



# HUSKY EXPANSION

COVER ALL KIDS IN CONNECTICUT 2019

## Medical Insurance Expansion Report

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# INTRODUCTION

## Medicaid Expansion in Connecticut

In 2010, Connecticut became the first state in the nation to expand Medicaid under the Affordable Care Act. The state also created its own health care exchange, which gave Connecticut the opportunity to build a personalized platform for its residents to access comprehensive care. The platform, called HUSKY D, expanded coverage to more than 200,000 low-income adults and reduced the number of uninsured by 45 percent<sup>1</sup>. In total, since its implementation, the ACA has brought in more than \$1 billion in new federal funds to the Connecticut economy, and the cost of uncompensated care has declined by 61 percent<sup>2</sup>. The ACA has significantly improved Connecticut's health and financial status, creating a clear precedent for further efforts to expand coverage.

## National Comparison

Since the Affordable Care Act (ACA) was implemented, the national uninsured rate has decreased from 13.3 percent to 9.1 percent in just two years—affecting all demographic groups significantly<sup>3</sup>. The Northeast performs well when compared to other parts of the nation on a variety of metrics, including its coverage gains and uninsured rate. **Connecticut's progress on the national scope is undeniable, but there are still areas where the state trails behind. The percent of uninsured children in Connecticut is among the highest in the Northeast**, especially in comparison to its direct neighbors (New York, Rhode Island, and Massachusetts)<sup>4</sup>. The state has come a long way since expanding in 2010, but as changes in uninsured rate begin to stagnate, the state must think of ways in which it can improve.

## Connecticut's Kids

According to the 2017 Census Bureau's American Community Survey (ACS), 17,100 children in Connecticut remain uninsured<sup>5</sup>. Medicaid and CHIP play an integral role in insuring the health of Connecticut's children. In fact, 40% of all HUSKY enrollees are children<sup>6</sup>. **HUSKY provides health coverage to Connecticut's most vulnerable children, but it overlooks a key demographic—undocumented kids.**

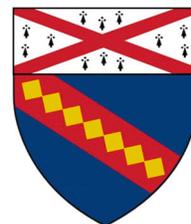
## Looking Ahead

*“Medicaid helps children grow up to reach their full potential. Children enrolled in Medicaid are more likely to graduate high school and attend college, earn higher wages, and pay more taxes.”*

*Georgetown University Center for Children and Families*

According to the US Census Bureau, Connecticut still has 194,000 uninsured individuals and 17,100 uninsured children<sup>7</sup>. The uninsured rate and number of uninsured in 2017 was not statistically different from 2016—signaling a stagnation in coverage efforts. **Connecticut prides itself in supporting its children and helping them achieve their greatest potential. If Connecticut expands HUSKY benefits to undocumented children, it will continue the state’s progress by joining a handful of others, including New York and Massachusetts, that cover all children.** Looking forward, Connecticut must continue to lead the country in protecting the health and livelihood of all its residents.

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# CONNECTICUT'S UNDOCUMENTED

According to the Migration Policy Center, there are an estimated 25,000 individuals under the age of 24 who are undocumented, uninsured, and do not qualify for HUSKY benefits<sup>8</sup>. Expanding HUSKY benefits in the past has:

- Increased the number of insured in Connecticut
- Decreased emergency room usage
- Decreased hospital losses due to uncompensated and unreimbursable care
- Improved education outcomes
- Improved health access and outcomes

**Expanding HUSKY benefits to undocumented children could have similar, if not greater, impacts on Connecticut's hospitals, schools, and economy.**

## Economic Contribution

Over 69,000 undocumented individuals contribute to Connecticut's economy by working in the labor force, holding various positions in various fields, ranging from human services and recreation to construction<sup>9</sup>. Of those in the work force, more than 13,000 undocumented immigrants in Connecticut were self-employed in 2014 and able to provide opportunities for others in the community. Undocumented entrepreneurs earned as estimated \$278.2 million in business income that fiscal year. **In Connecticut, undocumented immigrants earned roughly \$3.1 billion, of which \$145.2 million went to state and local taxes and \$252.7 million went to federal taxes<sup>10</sup>.** Nationally, undocumented immigrants also contributed directly to entitlement programs, accounting for an estimated \$54.6 million contribution to Medicare and \$207.4 million to Social Security in 2014<sup>11</sup>. Overall, Connecticut's undocumented contribute locally to the police force, public education, and city services, and federally to entitlement programs.

### National Movement to Cover All Kids

Currently, six states and the District of Columbia provide health coverage for undocumented children through state funding<sup>12</sup>. The states that have historically covered undocumented children have comparable, if not lower, uninsured rates than Connecticut and have been able to achieve coverage for virtually all kids<sup>13</sup>. Although Connecticut has made great strides since 2010, 24,300 children remain uninsured and vulnerable without access to affordable care. If Connecticut strives to stay ahead of the national curve, then insuring the most vulnerable would propel the state forward.



State	Name	Year Launched
California	Health Kids, CalKids & Kaiser Permanente Child Health Plan	2015, 2001, 1992, 1998
Illinois	All Kids	2006
Massachusetts	Children's Medical Security Program	1996
New York	Child Health Plus	1990
Washington	Washington Apple Health for Kids	2007
District of Columbia	Immigrant Children's Program	2000
Oregon	Cover All Kids	2018

# COST-BENEFIT ANALYSIS

After analyzing current approaches to estimate the cost of expansion from Nevada, New Jersey, and Oregon, we have projected the cost of expansion per capita in Connecticut. These numbers are based on population estimates from the US Census Bureau.

## Current Cost to Connecticut

- According to the Connecticut Hospital Association (CHA), Connecticut hospitals lost \$1.5 billion on uncompensated and unreimbursable care to patients<sup>14</sup>.
- In the same fiscal year, Connecticut hospitals spent a total of \$200 million on uncompensated care, \$111.4 million on charity care and another \$88.3 million on care hospitals had to “write off” on patients who could not afford to pay.

## Cost of Expansion

- If Connecticut were to expand HUSKY benefits to undocumented children, it would cost an **estimated \$2,482 per child** covered.
- Over 2 years, it would cost Connecticut roughly \$15 million to insure over 4,643 children, reducing the state’s rate of uninsured by almost 30%.

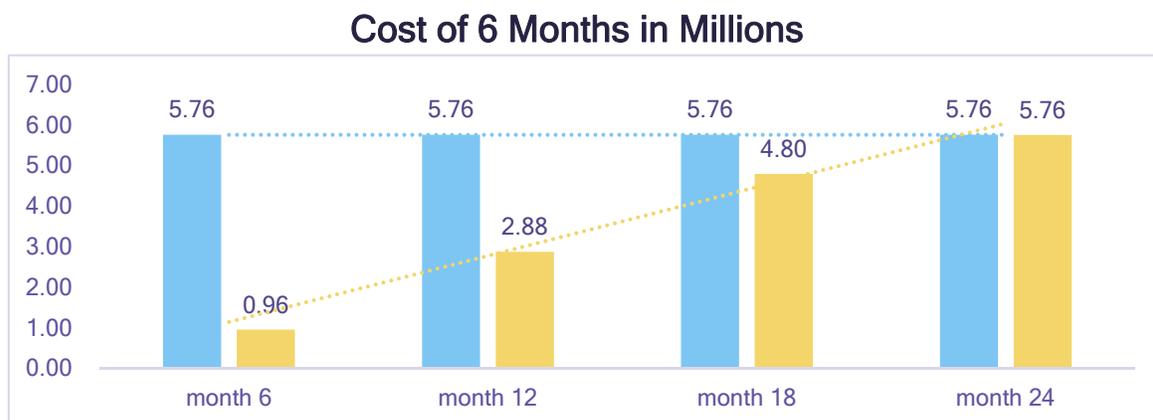


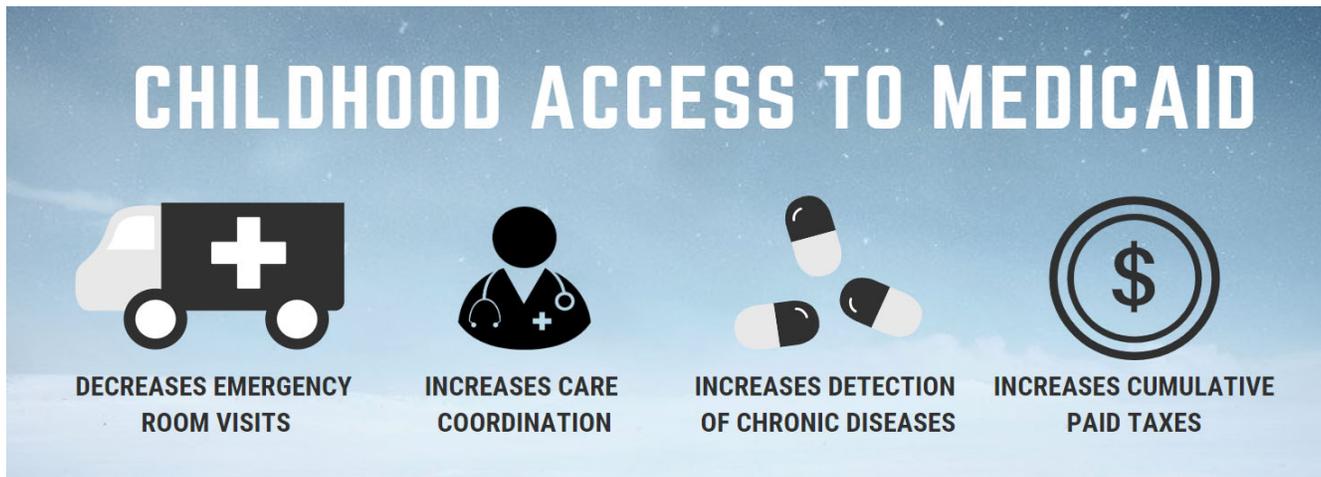
Figure 1. (refer to methodology section)

## Linear Growth Estimates: 2-Year

MONTH	PEOPLE COVERED	COST IN MLLIONS	ANNUAL COST
6	1,546	0.96	--
12	3,092	2.88	3.84
18	4,638	4.80	--
24	4,643	5.76	10.55
<b>Total</b>			<b>14.39</b>

# COST-BENEFIT ANALYSIS

## Opportunities to Save



## Hospitalization and Emergency Room Visits

- Influence on Health Behaviors

**Childhood Medicaid eligibility is linked to better health outcomes during adolescence and adulthood.** Adolescents who are eligible for Medicaid experience lower rates of risky sexual behaviors, drinking, and smoking, as well as a lower body mass index (BMI) compared to their noneligible counterparts<sup>15 16</sup>. Furthermore, Adults who were eligible for Medicaid as children have a 26% decreased incidence of high blood pressure<sup>17</sup>.

- Hospitalization and Emergency Room Visits

Adults who had access to Medicaid as children visit the emergency room and are hospitalized less frequently than adults who lacked Medicaid as children, suggesting a **decreased likelihood of catastrophic health care utilization later in life** attributable to having a regular source of care<sup>18</sup>. Hospitalization and emergency room visits are often far more costly than inpatient and outpatient services provided by Medicaid coverage, therefore lower rates of expensive services could lead to massive downstream savings<sup>19</sup>.

## Primary Care and Care Coordination

- **Influence Utilization of Downstream Health Care Services**  
This is one of the most immediate and tangible ways in which expansion of HUSKY could lead to savings. Expanding HUSKY could lead to savings through care coordination and limiting the overall misuse and overuse of unnecessary services.
- **Reduce Existing Misuse of Existing Health Care Services**  
With increased access to primary care, individuals can develop relationships with their primary physicians and address recurring issues instead of going to the emergency room. This will increase access to lower cost alternatives and drive down hospital losses due to unpaid care, thus realizing savings in the short-term.
- **Decrease Overall Need to Use Health Care Services by Keeping Children Healthier**  
The largest room for **savings will be found in the long term in the shape of addressing early stage childhood chronic diseases** like diabetes. Keeping individuals who have prediabetes from progressing to diabetes and the associated complications would lead to significant long-term savings and set children on a trajectory toward healthier and more productive lives.

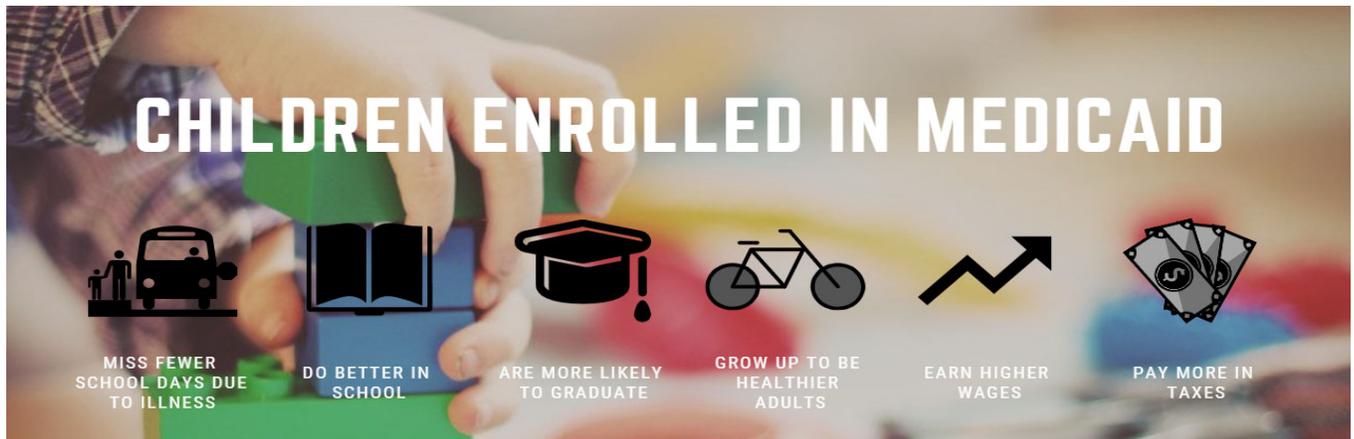
## Childhood Chronic Diseases

- The National Association of School Nurses estimated the annual per capita costs of five chronic conditions in children range from \$1,044 to almost \$10,000. Chronic conditions like diabetes, hypertension, and epilepsy can influence both health and academic outcomes, which may persist into adulthood. The rising rates of under-treated chronic conditions in childhood can lead to poorer life outcomes and increased dependency on public assistance as adults. Increasing HUSKY benefits could address chronic diseases earlier in the most vulnerable populations and lead to savings through future taxation and increased productivity in Connecticut's labor force<sup>20</sup>.

## Adulthood Savings

- **Investing in child health pays off**, as multiple studies have found. It is estimated that the **government would recoup 56 cents for every dollar invested in a child by the time they reach 60 years old**<sup>21</sup>. Each year of Medicaid eligibility from 0-18 increased tax payments in adulthood by \$186 per person. These increases returned 1/3 of initial expansion costs by the time the child was 28. Earnings difference between healthy and unhealthy siblings can be as high as 24%, and providing health insurance to low-income children increases consumer spending per family on average by \$800<sup>22</sup>.

# PUBLIC HEALTH IMPACT



## Childhood Morbidity and Mortality

Being uninsured is linked to receiving less medical care for unintentional injuries and chronic conditions, ultimately causing higher rates of premature deaths<sup>23</sup>. **HUSKY guarantees children the services they need such as check-ups, dental care, immunizations, prescriptions, and health screenings.** These services are critical to reducing childhood death and disability<sup>24</sup>. Research shows childhood access to Medicaid programs such as HUSKY is associated with a 26% decline in high blood pressure in adulthood and lower hospitalization and ER visits<sup>25</sup>. Childhood Medicaid access also increases the likelihood of reporting a regular source of care, which is associated with a greater chance of receiving appropriate care alongside lower mortality for from all chronic diseases<sup>26</sup>.

## Closing Gaps in Health Disparities

When it comes to health care, health disparities include differential access to care and preventive services, quality and affordability<sup>27</sup>. The uninsured are least likely to have a usual source of care and receive preventative services such as screenings<sup>28</sup>. Access to health coverage could reduce racial and ethnic disparities in terms of preventive and screening services. Additionally, increasing Medicaid access increased childhood utilization of preventative services and reductions in family medical debt<sup>29</sup>. Not only would expansion increase access to health services, it would also address health inequity in terms of childhood chronic diseases such as asthma, diabetes, and obesity<sup>30</sup>. Overall, expansion reduces racial and ethnic disparities in coverage and health by increasing access to comprehensive care<sup>31</sup>.

# PUBLIC HEALTH IMPACT

## Health Promotion and Literacy

Regular visits to the doctor and preventive care services promote health and increase quality of life<sup>32</sup>. Limited access to health care is associated with a greater likelihood of poorly managed chronic conditions<sup>33</sup>. Individuals with low health literacy are also more likely to use unnecessary or more costly health services<sup>34</sup>.

## Education

**Access to Medicaid not only improves the health of children but also their school attendance.** Children who benefit from Medicaid eligibility are 9.7% less likely to drop out of high school and 5.5% more likely to graduate from college<sup>35</sup>.

## Economic Security

Medicaid and HUSKY B cover 86% of children who live at or near poverty<sup>36</sup>. **Children with Medicaid have more economic success as adults** and are more likely to surpass their families' economic status<sup>37</sup>.

## Main Takeaways

- HUSKY provides affordable access to quality care for children.
- Increasing access to primary care increases the likelihood of addressing chronic disease at more treatable stages.
- Childhood Medicaid access promotes health and health literacy, creating a strong setup for adulthood.
- Expanding benefits would decrease childhood morbidity and mortality.
- Increasing access among the most vulnerable children in Connecticut can have long lasting impacts and close gaps in health disparities.
- Access to programs like Medicaid and HUSKY is critical to ensuring healthy childhood development and sets the foundation for success later in life.
- Investing in children is investing in the future of Connecticut.

## Fear of Deportation



citizenship applications, or other immigrant related concerns.

## Cost of Care

The cost of care increases as technology grows and advancements are made in health care. If Connecticut's payment model remains fee-for-service, concerns of unsustainable spending are certain and unavoidable.

## Public Charge Concern

Newly proposed amendments to the government's existing policy would include Medicaid, parts of Medicare Part D, SNAP,

and other low-income services as "public



charges"<sup>39</sup>. Fam

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## Opportunities

### Bending the Cost Curve

Although expanding HUSKY requires an initial upfront cost, the possible downstream savings and opportunities to innovate are rich. Undocumented children are not eligible for federal funds, meaning the cost of coverage would come out of Connecticut's state budget, making innovation to save that much more important. One step to bend the cost curve would be to redirect federal dollars into primary care services and infrastructure. This would help reduce hospital admissions, improve care coordination, and lead to a return on investment, as one study in Rhode Island showed<sup>4243</sup>.

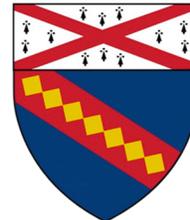


# CONCLUSION

## Connecticut's Future

The state has played a major role in the national effort to increase access to health care, including becoming the first state to expand under the Affordable Care Act. If Connecticut plans to continue its role as a pioneer, insuring all children regardless of immigration status is the next step. Although there have been great strides in Connecticut, 24,000 children remain uninsured and left without access to affordable care. An effort to expand HUSKY would not only be an investment in the future workforce of Connecticut but would also increase childhood access to a regular source of care, and decrease hospitalization. **In conclusion, expanding HUSKY is not only the moral action to cover all of Connecticut's children, but also a fiscally sound policy.** Investments made in the short term would become savings felt in health care, education, and taxes in the long term. Expanding HUSKY benefits would be an investment in the state's future and bring us a step closer to universal coverage.

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*Note: This is an internal report for the Children's Center for Advocacy authored by MPH candidates as part of the YSPH Student Consulting Group*

# REFERENCES

## Cost Methodology

Per data from Kaiser family, we estimated the population of uninsured, undocumented youth in CT is 17100. (KFF reported 24300 youth in CT are either lacking any health insurance, or under HIS, and we found that the number of American Indians in CT is 7300, from data released by National Center of Health Statistics. Also, given that CT is covering most of its youth population who are legally documented, we estimated the total undocumented youth population to be 17100.) We also found from KFF that 36% of total population in CT is under 320% FPL, and we use this percentage to estimate the proportion of our total population that is eligible for HUSKY-B plan. From HHS's report we also found that a maximum of 85% of total eligible children are participating in CHIP, thus we are using the proportion in our population estimation, with a 10% decrease to account for the fact that undocumented population are less likely to participate in government-administered program. The final population is  $17100 * 36% * 75% = 4643$ .

The per capita cost is estimated by referencing to HUSKY-B plan's monthly cost (\$188/person), multiplied by 110% to account for the fact that undocumented youth potentially has more severe health problems due to socioeconomic status. The annual per capita cost is estimated to be \$2481.6.

Figure 1 shows the graphical representation of the cost. The blue bars represent the cost for first two years, assuming (1) the maximum uptake is reached at month 17; (2) growth of uptake is linear. The annual cost under such assumption is \$3.83 million for the first year, \$10.55 million for the second year, and \$11.52 there-after. The orange bar assumes maximum uptake is reached at the very beginning of the program, and the annual cost is fixed at \$11.52 million.

<sup>1</sup> Dorn, Stan, et al. The ACA's Impact on Connecticut's Health Coverage and Costs. 2017, The ACA's Impact on Connecticut's Health Coverage and Costs. <https://www.cthealth.org/wp-content/uploads/2017/07/The-ACAs-Impact-on-CT-Full-Report-low-res.pdf>

<sup>2</sup> Blair, Russell. "Report: ACA Has Reduced Connecticut Uninsured Rate By 45 Percent - Hartford Courant." *Courant.com*, Hartford Courant, 20 July 2017, [www.courant.com/politics/hc-pol-obamacare-ct-report-20170720-story.html](http://www.courant.com/politics/hc-pol-obamacare-ct-report-20170720-story.html).

<sup>3</sup> Broaddus, Matt, and Edwin Park. "Affordable Care Act Has Produced Historic Gains in Health Coverage." *Center on Budget and Policy Priorities*, 15 Dec. 2016, [www.cbpp.org/research/health/affordable-care-act-has-produced-historic-gains-in-health-coverage](http://www.cbpp.org/research/health/affordable-care-act-has-produced-historic-gains-in-health-coverage).

<sup>4</sup> Kiernan, John S. "State Uninsured Rates." *WalletHub*, 11 Oct. 2017, [www.wallethub.com/edu/uninsured-rates-by-state/4800/](http://www.wallethub.com/edu/uninsured-rates-by-state/4800/).

<sup>5</sup> "Index of Programs and Surveys." *United States Census Bureau*, [https://www2.census.gov/programs-surveys/acs/summary\\_file/2017/data/?#](https://www2.census.gov/programs-surveys/acs/summary_file/2017/data/?#).

<sup>6</sup> "Snapshot of Children's Coverage." *American Academy of Pediatrics*, Georgetown University Health Policy Institute, [www.aap.org/en-us/Documents/ccs\\_factsheet\\_connecticut.pdf](http://www.aap.org/en-us/Documents/ccs_factsheet_connecticut.pdf).

<sup>7</sup> US Census Bureau. "Library." *Census Bureau QuickFacts*, United States Census Bureau, 13 Sept. 2018, [www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf](http://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf).

<sup>8</sup> "Profile of the Unauthorized Population - CT." *Migrationpolicy.org*, 1 Nov. 2018, [www.migrationpolicy.org/data/unauthorized-immigrant-population/state/CT](http://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/CT).

<sup>9</sup> "The Contributions of New Americans in Connecticut." *The New American Economy*, Aug. 2018, <https://www.newamericaneconomy.org/wp-content/uploads/2017/02/nae-ct-report.pdf>.

<sup>10</sup> "The Contributions of New Americans in Connecticut." *The New American Economy*, Aug. 2018, <https://www.newamericaneconomy.org/wp-content/uploads/2017/02/nae-ct-report.pdf>.

- <sup>11</sup> “The Contributions of New Americans in Connecticut.” *The New American Economy*, Aug. 2018, <https://www.newamericaneconomy.org/wp-content/uploads/2017/02/nae-ct-report.pdf>.
- <sup>12</sup> Heflin, Katherine, and Maia Crawford. “Sustaining Progress in 2017: Providing Health Care for Undocumented Residents.” *Center for Health Care Strategies*, 13 Jan. 2017, [www.chcs.org/sustaining-progress-2017-providing-health-care-undocumented-residents/](http://www.chcs.org/sustaining-progress-2017-providing-health-care-undocumented-residents/).
- <sup>13</sup> “Health Insurance Coverage of Children 0-18.” *Kaiser Family Foundation*, 2017, <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- <sup>14</sup> “Finance and Reimbursement.” *Connecticut Hospital Association*, [www.chime.org/advocacy/finance-and-reimbursement/](http://www.chime.org/advocacy/finance-and-reimbursement/).
- <sup>15</sup> Cohodes, Sarah R., et al. “The effect of child health insurance access on schooling: Evidence from public insurance expansions.” *Journal of Human Resources* 51.3 (2016): 727-759.
- <sup>16</sup> Meyer, Bruce D., and Laura R. Wherry. *Saving teens: Using a policy discontinuity to estimate the effects of medicaid eligibility*. No. w18309. National Bureau of Economic Research, 2012.
- <sup>17</sup> Boudreaux, Michel H., Ezra Golberstein, and Donna D. McAlpine. “The long-term impacts of Medicaid exposure in early childhood: Evidence from the program’s origin.” *Journal of health economics* 45 (2016): 161-175.
- <sup>18</sup> Miller, Sarah, and Laura R. Wherry. “The long-term effects of early life Medicaid coverage.” *Journal of Human Resources*(2018): 0816\_8173R1.
- <sup>19</sup> Wherry, Laura R., et al. *Childhood Medicaid coverage and later life health care utilization*. No. w20929. National Bureau of Economic Research, 2015.
- <sup>20</sup> Miller, Gabrielle F., et al. “Prevalence and costs of five chronic conditions in children.” *The Journal of School Nursing* 32.5 (2016): 357-364.
- <sup>21</sup> Brown, David W., Amanda E. Kowalski, and Ithai Z. Lurie. *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?*. No. w20835. National Bureau of Economic Research, 2015.
- <sup>22</sup> Roman, Linda, and Elizabeth Kushwa. *Cover All Kids 2017: An Oregon Perspective* <https://olis.leg.state.or.us/liz/2016R1/Downloads/CommitteeMeetingDocument/88633>
- <sup>23</sup> Hadley, Jack. “Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition.” *Jama* 297.10 (2007): 1073-1084.
- <sup>24</sup> “National Prevention Strategy CLINICAL and COMMUNITY ...” *Surgeon General*, May 2014, [www.surgeongeneral.gov/priorities/prevention/strategy/clinical-community-preventive-services.pdf](http://www.surgeongeneral.gov/priorities/prevention/strategy/clinical-community-preventive-services.pdf).
- <sup>25</sup> Akler, Joan. “Progress, Challenges, and Opportunities Medicaid for Children.” *Grade Level Reading*, 17 Nov. 2017, <http://gradelevelreading.net/wp-content/uploads/2016/11/Medicaid-for-Children-Joan-Alker.pdf>.
- <sup>26</sup> Chester, Alisa, and Joan Akler. “Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid.” *Medicaid at 50: A Look at the Long-Term Benefits of Childhood Medicaid*, 27 July 2015, <http://ccf.georgetown.edu/2015/07/27/medicaid-50-look-long-term-benefits-childhood-medicaid/>.
- <sup>27</sup> Mainous, Arch G., et al. “Continuity of care and trust in one’s physician: evidence from primary care in the United States and the United Kingdom.” *Fam Med* 33.1 (2001): 22-27.
- <sup>28</sup> Starfield, Barbara, Leiyu Shi, and James Macinko. “Contribution of primary care to health systems and health.” *The milbank quarterly* 83.3 (2005): 457-502.
- <sup>29</sup> Riley, Wayne J. “Health disparities: gaps in access, quality and affordability of medical care.” *Transactions of the American Clinical and Climatological Association* 123 (2012): 167.
- <sup>30</sup> Kilbourne, Amy M. “Care without coverage: too little, too late.” *Journal of the National Medical Association* 97.11 (2005): 1578.
- <sup>31</sup> Boudreaux, Michel H., Ezra Golberstein, and Donna D. McAlpine. “The long-term impacts of Medicaid exposure in early childhood: Evidence from the program’s origin.” *Journal of health economics* 45 (2016): 161-175.
- <sup>32</sup> Price, James H., et al. “Racial/ethnic disparities in chronic diseases of youths and access to health care in the United States.” *BioMed Research International* 2013 (2013).
- <sup>33</sup> Buchmueller, Thomas C., et al. “Effect of the Affordable Care Act on racial and ethnic disparities in health insurance coverage.” *American journal of public health* 106.8 (2016): 1416-1421.
- <sup>34</sup> Black, Lindsey, et al. “National Center for Health Statistics.” *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 10 May 2016, [www.cdc.gov/nchs/products/databriefs/db246.htm](http://www.cdc.gov/nchs/products/databriefs/db246.htm).
- <sup>35</sup> Williams, Mark V., et al. “Relationship of functional health literacy to patients’ knowledge of their chronic disease: a study of patients with hypertension and diabetes.” *Archives of internal medicine* 158.2 (1998): 166-172.
- <sup>36</sup> “Quick Guide to Literacy and Health Outcomes.” *U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion*, <https://health.gov/communication/literacy/quickguide/factsliteracy.htm>.
- <sup>37</sup> Hope, Cathy. “School Attendance and Health Care: Why Chronic Absenteeism Isn’t Just About Truancy.” *Center For Children and Families*, Georgetown University Health Policy Institute, 29 Sept.

---

2015, <https://ccf.georgetown.edu/2015/09/29/school-attendance-health-care-chronic-why-absenteeism-reasons-truancy/>.

<sup>36</sup>HUSKY Health (Medicaid and CHIP): Covering Connecticut's Children." *Center for Children and Families*, Georgetown University Health Policy Institute, <https://ccf.georgetown.edu/wp-content/uploads/2018/06/Connecticut-Snapshots-2018.pdf>.

<sup>37</sup>Akler, Joan. "Progress, Challenges, and Opportunities Medicaid for Children." *Grade Level Reading*, 17 Nov. 2017, <http://gradelevelreading.net/wp-content/uploads/2016/11/Medicaid-for-Children-Joan-Alker.pdf>.

<sup>38</sup>Capps, Randolph. "The health and well-being of young children of immigrants." 2005, [http://webarchive.urban.org/UploadedPDF/311139\\_ChildrenImmigrants.pdf](http://webarchive.urban.org/UploadedPDF/311139_ChildrenImmigrants.pdf).

<sup>39</sup>"Proposed Changes to 'Public Charge' Policies for Immigrants: Implications for Health Coverage." *The Henry J. Kaiser Family Foundation*, The Henry J. Kaiser Family Foundation, 24 Sept. 2018, [www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/](http://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/).

<sup>40</sup>"Public Charge Draft Comments." *Connect for Health Colorado Board of Directors Meeting*, 8 Oct. 2018, <http://connectforhealthco.wpengine.netdna-cdn.com/wp-content/uploads/2018/10/Public-Charge-Draft-Comments-Presentation.pdf>.

<sup>41</sup>Norris, Louis. "How Immigrants Are Getting Health Coverage." *Healthinsurance.org*, Health Insurance & Health Reform Authority, 21 Nov. 2018, [www.healthinsurance.org/obamacare/how-immigrants-are-getting-health-coverage/#undoc](http://www.healthinsurance.org/obamacare/how-immigrants-are-getting-health-coverage/#undoc).

<sup>42</sup>Phillips, Russell. *Investment In Primary Care Is Needed To Achieve The Triple Aim*. Health Affairs, 10 May 2017, [www.healthaffairs.org/doi/10.1377/hblog20170510.060008/full/](http://www.healthaffairs.org/doi/10.1377/hblog20170510.060008/full/).

<sup>43</sup>"ROI for Primary Care: Building the Dream Team." *Pwc.com*, Oct. 2016, [www.pwc.com/us/en/health-industries/health-research-institute/weekly-regulatory-legislative-news/pdf/pwc-hri-primary-care-roi.pdf](http://www.pwc.com/us/en/health-industries/health-research-institute/weekly-regulatory-legislative-news/pdf/pwc-hri-primary-care-roi.pdf).