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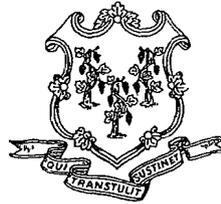
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PERMANENT COMMISSION ON THE STATUS OF WOMEN

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Written Testimony of the Permanent Commission on the Status of Women for the Human Services Committee Thursday, March 15, 2007

In support of:

**Senate Bill 3, AAC Increased Access to Health Care through the HUSKY Program;
Senate Bill 1425, AAC Managed Care Organizations Contracting with the
Department of Social Services;
House Bill 7278, AAC Improved Access to Health Insurance; and
House Bill 7375, AAC Health Care Access and Expansion of the HUSKY Program**

Senator Harris, Representative Villano and members of the Human Services Committee, thank you for this opportunity to provide written testimony on the above referenced bills. This testimony is submitted on behalf of the Permanent Commission on the Status of Women (PCSW), and the Connecticut Women's Health Campaign (CWHC), a statewide coalition of organizations representing consumers, providers and policy experts who have been committed to and working for the health and well-being of Connecticut women and girls for over ten years.

The PCSW and the CWHC support health care access reforms and expansions. According to the Office of Health Care Access, 166,652 women in Connecticut were uninsured at some point during the prior year, and 52,368 of these were working women.¹ Because national health reform failed and employer-sponsored insurance has eroded, public health insurance programs have been used to fill gaps in coverage.

¹ Office of Health Care Access, 2006 Household Survey.

PCSW and the CWHC support the expansion of Medicaid coverage for pregnant women up to 300% of the federal poverty level. Of the four bills we are commenting on today, only SB 3 includes a provision for pregnant women. SB 3 directs the DSS Commissioner to seek a Health Insurance Flexibility and Accountability (HIFA) waiver to cover pregnant women from 185 - 300% of the federal poverty level (FPL). HIFA waivers are not needed to expand pregnant women's eligibility, however. Federal Medicaid law allows states to make more generous income disregards for categorically eligible groups. Connecticut can achieve the same goal much more quickly by amending the state plan, and draw down federal financial participation, or 50% matching funds for pregnant women. I am attaching substitute language for legislation expanding Medicaid eligibility for pregnant women for your consideration.

Sec. 17b-277. (Formerly Sec. 17-134u). Medical assistance for needy pregnant women and children. Presumptive eligibility. (a) The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women and children up to one year of age whose families have an income up to ~~one~~ **three hundred eighty-five** per cent of the federal poverty level.

The PCSW estimates that the cost to expand HUSKY to pregnant women up to 300% of the federal poverty level would cost the state between \$4 and 6 million. The need for coverage for prenatal care is essential not only to establish a strong maternal and child health foundation for a growing family, but also to address Connecticut's health care budget. OHCA estimates that one out of every five uninsured hospitalizations in Connecticut is due to pregnancy and childbirth.² Thus, expanding coverage for uninsured pregnant women would likely save state dollars not only by early intervention, but reduced uncompensated hospital costs as well.

In addition, both SB 3 and HB 7375 include provisions to expand eligibility for parents and relative caregivers up to 185% of the FPL. **The PCSW supports a Medicaid expansion for parents and relative caregivers up to to 300% of the FPL.**

We support the provisions in SB 3, and HB 7378 which would eliminate the plan to impose cost-sharing on very low income parents and caretaker relatives. There are over 80,000 women of child-bearing age in our state with Medicaid coverage. Numerous national studies have shown that even *nominal* cost sharing is a disincentive for preventive care for low-income families. We applaud your leadership in lifting this disincentive.

Both the CWHC and the PCSW support raising the income limit for the aged, blind and disabled. Medically needy adults should be eligible for Medicaid at the same income levels as families in the HUSKY program – 185% of the FPL. Having consistent rules for different coverage groups would make the program easier to administer and

² Connecticut Office of Health Care Access. "Uninsured hospitalizations, FYs 2001-2005. December 2006.

understand. Simplification would result in higher enrollment among eligible uninsured residents. Connecticut should establish a separate income disregard which would effectively raise the medically needy income limit (MNIL) to the 185% of the federal poverty level. The change should be made through an amendment to the state's Medicaid State Plan. Connecticut's medically needy income limit has not changed since 1990. (SB 3 would raise the MNIL to 100% of the FPL.)

PCSW and CWHC support sections in House Bills 7278 and 7375 which would keep working families on HUSKY for up to 24 months with Transitional Medical Assistance (TMA). TMA helps to shore up HUSKY and fill gaps in health care coverage.

- Those most deeply affected by Connecticut's reduction in TMA are low-income working women who do not have employer-sponsored coverage. A recent study found that only eight percent of low income adults have the possibility of obtaining employer-sponsored insurance.³
- Nationally, over 30% of working women who left cash assistance remained uninsured after working for the same employer for 2 years or more.⁴

PCSW and CWHC also support raising the eligibility limit for the SAGA medical assistance program. SB 3 would raise the income eligibility limit for SAGA medical assistance to 100% of the FPL. Because of federal categorical rules, childless adults are not eligible for Medicaid unless they are aged, blind or disabled. SAGA medical is a lifeline for almost 30,000 residents and *women comprise 40% -- or approximately 12,000 -- of those with SAGA medical coverage.* Very low income and asset limits make it difficult to remain eligible for SAGA. We applaud your efforts to increase eligibility for SAGA and urge you to consider removing an asset test altogether, as we did for family Medicaid coverage. Allowing low-income people to retain a car or bank account would enable a pathway to self-sufficiency for our residents, and would be a great step forward for the health care safety net in Connecticut.

PCSW and CWHC support the implementation of continuous eligibility for children and adults in HUSKY, as detailed in both HB 7278 and SB 3. Continuous eligibility (CE) would help to fill the gaps in health insurance and keep families insured even if they experience temporary bumps in income due to temporary or seasonal increases in earnings. Having the same rules for multiple family members make the program easier to administer, understand, and stay enrolled in.

While SB 3 would raise reimbursement rates for children's dental providers, we urge the committee to support a rate increase for *all dental providers including those for adult dental care.* Please note that there are other proposals which include adding

³ S. K. Long and J. A. Graves, *What Happens When Public Coverage Is No Longer Available?* The Urban Institute for the Kaiser Commission on Medicaid and the Uninsured. January 2006.

⁴ B. Garrett and J. Hudman, "Women who left welfare: health care coverage, access and use of health services." Kaiser Commission on Medicaid and the Uninsured, June 2002.

periodontal services for pregnant women to the HUSKY benefit package. Oral health care during the prenatal and post partum period are critical.

SB 3 and HB 7375 also include provisions to raise rates for other providers to the Medicare equivalent reimbursement rate. We support this because it would help to create capacity and stability in the health care system as a whole. Please note however, that there are pediatric, ob-gyn related services and others for which there is no comparable service in Medicare.

Likewise, we applaud measures in SB 3 and HB 7375 which would simplify outreach and enrollment for HUSKY. SB 3 directs DSS to develop an on-line application which we support, as many other states have used this approach to streamline the application process.

Last, we believe it would be prudent for Connecticut to examine alternatives to Medicaid managed care through a primary care case management (PCCM) pilot as outlined in SB 1425. PCCM is used by thirty other states to deliver health care to their Medicaid participants. Coordination and management of health services is provided by health care providers under this system, rather than a managed care organization. Key points to evaluate in such a pilot include improved access, utilization and quality of care for low-income women and their families. PCCM may allow DSS to set policy for the program more directly and to regulate provider reimbursement rates in a way that helps to increase provider capacity and access in Medicaid.

Thank you for your attention.