Medicaid or Medicare. However, over 7 percent of Connecticut's residents said they had no health insurance coverage at the time of the survey (FIGURE 1).

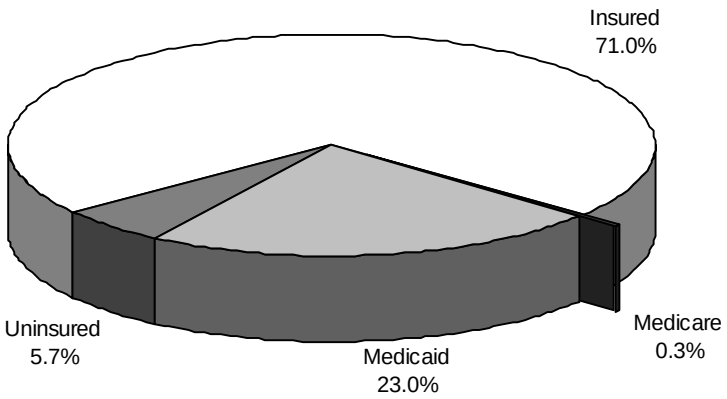
FIGURE 1: Health Insurance Coverage in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

More than 90 percent of the state's children age 18 and under were insured, either privately or publicly, but 5.7 percent of children did not have any health insurance coverage at the time of the survey. Almost 25 percent of all children were insured by government insurance, with 23 percent covered by Medicaid, and less than one percent covered by Medicare. Over 70 percent of Connecticut's children were covered by private insurance (FIGURE 2).

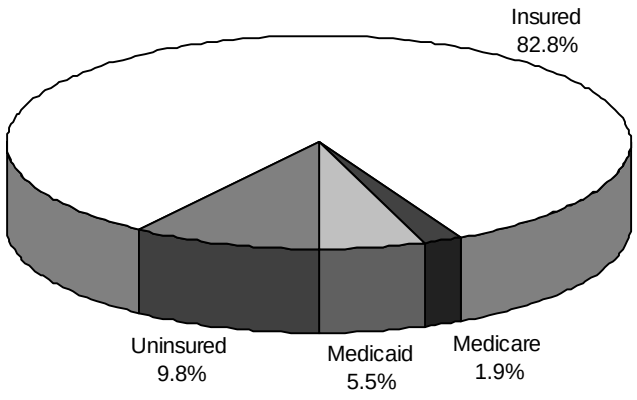
FIGURE 2: Health Insurance Coverage for Children Age 18 and Under in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

More than 80 percent of the state's non-elderly adults age 19 to 64 had private health insurance. Over 7 percent of this age group had government insurance coverage, while almost 10 percent were uninsured (FIGURE 3).

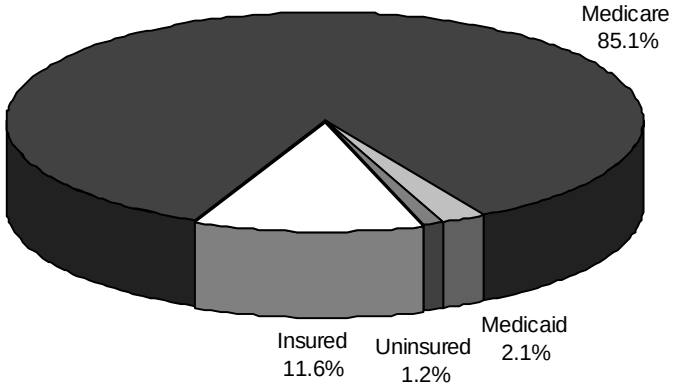
FIGURE 3: Health Insurance Coverage for Non-Elderly Adults Age 19 to 64 in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Nearly 90 percent of the state's population age 65 and over had government insurance, with the majority, 85.1 percent, covered by Medicare. Almost 12 percent of people age 65 and over had private insurance. Just over one percent of Connecticut's elderly residents reported not having any health insurance (FIGURE 4). Approximately 60 percent of privately insured people age 65 and over were still employed, and the vast majority of these persons (84.8 percent) were covered by employer-based insurance.

FIGURE 4: Health Insurance Coverage for Adults Age 65 and Over in Connecticut, 1995

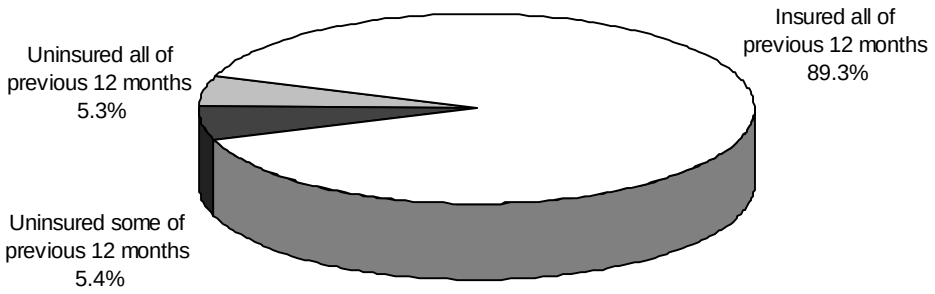


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Spells of Non-Coverage

Almost 90 percent of state residents were insured for the entire 12-month period prior to the survey. However, over 10 percent were uninsured during some part of the 12-month period prior to the survey. More than 5 percent of the state's total population reported being uninsured for *some* of the previous 12 months and an almost equal number reported being uninsured for the *entire* previous 12 months (FIGURE 5).

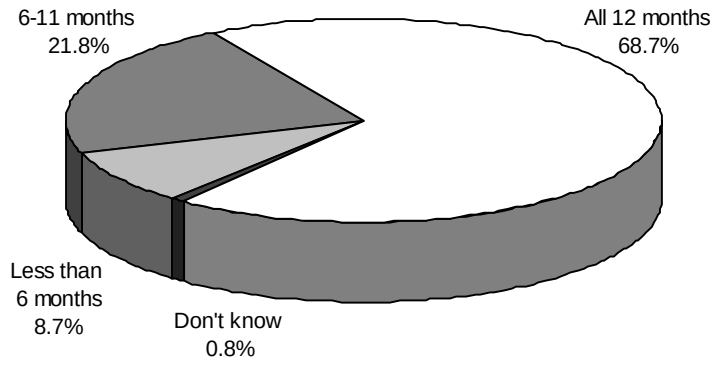
FIGURE 5: Health Insurance Status in Previous 12 Months in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Furthermore, lack of insurance appears to have been more than just a short-term problem for most uninsured Connecticut residents. The majority (68.7 percent) of state residents who were *uninsured at the time of the survey* were uninsured for the entire prior 12 months as well. More than 20 percent of those responding that they were not currently insured reported being uninsured for a period of between 6 and 11 months prior to the survey, while fewer uninsured residents, 8.7 percent, reported being uninsured for less than six months (FIGURE 6). Moreover, those persons who were uninsured for the 12 months prior to the survey may have been uninsured for some period *before* that 12 months and may have continued to be uninsured for some period *after* the survey.

FIGURE 6: Uninsured by Length of Time in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

CHARACTERISTICS OF THE UNINSURED

Employment is the leading indicator of health insurance coverage in the nation.[3] Other factors, closely linked to employment status, are also important determinants of an individual's likelihood of having health insurance. These factors include income, age, gender, race, ethnic origin, educational attainment level and citizenship.

In Connecticut, while the unemployed were more likely to lack health insurance, a significant percentage of working adults, 8.3 percent, also lacked insurance coverage. Moreover, 60.7 percent of adults who were uninsured at the time of the survey were employed.

Employment Status

In Connecticut, while the unemployed were more likely to lack health insurance, a significant percentage of working adults, 8.3 percent, also lacked insurance coverage. Moreover, 60.7 percent of adults who were uninsured at the time of the survey were employed.

Reasons for Not Enrolling in Employer-Based Health Insurance

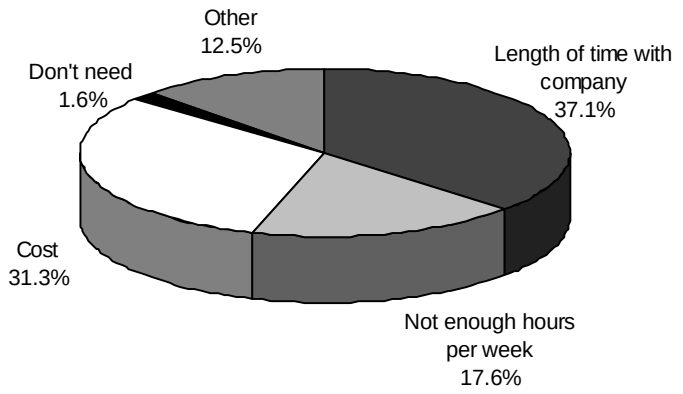
In recent years, some employers have been requiring employees to pay larger portions of health insurance premiums. Some workers have been unable to afford insurance because of these increased costs. Furthermore, structural economic changes in Connecticut, such as the increase in service sector retail trade in recent years, may have increased the number of part-time jobs that do not provide health insurance. More workers are also now employed as private consultants/ contractors or as temporary or part time employees, positions not typically accompanied by employer-based health insurance.

Nearly 50 percent of the state's uninsured workers were employed by companies that offered health insurance. The majority of those uninsured workers not enrolled in employer-based health insurance plans were between the ages of 19 and 34.

Uninsured workers offered a number of reasons for not enrolling in employer-based health insurance plans. Over 37 percent of uninsured workers had not worked at their firms long enough to qualify for health insurance and nearly 18 percent did not qualify because of part-time hours.

Moreover, many workers responded that they simply could not afford the high cost of health insurance premiums. More than 30 percent of uninsured workers stated they did not have employer-based health insurance coverage because it cost too much. For most, lack of insurance appeared to be an economic, rather than personal, choice. In general, pre-existing conditions or the notion that insurance was unnecessary were not frequently given as reasons for being uninsured. Only 1.6 percent of working adults refused insurance because they felt they did not need it (FIGURE 7).

FIGURE 7: Uninsured, Reasons for Not Enrolling in Employer-Based Health Insurance in Connecticut, 1995

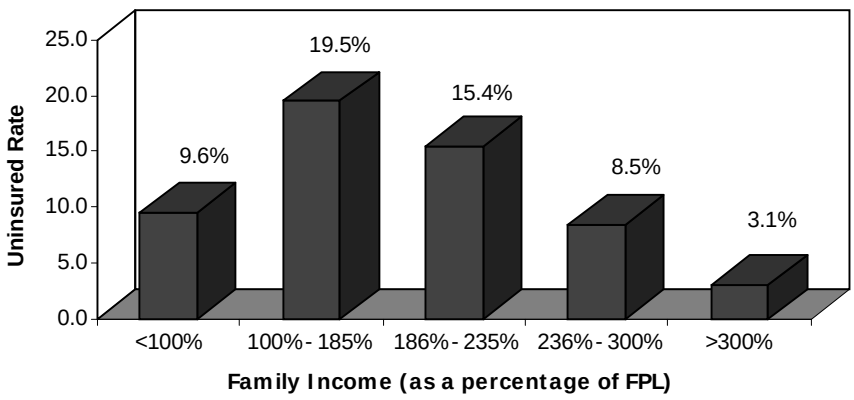


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Family Income

In general, those individuals with higher incomes were more likely to be covered by private health insurance, while those with lower income levels were more likely to be covered by a public insurance plan. With the exception of the poor -- those with family incomes under 100 percent of Federal Poverty Level (FPL)[4] -- as family income increased, the uninsured rate markedly decreased. While the poor were more likely to be covered by Medicaid, 9.6 percent of those with incomes under 100 percent of the FPL had no insurance, either private or public, at the time of the survey (FIGURE 8).

FIGURE 8: Uninsured Rate by Family Income in Connecticut, 1995



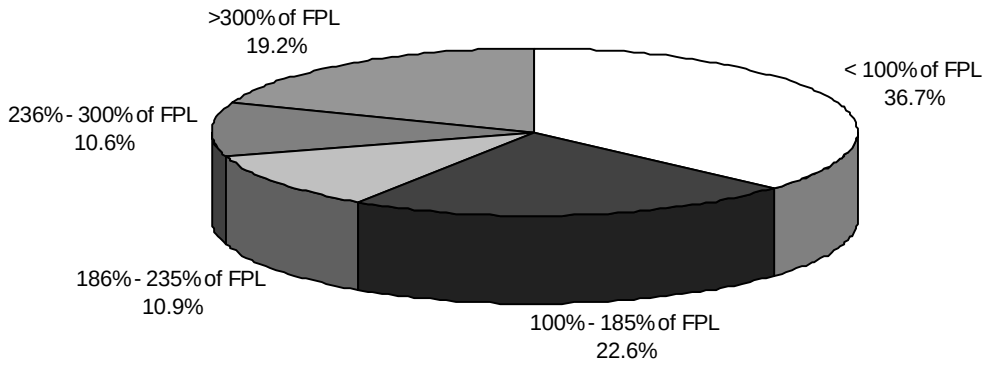
FPL-- 1995 Federal Poverty Level

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Family Income of the Uninsured

While 36.7 percent of the uninsured in Connecticut were considered poor, the majority of the uninsured (63.3 percent) did not fall within this income category. Surprisingly, almost 20 percent of the state's uninsured were middle income or higher, with family incomes over 300 percent of the FPL (FIGURE 9).

FIGURE 9: Family Income of the Uninsured in Connecticut, 1995



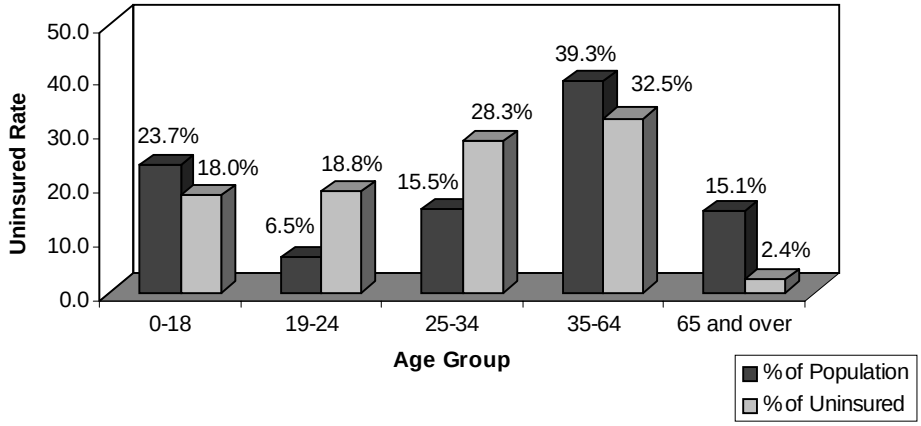
FPL-- 1995 Federal Poverty Level
SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Age

FIGURE 10 compares Connecticut's total population[5] by age with the total uninsured by age. While 0- to 18-year-olds represented more than three times the number of 19- to 24-year-olds, these two groups had nearly identical percentages of uninsured. Furthermore, both 25- to 34-year-olds and those 65 and over each comprised about 15 percent of the population, but the former group made up more than 25 percent of the total uninsured population whereas the elderly comprised only 2.4 percent of the uninsured.

Approximately 6.5 percent of the state's population was between the ages of 19 and 24, however this age group comprised nearly 20 percent of the uninsured. Similarly, while 25- to 34-year-olds made up just over 15 percent of the population, this group accounted for almost 30 percent of the uninsured.

FIGURE 10: Comparison by Age, Population vs. Uninsured in Connecticut, 1995

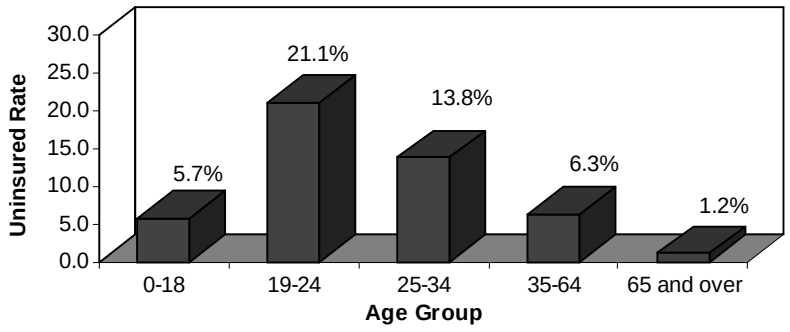


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Age

In terms of total population, young adults age 19 to 24 were more likely than any other age group to lack coverage (FIGURE 11). More than 20 percent of all 19- to 24-year-old adults were uninsured, followed by 13.8 percent of those between the ages of 25 and 34. 6.3 percent of adults between ages 35 and 64 were uninsured. Over five percent of children age 18 and under were uninsured. Relatively few, 1.2 percent, of the state's elderly were uninsured.

FIGURE 11: Uninsured Rate by Age in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Age and Sex

Overall, males were more likely to be uninsured than females. Males were more likely to be uninsured across all age groups except age group 35 to 64, where females were slightly more likely to be uninsured. The largest gap between sexes with regard to insured rate fell in the 25-34 age group, with a 2.6 percentage point difference. Elderly males were almost twice as likely to be uninsured as elderly females, although both rates were quite low (TABLE 1).

The difference between males and females in overall health insurance coverage may be partially attributable to differences in economic status. Women are more likely than men to live in families with incomes below poverty level and are more likely to participate in state or local general assistance programs. Furthermore, there are more women over age 65 than men, and Medicare covers virtually everyone in that group.[6]

Table 1: Uninsured Rate by Age and Sex in Connecticut, 1995

Age	Uninsured rate Males	Females
0-18	6.4%	5.0%
19-24	23.0%	21.1%
25-34	15.2%	12.6%
35-64	6.0%	6.5%
65 and over	2.3%	0.4%
All	8.2%	7.0%

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Age and Race

The uninsured rate for black children age 18 and under was nearly twice as high as for white children in the same age group. Whites between age 19 and 24 were nearly 1.4 times as likely to be uninsured than blacks in that same age group. Whites between ages 25 and 34 were also more likely to be uninsured than blacks of that same age category. The largest difference in uninsured rates were for those in the 35 to 64 age group, where blacks were more than twice as likely to be uninsured. The uninsured rate for elderly blacks was almost twice the rate for elderly whites, although both rates were relatively low. Among all age groups, the uninsured rate for blacks was about 1.6 times the rate for whites (TABLE 2).

Table 2: Uninsured Rate by Age and Race in Connecticut, 1995

	Race	
Age	**White**	**Black**
0-18	4.7%	8.7%
19-24	20.1%	14.7%
25-34	14.0%	11.9%
35-64	5.5%	13.3%
65 and over	1.1%	2.1%
All	6.8%	10.6%

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Age and Ethnic Origin

Persons of Hispanic origin were almost twice as likely to lack insurance coverage than non-Hispanics. The uninsured rate for Hispanic children age 18 and under was almost 1.4 times higher than the rate for non-Hispanic children. The uninsured rate for Hispanics age 19 to 24 was more than twice the rate for non-Hispanics and the uninsured rate for Hispanics ages 25 to 34 was more than 1.6 times the rate for non-Hispanics. In both the 35 to 64 and 65 and over age groups, the uninsured rate for Hispanics was about 1.2 times the rate for non-Hispanics (TABLE 3).

Table 3: Uninsured Rate by Age and Ethnic Origin in Connecticut, 1995

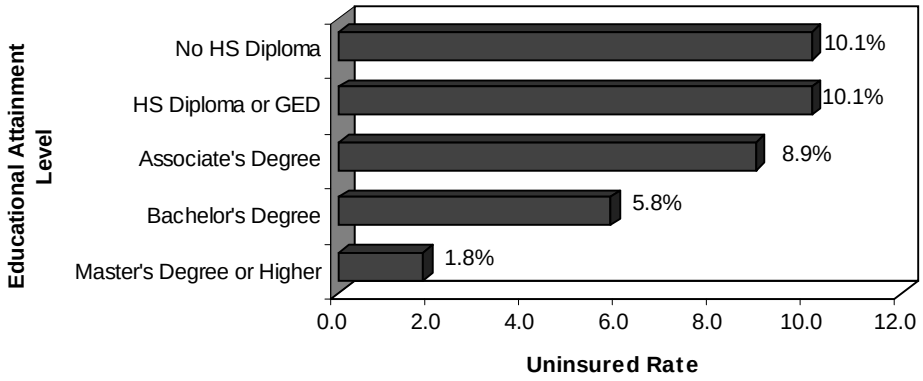
	Ethnic Origin	
Age	**Hispanic**	**Non-Hispanic**
0-18	7.5%	5.5%
19-24	42.6%	19.8%
25-34	21.9%	13.0%
35-64	7.0%	6.2%
65 and over	0.0%	1.2%
All	12.5%	7.2%

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Educational Attainment Level

Attaining a high level of education appears to have a major impact on insurance status. Among Connecticut residents age 18 and over, the likelihood of being uninsured generally declined as the level of education rose. Those individuals with a high school diploma, GED, or no high school diploma were almost twice as likely to be uninsured as those with four-year college degrees and were more than five times as likely to be uninsured as those with advanced degrees (FIGURE 12). It may be that more educated people are better able to understand the importance of health insurance coverage and therefore, make better decisions. It is however, more likely that education indirectly affects insurance status, with higher education levels resulting in higher incomes and better job benefits.

FIGURE 12: Uninsured Rate by Educational Attainment Level in Connecticut, 1995

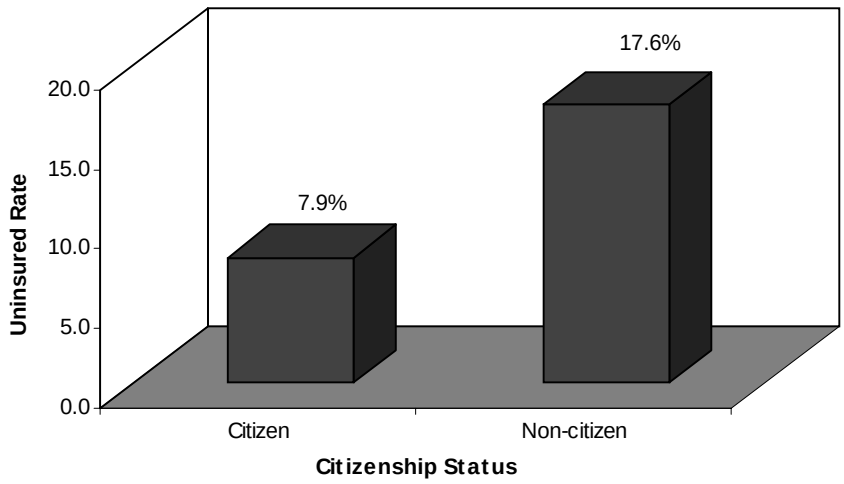


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured Rate by Citizenship

Noncitizens were more than twice as likely to be uninsured as citizens were. This may be due in part to the fact that a higher proportion of noncitizens than citizens were in low income families and were more likely to be unemployed (FIGURE 13).

FIGURE 13: Uninsured Rate by Citizenship in Connecticut, 1995

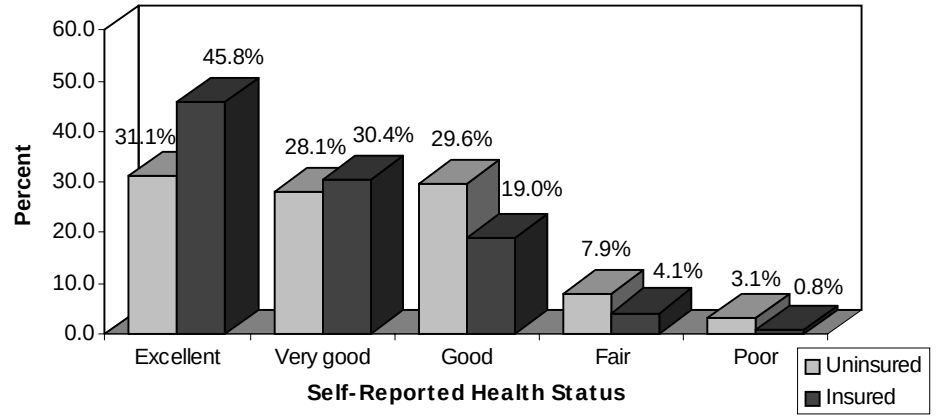


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Self-Reported Health Status of Uninsured vs. Insured

About 60 percent of Connecticut's uninsured reported their own health status as either excellent or very good compared to approximately 75 percent of the state's insured. Eleven percent of the uninsured rated their own health status as fair or poor, while less than five percent of the insured ranked their health as fair or poor. Overall, the self-reported health status of the uninsured was not as favorable as that of the insured (FIGURE 14).

FIGURE 14: Comparison of Self-Reported Health Status, Uninsured and Insured in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

CHARACTERISTICS OF UNINSURED CHILDREN IN CONNECTICUT

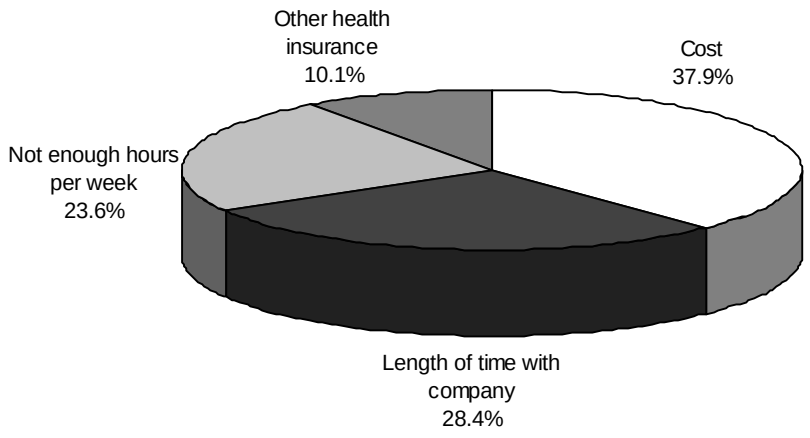
As noted in FIGURE 2 on page five, 5.7 percent of children in Connecticut age 18 and under were uninsured at the time of the survey. The majority of these uninsured children (82.5 percent) also had uninsured parents. Of those uninsured children with insured parents, 11.3 percent of parents were privately insured, 5.3 percent were covered by Medicaid, and just under one percent were covered by Medicare.

Approximately 72 percent of uninsured children in Connecticut were in employed families -- where the head of household was employed -- while 5.1 percent were in unemployed families. This figure does not include almost 22 percent where the head of household responded that they were either keeping house or unable to work. More than half of all uninsured children were in families where the head of household worked for an employer (or union) that offered insurance to at least some of its employees. Approximately 25 percent of employed parents of uninsured children were enrolled in employer-based health insurance, while 75 percent were not.

Approximately 72 percent of uninsured children in Connecticut were in employed families -- where the head of household was employed -- while 5.1 percent were in unemployed families.

The vast majority of working parents with uninsured children were also uninsured. The reason most frequently cited by uninsured children's parents who were offered insurance but did not enroll was that it cost too much (FIGURE 15). Over 28 percent of parents not enrolled in employer-based insurance said they were not eligible because they had not worked for their current employer long enough to qualify. Almost 24 percent said they were not eligible because they did not work enough hours per week to qualify. Only 10.1 percent declined employer-based insurance because they had other health insurance coverage.

FIGURE 15: Reasons Employed Parents of Uninsured Children Not Enrolled in Employer-Based Insurance in Connecticut, 1995

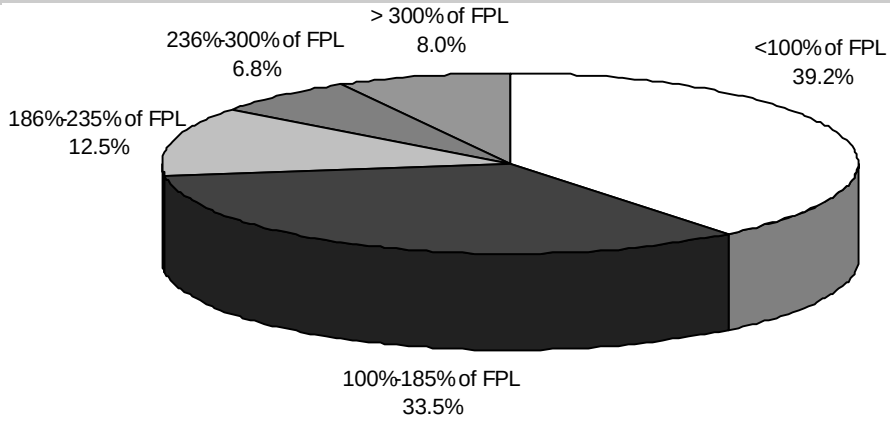


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Family Income of Uninsured Children

At the time of the survey, the largest percentage of uninsured children in Connecticut lived in poor families. Almost 40 percent of uninsured children in the state were in families with incomes under 100 percent of the Federal Poverty Level (FPL). Nearly 75 percent of the state's uninsured children were well under the 200 percent FPL. Fewer than 10 percent of uninsured children were in families living above 300 percent of the FPL (FIGURE 16).

FIGURE 16: Family Income of Uninsured Children in Connecticut, 1995



FPL-- 1995 Federal Poverty Level

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Children, Uninsured Rate by Race and Family Income

Overall, black children were almost twice as likely as white children to be uninsured. The largest gap between races with regard to insured rate fell in the income group between 236 and 300 percent of the Federal Poverty Level, where black children were more than twice as likely as white children to be uninsured (TABLE 4).

Table 4: Children, Uninsured Rate by Race and Family Income in Connecticut, 1995

FPL	Race	
	White	Black
<100%	6.3%	8.3%
100% - 185%	16.3%	19.0%
186% - 235%	12.6%	12.4%
236% - 300%	2.9%	6.5%
>300%	1.2%	0.0%
All	4.7%	8.7%

FPL-- 1995 Federal Poverty Level

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Children, Uninsured Rate by Ethnic Origin and Family Income

Mirroring the national trend, Connecticut children of Hispanic origin were more likely than their Non-Hispanic counterparts to be uninsured. Overall, the uninsured rate for Hispanic children was about 1.4 times higher than the rate for non-Hispanic children. The uninsured rate for Hispanic children between 100 and 235 percent of the FPL was more than double the rate for non-Hispanic children. Specifically, Hispanic children between 100 and 185 percent of the FPL were 1.5 times as likely to be uninsured than their non-Hispanic counterparts. Hispanic children between 186 and 235 percent of the FPL were almost four times as likely to be uninsured than non-Hispanic children at the same family income level (TABLE 5).

Table 5: Children, Uninsured Rate by Ethnic Origin and Family Income in Connecticut, 1995

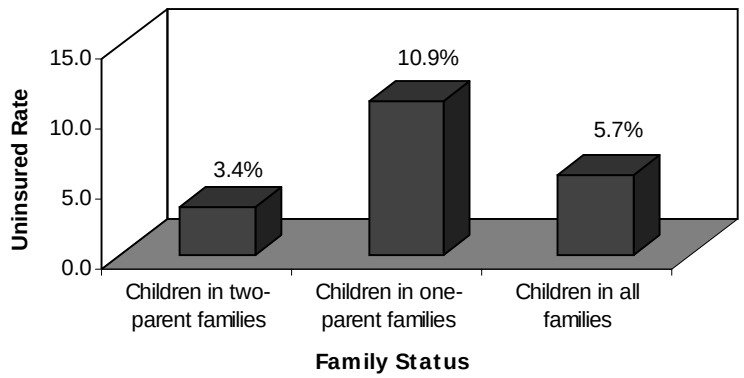
FPL	Ethnic Origin Hispanic	Non-Hispanic
<100%	4.5%	8.0%
100% - 185%	25.5%	17.0%
186% - 235%	42.0%	11.0%
236% - 300%	0.0%	4.4%
>300%	0.0%	1.2%
All	7.5%	5.5%

FPL-- 1995 Federal Poverty Level
SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Children, Uninsured Rate by Family Status

One-parent families were more than three times as likely to have uninsured children as two-parent families. Of those children living in two parent families, 3.4 percent were uninsured, compared to 10.9 percent of children in one-parent families (FIGURE 17).

FIGURE 17: Children, Uninsured Rate by Family Status in Connecticut, 1995

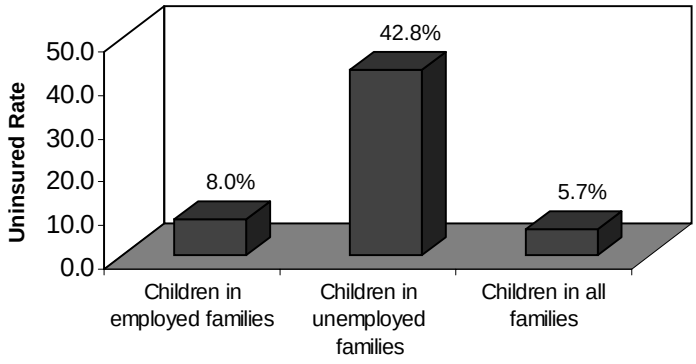


SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Children, Uninsured Rate by Family Employment Status

Children in unemployed families were more than five times as likely to be uninsured as those in employed families. However, the rate of uninsured children in employed families, 8 percent, was considerable (FIGURE 18).

FIGURE 18: Children, Uninsured Rate by Family Employment Status in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

OVERVIEW OF PRIVATE INSURANCE SOURCES, SATISFACTION AND COSTS

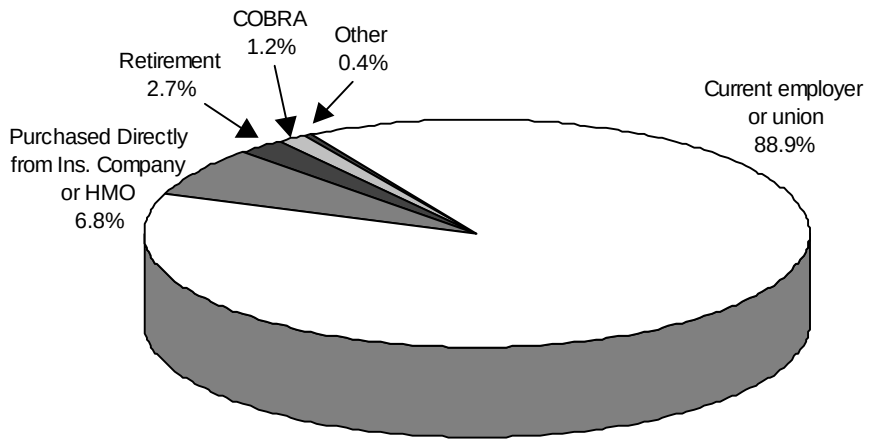
Private Insurance Sources

There are a variety of sources of private health insurance. Employer-based health insurance is generally directly provided through one's current employer or union. However, family members may be indirectly insured by a working relative's employer.

Retirees may be covered by insurance plans offered by former employers. Former employees of companies may be covered via COBRA, a federal mandate requiring employers to offer continued health insurance to certain employees and their beneficiaries whose group health insurance coverage has been terminated. Individuals may also purchase health insurance directly from an insurer. Whatever the source, whether employer-based, retirement-based, COBRA-mandated or directly purchased, such coverage may be provided by a traditional indemnity insurance company or a health maintenance organization (HMO).

Employer-based health insurance coverage was the most common source of coverage for most insured Connecticut residents. Almost 90 percent of insured Connecticut residents were insured through their (or their family members') current employer or union. Nearly 7 percent of individuals were insured through insurance purchased directly from an insurance company or HMO, while the remaining individuals were insured either through a retirement plan or COBRA (FIGURE 19).

FIGURE 19: Sources of Private Insurance Coverage in Connecticut, 1995



SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Satisfaction with Insurance Plans

HMOs fared better than Blue Cross/Blue Shield and other insurance plans in terms of insured residents' overall satisfaction ratings of their insurance plans. In general, those residents with HMO or Blue Cross/ Blue Shield plans were more satisfied than those with other insurance plans (TABLE 6).

Costs of Insurance Plans

The average annual premium paid by the insured was $1,062. This amount may have been supplementary to employer-paid premiums. Almost 50 percent of the state's insured residents who paid for at least part of their health insurance paid less than $44 per month.

Table 6: Satisfaction with Insurance Plans in Connecticut, 1995

Satisfaction Rating	HMO	Blue Cross/ Blue Shield	Other
Very satisfied	48.9%	44.7%	37.0%
Somewhat satisfied	36.3%	39.4%	34.0%
Overall satisfaction	85.2%	84.1%	71.0%
Somewhat dissatisfied	10.5%	12.6%	17.7%
Very dissatisfied	3.0%	2.9%	10.0%
Overall dissatisfaction	13.5%	15.5%	27.7%

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

ACCESS ISSUES

Adequate access to health care services can significantly affect health care use and health outcomes. Access is more than physical proximity; it includes demographic, financial, language and transportation factors. Although health care services may be readily available, individuals may not have a usual source of care or may experience barriers to receiving services because of lack of insurance, inadequate finances, or other obstacles such as transportation problems or geographic impediments.

The uninsured have more difficulty gaining access to the health care system and use care less frequently than their insured counterparts. They are also less likely to visit doctors for primary care, and they receive fewer preventive services. Lack of insurance may also influence the way individuals seek medical care. They may delay or go without needed care because of financial reasons. When they ultimately do seek care, their health problems are likely to be worse and more difficult to treat. Furthermore, the uninsured are more likely to be hospitalized for such health problems as diabetes, hypertension, and immunizable conditions that ordinarily are handled via ambulatory care.[7]

TABLE 7 illustrates how insurance status plays a key role in explaining variations in access to care. In Connecticut, uninsured adults were approximately three times as likely as the insured to have no usual source of care other than the emergency room. Uninsured children were almost four times as likely as insured children to have no usual source of care.

Table 7: Access to Care for Adults and Children in Connecticut, 1995

Access Measure/Age Group	All	Insured*	Uninsured
No usual source of care, other than emergency room			
Adults	12.8%	10.9%	33.8%
Children	1.3	1.1	4.1
Did not get emergency care when needed			
Adults	1.7	1.2	8.3
Children	0.5	0.5	0.0
No physician visit in past 12 months			
Adults	15.1	13.9	29.4
Children	9.2	9.1	9.8
No Pap smear			
Adult women age 19-64	4.3	3.6	11.2
No mammogram			
Adult women age 19-64	14.2	12.1	45.7
Did not receive at least one in series of immunizations for DPT, Polio, Measles, Mumps and Rubella			
Children, age 2 to 4	10.3	10.3	10.0

**Insured -- either private or public insurance*

SOURCE: Connecticut Office of Health Care Access Family Health Care Access Survey

Uninsured adults were nearly seven times more likely than the insured to report an episode of needing but not getting emergency medical care. Uninsured children fared much better than uninsured adults in terms of receiving emergency care when needed. This may be the result of more extensive care available to children, in terms of higher rates of Medicaid eligibility as well as specific local programs (e.g., free clinics) that may be directed toward the young.

Uninsured adults were more than twice as likely as insured adults to not have visited a physician in the 12 months prior to the survey.

In Connecticut, uninsured women between age 19 and 64 were roughly three times less likely to have had a Pap smear and four times less likely to have had a mammogram as insured women of the same age.

An unfortunate consequence of lack of insurance is that care may be postponed until medical conditions reach more advanced stages, sometimes resulting in higher mortality rates than the insured population. For example, uninsured women are more likely than insured women to be diagnosed at a more advanced stage of breast cancer, and are almost 50 percent more likely to die during the four to seven years following their initial diagnosis.[8] In Connecticut, uninsured women between age 19 and 64 were roughly three times less likely to have had a Pap smear and nearly four times less likely to have had a mammogram as insured women of the same age.

Although children were more likely than adults to have a usual source of care, to receive emergency care when needed, and to visit physicians annually, 10.3 percent of all children had not received at least one in a recommended series of childhood immunizations at the time of the survey. Interestingly, uninsured children were slightly more likely to have received such immunizations. It is important to note, however, that in 1995 Connecticut ranked third in the nation in immunizations of children age 19 to 35 months, and ranked first in the nation in both 1996 and 1997.

Among those who experienced barriers to care, lack of insurance or the inability to afford health care was cited by more than 50 percent of Connecticut residents as the main reason for difficulty, delay or not receiving needed health care.

CONCLUSION

Lack of health insurance matters not only to uninsured individuals and their families, but also to society as a whole. For both individuals and families, health insurance affects job decisions, financial security, health status and access to care. Who are the uninsured? Our survey findings were consistent with a large body of national health insurance status studies that suggest that age, race, ethnic origin, income and educational attainment level, among other factors, impact the likelihood of being uninsured. Individuals lacking health insurance in Connecticut were found to be a diverse group, as evidenced by the following highlights:

Who are the Uninsured?

- 18 percent were children under age 19
- 39 percent were poor children
- 61 percent were employed adults
- 37 percent were poor
- 52 percent were male
- 13 percent were black
- 76 percent were white
- 13 percent were Hispanic
- 69 percent lacked health insurance for an entire year

This list illustrates the complexity of the task of developing strategies for providing the state's citizens with health insurance coverage and improving their access to care. This report, along with future studies on health insurance status conducted by the Office of Health Care Access, is intended to assist a variety of agencies, policy-makers and other interested parties in this process.

SURVEY METHODOLOGY

Accuracy of Estimates

The statistics presented in this report are affected by both sampling error and nonsampling error, which includes nonresponse bias, respondent reporting errors, interviewer effects and data processing misspecifications.

Because of methodological differences, use caution when comparing these data with data from other sources or surveys.

Sample Design

The sample design attempted to (1) provide an adequate sample of persons by type of insurance coverage; (2) minimize bias due to noncoverage without substantial in-person data collection; and (3) provide statewide estimates for the noninstitutionalized population. Type of insurance is defined as: insured by private and government sources other than Medicare and Medicaid, insured by Medicaid, insured by Medicare, or uninsured.

Because sample frames do not exist to directly survey persons by type of insurance coverage (other than Medicaid beneficiaries), the sample design targeted 1900 family interviews, of which at least 400 were families including one or more uninsured persons and 400 were families including one or more Medicaid beneficiaries. Mathematica exceeded its targets, interviewing a total of 2,079 families, with 422 including one or more Medicaid beneficiaries and 398 including one or more uninsured persons. Because Medicaid beneficiaries and the uninsured are less prevalent in the population, the sample design focused on identifying and oversampling families including Medicaid and uninsured persons.

Mathematica used general population screening to identify families with uninsured persons, and obtained lists of Medicaid beneficiaries to more effectively target that group.

The sample design also addressed noncoverage bias. Based on CPS data, Mathematica estimated that more than 95 percent of the total eligible population in Connecticut had telephones. CPS-based estimates also revealed that the income of families including Medicaid recipients without phones is lower than the income of those with telephones. However, Medicaid recipients are substantially less likely to live in households with telephones that are other persons. To avoid omitting or underrepresenting non-telephone Medicaid families, which would lead to biased survey estimates for Medicaid recipients, in-person interviews were used to obtain data on a small sample of nontelephone Medicaid households in the state.

Study Population

The study population consisted of the noninstitutionalized population, with different sampling rates for persons living in households with varying degrees of insurance coverage. The household, consisting of all persons residing at a dwelling unit, was the unit screened for survey eligibility. Households were subsampled based on screening reports of the health insurance coverage of their members. The family, reflecting definitional groupings typically used by insurance carriers, was the interviewing unit.

Family was defined as the householder, spouse, their children and step-children under 18, and any children or step-children 18 to 22 years old who were unmarried, full-time students;

Other related and unrelated adults and their spouses and children, if any, formed separate family units, except for unmarried full-time students, 18 to 22 years old, who were not children of the householder, who were excluded from the survey. Unrelated persons under 18 years old who did not have a guardian in the household were also excluded from the survey.

If there were more than one family unit within a sampled household, Mathematica attempted to interview all families within that household. Person-level information was obtained for all eligible adults within a family, and for one randomly-selected child, if the family included any eligible children under age 18.

Sample Stratification

A distinction must be made between strata and domain. Strata are subgroups of the study population that can be identified on the sample frame(s), whereas domains are subgroups that will be examined during the analysis. The study defined three primary domains: (1) non Medicaid/ Medicare insured, (2) uninsured, and (3) Medicaid beneficiaries. Of the three domains, only Medicaid beneficiaries could have been treated as a sampling stratum, because they could be sampled directly from a list frame of Medicaid recipients. Mathematica used stratification in its sample design to achieve the desired distribution over the three domains. Weights were post-stratified to census figures. Weight distributions of race, ethnic origin, sex, median income, and age were examined and compared with 1990 Census distributions, CPS projections for 1995, and actual CPS figures for 1992 (income) and 1994 (persons).

Design Effects

Variance of estimates resulting from surveys such as this one which deviates from simple random sampling (because it involves clustering, multiple stages of selection, and oversampling) can differ substantially from the variances resulting from more straightforward design. This difference is generally represented by the design effect, which is the ratio of the estimate of the variance of a statistic adjusted for survey design complexities to the variance one would have obtained under simple random sampling assumptions. The survey used oversampling, stratification and, for the in-person component, multi-stage sampling.

DEFINITIONS AND EXPLANATIONS

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

Age. Age classification is based on age at the time of the survey interview.

COBRA. A federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

Family. The interviewing unit. Defined to reflect groupings typically used by insurance carriers. Family is defined as: the householder, spouse, their children and step-children under age 18, and any children or step-children age 18 to 22 who were unmarried, full-time students.

Health Maintenance Organization. An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are four basic HMO models: the group model, the individual practice association, the network model and the staff model.

Hispanic Origin. Persons of Hispanic origin were determined on the basis of a question that asked the respondent if he/she or the person in question was of Spanish or Hispanic origin or descent. It should be noted that persons of Hispanic origin may be of any race.

Household. Included all persons residing at a dwelling unit. The unit screened for survey eligibility.

Income-to-Poverty Ratios. Income-to-poverty ratios represent a way of characterizing individuals by their relative economic status. The ratios are computed by summing the annual personal or family income and dividing this total by the annual poverty thresholds.

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

Medicaid. The Medicaid program is designed to furnish medical assistance on behalf of needy families with dependent children, and of aged, blind, or permanently and totally disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services. The program is administered by State agencies through grants from the Health Care Financing Administration of the Department of Health and Human Services.

Medicare. The Medicare program is designed to provide medical care for the aged. The plan also covers persons under age 65 who receive Social Security or railroad retirement benefits based on long-term disability (Medicare SSI).

Mortality. An actuarial determination of the death rate at each age as determined from prior experience. A mortality study shows the probability of death and survival at each age for a credible unit of population.

Pool. A defined account (e.g., defined by size, geographic location, claim dollars that exceed "x" level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability. Pooling is the process of combining risk for all groups or a number of groups.

Population. The estimates in this report are based on the noninstitutionalized population, with different sampling rates for persons living in households with different mixes of insurance coverage. Persons residing on a long-term basis in institutional settings, such as nursing homes, dormitories, prisons or military barracks were excluded from the survey.

Premium. The amount paid to an insurance carrier for providing coverage under a contract.

Preventive Care. Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well person care.

Race. The population was divided into six categories on the basis of race: White, Black, Native American (American Indian), Alaska Native, Asian or Pacific Islander or Other.

Unemployed. A person is considered unemployed if he or she was not in the labor force at the time of the interview and spent no time looking for work or on a layoff.

ENDNOTES

[1]Employee Benefit Research Institute. Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1996 Current Population Survey, (November 1996). ERBI Issue Brief Number 179, 3.

[2]Employee Benefit Research Institute, 3.

[3]Bennefield, Robert L., U.S. Department of Commerce Economics and Statistics Administration, Bureau of the Census. Health Insurance Coverage: 1996, Current Population Reports, Consumer Income, P60-199. (U.S. Government Printing Office, Washington, DC, 1997), 1.

[4]Federal Poverty Guidelines are designated by the year in which they are issued. For instance, the guidelines issued in March 1995 are designated as the 1995 poverty guidelines. However, the 1995 poverty guidelines only reflect price changes through calendar year 1994. This report uses the 1995 Federal Poverty Guidelines.

[5]Because Current Population Survey (CPS) population estimates for 1995 were not available at the time the survey was conducted, MRPI estimated Connecticut's 1995 population by applying the percent change between 1993 and 1994 CPS population estimates to the 1994 CPS population estimate.

[6]Bennefield, Robert L., U.S. Department of Commerce Economics and Statistics Administration, Bureau of the Census. Dynamics of Economic Well-Being: Health Insurance 1991 to 1993, Current Population Reports, Household Economic Studies, P70-43. (U.S. Government Printing Office, Washington, DC, 1995) 6-7.

[7]Rowland, Diane et al. "A Profile of the Uninsured in America," Health Affairs, Spring (II) (1994): 286.

[8]Rowland, Diane, 286.