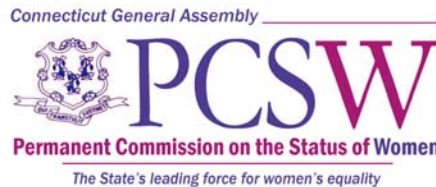


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**Written Testimony of  
The Permanent Commission on the Status of Women  
Before the  
Appropriations Committee  
Wednesday, February 18, 2009**

**Re: H.B. 6365, AAC The State Budget for the Biennium Ending June 30, 2011, and Making Appropriations Therefor – Department of Social Services Budget**

Senator Harp, Representative Geragosian and members of the committee, thank you for this opportunity to provide testimony on the Department of Social Services budget on behalf of the PCSW, the Connecticut Women's Health Campaign, and the Young Women's Leadership Program.

Once again during a time of economic crisis, a budget is proposed that attempts to solve a significant portion of our state budget problems by reducing or eliminating health care for poor families. The Governor proposes to **cut \$273 million from health care programs** for families and individuals. The proposed cuts would limit access to health care for pregnant women, parents in HUSKY A, children in HUSKY B, senior citizens and others who rely on Medicare Part D for prescription drugs, and recent legal immigrants. Our state budget deficit is everybody's problem, and should not be solved by taking health care away from low-income families and immigrants.

Medicaid, the state-federal health coverage program for the poor, provides over 20 million low-income women with basic health and long-term care coverage.<sup>1</sup> While often not considered to be a women's health program, women comprise 69% of adult beneficiaries nationally,<sup>2</sup> and 71% of adult beneficiaries in Connecticut.<sup>3</sup> In 2005, 10% of all women and 22% of low-income women had health insurance through Medicaid.<sup>4</sup> For these women, Medicaid covers a wide range of

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<sup>1</sup> Kaiser Family Foundation. *Medicaid's Role for Women*, 2007 Update.

<sup>2</sup> Ibid.

<sup>3</sup> National Women's Law Center. *Cuts to Medicaid Will Hurt Connecticut*, May 2005.

<sup>4</sup> Kaiser Family Foundation. *Medicaid's Role for Women*, 2007 Update.

health services, including reproductive healthcare, care for chronic conditions and disabilities, and long-term services. In addition, SAGA medical is a lifeline for almost 30,000 residents, and women comprise 40% of those with SAGA medical coverage – or about 12,000 of those with SAGA.

The majority of Medicare, ConnPACE and nursing home residents are also women. Medicare provides a health and financial safety net for virtually all older Americans and for many people with disabilities who are under the age of 65. Because women have longer life expectancies than men, more than half (57%) of those covered by the program are women. By the time women are 85 and older, they account for nearly three-quarters of all beneficiaries.<sup>5</sup> The security that Medicare provides through its coverage of health benefits is especially important to women because with their longer lifespans, they are more likely to have multiple chronic conditions. Medicare covers the costs associated with hospital and physician care, and other basic health services, but does not cover the outpatient prescription drugs necessary to manage their conditions. Because of their lower incomes and greater health needs, women on Medicare spend a significant share of their incomes on prescription drugs.

**We urge you to reject the following budget cut proposals:**

**Suspension of Reproductive Health Services**

The Governor's budget proposes to suspend supplemental payments to FQHC's and hospitals for unreimbursed costs for pregnant women to save \$4M over the biennium.

**Implementing Co-pays, Premiums, and Access to Prescription Drugs**

The Governor's budget proposes to implement co-pays and premiums for Medicaid, HUSKY A adults, HUSKY B, and increase the annual enrollment fee for ConnPACE to save approximately \$40.2M over the biennium. It also proposes to limit access to prescription drugs by enforcing prior authorization for certain drugs, including mental-health related drugs in the Preferred Drug List System, and eliminating Medicaid coverage for over-the-counter drugs to save \$23.9M over the biennium.

**Eliminating Health Care for Recent Legal Immigrants**

The Governor's budget proposes to eliminate health care for recent legal immigrants to save \$48.1M over the biennium. Now is not the time to cut healthcare services. Especially when the federal Children's Health Insurance Program legislation will provide new funding for children and pregnant women in HUSKY A and HUSKY B who are recent legal immigrants.

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<sup>5</sup> Ibid.

### **Implementing the HIV/AIDS Community-Based Services Waiver**

The Governor's budget proposes to delay implementation of the HIV/AIDS community-based services waiver for a savings of \$5.6M over the biennium. Connecticut ranks ninth in the nation in AIDS cases per capita and in 2005 had the fastest growing rate of AIDS in New England. Since 1980, 14,399 people in Connecticut have been diagnosed with AIDS, and there are currently 8,821 people living with HIV/AIDS in the state.<sup>6</sup> HIV/AIDS is one of the leading causes of death for women in the state of Connecticut.<sup>7</sup> Of the 14,487 reported AIDS cases- 28% are female, 36.7% are Black, and 25.5% are Hispanic.<sup>8</sup> Of the reported new AIDS cases – 35.9% are female, 33% are Black, and 32.6 % are Hispanic.<sup>9</sup> Racial and ethnic populations have been disproportionately affected by the HIV/AIDS epidemic in Connecticut. Although Blacks/African-Americans and Hispanics represent 9.1% and 9.4% of Connecticut's population,<sup>10</sup> 62.3% of reported AIDS cases and 65.9% of reported HIV infections are among these populations.<sup>11</sup> Among women, the disparities are even more dramatic, with Black/African-American and Hispanic women representing 70.2% of females with AIDS, and 72.3% of females with HIV infection.<sup>12</sup>

### **Eliminating Medicaid Coverage for Medical Interpreters and; Implementing a Medical Necessity and Appropriateness Definition**

The Governor's budget proposes to eliminate Medicaid coverage for medical interpreters for a savings of \$11.5M, and implement a medical necessity and appropriateness definition for a savings of \$13.5M. The combined effect of eliminating \$25M from the Medicaid plan will impact access to healthcare negatively. The Legislature has debated these two issues for the past few years, and each year the Appropriations Committee wisely decided not to take the Governor's recommendation. Inability to communicate with a health care provider can result in serious injury or death. An estimated 22,000 Medicaid recipients in Connecticut face an additional barrier to accessing health care due to limited English proficiency. Enforcing a medical necessity and appropriateness definition would also impede access to health care, and deprive Medicaid recipients of medical care that they need to lead healthy and productive lives. Although it may appear

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<sup>6</sup> Ibid.

<sup>7</sup> U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Mortality by State, Race/Ethnicity, Gender, Age and Causes, 1999-2002*, accessed 9/05 at <http://www.cdc.gov/nchs>.

<sup>8</sup> *Connecticut: Distribution of Reported AIDS Cases*. The Henry F. Kaiser Family Foundation accessed 2/07 at [www.statehealthfacts.org](http://www.statehealthfacts.org).

<sup>9</sup> Ibid.

<sup>10</sup> U.S. Census Bureau, Census 2000, *Table DP-a. Profile of General Demographic Characteristics*.

<sup>11</sup> CT Department of Public Health. *CT HIV/AIDS Statistics through December 31, 2004*, available at [www.dph.state.ct.us/BCH/infectiousdise/2003/final%20pages/topic\\_index\\_X.htm](http://www.dph.state.ct.us/BCH/infectiousdise/2003/final%20pages/topic_index_X.htm), accessed on 1/19/06.

<sup>12</sup> Ibid.

to be a technical matter, in actuality it would result in limited access to health care, especially for specialty care and chronic conditions. The administrative hurdles that are erected for commercial plans may prove insurmountable for clinicians participating in Medicaid. The result would be reduced access to care for the poorest and neediest families in Connecticut. Commercial policies use such “technical” provisions to require pre-approval for on-going medical treatments. The current definition is set up not only to ameliorate medical conditions, but to *maintain* a patient’s health status. There is no commercial equivalent for this and it was designed in order to address chronic needs as well as the special barriers that poverty places on access to health care. Connecticut’s seniors, disabled and low-income individuals cannot pay for the health services that are denied by Medicaid. In the end, it is likely that the state could incur more costs as individuals become sicker and the services more expensive.

### **Eliminating Non-Emergency Medical Transportation Under SAGA**

The Governor’s budget proposes to eliminate vision care and non-emergency medical transportation in SAGA for a savings of \$2.2M over the biennium. This critical benefit is essential to ensuring access to care for the tens of thousands of very low income residents who rely on SAGA for medical care and must travel long distances to avail themselves of participating providers.

Most of these measures have been proposed and rejected many times in the past. Some have been adopted then rejected when their impact became clear. Some have been implemented and then rescinded. Experience has shown that cutting healthcare services in times of economic crisis does not solve the problem.

Adequate health insurance is critical to helping low-wage mothers stay employed. During the state fiscal crisis of the early 2000s, many publicly funded work support programs were either reduced or eliminated, with those working often the first cut from the programs. A study conducted by the Center for Economic and Policy Research examined how patterns of Medicaid and childcare access affect women’s employment outcomes.<sup>13</sup> It found that less than a quarter of women who stopped receiving Medicaid in 2002-2003 went on to receive health coverage from employers. In addition, those who left Medicaid in 2002-2003 were less likely to receive employer-provided health insurance than those who left in 1997-1998. Further, women who lost Medicaid without receiving employer-provided health insurance were nine times as likely to leave the labor market, compared to women who moved into employer-provided health insurance. Many working families cannot afford to purchase health insurance, and only those

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<sup>13</sup> Heather Boushey, Ph.D. *The Effects on Employment and Wages When Medicaid and Child Care Subsidies are No Longer Available*. Center for Economic and Policy Research, January 26, 2005. <[http://www.cepr.net/publications/Effects\\_on\\_employment\\_wages\\_without\\_medicaid\\_child\\_care\\_subsidies.htm](http://www.cepr.net/publications/Effects_on_employment_wages_without_medicaid_child_care_subsidies.htm)>.

who very recently left welfare have any likelihood of receiving public benefits. This creates a hole in the safety net for low-wage working women that do not receive welfare, who are not likely to have access to employer-provided health insurance or to have sufficient income to purchase health insurance in the market.

Further, The federal government has expanded funding for Connecticut's Medicaid and HUSKY programs by at least \$1.3 billion in stimulus payments. The federal government will pay more than half the costs of the Medicaid program by increasing the federal share from 50% to at least 56.2%. If the state decides to use the stimulus money to fill the budget gap, rather than pay for healthcare costs, it should at least maintain benefits for the recipients under Medicaid and other state health insurance programs for low-income residents.

We appreciate your attention to these matters.