ACCY Advocates for Connecticut's Children and Youth

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Testimony Supporting:

S.B. 3, An Act Concerning Increased Access to Health Care Through the HUSKY Program
S.B. 1425, An Act Concerning Managed Care Organizations Contracting with the Department of Social Services
H.B. 7322, An Act Concerning Medicaid Managed Care Reform

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Human Services Committee Public Hearing

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Dear Senator Harris, Representative Villano, and Members of the Human Services Committee:

Sharon Langer is a Senior Policy Fellow, Mary Glassman is Director of Legislative Affairs, and Shelley Geballe is President of Connecticut Voices for Children, a research-based public education and advocacy organization that works statewide to promote the well being of Connecticut's children, youth and families. We are here today to testify on behalf of the sister lobbying organization – Advocates for Connecticut's Children and Youth (ACCY), a statewide, independent, citizen-based organization dedicated to speaking up for children, youth and families.

We enthusiastically support S.B. 3, An Act Concerning Increased Access to Health Care Through the HUSKY Program, and many of the provisions in S.B. 1425, An Act Concerning Managed Care Organizations Contracting with the Department of Social Services, and H.B. 7322, An Act Concerning Medicaid Managed Care Reform, and commend members of the Legislature for recognizing the need to provide all Connecticut children and families with access to quality, affordable health care and making health care a priority for the 2007 Legislative Session. As you are aware, two recent public opinion polls provide a resounding endorsement of lawmakers' efforts this session to improve our state's health care system for all residents of the state.[1]

[1] *Children's Health Coverage Survey* sponsored by the New England Alliance for Children's Health, available on the website of CT Voices for Children at www.ctkidslink.org According to the Survey, conducted Jan. 26 through February 8, 2007, 82% of Connecticut voters favor state elected officials doing more to make health care coverage available to state residents who cannot get coverage through their jobs or afford it on their own. Also, see national New York Times/CBS New Poll conducted Feb. 23-27, findings summarized in *Most Support U.S. Guarantee of Health Care*, The New York Times (Mar. 2, 2007). In both polls, majorities of those surveyed expressed their willingness to pay additional taxes to provide coverage to the uninsured. Also see, telephone survey commissioned by the Universal Health Care Foundation of Connecticut and conducted Dec. 6-10, 2006, which indicates 84% of those surveyed support universal health care and ranks this issue above others, including reducing taxes, improving public education, and creating jobs, available at www.universalhealthct.org.

There is no dispute that uninsured children and families who do not have access to preventive care are often forced to forego needed care or seek more costly emergency room medical care – shifting health care costs to providers and taxpayers. So it not only makes medical sense to provide access to health care to these children and families, it makes economic sense as well.

We applaud efforts to create a universal, single-payer system in Connecticut as we believe, based on evidence from other developed countries, that better health outcomes at lower cost for *all* residents would result from such a system. It is particularly heartening to learn that the Insurance Committee just yesterday voted out S.B. 1371, An Act Establishing the Connecticut Saves Health Program, which would create such a system. We also appreciate, however, the unique challenges of an individual state moving to such a system, particularly given the legal constraints of the ERISA preemption. We urge the General Assembly to create a formal process that takes the time needed, and brings in the expertise necessary, to fashion the best plan possible given current federal constraints.

While the General Assembly considers and addresses the complexities of adopting a universal, single payer system, other improvements to the current system should be made immediately.

Improvements to HUSKY -- Now

For example, in crafting a health care plan for Connecticut this session, legislators can address improvements to the HUSKY system to keep children and families healthy and insured. Indeed, legislators can consider HUSKY coverage for low-income families as the base upon which to build efforts to improve coverage for higher income uninsured persons. It makes sense to restore trust and stable coverage in this important program as a first step toward solutions that will help others. Increased funding, along with increased transparency and accountability, are essential components of this task.

As you know, the Connecticut HUSKY program provides low-cost or free health care coverage to more than 300,000 children, parents and pregnant women. Although HUSKY has a record of being successful in reducing the number of uninsured families in the state, recent cutbacks and confusion about program rules have threatened its success. Since June 2005, HUSKY enrollment has dropped by 19,000 persons; about 15,000 of them are children under the age of 19.

While there is no magic solution to the health care problem in Connecticut, focusing on improvements to HUSKY would have a significant impact on reducing the number of uninsured children and families in our state. Nationally, it is estimated that more than 70% of uninsured children are currently eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) which together help fund our HUSKY program in Connecticut.[2]

S. B. 3 improves HUSKY.[3] Specifically, we support the following provisions in the bill:

- Restoring "continuous eligibility";
- Raising the income limit for parents in HUSKY A to match the income limits for children in HUSKY A -- both at 185% of the federal poverty level;
- Increasing the income limit for pregnant women to match the income limits for children in HUSKY B -- at 300% of the federal poverty level;

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[2] See, for example Kaiser Commission on Medicaid and the Uninsured, *Enrolling Low Income Uninsured Children in Medicaid and SCHIP*, Jan. 2007.

[3] We recognize that other bills before the Committee also seek ways to improve HUSKY (see, H.B. 7278, H.B. 7375) In our opinion, however, S.B. 3 provides the most comprehensive approach.

- Eliminating a statute that authorizes DSS to impose premiums and co-pays on low-income HUSKY A parents;
- Aligning reimbursement rates for HUSKY health care providers with Medicare fees;
- Increasing HUSKY dental provider rates to the 70th percentile of the usual and customary fees for private dentists;
- Targeting outreach to adults, as well as children, and requiring schools to disseminate information about HUSKY at the beginning each school year; and
- Streamlining the HUSKY eligibility system by creating one centralized unit at the Department of Social Services.

S.B. 1425 and H.B. 7322 would provide additional transparency and oversight of the current Medicaid managed care system, as well as offer an alternative to the risk-based managed care system through piloting a Primary Care Case Management System (PCCM). Among other things, a PCCM pays HUSKY primary care and other health care providers a small fee to coordinate care of their patients.

After a decade of experience with managed care in the HUSKY program, we are *not* convinced that this is the best model for ensuring access to high quality care. The financial incentives of this system work at cross-purposes to the goals of providing timely and high quality care.

The recent carve out of behavioral health services for children and youth, with an Administrative Services Organization (ASO) that is *not* at financial risk involved in key administrative tasks, is both a reflection of the deficiencies of the current managed care system, and provides an alternative model that should be considered for *all* care being provided to all persons on Medicaid. The addition of targeted care management as a covered service, particularly for persons with more complex health care needs, would be an important addition. H.B. 7322 would mandate the use of an ASO in its PCCM formulation.

Comments On Specific Sections of S.B. 3:

We offer the following suggestions for changes to S.B. 3:

HUSKY Outreach (Sec. 2): We support the allocation of additional funding for community-based HUSKY outreach. The Governor has recently restored some but not all of the monies for outreach that have been cut since 2002, and has targeted needy communities and school districts. S.B. 3 provides for outreach monies "within available appropriations." We suggest that outreach funding be increased by an additional $1 million over what the Governor has proposed to approach the outreach funding level in FY 02 ($4.44 million). When money for outreach was drastically cut, enrollment declined as well.

We also believe that outreach and application assistance should be focused at the community level. As the convenor of the Covering Connecticut's Kids and Families (CCKF) coalition (a large group consisting of safety net health care providers, DSS staff, the HUSKY enrollment broker, HUSKY 211 InfoLine, and other stakeholders that work to improve the HUSKY program), Connecticut Voices has learned much about effective outreach strategies over the last several years.[4] We would urge the Committee to amend Sec. 17b-297(c) as follows:

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[4] *Covering Connecticut's Kids and Families* was initially funded through a grant from the Robert Wood Johnson Foundation to the Children's Health Council and then to Connecticut Voices for Children. Preliminary results of an independent evaluation of the successful outreach strategies by the 46 grantees in all the participating states has recently been released. J. Wooldridge, *Making Health Care a Reality for Low-Income Children and Families: Lessons from Covering Kids and Families* (Mathematica Policy Research, Inc, February 2007), available at: www.rwjf.org/files/publications/other/CKFissueBrief2.pdf.

(c) The commissioner shall, within available appropriations, contract with severe-need schools and community-based organizations for purposes of public education, outreach, [and] recruitment, application assistance, and retention of eligible children and adults, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of organizations, and ensure that outreach occurs in all geographical areas of the state in which severe need schools are located, and in any other geographical areas of the state where outreach is likely to reach the greatest number of eligible-but-not-enrolled children and adults. Such organizations shall have a demonstrated ability to reach linguistic minorities and other hard-to-reach, eligible-but-not-enrolled children and adults. Such organizations shall participate in department-directed HUSKY outreach training, use department-approved HUSKY outreach materials, and collect department-specific data for evaluation of outreach efforts.

Alignment of parent and children income limits in HUSKY A (Sec. 19). We wholeheartedly support aligning the income limits of parents with the current income limits for children and pregnant women in HUSKY A at 185% of the federal poverty level (FPL). We applaud the Committee's proposal to raise the income limit for pregnant women to 300% of the federal poverty level, and urge the Committee to go farther and increase the income limits for parents to 300% of the FPL, as well. (Currently, children are eligible for subsidized coverage up to 300% of FPL in HUSKY B, but parents and pregnant women are not.)

Medicaid Reimbursement Rates for Providers (Secs. 11 and 12): These sections rightly recognize the need to raise provider rates in both the fee-for-service and HUSKY managed care program in Medicaid. It is crucial that the Medicaid program reimburse health care providers at a level that encourages participation by primary, specialty, and ancillary care providers. We agree with the Committee's proposal to adopt the Connecticut Health Foundation's recommendation that dental provider rates be increased to the 70th *percentile* of customary and usual charges of private dentists[5]. We also support this proposed legislation that seeks to align Medicaid reimbursement rates with the fees paid to providers in the Medicare system. While we understand that the Medicare reimbursement system has its own flaws, this would be an important step in bringing up Medicaid rates to something approaching a more reasonable rate that would encourage increased participation among providers across the state. Assuming that risk-based managed care continues to be used for HUSKY A and B, the bill should require that 100% of the increase in rates be passed on to participating health care providers. The managed care plans also should be required to provide information about current, and updated, fees to health care providers to assure that the increase reaches the providers.

Other Ideas To Pursue

We offer the following suggestions that legislators should pursue to improve access to HUSKY for children and families:

- Extend coverage during pregnancy for undocumented pregnant women since their infants will be HUSKY A eligible U.S. citizens;

[5] Connecticut Health Foundation, *HUSKY A Dental Care: Avoiding the Repercussions of Poor Dental Care for Children on Medicaid* (Feb. 2007), available at www.cthealth.org This brief explains that significant numbers of providers will participate in Medicaid if fees are raised to the 70th percentile -- meaning that 70 percent of Connecticut's private dentists charge this fee or less as their normal and customary fee. In South Carolina, for example, the number of participating providers increased by 43 percent when reimbursement rates were raised to the 75th percentile.

- Extend coverage to undocumented children under HUSKY;
- Ensure state-funded coverage for applicants who make a good-faith effort to obtain documents to meet new federal requirements for proving their citizenship and identity, but are unable to do so within the required federal timeframe;
- Create a more graduated premium structure in the HUSKY B program. This would eliminate the "cliff" that occurs when family income exceeds 300% of FPL. Over 300% of FPL, the cost of health insurance for children in HUSKY B is *not* subsidized by the State, so the cost of premiums rises dramatically, making it unaffordable for many families.

Thank you for the opportunity to share these recommendations with you. While the HUSKY program has helped reduce the number of uninsured children and families since its inception in 1997, it is now time for some much needed improvements to the HUSKY system which will enable even more children and families to get the cost effective and health care they need most.