HEALTHCARE COVERAGE FEASIBILITY STUDY

The Office of Health Strategy (OHS), in consultation with the Office of Policy and Management (OPM), the Department of Social Services (DSS), the Connecticut Health Insurance Exchange dba Access Health CT (AHCT), and the Insurance Department (CID), was charged under §5 of Public Act 21-176 to conduct a feasibility study regarding the offering of healthcare coverage for certain uncovered populations. This report includes an overview of current efforts in Connecticut related to the statutory charge, uninsured statistics, recent legislation expanding healthcare coverage for undocumented residents in other states, and an overview of available data related to the feasibility of covering the specified populations.

A Report Pursuant to §5 of Public Act 21-176 for the Appropriations, Human Services, and Insurance and Real Estate Committees

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I. Introduction

Public Act (P.A.) 21-176, signed into law by Governor Lamont on July 12, 2021, charges the Office of Health Strategy (OHS), in consultation with the Office of Policy and Management (OPM), the Department of Social Services (DSS), the Connecticut Health Insurance Exchange dba Access Health CT(AHCT), and the Insurance Department (CID), with conducting a:

> "*feasibility study of offering health insurance coverage for (1) income-eligible children ages nine to eighteen, inclusive, regardless of immigration status, who are not otherwise eligible for Medicaid, the Children's Health Insurance Program, or an offer of affordable employer sponsored insurance as defined in the Affordable Care Act, as an employee or a dependent of an employee, and (2) adults with household income not exceeding two hundred percent of the federal poverty level who do not otherwise qualify for medical assistance, an offer of affordable, employer-sponsored insurance as defined in the Affordable Care Act, as an employee or a dependent of an employee, or health care coverage through the Connecticut Health Insurance Exchange due to household income.*"[1]

Over the last year, the above-named agencies have explored options for coverage, researched legislation in other states, and met with state officials from those states that enacted legislation to cover undocumented immigrants or documented resident immigrants who have lived in the United States for less than five years. The agencies regularly met with the HUSKY for Immigrants Coalition and Students for a Dream to discuss various models of coverage and costs of model options. This report represents a summary of the work and the state agencies' best efforts thus far to explore the feasibility of such coverage.

The agencies include reference to at least two financial modeling exercises conducted by RAND, on behalf of the Universal Health Care Foundation, and Manatt, on behalf of the Connecticut Health Foundation, on expansion options for coverage. However, additional modeling would need to be conducted to inform further analysis that aligns with current coverage offerings under P.A. 21-2, June Special Session, and P.A. 22-118[2].

II. Current Efforts – Covered CT – Status of Expansions

P.A. 21-176 is part of a suite of recent expansions of healthcare coverage options for children and adults in Connecticut. Building on existing Medicaid (HUSKY A and HUSKY D) and Children's Health Insurance Program (CHIP, or HUSKY B) coverage, significant coverage expansions for individuals unable to qualify for Medicaid and CHIP due to immigration status began in April

[1] §5 of Public Act 21-176

[2] See §§234 and 235 which increase eligibility for state-funded medical assistance regardless of immigration status to cover children ages 12 and under, rather than ages 8 and under, and requires children eligible for the benefit to continue receiving it until they are 19 years old.

2022 and will continue in 2023. Additionally, the Covered Connecticut program, established in 2021 by P.A. 21-2, June Special Session, expands no-cost coverage to adults up to 175% of the federal poverty level (FPL). Covered Connecticut provides fully-subsidized qualified health plan coverage through Access Health CT, supplemented by dental and non-emergency medical transportation (NEMT) coverage delivered through the HUSKY service network. Covered CT was modified by P.A. 22-118 to transfer overall administration of the program to DSS while OHS retained the budget for reimbursement to carriers.

By January 1, 2023, P.A. 21-176 requires the DSS commissioner to provide state-funded medical assistance, within available appropriations, to children age 0-8, regardless of their immigration status, who are not eligible for Medicaid, CHIP, or affordable employer-sponsored insurance, and have household incomes: (1) up to 201% of the federal poverty level (FPL) without an asset limit (aligning with HUSKY A limits under Medicaid) or (2) over 201% and up to 323% of FPL (generally aligning with HUSKY B limits under CHIP). P.A. 22-118 expands this requirement by applying it to children ages 12 and under, rather than ages 8 and under as required under P.A. 21-176. Under P.A. 22-118, a child who is eligible for assistance under these provisions must continue to receive it until such child is 19 years old, as long as the child continues to (1) meet income requirements and (2) be ineligible for Medicaid, CHIP, and affordable, employer-sponsored insurance. In addition, P.A. 21-176 requires the Office of Health Strategy, in consultation with DSS and others, to study the feasibility of offering healthcare coverage for income-eligible children ages 9 to 18, regardless of immigration status, who are not otherwise eligible for other programs.

Table 1 on the following page shows the suite of coverage expansions recently enacted.

Table 1. Health Coverage Expansions (2021 and 2022 Legislative Sessions)

Health Coverage Expansions (2021 and 2022 Legislative Sessions)

Last Updated: June 30, 2022

Note: FPL eligiblity bands not to scale

FPL -->	138%	160%	175%	201%	263%	323%	Coverage	FMAP*	Effective Date	New Authorizing Legislation
Children										
Citizen/Qualifying	Current						Medicaid (HUSKY A)	50%	Existing	
Citizen/Qualifying							CHIP (HUSKY B)	65%	Existing	
Non-Qualifying Immigrant										
Age 0-8	Authorized						State-funded	None	1/1/2023	PA 21-176 Section 1
Age 0-8							State-funded	None	1/1/2023	PA 21-176 Section 3
Age 9-12							State-funded	None	1/1/2023	PA 22-118 Section 232
Age 9-12							State-funded	None	1/1/2023	PA 22-118 Section 233
Age 9-18	Being studied						*Study in progress*		*Due 7/1/2022*	PA 21-176 Section 5
Pregnant Women										
Citizen/Qualifying							Medicaid (HUSKY A)	50%	Existing	
Non-Qualifying Immigrant							CHIP Unborn Child Option (HUSKY B)	65%	4/1/2022	PA 21-176 Sec 4; PA 21-2 (June SS) Sec 344
Postpartum (12 months)										
Citizen/Qualifying							Medicaid (HUSKY A)	50%	4/1/2022	PA 21-2 (June SS) Sections 335-336
Non-Qualifying Immigrant							State-funded	None	4/1/2023	PA 21-176 Section 2
Parents/Caretakers										
Citizen/Qualifying							Medicaid (HUSKY A)	50%	Existing	
Citizen/Qualifying							Covered CT (AHCT QHP)		7/1/2021	PA 21-2 (June SS) Sections 16-19
Citizen/Qualifying							Covered CT (AHCT QHP + Medicaid 1115)		7/1/2022	PA 21-2 (June SS) Sections 16-19
Citizen/Qualifying							*Study in progress*		*Due 7/1/2022*	PA 21-176 Section 5
Non-Qualifying Immigrant							*Study in progress*		*Due 7/1/2022*	PA 21-176 Section 5
Adults w/o Dependents										
Citizen/Qualifying							Medicaid (HUSKY D)	90%	Existing	
Citizen/Qualifying							Covered CT (AHCT QHP + Medicaid 1115)		7/1/2022	PA 21-2 (June SS) Sections 16-19
Citizen/Qualifying							*Study in progress*		*Due 7/1/2022*	PA 21-176 Section 5
Non-Qualifying Immigrant							*Study in progress*		*Due 7/1/2022*	PA 21-176 Section 5

Chart depicts current and future income eligiblity in select areas of medical coverage authorized during 2021 and 2022 legislative sessions; this is not a comprehensive view of all state medical coverage.

***FMAP does not reflect enhanced FMAP available under the public health emergency**

PA 21-176	https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00176-R00HB-06687-PA.PDF
PA 21-2 (June SS)	https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00002-R00SB-01202SS1-PA.PDF
PA 22-118	https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00118-R00HB-05506-PA.PDF

FPL	Federal Poverty Level
FMAP	Federal Medical Assistance Percentage
AHCT QHP	Access Health Connecticut Qualified Health Plan

III. Connecticut's Uninsured Statistics

A. Census and Related Data

As of June 2022, Connecticut's uninsured rate for people under age 65 is 7%.[3] The Migration Policy Institute estimates that in 2019, 113,000 residents in Connecticut were undocumented[4] and about 58% are uninsured. The vast majority are adults over the age of 25 while nearly half are identified as female.[5] The survey also notes that approximately 32,000 parents reside with at least one U.S. citizen child under the age of 18, while 7,000 reside with noncitizen children only. Approximately 68,000 reside with no children. At least 55,000 have estimated incomes below 200% of poverty level. Family income and insurance status are included in Table 2 below.

Table 2. Family Income Profile of Undocumented Immigrant Population of Connecticut 2019

Family Income		
Below 50% of the poverty level	12,000	11%
50-99% of the poverty level	13,000	12%
100-149% of the poverty level	15,000	13%
150-199% of the poverty level	15,000	13%
At or above 200% of the poverty level	58,000	51%
Access to Health Insurance		
Uninsured	65,000	58%

Source: Migration Policy Institute Data Hub, Profile of the Unauthorized Population: Connecticut

B. Hospital and Federally Qualified Health Center (FQHC) Data

OHS obtained data from the federal Health Resources and Services Administration (HRSA)[6] on the number of visits by uninsured patients to FQHCs. While these data are not fully reflective of the number and percentage of undocumented immigrants in the uninsured population, these are indicative of the large numbers of uninsured Connecticut residents seeking services at FQHCs. In 2020, 66,328 uninsured patients received outpatient services from 16 FQHCs costing over $87 million. Total payments for hospital uninsured discharges statewide in 2020 were approximately $126.1 million and the average payment per uninsured discharge was $7,157. In addition, in 2021 uninsured individuals made 78,135 emergency room visits to Connecticut hospitals.

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[3] U.S. Census Bureau QuickFacts: United States

[4] Migration Policy Institute Data Hub, Profile of the Unauthorized Population: Connecticut, available at Profile of the Unauthorized Population - CT | migrationpolicy.org.

[5] Id.

[6] Health Center Program Uniform Data System (UDS) Data Overview (hrsa.gov)

C. Health Conditions of Patients/Need

OHS met with the HUSKY Immigrant Coalition and other states and used FQHC data to extrapolate the pent-up demand of the uninsured group of children and adults up to 201% FPL. Table 3, reflecting data from DSS, demonstrates that a significant number of uninsured adults and children utilized emergency coverage available to noncitizen individuals under the Medicaid program. Table 3 also illustrates the costs of coverage associated with utilization of such coverage. Coverage under emergency Medicaid covers only the cost of the emergency and does not include ongoing coverage for other health needs. DSS recently began covering outpatient dialysis services as an emergency medical condition as outlined in provider guidance in April 2022.[7]

Table 3. Emergency Medicaid Payments by Calendar Year Dates of Service

Year	Total Paid*	Members Served	Average Cost PMPY**
2017	$ 9,430,924	1,363	$ 6,919.24
2018	$ 20,692,592	2,219	$ 9,325.19
2019	$ 37,833,440	3,162	$ 11,965.03
2020	$ 47,450,345	3,717	$ 12,765.76
2021	$ 30,187,865	2,502	$ 12,065.49

* Includes full Rx costs and is not net of rebates. Rebates typically account for approximately 60% of Rx costs.

** PMPY= Per Member Per Year

D. Community Concerns about Lack of Health Insurance Coverage for Undocumented Children and Adults

The HUSKY Immigrant Coalition shared serious concerns regarding lack of coverage for undocumented children and adults. In some cases, individuals were able to access primary care services, but unable to find any specialists that would see them without cash up front. Many were afraid to seek help not only because of potential issues with U.S. Immigration and Customs Enforcement (ICE), but because of fear of medical debt from sliding scale charges or the unavailability of any financial assistance at all. Some reported the inability to keep or obtain employment because of a disability for which they were unable to get medical help. Others reported a lack of access to providers because of the requirement of a photo ID. Resources for obtaining photo IDs that providers consider reliable are an ongoing challenge for undocumented immigrants. Beyond these obvious medical issues, some reported unfair treatment by providers, language and cultural barriers, and the lack of care coordination.

[7] Connecticut Department of Social Services (ctdssmap.com)

According to a report conducted by the Kaiser Family Foundation[8], the pandemic likely contributed to increased health and financial needs among immigrant families. Many immigrants' work, living, and transportation situations put them at increased risk for potential exposure to coronavirus and its variants. Noncitizen immigrants also faced financial difficulties due to the pandemic, as many work in service industries, such as restaurants and food services, that suffered cutbacks.

IV. Recent Legislation Expanding Health Coverage for Undocumented Residents in Other States

A. Kaiser Family Foundation Report

According to the Kaiser Family Foundation[9], many states have expanded coverage for immigrant populations:

> ***"Several states have proposed or taken action to expand coverage for immigrant children and pregnant individuals.*** *Currently, six states (California, DC, Illinois, New York, Oregon and Washington) provide comprehensive state-funded coverage to all income-eligible children, regardless of immigration status. Massachusetts provides primary and preventive services to all children, regardless of immigration status or income. Several states will extend Medicaid-like, state-funded coverage to immigrant children, including Maine and Vermont in July 2022, and Connecticut to children under age [thirteen] in January 2023. New Jersey has also proposed to expand coverage to children currently ineligible due to immigration status in the FY 2023 Governor's budget. A number of states also provide state-funded pregnancy coverage regardless of immigration status, including DC, New Jersey, and New York. DC plans to adopt the CHIP unborn child option in 2022 along with Connecticut and Maine, and Vermont will extend state-funded Medicaid-like coverage to pregnant individuals regardless of immigration status in July 2022. The American Rescue Plan Act gives states the option to extend Medicaid postpartum coverage from 60 days to 12 months beginning in April 2022. Five states—California, Connecticut, Massachusetts, Minnesota, and Washington—that are planning to take up this option will also extend the coverage to postpartum individuals who are not eligible due to immigration status. California and Illinois recently implemented 12 months postpartum coverage regardless of immigration status through CHIP Health Services Initiatives amendments.*
>
> ***Some states are also taking action to expand fully state-funded coverage to adult immigrants.*** *California Governor Gavin Newsom's 2022-2023 proposed budget would provide fully state-funded Medicaid coverage to all income-eligible adults, ages 26 to 49, regardless of immigration status, no sooner than January, 1 2024. The state previously*

[8] Health Coverage of Immigrants | KFF
[9] Health Coverage of Immigrants | KFF

extended state-funded Medicaid coverage to young adults ages 19-26 regardless of immigration status, and adults ages 50 and older will become eligible on May 1, 2022. In December 2020, Illinois extended state-funded coverage to low-income individuals ages 65 and older who were not eligible due to their immigration status. As of May 2022, coverage will also be extended to low-income immigrants ages 55 to 64, regardless of immigration status, and proposed legislation would further expand this coverage to all adults ages 19 and older. In Oregon, the Cover All People Act, will extend state-funded coverage to all low-income adults who are not eligible due to immigration status, starting on July 1, 2022, subject to available funding. Prior to this recent state activity, only the District of Columbia's locally funded Healthcare Alliance program, created in 1999, provided health coverage to low-income residents regardless of immigration status. States can also provide state-funded premium subsidies to immigrants who are ineligible for federal premium subsidies in the Marketplace due to their immigration status. In Colorado, beginning in 2023, state residents with income up to 300% FPL who do not qualify for health insurance under the Affordable Care Act or other public programs because of their immigration status will be eligible for state-funded premium subsidies to assist them in purchasing individual coverage."

B. Review of Similar Initiatives in Other States

California: On May 1, 2016, pursuant to SB 75, California children under 19 years of age became eligible for full-scope Medi-Cal (California's Medicaid Program) benefits regardless of their immigration status. Full-scope Medi-Cal provides medical, dental, mental health, and vision care, as well as alcohol and drug use treatment. In 2019, California became the first state to extend full-scope Medi-Cal coverage to all eligible undocumented young adults up to the age of 26.

Colorado: Beginning in 2023, Colorado state residents with household incomes up to 300% of the FPL, who do not qualify for coverage under the Affordable Care Act or other public programs due to immigration status, will be eligible to purchase subsidized coverage through a public benefit corporation that will be operated by the Colorado health insurance exchange. The State of Colorado will generate funding for the subsidies by assessing fees on hospitals and health insurance companies.

Details: Colorado Senate Bill 20-215 ("CO 20-215"), which was passed in 2020**,** created the Health Insurance Affordability Enterprise (the "Enterprise") within the Division of Insurance in the Department of Regulatory Agencies. The Enterprise is authorized to assess fees on private hospitals and insurance companies to subsidize several programs.

Specifically, beginning in 2021, the Enterprise is to assess and collect from carriers, by July 15th of each year, a health insurance affordability fee. CO 20-215 § 10-16-1205 (2)(d)(I)(B). The Enterprise may assess a fee of 1.15% "of premiums collected by nonprofit carriers" and 2.1% "of premiums collected by for-profit carriers." CO 20-215 § 10-16-1205 (1)(a)(I)(A); CO 20-215 § 10-16-1205 (1)(a)(I)(B). In addition, for calendar years 2022 and 2023, the Enterprise is to assess

and collect from hospitals a special assessment of $20 million per year. CO 20-215 § 10-16-1205 (1)(a)(II).

Revenue that is generated from these assessments is deposited into the Health Insurance Affordability Cash Fund, and the Enterprise must annually allocate the revenues collected in 2023 and in the years thereafter as follows: (1) 3% for administrative expenses; (2) up to 73% of the revenues, but not to exceed $90 million, to the state's reinsurance program cash fund; and (3) $18 million for subsidies for state-subsidized individual health coverage plans purchased by qualified individuals. CO 20-215 § 10-16-1205 (1)(d)(I).

A "qualified individual" means an individual "regardless of immigration status" who is (a) a Colorado resident, (b) has a household income of not more than 300% of the FPL, and (c) is not eligible for the premium tax credit, Medicaid, Medicare, or CHIP. CO 20-215 § 10-16-1203 (12).

A "state-subsidized individual health coverage plan" means "a subsidized individual health coverage plan offered by carriers to qualified individuals through the public benefit corporation." CO 20-215 § 10-16-1203 (15). A "public benefit corporation" means "a public benefit corporation . . . that is organized and operated by the exchange . . . for the purpose of administering and operating a subsidy to reduce the costs of health care coverage offered under a state-subsidized individual health coverage plan." CO 20-215 § 10-16-1203 (11).

Maine: Maine Statute Title 22 § 3174-FFF which was passed on July 1, 2021, provides: "Effective July 1, 2022, a person is eligible for the same scope of medical assistance provided under section 3174-G if the person is a child under 21 years of age who would be eligible for assistance under the federal Medicaid program . . . but for the person's immigration status. . . . [T]he State shall appropriate funds in the state budget to provide state-funded medical assistance through the MaineCare program and the children's health insurance program . . . for noncitizen individuals who reside in the State and are ineligible for coverage due to federal restrictions relating to immigration status in the federal Medicaid program and the children's health insurance program." (Section 3174-G concerns Medicaid coverage.)

Massachusetts: For PRUCOL ("permanently residing under color of law") individuals, Massachusetts offers state-funded medical assistance that mirrors Medicaid for adults and children, up to 300% of FPL (under MassHealth). For undocumented individuals, coverage is limited to emergency Medicaid under MassHealth Limited. Since 2020, Massachusetts has another program for children under age 19 who must be state residents, called the Children's Medical Security Plan (CMSP). Key components are below:

- Citizenship is not a requirement
- Has some premiums and copays
- Members receive dental, behavioral health, etc. but no transportation
- Enrollment of 60,000 – 62,000
- FY 2022 budget is approximately $16 million

Funding for CMSP is set by the Massachusetts state legislature which fluctuates in budgeted funding based upon on the plan's needs from year to year (i.e., membership enrollment and claims per year).

Massachusetts also has a wraparound program called the Health Safety Net (HSN) for CMSP and limited benefit plans which reimburses providers based on medical necessity. HSN is state-funded with a surcharge from hospitals and insurers assessment. If demand is greater than the surcharge, then it is unfunded.

New Mexico: In 2021, New Mexico passed Senate Bill 317 ("NM 317"), which created the Health Care Affordability Fund that is similar to Colorado's fund.

Section 4 of NM 317 created a health care affordability fund that is housed in the state's treasury and is administered by the Office of the Superintendent of Insurance. NM 317 tasks the Superintendent with developing a "plan for extending health care coverage access to uninsured New Mexico residents who do not qualify for federal premium assistance or, except by reason of incarceration, qualified health plans, through the New Mexico health insurance exchange." NM 317 § 5 (B). No later than June 30, 2022, the Superintendent is required to submit "the plan to the legislative finance committee and the legislative health and human services committee that could offer health care coverage for eligible New Mexico residents beginning July 1, 2023." NM 317 § 5 (B). The plan must include, inter alia, "(1) details about health care benefits; [and] (2) health care affordability criteria designed to reduce the amount that individuals pay in premiums and out of pocket medical expenses under the plan and that result in, to the greatest extent possible, health care costs comparable to costs for New Mexico residents" who are eligible for enhanced premium and cost-sharing assistance from the Health Care Affordability Fund for the purchase of qualified health plans on the New Mexico exchange. NM 317 § 5 (B).

The Health Care Affordability Fund will be financed by a surtax on insurance companies.

Oregon: In 2017, the Oregon legislature passed SB 558, the "Cover All Kids" bill. SB 558 officially took effect as law on January 1, 2018, opening the Oregon Health Plan (OHP) to children younger than 19, regardless of immigration status. The program was legislatively required to form an external stakeholder workgroup. This workgroup gave advice to develop a culturally and linguistically responsive outreach campaign. The campaign focus was to connect the Cover All Kids population with local, trusted community partners who could help them enroll in the program. Children who qualified for OHP-Cover All Kids included: younger than 19; had status as an undocumented immigrant including Deferred Action for Childhood Arrivals (DACA) recipients, or, before 2018, only qualified for emergency Medicaid (Citizen Alien Waived Emergent Medical, or CAWEM) due to immigration status; and met income eligibility limits (up to 305% of the federal poverty level). About 8,000 enrolled in this program.

Recent legislation, HB3352 (oregonlegislature.gov), expanded the "Cover All Kids" to a program called "Healthier Oregon," which is now covering all children, young adults ages 19-25, and

adults 55 and over. The Oregon Health Authority (OHA) was authorized to limit eligibility to certain groups in the first year through recommendations of a community-led advisory board that made decisions as to how to narrow the program as they launched. The program is expected to launch to all age groups in 2023. The current expansion includes approximately 12,000 enrollees in this new expansion group. After July 2023, expansion to all adults is estimated to cover approximately 55,000 individuals.

Oregon utilizes coordinated care organizations as their network of healthcare providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive healthcare coverage under the Oregon Health Plan (Medicaid).

OHA gives grants to community-based organizations who help certify individuals (affiliated with a designated organization) who are trained and certified to help clients understand health coverage options and help them complete eligibility and enrollment forms. Their services are free to consumers. Many of those certified are community health workers[10].

Utah: There is a fiscal analysis of SB 158, which was introduced in 2021 and would expand eligibility for Medicaid for children and CHIP to undocumented Utah children under the age of 18.

Vermont: On June 1, 2021, H.430 ("VT 430") was passed. Subsection 2092 (b) provides: "The Agency of Human Services shall provide hospital, medical, dental, and prescription drug coverage equivalent to coverage in the Vermont Medicaid State Plan to the following categories of Vermont residents who have an immigration status for which Medicaid coverage is not available and who are otherwise uninsured: (1) children under 19 years of age whose household income does not exceed the income threshold for eligibility under the Vermont Medicaid State Plan; and (2) pregnant individuals whose household income does not exceed the income threshold for eligibility under the Vermont Medicaid State Plan, for coverage during their pregnancy and for postpartum coverage equivalent to that available under the Vermont Medicaid State Plan."

Such coverage begins on July 1, 2022. In addition, on July 1, 2022, the Agency of Human Services is required to present to the House and Senate Appropriations and Health Care Committees on the estimated fiscal year 2023 costs of providing the expanded coverage.

Virginia: Proposed legislation in Virginia would have established a state subsidized health program for undocumented children under 19 years old. Virginia created a 2022 fiscal impact statement of the proposed program. Virginia recently rejected the proposed legislation on primarily financial grounds. The fiscal impact statement provides, in relevant part:

[10] Oregon Health Authority : Oregon Health Plan Certified Community Partners : Oregon Health Plan : State of Oregon

"According to [Department of Medical Assistance Services (DMAS)], there are an estimated 13,000 potentially eligible undocumented children in Virginia who are within current income limits for Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). However, DMAS maintains not all eligible children would be enrolled in this new program. As such, DMAS expects a ramp up with enrollment reaching 4,550 (35 percent of the 13,000) by the end of the first year of the program and 5,590 (43 percent of the 13,000) by the end of the second year. These ramp-up assumptions reflect the recent experience of Oregon's Cover All Kids program, implemented in 2018. . . . As such, per member per month costs are initially estimated at $226.01. As there is no feasible way to immediately establish the program and begin providing the required coverage, DMAS assumes that the program would be operational by July 1, 2023, resulting in medical costs of $7.3 million in fiscal year 2024 and $14.5 million in fiscal year 2025. Should coverage begin sooner, then first year costs would increase.

Setting up a comprehensive health care program, as provided for in the bill, would require administrative funds with some costs expected to begin in FY 2023. While there is significant additional planning required before this benefit can be operationalized, DMAS provided a series of administrative cost estimates based on available data. DMAS estimates that $4.2 million in FY 2023 and $3.1 million each year thereafter would be needed to cover the costs associated with service provider contracts (i.e. dental, enrollment broker, service authorization, rate setting, etc.), outreach, and readiness review. In addition, system costs are expected to be $1.7 million in FY 2023 and $0.2 million in subsequent years. DMAS also identified the need for 10 additional positions to administer the program. These positions are expected to cost $1.4 million each year. The administrative cost for DMAS would total approximately $7.3 million in FY 2023 and $4.7 million thereafter."

V. Existing Data Modeling and Projected Costs

A. History

Connecticut has a history of offering healthcare coverage to qualified immigrants.[11] In 1997, the State Medical Assistance for Non-Citizens (SMANC) program offered state-funded health insurance coverage to qualified immigrants who were ineligible for Medicaid because they had lived in the country for less than five years. In 2009, the legislature eliminated most of the program, except for: (1) certain pregnant women and children up to age 21 (whose federal coverage under the federal Children's Health Insurance Program Reauthorization Act of 2009 had not yet begun) and (2) individuals who were receiving long-term care as of September 8, 2009 (PA 09-5, September Special Session). As a result, 4,889 individuals lost health insurance coverage. OHS was unable to obtain data on the number of lawful immigrants currently residing in Connecticut who would qualify for SMANC had it not been eliminated. Court challenges temporarily halted the termination on constitutional grounds, but the state Supreme Court upheld the state's right to terminate these benefits.

[11] : STATE MEDICAL ASSISTANCE FOR NON-CITIZENS (ct.gov)

According to the Office of Fiscal Analysis, the state spent approximately $24 million per year on SMANC before the program was eliminated. Considering the Supreme Court ruling, DSS moved forward with the legislative requirement to eliminate state-funded coverage for those legal immigrants whose coverage was scheduled to end starting on July 1, 2011. The legislature amended the law again in 2011 to reflect the delay in program termination. Specifically, it (1) extended the grandfather period for individuals already receiving SMANC-covered nursing home care from September 8, 2009 to June 30, 2011; (2) allowed individuals receiving nursing home care to apply for the care by June 1, 2011 instead of September 8, 2009; and (3) clarified that the noninstitutional care for SMANC enrollees would be home- and community-based services equivalent to that under the Connecticut Home Care Program for the Elderly, not simply home care.

B. Recommendations from Stakeholder Reports

i. CT Health Foundation Recommends HUSKY Expansion 2020

In a document entitled Expanding HUSKY Coverage for Children in Connecticut written by the CT Health Foundation in 2020[12], the Foundation recommended expanding Connecticut's Medicaid and CHIP coverage (HUSKY A and HUSKY B) to children and youth under age 19 who are not in the country with legal status. Based on factors outlined in their publication, the total estimated costs to the state was projected to be approximately $25.3 million over a two-year period, to cover a total of approximately 13,000 recipients. Their modeling assumes a gradual enrollment (based upon Oregon's experience) over two years since many eligible immigrants will not enroll right away and may never enroll. Enrollment is expected to increase over time, starting with about 4,550 children in year one and reaching about 5,590 children in year two. The Foundation also points out that "The Connecticut Office of Fiscal Analysis estimates that HUSKY A costs $315 per member per month, and HUSKY B costs $183 per member per month. Additionally, research shows that immigrants have 14 to 20 percent lower health care utilization, even after adjusting for health status, race/ ethnicity, gender, health insurance coverage, and other factors."

ii. RAND Study 2022[13]

In June 2022, the RAND Corporation, working with the Universal Health Care Foundation of Connecticut and advocacy organizations, released a publication entitled "Expanding Insurance Coverage to Undocumented Immigrants in Connecticut."

The RAND Corporation conducted modeling using three scenarios. In Scenario 1, Medicaid eligibility is further expanded to the full population of otherwise-eligible undocumented and legally present recent immigrants. Scenarios 2 and 3 additionally expand marketplace subsidy

[12] Expanding-HUSKY-Coverage-for-Children-Sept-2020.pdf (cthealth.org)
[13] Expanding Insurance Coverage to Undocumented Immigrants in Connecticut | RAND

eligibility to undocumented immigrants, with two different levels of income eligibility: (1) eligible if income is less than or greater to 200% FPL and not Medicaid/CHIP eligible or otherwise have an affordable coverage option; and (2) eligible if income is less than or equal to 400% FPL and not Medicaid/CHIP eligible or otherwise have an affordable coverage option[14]. Their assumptions also assume that all eligible enrollees would enroll at once and not gradually.

We note that the RAND report's references to "extending Medicaid" should be understood as expansions of Medicaid-level healthcare services, and not an expansion of the actual state Medicaid program. Unlike Medicaid, there would be no federal contribution for these services, as federal funding is not permitted.

OHS and its agency collaborators, when producing this report within available resources, relied on existing available data sources to attempt to derive a quantifiable impact on the implementation of the requirements outlined in the bill. It should be recognized that the RAND report, while informative, does not precisely align with the more granular population segments outlined in the bill. Additional modeling focused on implementing coverage for the following populations would need to be conducted to drill down further and develop a more refined fiscal estimate:

- ✓ 160-175% Covered CT coverage for undocumented adults
- ✓ 175-201% expansion of Covered CT for documented residents and then undocumented residents
- ✓ 202-323% expansion of Covered CT to undocumented children to match the current HUSKY B program

In addition, OHS would like to note that assumptions in the CT Health Foundation and RAND reports are slightly different, and total cost of the populations covered are included in the RAND report. The RAND report includes some potential additional savings to the state in the form of reduced emergency Medicaid coverage and savings to hospitals from a reduction in uncompensated care costs.

Further analyses would need to be conducted to consider a gradual enrollment beyond fully implemented cost projections to ensure the most accurate budget projections possible. Many states, like Oregon, have experienced a gradual enrollment process, even with efforts to leverage community partners to assist in engagement and enrollment activities.

iii. Access Health CT Projected Costs

One possible option for expanding coverage would be to sell health insurance coverage through Access Health CT (AHCT). This would likely require the creation of a new subsidiary dedicated to offering these plans. Setting up a subsidiary of AHCT that sells health insurance to a

[14] Please refer to Table S.1 in Rand Report, viii

population that is not eligible to purchase through the Exchange would be a substantial task and could have a significant cost. Some of the factors that will determine the costs are:

1. The type of coverage being offered;
2. The insurance companies/underwriters participating as partners with AHCT;
3. The pricing of the product;
4. The support of undocumented insured clients;
5. The marketing plan to reach the undocumented insured;
6. The technology needed to integrate with the current AHCT website;
7. The ability to utilize existing AHCT staff to manage the product, market and insured;
8. The role of employers of undocumented insured clients; and
9. The competition for this niche market.

The history of AHCT provides some context to the challenge of estimating the cost of starting this subsidiary. The federal government contributed over $120 million in the first two years of AHCT's existence. That investment has generated over 100,000 new insured clients. It is our view that setting up a subsidiary to service the undocumented market would be able to leverage many of these early investment dollars. For example, the website development, the physical space, the development of relationships with underwriters, brokers, consultants, and others have multiple years of experience. A subsidiary for immigrants regardless of immigration status/undocumented clients would not have to start from ground zero.

AHCT's estimate of how much would have to be invested ranges from $10 to $15 million. This is largely based on the factors listed above and does not include ongoing operating costs to run a subsidiary exchange. This potential solution would also require legal and regulatory review in order to determine if it was feasible to implement.

VI. Conclusion

OHS, OPM, DSS, CID, and AHCT thank participants for their contributions to this report. Because of resourcing constraints, it was necessary to utilize data and reporting from external stakeholders such as the CT Health Foundation and the RAND Corporation to derive deliverables to fulfill the statutory requirement under P.A. 21-176. This report details the underlying assumptions and limitations of this available data, as well as provides information regarding further analyses that can be completed to more fully explore the policy and fiscal impact of making further changes to healthcare coverage for the populations discussed in this report. OHS is committed to working with its sister agencies to continue to enhance equitable access to high quality healthcare and control costs in order to ensure better health for all of the people of Connecticut.