

Parents' Experiences with the 2008-2009 HUSKY Network Transition

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Executive Summary: Parent's Experience with Recent HUSKY Transition

Introduction:

The purpose of this study was to investigate the experiences of HUSKY families following January 2009 changes to the program that required families to choose among three new provider networks. A team of four Wesleyan University students collaborated with the Middlesex Coalition for Children to examine the effects of this most recent transition in the program on parents' satisfaction with their new plans and services, access and use of healthcare for their children, and general opinions about their experiences navigating the HUSKY program.

The Study:

- **Telephone Survey**
 - 1455 randomized calls were made, resulting in 63 surveys of HUSKY-enrolled parents of Middletown public school students.
 - Topics: previous and present insurance plans, satisfaction with plans, experience with the insurance transition process, access to and use of health providers, service denial, and additional open-ended questions.
- **Qualitative Interviews**
 - Participants were randomly selected from a pool of willing survey respondents.
 - Five in-person interviews were completed covering similar topics as the phone interviews.

Major Findings:

- **The Transition: The Importance of Continuity of Care**
 - The majority of parents (68.3%) selected their new plan. Of the parents who selected their new plan, the vast majority (75.6%) did so in order to stay with their same doctor.
 - Continuity of care was a major reason that parents did not feel particularly negatively about the forced plan-switch. Overall, 52.6% of parents felt positively about the transition, while 31.6% were neutral, and only 15.8% felt negatively.
 - People's satisfaction with the transition was aligned with their satisfaction with their new plans. For example, 67.6% of people who were satisfied with their new plan felt positively about the transition. Only 5.9% of parents who felt positively about their new plan still felt negatively about the transition. However, this percentage shows that a small minority of parents was dissatisfied with the transition itself, regardless of their satisfaction with their new plan.
- **Network Shifts and New Plan Satisfaction: The Move to CHNCT**
 - Most surveyed families were in the Community Health Network of Connecticut (CHNCT) after the transition, the only not-for-profit provider amongst the new plans.
 - The majority of surveyed families felt satisfied or neutral about their experiences with HUSKY.
 - Parents were more likely to be satisfied in the CHNCT than Aetna or AmeriChoice. Satisfaction by current plan: CHNCT (72.5%), Aetna (33.3%), AmeriChoice (40.0%).

Network Distribution Pre- and Post-Transition

	Aetna Better Health	AmeriChoice by United Healthcare	Community Health Network of Connecticut (CHNCT)	Anthem Blue Care Family Plan	Traditional Medicaid	Unsure
Family's Old Plan	N/A	N/A	15.9% (10)	50.8% (32)	22.2% (14)	12.7% (8)
Family's Current Plan (N=63)	20.6% (13)	7.9% (5)	63.5% (40)	N/A	N/A	7.9% (5)

Parent Satisfaction with New and Old Plans

Satisfaction	Old Insurance Plan	New Insurance Plan
Negative	12.7% (8)	4.9% (3)
Neutral	4.8% (3)	37.7% (23)
Positive	79.4% (50)	57.4% (35)

- **Additional Findings Beyond the Survey**

- Parents expressed concern about:
 - Poor communication with the Department of Social Services;
 - Discontinuous coverage due to doubts of citizenship, paperwork errors, or income ineligibility;
 - Trouble finding dentists who accepted HUSKY, finding quality dentists, and problems with constant switching of dental plans.

Conclusion:

We found that the transition to new providers went relatively smoothly in Middletown. This can be seen as the result of many Middletown residents benefitting from a continuity of care; parents actively communicated with primary care physicians to maintain relationships despite the shift in providers. In tandem with this ability to stay with preferred doctors, satisfaction with both HUSKY insurance and the transition to new providers was higher than we had initially anticipated. However, issues we had not anticipated were revealed throughout the course of research collection including problems with secondary support networks, such as DSS case workers and an overall lack of communication between HUSKY and recipients, and lack of access to care specialists. In the future, it may be productive for HUSKY to seek input and experience from the families themselves to improve the program.

Introduction

The purpose of this study was to investigate the experiences of HUSKY¹ enrollees following recent HUSKY program changes. Previous network transitions have shown drops in enrollment that have resulted in loss of coverage and restricted access to healthcare services. A team of four Wesleyan University students collaborated with Betsy Morgan, Executive Director of the Middlesex Coalition for Children (MCC), to examine the effects of this most recent transition on parents' satisfaction with their new plans and services, access and use of healthcare for their children, and general opinions about their experiences navigating the HUSKY program.

The MCC was founded in 1992 after Middletown Public School achievement tests reported that more than 40% of Middletown children were failing across multiple educational domains, but broadened its scope soon after to encompass the full range of issues affecting parents and children. Currently, the MCC offers a comprehensive and multi-faceted community approach to improve the well-being of Middletown children through social change and improvement in areas such as education, safety, and health. The board of the MCC is composed of local leaders who play crucial roles in the future of Middletown children. The MCC requested the services of Wesleyan University's undergraduate Community Research Seminar to implement this study.

After agreeing upon the purpose of the study, the research team and the MCC collaboratively designed a standardized telephone survey that was administered randomly to a sample of Middletown public school parents who have children covered by HUSKY. To gather additional information in a less restricted manner, longer in-depth

¹ Health insurance for Uninsured Kids and Youth in Connecticut

qualitative interviews with some respondents were subsequently conducted in person. While the information collected in this study cannot be generalized to other communities in Connecticut, we hope that this case study will expose parents' experiences of both this particular policy change and the HUSKY program in general, so as to make future transitions more successful.

Literature Review

Health Disparities Faced by Low-income Families

Currently in the United States, healthcare is not distributed equally among all demographics of the population. This inequality of distribution mostly affects children, as they are subject to both the barriers that their parents face and the limited ability to procure services for themselves. Children in families below the poverty line have greater health care needs than any other economic sub-sector of children (Krieger et al., 2003). Poor children are more likely to have low birth weights or be pre-term at birth. Low-income children are also more likely to be exposed to environmental, nutritional, and other health risk factors. They are also more likely to be in need of health care services due to the lack of availability of early preventative measures (Currie, 1995).

Compared to families with insurance, uninsured families do not have as much access to preventative care and often end up relying on emergency rooms or hospitals for service, which is a burden on the entire health care system (National Coalition on Health Care, 2009). In addition, discontinuous health care has been shown to be nearly as detrimental to children's health as a complete lack of insurance. According to Olson et al. (2005), continuity of coverage is extremely important in determining the quality of health services provided. While they found that children lacking health insurance experience increased unmet health needs, they also found that children lacking coverage for even part of the year also have significantly less access to preventative care, and have increased unmet medical care and unfilled prescriptions.

Thus, these children with only partial coverage constitute a "hidden uninsured" group in the United States, leading to underestimates of the uninsured population in the

country (Olson et al., 2005). Continuous coverage, whether public or private, protects children's health significantly compared to discontinuous coverage or complete lack of coverage. Olsen et al. calculate that in addition to the 6.6% of children in the United States who lack year-round coverage, an additional 7.7% had gaps in insurance (Olson et al., 2005). Moreover, the Current Population Survey (CPS), which is often used to estimate and analyze percentages of the uninsured, does not differentiate between those who are underinsured and those with comprehensive coverage. Thus coverage is often underreported (CVC, 2008a).

It has been shown, however, that low-income families, even when insured, still face significant barriers to utilizing health care services. De Voe et al.'s (2007) survey of Oregon families receiving food stamps found that families with insurance remained worried about whether they could use the insurance, particularly about whether clinicians would accept the insurance and whether the insurance would cover enough of the services so that health services remained affordable. Essentially, insurance does not equal access.

Medicaid for Children in Connecticut

Medicaid began in 1965 as a state-administered health insurance program. Each state sets its own guidelines regarding eligibility and services. States are also federally funded for health insurance programs for children up to age 19 under the State Children's Health Insurance Program (SCHIP). While SCHIP programs target children whose parents have too much money to be eligible for Medicaid, but not enough to purchase private insurance, Medicaid Programs target extremely low-income children.

Most states offer SCHIP insurance coverage to children in families whose incomes are at or below 200% of the Federal poverty level. In some states, SCHIP is part of the state's Medicaid program while in other states it is separate. In Connecticut, as well as in some other states, Medicaid and SCHIP are combined under one program. For Connecticut, this combined program is called HUSKY. The Medicaid-based program is HUSKY A while HUSKY B is the SCHIP program.

Nearly every uninsured Connecticut child is eligible for HUSKY coverage. Within HUSKY A, the Medicaid-funded component of the program, children less than 19 years of age in families with incomes below 185% of the Federal Poverty Level (FPL) qualify for the program as well as parents and caretaker relatives in families with an income of less than 150% of the Federal poverty level.

Table 1: HUSKY Plan Features and Qualifications Based on Income for a Family of 4 People

Family of 4	HUSKY Plan features
under \$40,792	Free health care for children under 19 and their parents, or a caregiver relative like a grandparent who lives with the children [HUSKY A]
\$40,792 to \$51,817	Health care for children under 19; some co-payments. Eligible for HUSKY Plus Physical. [HUSKY B]
under \$55,125	Free health care for pregnant women (note: for eligibility of pregnant women, unborn child is also counted as a family member) [HUSKY A]
\$51,817 to \$66,150	Health care for children under 19; monthly premium of \$30 for first child; maximum monthly premium of \$50, regardless of number of children; some co-payments. Eligible for HUSKY Plus Physical. [HUSKY B]
over \$66,150	Health care for children under 19: Group premium rate \$195 monthly per child; some co-payments. [HUSKY B]

(Source: <http://www.huskyhealth.com/qualify.htm>)

HUSKY has helped reduce the number of uninsured people in Connecticut. It covers 340,000 people, 70% of whom are children, yet there are still 326,000 people

(9.4% of the population) without health insurance in Connecticut; 5.2% of the Connecticut population is both without insurance and under 18 (CVC, 2008b).

Most people who are uninsured qualify for HUSKY, so one future goal for HUSKY is to do more outreach in an attempt to enroll these individuals in the program (CVC, 2008b). As of July 2007, HUSKY has increased the maximum income level for parents from 150% to 185% of the Federal Poverty Level in order to include more of the lower-middle class and decrease the number of families who are uninsured. Furthermore, the maximum income level for pregnant women increased from 185% to 250% of the federal poverty level in order to cover more pregnant women and babies (CVC, 2008c).

While HUSKY has attempted to decrease the number of uninsured people in Connecticut, legislative changes have proved disruptive for the program over the past few years. Previous instances of bureaucratic and policy changes have led to decreases in enrollment and proven more costly to the state in the end. For example, a previous HUSKY policy change that raised the requirements for eligibility, application, and cost sharing resulted in an enrollment dip of 10,000 people in the summer of 2005 and another 15,000 in the summer of 2006, with children making up the largest portion of those dropped (a decrease of 20,000 in 13 months). In addition, outreach to enroll more uninsured people in HUSKY was eliminated, there was little help with the new and more complicated application process, and enrollees were often genuinely confused about their eligibility status (CVC, 2006).

While in the short run the state may save money because fewer people are insured, in the long run, an increase in the number of uninsured people poses a

financial burden. As stated earlier, people without health insurance lack access to preventative care and tend to rely on hospitals and emergency services instead. While the uninsured pay a considerable portion of their health fees out-of-pocket, hospitals incur large costs for unaffordable services. Federal and state governments end up having to pay large sums of money to cover these expensive hospital visits and emergency services that would have been largely avoidable if people were insured and had access to preventative care (National Coalition on Health Care, 2009).

Recent Legislative Changes to HUSKY

In the summer of 2008, Connecticut Governor M. Jodi Rell proposed a new health insurance plan approved by the General Assembly called Charter Oak Health Plan. The plan is designed to cover uninsured adults of all income levels, particularly those struggling to pay unaffordable non-group premiums (Charter Oak Health Plan, 2008). Currently, Charter Oak covers less than 3,000 individuals. The Governor feared that for-profit HMOs² would not support Charter Oak, so she decided to link the new Charter Oak plan with the existing HUSKY plan for low-income families. In addition to covering Charter Oak enrollees, the new HMOs would then benefit from the profits of about 345,000 low-income HUSKY enrollees. Basically, HUSKY enrollees were used as an incentive to get new risk-based HMOs to cover the Governor's Charter Oak Health Plan (Toubman 11, 2008).

² HMO: "health maintenance organization, a company or non-profit paid to manage health care for a given population" (Toubman 11, 2008).

In order for this to happen, HUSKY enrollees were forced to switch from three non-risk plans³ (Community Health Network of Connecticut (CHNCT), Anthem Blue Care Family Plan, and Traditional Medicaid) to three risk plans⁴ (CHNCT's capitated⁵ plan, Aetna Better Health, and AmeriChoice United Healthcare). Middlesex County was the first county to make the transition to the new capitated HMOs. Enrollees were allowed to select their new plans until January, giving most families only a few weeks to make the transition. After January 2009, those who did not selected a new plan were randomly assigned to one of the new HMOs, except those previously enrolled in CHNCT who were simply moved to CHNCT's capitated plan. At the time, it was estimated that even if everyone in CHNCT stayed in CHNCT, about 238,000 would still be forced to select a new plan (Toubman 3, 2008).

Federal Medicaid law dictates that the state must have documentation that there is an adequate network of providers in the area that is willing to accept the new HMOs "at least to the extent that such care and services are available to the general public" before the state asks people on Medicaid to enroll in these new plans (Toubman 3, 2008). Still, advocates feared this transition would be a potential "slow-motion train wreck," as one described it, based on previous transitions that led to gaps in coverage

³ Non-risk plan: "an HMO or insurance company paid for administration services only (maintaining a provider network, reviewing requests for services, customer service), with the payer also reimbursing the HMO for all payments to health providers for actual health services, such that the HMO does not have a financial incentive to deny health care" (Toubman 11, 2008).

⁴ Risk plan: "an HMO or insurance company plan paid by the state or other payer on a capitated basis" (Toubman 11, 2008).

⁵ Capitated: capitated plans are 'risk plans', they are "a type of payment to an HMO or insurance company, wherein it is paid a fixed amount of money per member per month to provide all needed health care under a contract and thus has a financial incentive to deny care because money not spent on health care goes toward the entity's bottom line" (Toubman 11, 2008).

(Campbell, 2008). During a previous transition in April 2008, despite notices being sent asking people to switch plans, 40% did not respond and were involuntarily moved. Luckily, during this previous transition in April, people were moved into plans that had existing networks. However, the recent transition was expected to have greater consequences on recipients due to the larger volume of people switching plans and the fact that the two new HMOs, Aetna and AmeriChoice, had unestablished provider networks (Toubman 2, 2008).

Although the Governor promised that “there [would] be no gaps in benefits or coverage” during this transition, many advocates were worried about the provider networks in place for Aetna and AmeriChoice (Toubman 2, 2008). At the beginning of the transition, Aetna and AmeriChoice combined had far fewer primary care physicians (PCPs) than the original non-risk Anthem Blue Care Family Plan (Toubman 5, 2008). Compared to Anthem, AmeriChoice had 16.7% of the number of PCPs and only 9.6% of the number of specialists per capita in Middletown. Similarly, Aetna had 23.0% of the number of PCPs and 26.7% of the number of specialists per capita. In Middlesex County, this amounted to one pediatrician for AmeriChoice and six pediatricians for Aetna. Moreover, many hospitals, including Middlesex Hospital, had not set up contracts with the new for-profit HMOs (Toubman 3, 2008).

Additionally, providers were reluctant to sign up for HUSKY because they were required to also sign up for Charter Oak. While there is currently no link between HUSKY and Charter Oak for providers, the two programs remain associated at the HMO level (Toubman 10, 2008). Further, advocates attempted to prevent

discontinuous coverage by urging enrollees to hold off as long as possible before switching to one of the new HMOs.

People who did switch promptly seemed to change primarily to Aetna, probably due to name recognition and a false hope that through Aetna they would have the same access to providers as those who are on Aetna commercial plans (Toubman 9, 2008). Although CHNCT and Anthem were both willing to run HUSKY on a non-risk basis indefinitely, in total, thousands of HUSKY enrollees have involuntarily changed plans, some for the fourth time in one year (Toubman 8, 9, 2008). Ironically, according to critics, this move has not saved money. Connecticut taxpayers are paying 24% more for the new HMOs compared to the previous HMOs. Instead, critics claim this transition was made to offer HMOs profits made off the HUSKY population as an incentive for them to cover the Governor's Charter Oak Health Plan (Toubman 3, 2008).

In light of the negative effects that previous HUSKY transitions had on enrollment and the inadequate networks of the new HMOs at the start of this recent transition, the transition was the subject of the research question proposed by the MCC for this study. Until now, parents' experiences of such HUSKY changes have not been systematically studied.

Methodology

Randomized Telephone Survey:

A randomized telephone survey of parents of Middletown public school children was conducted to collect both qualitative and quantitative data regarding parents' experiences with the recent HUSKY program transition. Based on census data and free and reduced meal numbers within the public schools, about a third of the children in the Middletown public school system were expected to be enrolled in HUSKY. The survey was pretested on 10 individuals of a non-sample group from the survey population. The public school directory containing 5,177 students in total was then split equally among the four researchers, controlling for students with the same phone number or address as another student (i.e., presumably siblings) to prevent repeat calls to families with more than one child. Once duplicate household entries were deleted, we each called every eighth person on our lists, moving to the next eighth person if the respondent did not answer, was not on HUSKY, or refused to participate in the survey. Once the list was exhausted, each team member went back and called every eighth person starting with the fourth person from the top of the list. After exhausting that list, each team member called every eighth person starting from the second person from the top.

Calling was done primarily in the evenings from 5-9 PM. Calls were made from local landlines that displayed Wesleyan University on caller ID. A universal telephone script was used to introduce ourselves and the purpose of the study and phone survey. If parents had children who were currently on HUSKY or who had participated in HUSKY within the last year, they were asked if they would complete the survey. Participants were asked for verbal consent after we described the information collection

process and the confidentiality of their responses. The topics discussed included information regarding previous and present insurance plans, satisfaction with plans, experience with the insurance transition process, access to and use of health providers, and service denial. The telephone survey consisted of 28 closed-answer questions and 8 open-ended questions (Appendix C). In the final question, participants were encouraged to elaborate on their experiences outside of what was asked in the survey. On average, the survey took 5-20 minutes to complete, depending on the length of responses provided.

In total, 1436 calls were made, and 63 surveys were completed. Of the calls made, 53.0% did not answer or were not home, 12.8% were disconnected or wrong numbers, and 27.0% answered but were not on HUSKY. Of those who answered and were on HUSKY, 0.9% refused to participate in the survey, 0.5% could not participate due to language barriers, and 0.2% completed the survey but with notable language difficulty. All quantitative questions were immediately coded and entered into an Excel spreadsheet, and the qualitative questions were entered directly into the database. Following data collection, analyses were run using SPSS. We performed a number of relevant crosstab tests in order to test hypotheses.

Qualitative Interviews:

At the end of the telephone survey, participants were asked if they were willing to participate in a longer, in-depth, in-person interview to obtain more detailed descriptions of their experiences in a less structured format (Appendix D). Participants were offered a \$20 Wal-Mart gift card as an incentive and thank you for their time. From the pool of

people who agreed to do the longer interview, a random number generator was used to prioritize the order in which respondents were contacted so as to create a random sample for the qualitative interview. Ultimately, 5 qualitative interviews were completed. Interviewees were provided with a written and verbal description of the project, and were asked to sign a consent form before proceeding (Appendix E). Interviews were digitally recorded and later transcribed and analyzed qualitatively. Most interviews lasted between 20 and 30 minutes.

Additional Procedures:

Following the randomized telephone survey, or after the in-depth interview for those who participated, respondents were offered a document concerning their legal rights as HUSKY enrollees (Appendix F). Additionally, they were invited to attend a public presentation of the findings and were either mailed or given an executive summary of the report.

In addition to the data collected from Middletown parents on HUSKY, online lists of providers posted by the HMOs were monitored bi-weekly to gather information regarding provider availability. An archive of primary care physicians, family practice physicians, and pediatricians accepting Aetna, AmeriChoice, and CHNCT was established and tracked throughout the project to determine whether there were large shifts in providers accepting each plan throughout the period following the transition (Appendix B).

Limitations:

After collecting data through the randomized telephone surveys, it appeared the original research question may have been too narrow. People reported complaints about their plans, especially regarding DSS, but these problems did not seem to be centered specifically on the most recent HUSKY transition. For some, there have been so many transitions that this one did not seem particularly troublesome. Although many of the questions in the end revealed these overarching problems, the survey was created to deal specifically with the most recent transition. For example, the survey questions regarding switching to a new doctor were largely irrelevant because many families picked their new plan based on which plans their original doctors accepted. Moreover, since the change happened relatively recently, many of those who did have to change providers had not necessarily used the new services yet and so were unable to compare their old and new providers accurately.

A few respondents were on HUSKY but were unable to complete the survey due to communication barriers . There were five incidents of parents who did not speak English, and in one instance, both the parents of a HUSKY-enrolled child were deaf. In a couple of these cases, family members attempted to translate for the parents, but in the end, they were unable or unwilling to complete the survey. In other instances, children stated from the beginning that their parents would be unable to complete the survey because of language barriers. Additionally, there was a high proportion of disconnected phones, wrong numbers, and calls that went unanswered. This poses a problem because we were unable to capture the experiences of a whole subset of

potential HUSKY enrollees who may (or may not) have been especially affected during the transition due to economic, cultural, and language barriers.

The number of qualitative interviews was also limited due to scheduling difficulties. Because we wanted to do a random sample of qualitative interviews from those who did the telephone survey, we had to recall selected participants to schedule the interview. Unfortunately, reaching these parents a second time proved troublesome. Furthermore, some of the interviewees who we were able to schedule did not show up, even though we called to remind them the day before and the day of the interview. While we told parents that children were welcome to come, it might have been easier to hold the interviews at participants' homes rather than at the local public library. This would have also eliminated any transportation barriers.

Finally, we would like to note that while many respondents reported problems concerning HUSKY that may be consistent with issues faced in other cities in Connecticut, or even related to concerns with the Medicaid program nationally, this report does not attempt to compare the issues of Middletown families with those of other neighborhoods that may have different provider networks, varying experiences with the transition, or more or less support through this shift.

Results and Analysis

Overall, our study revealed four major findings. The first was that in general, parents experienced the recent transition to the new networks relatively smoothly, mainly due to remaining with their same primary care physician. Second, we found a major shift of Middletown families into the Community Health Network of Connecticut (CHNCT), the reasons for and results of which we will discuss. Third, parents describe far more ongoing problems with HUSKY than simply those related to the recent transition. Three unsolicited patterns of discontent emerged regarding lack of communication with the Department of Social Services, discontinuity in coverage, and dissatisfaction with HUSKY dental coverage. Finally, we found that parents exhibited considerable agency in negotiating these healthcare transitions, and were central in guaranteeing the continued coverage of their children. For raw telephone survey data tables, see Appendix G.

The Transition: The Importance of Continuity of Care

By the end of January 2009, all HUSKY families in Middlesex County were required to switch into one of three networks: CHNCT, Aetna, or AmeriChoice. Those who failed to select one of the three plans by the deadline were automatically enrolled into one of the three plans. While previous transitions have resulted in decreased enrollment, this effect has not been observed in the enrollment data surrounding the most recent transition. An analysis of enrollment data in HUSKY A and B over a nine-month span from August 2008 to March 2009 shows only an insignificant decrease of 7 HUSKY enrollees (Appendix A).

One of the most striking findings of this study was that the majority of parents (68.3%) selected their new plan. Of the parents who selected their new plan, the vast majority (75.6%) did so in order to stay with their same doctor. One mother details this process:

The good thing is that [my son's] primary doctor accepts the HUSKY program, which is great because I really didn't want to move him from doctor to doctor to doctor, because this doctor has known [my son] since he was about 3 months old, and he's been with him all this time, so he knows [my son] inside and out and all that good stuff. So I was like, why don't we try to stick with him? When we switched, that was my main worry.

The continuity of care, we believe, was a major reason that parents did not feel particularly negatively about the forced plan-switch. Overall, 52.6% of parents felt positively about the transition, while 31.6% were neutral, and only 15.8% felt negatively. As one parent described the process succinctly, "It was pretty easy, I just sent in the paperwork, and they sent the card back." One important reason that the transition might have been particularly smooth in Middletown was that Middlesex County was the initial test-run county for the switchover, and thus enrollees received additional time to make the switch and consult with their various health care service providers.

It should be noted, however, that the high percentage of neutral feelings about the transition may be due to the timing of our survey in light of the switch. At the time of the survey, many of the families had not actually used their new plan; only about half of the children (49.2%) had been seen for a check-up in the new network. In general we found that people's satisfaction with the transition was aligned with their satisfaction with their new plans. For example, 67.6% of people who were satisfied with their new plan felt positively about the transition⁶ (see Table 1). Only 5.9% of parents who felt

⁶ This finding, like all correlations that we report in this analysis, was statistically significant ($p < 0.05$) unless noted otherwise.

positively about their new plan still felt negatively about the transition. However, this percentage shows that a small minority of parents was dissatisfied with the transition itself, regardless of their satisfaction with their new plan.

Underscoring the importance of staying with their doctor, one repeated cause for dissatisfaction with the transition was when parents tried to stay with their doctor who was no longer included in the new network, forcing parents to pay for visits out-of-pocket. For example, one parent explained, “we kept going to the same doctor, but the doctor was no longer in our network, so now I have large bills to pay.” This again emphasizes how the ability to stay with the same doctor appeared to make or break the experience of the transition for families in Middletown.

Table 1: Experience of Transition versus Satisfaction with New Plan

Satisfaction with New Plan	Parent Satisfaction with Transition		
	Negative	Neutral	Positive
Negative	50.0% (2)	50.0% (2)	0.0% (0)
Neutral	28.6% (6)	38.1% (8)	33.3% (7)
Positive	5.9% (2)	26.5% (9)	67.6% (23)

p=0.032

Another cause for dissatisfaction with the transition seems to have been the limited amount of information provided about the transition itself. One woman described her qualms with the recent transition experience:

Well, all of a sudden you get a three-page letter in the mail and all it says is you have this one, this one, this one to pick from. If you do not pick one we're picking one for you. And you've got 60 or 90 days to get it done. It's like OK, there's no first letter explaining HUSKY will be changing, switching over, or

we'll be doing this, explaining it in length before you get that letter saying pick this, pick this, pick this, or we're picking it for you. There's no prior notice, you just get that letter in the mail and that's it. That is one thing I would change.

Perhaps this negative experience with the transition could have been largely avoided if more information was provided to help parents understand what was going on. We are not able to generalize from this experience, but it may be one area that future studies should explore to continue improving network transitions for HUSKY families.

Network Shifts and New Plan Satisfaction: The Move to CHNCT

At the time of the survey, the majority of families (63.5%) were enrolled in CHNCT. Aetna Better Health (Aetna) had a total of 20.6% of families, and AmeriChoice by United Healthcare (AmeriChoice) had only 7.9% of families (the remaining parents were unsure of their current HUSKY network). This contrasts with the distribution of parents in networks before the recent transition, where only 15.9% of parents were enrolled in CHNCT (see Table 2), and the majority of families were enrolled in Anthem Blue Cross or Traditional Medicaid, a major shift in networks for Middletown HUSKY families. This study is limited in its ability to understand exactly why this major shift took place because we only spoke to parents. As mentioned earlier, overwhelmingly the parents that selected their plan did so in order to stay with their doctor, which leads us to conclude that doctors may have led the shift to CHNCT. This is supported by our finding that the majority (74.4%) of people who selected their plan chose CHNCT. Future studies would be wise to also study the reasons providers switched to the network that they did, so as to fully understand the process by which transitions such as this took place.

Table 2: Network Distribution Pre- and Post-Transition

	Aetna Better Health	AmeriChoice by United Healthcare	Community Health Network of Connecticut (CHNCT)	Anthem Blue Care Family Plan	Traditional Medicaid	Unsure
Family's Old Plan	N/A	N/A	15.9% (10)	50.8% (32)	22.2% (14)	12.7% (8)
Family's Current Plan (N=63)	20.6% (13)	7.9% (5)	63.5% (40)	N/A	N/A	7.9% (5)

In both their pre- and post-transition plans, a minority of families were unsatisfied with their HUSKY insurance. While less people were unsatisfied with their new plan than their old plan (4.8% versus 12.7%, respectively), less people were also satisfied with their new plan than their old plan (56.4% versus 79.4%). These somewhat contradictory results can be attributed to the fact that a very large portion (37.1%) of parents was neutral towards their new plan (see Table 3). The widespread neutrality is likely the result of the fact that the transition between networks occurred as late as January 2009, only two months before our survey commenced. Thus, many of the families had not actually used their new plan.

Table 3: Parent Satisfaction with New and Old Plans

Satisfaction	Old Insurance Plan	New Insurance Plan
Negative	12.7% (8)	4.9% (3)
Neutral	4.8% (3)	37.7% (23)
Positive	79.4% (50)	57.4% (35)

The far more widespread satisfaction with HUSKY showed up repeatedly in the open-ended questions and qualitative interviews. For example, one mother explained,

Well I like the fact that it's coverage that you can basically afford, because if it wasn't for that, I do not really know how I'd be making ends meet. Because my job has this program and I can't join because it's \$389 every two weeks out of my paycheck, that's almost \$700 out of my paycheck every month. Just to cover me and [my son] on the family plan. I couldn't afford that. I basically live paycheck to paycheck and everything is budgeted out. So with the plan, financially it's good, good for me right now. I don't mind any of the little changes they had, which really weren't that many. And I don't really even remember any.

In addition to being generally satisfied with the existence of state-funded health insurance for low-income children and their caregivers, parents also had significant praise for their primary care physicians. As one mother said, "I can't complain about the doctors, they were very good. And thank god I never had to use an emergency room or nothing like that. Just the regular doctors. Twice a year visits, physicals and stuff. I think it works very good, it's a very good health plan." Furthermore, the majority of parents (79.4%) had never been denied services under HUSKY, which might account for the high levels of satisfaction. However, it should be noted that more time in the new HMOs may lead to a higher level of denial of services.

Our statistical analyses did find, however, that parents were far more likely to be satisfied in some networks than in others. Families enrolled in CHNCT were most likely to be satisfied with their new plan (72.5%), compared with only 33.3% in Aetna, and 40.0% in AmeriChoice. One possible reason for this finding might be that CHNCT was the only health network to remain an option after the transition, making it easier for patients to navigate to. Furthermore, we found that CHNCT had the highest amount of primary care physicians in Middletown throughout the transition (Appendix D). This

finding may help to explain not only the large shift into the CHNCT network, but also the greater satisfaction once enrolled.

Beyond the Survey

Although our survey lacked questions specifically targeting the experience of discontinuity of care and interactions with the Department of Social Services (DSS), parents repeatedly offered their experiences concerning these two issues to the research team. Three major concerns with HUSKY emerged from these interviews: lack of communication and accessibility with the staff at DSS, sudden cuts in coverage due to either alleged ineligibility or DSS error, and a lack of quality specialty services, particularly dental care.

Department of Social Services Communication

As one mother explained, “Basically it’s pretty useless to try and contact your social worker. Why she’s called a social worker I have no clue, she’s not very social at all... She won’t call me back, and I can’t get in touch with her, you know, so we’ve been going without insurance since [her coverage was dropped].” This frustration concerning the failure of DSS workers to return calls was reported by many participants. In this particular case, a woman and her young daughter were dropped from HUSKY under circumstances that the woman did not fully understand. However, as her statement above illustrates, when she sought to sort it out with her DSS social worker, she did not get a call back, thus leading to continued lack of coverage for her and her child.

This sentiment was echoed by another woman, whose coverage for her infant child had also been unexpectedly dropped. She explained,

And the worker I had to begin with... he was a total idiot. I would call him, and it would take forever to even get a hold of him, and then he would get mad at me if he didn't have something turned in on time. And I'm like, I've been trying to get a hold of [him] to even find out what it is [he] needs to get from me. In general, for anything about it, I couldn't get a hold of him about half the time.

This pattern of lack of access to DSS workers and their assistance was found also amongst parents who were otherwise satisfied with HUSKY. One mother explained, although "the idea [of HUSKY] is good,"

The worst right now is when you call, you really need a person to talk to. You do not want to talk to an answering machine. You really need a person, and when you talk to that person, they need to be conscious that they are dealing with people. When you're dealing with people, you need to be able to understand what they're asking and be knowledgeable about what they talk, especially about medical, you really need to be knowledgeable. When you call a lot of people, they do not even know what you're talking about. They do not understand you.

As this woman states, parents are generally very satisfied with the spirit and aim of HUSKY. Where their experience breaks down is often in the communication with DSS when they are having problems. One element of communication that this mother brings up is problems with potential language barriers for both English second-language parents and DSS workers. Our study was limited in that our research team was monolingual and could not obtain HUSKY experiences of parents who did not speak English. Thus, our ability to probe into the issue of communication barriers for non-English speaking parents was hindered. However, as this parent alludes to, we suspect that obstacles accessing help from DSS increase when parents do not speak fluent English.

In addition to the obstacle of making in-person contact with DSS to help sort out problems with coverage or the transition, parents also cited issues with written communication about the plans. For example, some parents complained about a lack of

information about physicians and specialists who would accept HUSKY insurance. As the mother (M) and grandmother (G) of the infant whose coverage was unexpectedly dropped said,

M: Well doctors, [DSS] did start to get better with that, because after the first year I was on there, they started sending out books that had the list of doctors, except the problem with that is that they weren't updated, so you would call some of them and they would say you weren't covered, so you'd have to fight with that still.

G: Which I'm sorry, books are kind of stupid, because of all that money on the paper and stuff, I couldn't see why they didn't just have it online.

M: That would make it a lot easier. Even with the books they only had regular doctors and some specialist doctors, no dentists, no number that you could call and find out a list of doctors in the area, [that] type of thing, there was no way to look that up online.

G: It almost makes you wonder if they were doing that so that you couldn't use the benefit and therefore not cost them money. I do not want to think like that but...

Troublesome communication with DSS can be demoralizing for families working hard to keep their children covered. This lack of clear communication seems especially dangerous when it involves losing coverage as the above examples illustrate.

Discontinuous Coverage

Through the course of our study, parents offered a number of anecdotes chronicling how HUSKY unexpectedly dropped their coverage for a variety of reasons including doubts about citizenship, mysterious paperwork errors, or income ineligibility.

One mother describes in detail how she was dropped from HUSKY because she couldn't prove she was a citizen:

Well, I've been unsatisfied with what happened to me. When they turned around there was no notice, no like thirty days. It was just you're cut, you're stopped, you have no insurance. And I'm trying to explain to the lady, you really can't do that, I have diabetes, high cholesterol and high blood pressure, I take insulin shots and the pills and if you cut my

insurance I have no way of getting my medication unless I buy it and it's expensive just to get my flex pen and my diabetic pills, it's almost \$300. So it's like, OK, what do you want me to do? They were just like we don't have any proof that you're a citizen. Do you have a green card? And I was like, it's real simple. When I became a citizen I gave up my green card. So no I do not have a green card number. And they were like, do you remember it? And I was like, let's see, I was fourteen?

This woman has had to rely on her sisters for the past year and a half to cover the cost of her medications. As she puts it, "my sister at one point sent me \$500 for my medication, my other sister sent me money for my medication. My doctor was giving me samples. And I've been trying to put a little bit away for this one, a little away for that one. And I can't not take it, or I'll get sick." HUSKY is designed to provide low-income children with health care, but also their caregivers. This underscores the need for parents to remain covered, so that they can remain healthy enough to care for their children.

Another mother discovered that her infant's insurance had been dropped when her child was taken to an emergency room in Florida in September 2008. As of March 2009, the insurance for her child had not been reinstated. The grandmother of the child describes the aftermath of this hospital visit:

And from Pensacola, I keep getting the collection calls. And I have to keep explaining to the people that we're trying to get everything resolved here and to just try to be patient with us, but I can't say I blame them. You know it's been six, seven, months. The hospital actually turned it over to a collection agency, so I'm getting those harassing phone calls. And I do not really need that. She's trying to explain to these people at the state office. I've had four strokes, I'm a diabetic, I've got medical problems, I've got my own life to deal with, I do not need the harassment of these collection calls. I also do not want the worry of, does my grandchild have medical coverage, you know.

For this family, the ongoing lack of coverage and the persisting collection calls from a visit they assumed would be covered by their insurance is a constant subject of stress

and worry. In addition, due to communication failures with DSS, the family has been unable to reinstate their insurance in a timely manner.

In addition to citizenship and paperwork issues, some HUSKY children become ineligible because of income requirements. One woman discussed her frustration with the income cut offs, which raised her premiums so dramatically for earning additional income that she can no longer afford to cover her children. She said,

I'm disappointed because I feel like they're penalizing people who really want to fulfill their dreams and actually get what they want to get. I came here to get a job and to live for my kids and for myself, you know... to depend on the government for nothing, but I think that they penalize you every time you want to get a job and do the right thing. I have two jobs just to pay the bills and all these stuff and then they penalize. You get a little bit more and now we're taking away the little help you were providing for me. I just think it's disappointing and frustrating. I was thinking that it was going to go up because I'm earning a little bit more, but I didn't think it was going to be that extreme. I thought ok, maybe 75 dollars, maybe 100 bucks instead of \$50, ok that's fine, I could afford that. But going from \$50 to now \$400 a month, it's a big change, a big jump, and I think it's just too much.

These breaks in income eligibility are not exclusive to the Connecticut HUSKY program, but rather are reflective of the national Medicaid system. However, these remain important concerns for working low-income Connecticut parents.

Dental Insurance

Although there were no questions in our survey specifically about dental services, 11% of respondents expressed frustration over HUSKY dental care options. Parents' issues with dental insurance were numerous—they included locating dentists in the first place, finding quality dentists, and then dealing with the constant switching of plans. As one mother explained,

The dental I can't stand... it's all the lowest it could possibly be, that's what insurance it is. So every time I would find a dentist for [my daughter], they would switch her dental, they were switching every couple of months which one they were actually going to use. And I'm like, seriously, you're not helping us out here, because it's already difficult enough to find doctors. And when... they send you the regular insurance stuff, they do not also send you information to contact dental places. So I had to go online and try to find it and all this other information.

This parental frustration over dental service is not surprising in the context of previous research on HUSKY. For example, a 2006 study showed that only 27% of privately sampled recipients were able to get a preventive dental appointment for a HUSKY child (Jeanerro, 2006). Furthermore, 67% of children enrolled in HUSKY A for all or any part of 2004 received no dental care whatsoever (Beazoglou, 2006). Even amongst children continuously enrolled in HUSKY A in 2005, the best of circumstances, over half received no dental care (CVC, 2006).

The Role of the Parent: Crucial to Maintaining Coverage for Children

Throughout our study, we found that despite the trends of problems just chronicled, Middletown HUSKY parents often exhibited significant agency and resiliency in their commitment to maintaining coverage and care for their children. With the transition, parents took the initiative to call their doctors and their pharmacists, to see which plan providers were choosing so as to maintain a continuity of care for their children. When navigating situations where DSS is unresponsive, parents have utilized extended family networks and their relations with sympathetic doctors, as in the case of this mother attempting to regain coverage for her daughter: "And our doctor even tried calling. [She] is one of the most amazing doctors, and you do not want to mess with one of her patients. She tried calling them, and she said, 'you need to get this coverage

straightened out because my patient needs to be taken care of', and she got nowhere with them.”

Furthermore, as many of the previous quotations suggest, HUSKY parents have concrete ideas about how to improve communication with DSS (e.g., more information online and supplemental letters of notification before network switches). In the future, we recommend that HUSKY and advocacy groups seek input and experience from families themselves to improve the program.

Conclusion

The research questions that began this collaborative process were: How have parents experienced this recent network transition, and how have their experiences (if at all) impacted their children's health? Ultimately, we found that the transition in Middletown generally went quite smoothly, in large part because so many parents were able to stay with their primary care physician and thus maintain continuity of care. Parents actively communicated with primary care physicians to maintain relationships despite the changes in HMO networks. In addition, we found that the majority of families were now enrolled in the CHNCT, the only non-profit HMO, and were more likely to be satisfied in that plan than parents in the other two HMOs. Overall satisfaction with HUSKY was high, but patterns of issues arose throughout the course of our open-ended telephone survey and our longer in-person interviews, particularly lack of communication with DSS, discontinuous coverage, and poor dental care coverage.

In addition to addressing the three main frustrations that parents expressed with the HUSKY program, it may be productive for HUSKY to seek input and experience from the families themselves to improve the program. Our study shows an impressive resiliency of Middletown parents to maintain health coverage and care for their children, even in the face of major network changes. Keeping children in Connecticut healthy should indeed remain a priority of the state, but such a goal can only be accomplished through full partnership with their caregivers.

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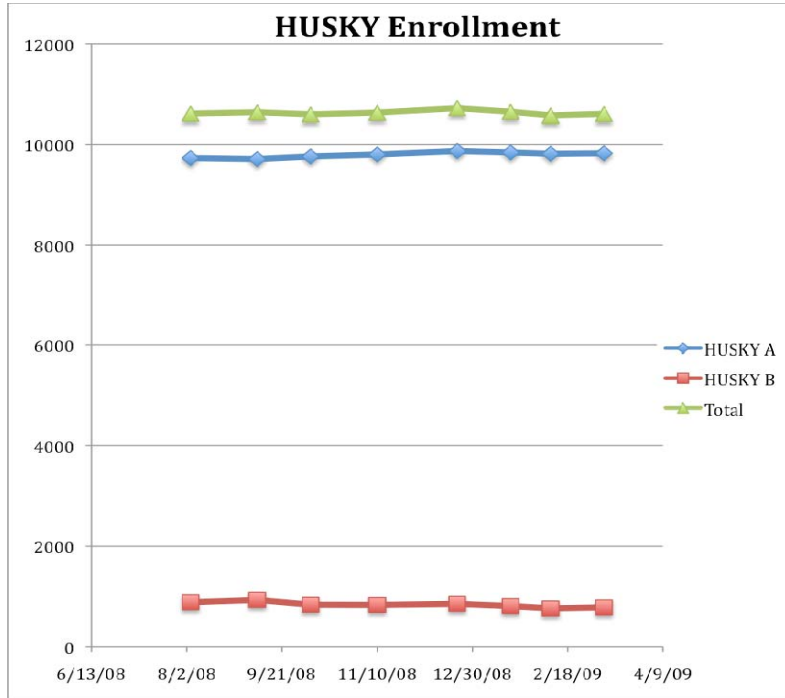
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APPENDIX

A. Middletown Enrollment Data



Date	HUSKY A	HUSKY B	Total
8/4/08	9726	883	10609
9/8/08	9705	931	10636
10/6/08	9759	833	10592
11/10/08	9799	829	10628
12/22/08	9869	851	10720
1/19/09	9840	806	10646
2/9/09	9813	758	10571
3/9/09	9823	779	10602

B. HUSKY A Providers in Middletown, CT

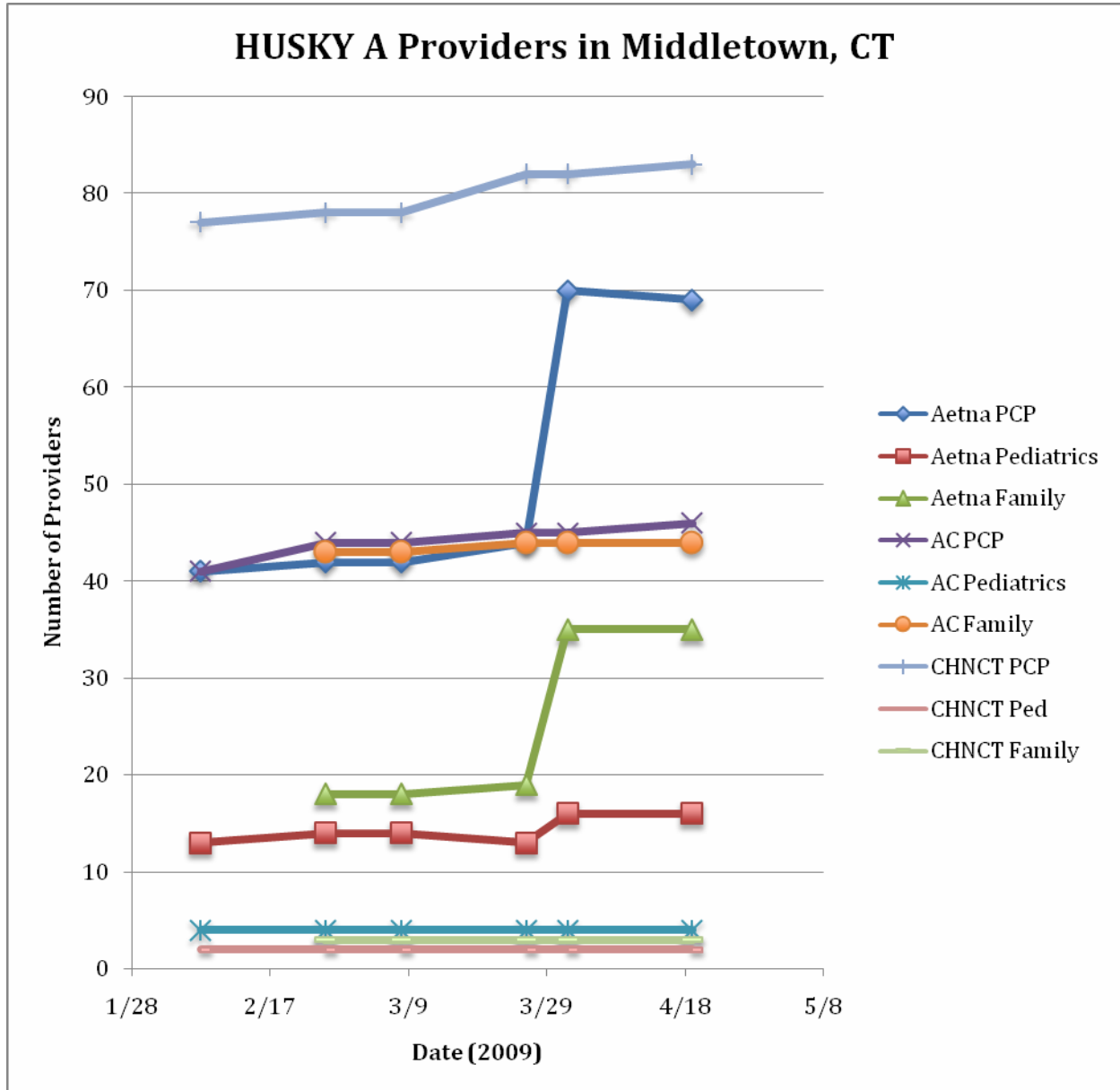


Figure 1: HUSKY A Providers in Middletown, CT

Provider	Aetna			AmeriChoice			CHNCT		
	PCP	Ped	Family	PCP	Ped	Family	PCP	Ped	Family
02/08/09	41	13		41	4		77	2	
02/26/09	42	14	18	44	4	43	78	2	3
03/09/09	42	14	18	44	4	43	78	2	3
03/27/09	44	13	19	45	4	44	82	2	3
04/02/09	70	16	35	45	4	44	82	2	3
04/20/09	69	16	35	46	4	44	83	2	3

Table 1: HUSKY A Providers in Middletown, CT

C. Standard Telephone Survey

“Hello, is the parent or guardian of _____ (Child’s name) available?”

If not, “When do you think would be a better time to call?”

“Hi, my name is _____, I’m a student at Wesleyan University working with the Middletown Coalition for Children. We are working on a survey looking into parent’s experiences with recent HUSKY insurance changes. Are you or any of your family members currently participating in HUSKY?

(if asked : HUSKY is the state of CT health insurance program for qualifying families)

If not, “Did you participate last year?”

If not, “Thank you for your time. Have a good evening.”

“Would you be willing to participate in a quick 5-10 minute phone interview about your recent experience with HUSKY? We would really appreciate hearing your thoughts, and we hope this research can help improve the HUSKY program in the future. All the information collected in this interview will be kept strictly confidential. While I will have this information, in no way will your responses be used to identify you or your child/children. All responses will be stored in a secured location and will be destroyed at the conclusion of the study.”

If not, “OK. Thank you for your time. Have a good evening.”

“Great. Thank you so much. We’ll get started then.”

“Do you have any questions before we begin?”

1. How many children in your family are enrolled in Husky A or Husky B?

2. In which of the following HUSKY insurance plans are the child/the children currently enrolled?

- 1) Aetna Better Health
- 2) AmeriChoice by United Healthcare
- 3) Community Health Network of Connecticut (CHNCT)
- 4) Not sure

3. Overall, how would you rate your satisfaction with your new plan?

1	2	3	4	5
Very Unsatisfied	Unsatisfied	Neutral	Satisfied	Very Satisfied

3.1 Why?

4. In which of the following insurance plans were the child/the children previously enrolled?

- 1) Anthem (Blue Care Family Plan)
- 2) Community Health Network of Connecticut (CHNCT)
- 3) Traditional Medicaid
- 4) Not sure
- 5) Other (not previously enrolled in another plan because joined after changes)

“We know you haven’t been in your current plan for very long, but I have a few questions specifically about your new plan”

12. If you have a child enrolled in HUSKY A, have you been told that any services for that child were “not covered” under HUSKY? Yes (1) No (0)

12.1.If YES: What Services?

13. Has your plan denied you requested services without sending you a written notice of appeal? Yes (1) No (0)

14. Anything else you’d like to share about your experience with HUSKY?

15. Would you be willing to participate in a more in-depth interview to help us better understand your experiences? As a thank you for your time, you will be given a \$20 Wal-Mart gift certificate.

If YES: Wonderful! Thank you so much. What date/time in _____ week would work for you? (One of our research team members can meet you at the Russell Library?)

- **Get contact info:** Name, address, phone number or email address. Give contact info.

16. If NO: Thank you so much for your participation. We would love to share a 1 page summary of our report with you, would you like a copy sent to your house? It will also be available online and in the Russell Library in Middletown.

17. IF NO: We will also be giving a public presentation on what we have found on May 12th from 9-10am at 27 Washington Street. Would you be interested in attending?

If Yes: Check box.

18. Finally, I have some information about your legal rights as a HUSKY enrollee that I would be happy to share with you. Would you be interested in having them sent to your home? If YES: Check box.

“THANK YOU SO MUCH FOR YOUR TIME!”

D. Qualitative Interview Guide

1. Introduce yourself.
2. Thank you so much for taking the time to speak with us! Reiterate that the interview should take between 30min-1hr.
3. CHECK TAPE RECORDER.
4. A little about me and this project: I'm part of a team of four Wesleyan University students working who were selected to research parent's experiences of the recent HUSKY insurance changes. Our community partner is the Middlesex Coalition for Children, and they've worked with us at every step of the way to design this project. We hope that this research will allow us to better understand how parents and families are affected by HUSKY changes, and hopefully improve the program in the future. We cannot tell you how much we appreciate your involvement in this project! Thank you so much for being here!
5. Provide consent form. Reiterate confidentiality.
6. Any questions that you have for me?
7. Let's get going. This is really just a chance for our team to hear more about your experience with HUSKY, especially with regard to recent changes that have taken place in the program. I have some questions, but you don't have to answer anything that you don't want to, and please, please, please feel free to talk about anything that you think is important that I forget to ask. You are definitely more of an expert on this than I am.

- To begin, maybe you could start by telling me a little about you and your family?
- In general, how has your experience with HUSKY been for you, specifically in past year?
- How have you liked your primary doctor?
- Has anyone in your family been sick in the past year? Tell me about your experience getting care.
- Have you been denied services for any reason? If yes, please explain.
- What about the recent transition with providers? What plan were you on before? What plan are you on now? How has the transition been for you and your family?
- Have you had any issues with accessing providers or finding doctors under your new plan?
- Have you ever been denied services under your new plan? If yes, please explain.

- In your opinion, what are the best things about the HUSKY program? What have been the worst aspects of the program? Why?
- What would you change about HUSKY, or the way this transition has happened, if anything?
- Is there anything else you would like us to know? Are there questions we should we be asking?
- Do you have any last questions for me?

8. THANKS SO MUCH FOR YOUR TIME.

9. Post-interview:

- a. Give gift card.
- b. Hand out legal rights if they would like it.
- c. Invitation to speak/attend the meeting.

*We will send summary of our report!

E. Consent Form

Project Title: Enrollees' Recent Experience with the HUSKY Program

Researchers: Roy Chung, Ari Tolman, Ashley Un, and Liana Woskie

Faculty Advisor: Rob Rosenthal, Wesleyan University

Community Partner: Betsy Morgan, Middletown Coalition for Children

Introduction:

You are being asked to take part in a research study being conducted by Roy Chung, Ari Tolman, Ashley Un, and Liana Woskie for the Community Research Seminar under the supervision of Rob Rosenthal in the Department of Sociology at Wesleyan, Middletown, CT.

You have been asked to do a longer in-depth interview concerning your recent experiences with HUSKY Children's Health Insurance.

Purpose:

The goal of this project is to understand the HUSKY program from the recent experiences of enrolled families.

Procedures:

The interview will take approximately a half hour. During the interview you will be asked questions about your experiences with HUSKY, the effects of the recent changes, and your satisfaction with care.

The interview will be audio-taped and transcribed. The results of your interview will be incorporated into our final report, as well as in a public presentation of our work.

Risks/Benefits:

The risks associated with participation in this interview are minimal. However, we are asking you to retell your personal experiences with your provider and about your family's health.

There are no direct benefits to you from participation, but your willingness to share your knowledge and experiences will contribute to our research, which will be used to inform the public about the effects of these recent changes and hopefully improve the HUSKY program in the future.

Compensation:

As a thank you for your time and participation in this interview, we will compensate you with a \$20 gift certificate to Wal-Mart.

Confidentiality:

Unless you check below to request anonymity, your name will be referenced in the transcript and audiotape and in any material generated as a result of this research. If you request anonymity, the tape of your interview will be closed to public use, and your name will not appear in the transcript or referenced in any material obtained from the interview.

Voluntary Participation:

Your participation in this interview is voluntary. Even if you decide to participate, you may withdraw from the interview without penalty, or request confidentiality, at any point during the

interview. You may also choose not to answer specific questions or discuss certain subjects during the interview or to ask that portions of our discussion or your responses not be recorded on tape.

Contacts and Questions:

If you have any questions about this research project or interview, feel free to contact any of the researchers or the faculty supervisor.

Researchers:

- Roy Chung at rchung@wesleyan.edu
- Ari Tolman at atolman@wesleyan.edu
- Ashley Un at aun@wesleyan.edu
- Liana Woskie at lwookie@wesleyan.edu

Faculty Supervisor:

Rob Rosenthal at rrosenthal@wesleyan.edu

Statement of Consent:

I agree to participate in this interview, and to the use of this interview as described above. My preference regarding the use of my name is as follows:

I agree to be identified by name in any transcript or reference to the information contained in this interview.

I wish to remain anonymous in any transcript or reference to the information contained in this interview.

I am willing to be contacted in the future about my experiences with HUSKY by (check all that apply):

- The Researchers
- The Middletown Coalition for Children (MCC)
- Other advocacy groups working in collaboration with the MCC

Please write preferred contact information if third statement is checked:

Participant's Signature

Date

Researcher's Signature

Date

F. HUSKY Enrollees' Legal Rights Document

Know Your Rights in HUSKY Managed Care:

If you or your child are covered by HUSKY A or B through any of the HUSKY Managed Care plans/HMOs (Aetna Better Health, AmeriChoice by United Health, or Community Health Network of Connecticut (CHNCT)):

You have a right to change managed care plans (effective the 1st of the next month). HUSKY A families may change plans *at any time*. HUSKY B families may change plans at the next open enrollment period, or sooner if they have a good reason to switch (such as the lack of a doctor within a reasonable distance in their current plan)

You have a right to all medically necessary and appropriate treatment:

- Your plan must fully cover treatment for both chronic and acute conditions.
- It must cover treatment even if the treatment will not improve your condition, or it will simply prevent it from worsening or worsening faster.
- Your plan cannot substitute a cheaper treatment unless it is as good as the one recommended by your doctor.

HUSKY recipients under 21 can **never** permissibly be denied medically necessary and appropriate treatment. **If denied, file an appeal!**

You have the right to see an out-of-network specialist paid by your HMO:

If your HMO does not have a particular kind of needed provider in your area in its network, it **must** grant approval for payment to an out-of-network provider.

You have a right to due process:

If a request for any health services or items, or a request to see a particular medical provider, is denied, changed, cut back, or ended, you have a right to be notified in writing by your HMO. The notice must explain why the services were denied or changed, cite the law that backs up the HMO's action, and explain how you can appeal the HMO's decision.

If services you already receive are being ended or changed, you have a right to **continue** receiving the services while you appeal the HMO's decision, if you request an appeal in writing before the effective date of the change.

Fight for your rights:

1. **Know** the services you are entitled to. Do not assume the HMO or your health care provider is correct about the limits of your coverage or that the HMO is correct about whether you need health care.
2. **Track** all communications with health providers and your HMO. Keep a record, in a notebook or on a calendar, and note when the communication occurred, what was said, and the name of the person you spoke with.
3. **Challenge** all denials or limits on services if you think a mistake has been made. Ask for help from an advocate in appealing those decisions.

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G. Telephone Survey Raw Data Tables

Plan Distribution and Plan Satisfaction Pre-Transition

In what plan were you previously enrolled?	Frequency	Valid Percent
Anthem	31	49.2
CHNCT	10	15.9
Traditional Medicaid	1	1.6
Not Sure	8	12.7
Previously another plan	2	3.2
Total	63	100.0

How would you rate your satisfaction with your old plan?	Frequency	Valid Percent
Very unsatisfied	6	9.5
Unsatisfied	2	3.2
Neutral	3	4.8
Satisfied	23	36.5
Very satisfied	27	42.9
Total	63	100.0

Plan Distribution and Plan Satisfaction Post-Transition

In what plan are you currently enrolled in?	Frequency	Valid Percent
Aetna	13	20.6
Americhoice	5	7.9
CHNCT	40	63.5
Not sure	4	6.3
Total	63	100.0

Overall how would you rate your satisfaction with your new plan?	Frequency	Valid Percent
Very unsatisfied	2	3.2
Unsatisfied	1	1.6
Neutral	23	37.1
Satisfied	19	30.6
Very satisfied	16	25.8
Total	62	100.0

Explain your satisfaction-rating.	Frequency	Valid Percent
Haven't used plan yet.	20	34.5
Hard to find doctors.	2	3.4
Unsatisfied with coverage.	3	5.2
Problems with dental plan.	2	3.4
Dropped from HUSKY.	2	3.4
Good service.	6	10.3
Easy to find doctors.	7	12.1
Good coverage.	12	20.7
Neutral.	4	6.9
Total	58	100.0

The Transition

Overall, how has this transition been for your family?	Frequency	Valid Percent
Negative	5	7.9
Slightly negative	4	6.3
No change	18	28.6
Slightly positive	19	30.2
Very positive	11	17.5
Total	63	100.0

If your insurance plan changed, did you select a new plan, or were you assigned to it?	Frequency	Valid Percent
Selected	43	72.9
Assigned	16	27.1
Total	59	100.0

Why did you select your new plan?	Frequency	Valid Percent
Randomly selected	3	7.3
Stay with doctors/stay with same plan	31	75.6
More features in the packet	1	2.4
Past experience with plan	2	4.9
Plan with the most providers	4	9.8
Total	41	100.0

Are you/the child/children seeing the same doctor as before?	Frequency	Valid Percent
No	6	10.3
Yes	52	89.7
Total	58	100.0

Do you feel comfortable with your new doctor?	Frequency	Valid Percent
No	1	1.6
Yes	8	12.7
Total	63	100.0

Is this new doctor's office more or less convenient to travel to than your previous doctors?	Frequency	Valid Percent
Less	3	4.8
Same	7	11.1
More	4	6.3
Total	63	100.0

Have your kids gotten a routine check-up in your new network?	Frequency	Valid Percent
No	30	50.8
Yes	29	49.2
Total	59	100.0

Have you had to miss any doctor appointments during or recently after the transition for any reason?	Frequency	Valid Percent
No	49	84.5
Yes	9	15.5
Total	58	100.0

Why did you miss an appointment?	Frequency	Valid Percent
Hard to find doctors.	1	16.7
Problems finding/with dental insurance.	3	50.0
Had appointment but was charged for it.	2	33.3
Total	6	100.0

Has your child/children been sick under your new plan?	Frequency	Valid Percent
No	37	60.7
Yes	24	39.3
Total	61	100.0

How would you rate your experience getting care?	Frequency	Valid Percent
Very unsatisfied	1	4.0
Unsatisfied	2	8.0
Neutral	3	12.0
Satisfied	11	44.0
Very satisfied	8	32.0
Total	25	100.0

If you have a child enrolled in HUSKY A, have you been told that any services for that child were “not covered” under HUSKY?	Frequency	Valid Percent
No	50	79.4
Yes	7	11.1
Total	63	100.0