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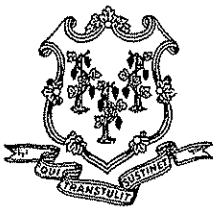

PERMANENT COMMISSION ON THE STATUS OF WOMEN

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Testimony of
Teresa C. Younger
Executive Director
Permanent Commission on the Status of Women
Before the Public Health Committee
Wednesday, January 31, 2007

Re:

S.B. 1, AA Increasing Access to Affordable, Quality Health Care
H.B. 6332, AA Increasing Access to Health Care
H.B. 6843, AA Cardiovascular Disease Prevention Programs

Good morning Senator Handley, Representative Sayers and members of the Public Health Committee. My name is Teresa C. Younger, the Executive Director of the Permanent Commission on the Status of Women (PCSW). Thank you for giving me the opportunity to speak with you about **S.B. 1, AA Increasing Access to Affordable, Quality Health Care, H.B. 6332, AA Increasing Access to Health Care, H.B. 6843, AA Cardiovascular Disease Prevention Programs** and generally about the need for accessible health care options.

The PCSW convenes the Connecticut Women's Health Campaign (CWHC), which is a broad coalition of groups 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 universal health coverage, and believe that coverage cannot be truly universal without recognizing the special needs of women. According to the Office of Health Care Access, 166,652 women in Connecticut were uninsured at some point during 2005, and 52,368 of these were working women.[1] Findings from our Health Economic Self-Sufficiency Standard[2] further illustrate that:

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[1] Office of Health Care Access, 2006 Household Survey.

[2] Foundation for Connecticut Women, "The Real Cost of Living and Getting Health Care

- Women are more vulnerable to medical debt than men. Fifty-six percent of medical bankruptcy filers are women.
- HUSKY has filled some of the void as employer-sponsored insurance has eroded, preventing a jump in the number of uninsured.
- Female-headed households have higher out-of pocket expenditures than male-headed households.[3] (Out-of-pocket costs account for about 20% of total health care spending in Connecticut.[4])

What Universal Care Means for Women. In the context of health care, women's special needs and concerns must be addressed to ensure that we have truly equal access to health care. Universal health care for women must be:

- Gender appropriate
- Culturally competent
- Comprehensive and preventive; and
- Confidential.

These principles inform our position on any plan for health care reform. I have attached the CWHC's position paper on universal health care and I urge you all to consider our principles as you deliberate health care reform proposals this year. We also ask that you consider the unique needs of women and girls as you convene a panel to examine policy options for the remaining uninsured.

Public Insurance is a Building Block for Universal Coverage. PCSW and CWHC applaud bipartisan efforts to strengthen and build on public insurance programs such as HUSKY, Medicaid and Medicare to maximize federal dollars for Connecticut. Because employer-sponsored insurance has eroded, public health insurance programs have been used to fill gaps in health care coverage. While often seen as a children's health program -- HUSKY covers over 80,000 women in our state -- and Medicaid serves thousands more elderly and disabled women. Medicaid plays a vital role for women's health throughout the lifecycle. It prevents women from being over represented among the uninsured.

We would recommend an additional item for consideration in filling the gaps in HUSKY. Transitional Medical Assistance (TMA) basically acts as "continuous eligibility" for adults in the program -- allowing working adults with very low income to remain covered if they had family coverage. Restoring the 24 months of TMA we

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in Connecticut: the Health Economic Sufficiency Standard." HESS measures the economic burden of health care and illness on Connecticut families. See http://www.cga.ct.gov/PCSW.

[3] M. Merlis, "Family Out-Of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity," Commonwealth Fund, June 2002.

[4] J. Hadley and M. Cravens, "Estimating the Cost of Uninsured in Connecticut," for the Economic and Social Research Institute by the Urban Institute, August 2005.

used to have in Connecticut before recent cuts (to 12 months) would help to shore up HUSKY and fill gaps in health care coverage for workers who are least likely to have employer-sponsored coverage.

- Those most deeply affected by the 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.[5]
- Nationally, over 30% of working women who left cash assistance remained uninsured after working for the same employer for two years or more.[6]
- Over half of women who leave welfare report at least one health problem. 22% of women said they had a health condition that limits the type or amount of work they can do.[7]

Because of federal categorical rules, childless adults are not eligible for Medicaid/HUSKY unless they are aged, blind or disabled. SAGA medical is a lifeline for almost 30,000 residents. Very low income and asset limits make it difficult to remain eligible for SAGA as well. It is estimated that increasing access to the State-Administered General Assistance Medical program for childless adults would expand coverage to an additional 10,000 individuals. Women comprise 40% of those with SAGA medical coverage. Finding a way to obtain federal dollars to support and stabilize this system would be a great step forward for Connecticut.

Young adults need expanded coverage. We urge the committee to consider raising the age of private, commercial coverage to 30 years, as young adults ages 19-30 are more than twice as likely to be uninsured as children or the elderly. According to the Office of Health Care Access (OHCA) 2006 Household Survey, an estimated 6.4% or nearly 223,000 Connecticut residents do not currently have health insurance coverage.[8] OHCA also estimates that while the percentage of residents without insurance is low relative to other states, CT youth, ages 19-29 are disproportionately represented among the uninsured. Women aged 19-29 represent almost a quarter of all uninsured women in the state (23.8%), and men aged 19-29 represent almost more than a third of all uninsured men in the state (36.1%).[9]

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[5] S. K. Long and J. A. Graves, *What Happens When Public Coverage Is No Longer Available?* The Urban Institute for the Kaiser Commissionon Medicaid and the Uninsured. January 2006.
[6] 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.
[7] Ibid.
[8] Office of Health Care Access. *2006 Household Survey and U.S. Census Bureau 2006 Annual Economic and Social Supplement*, accessed 1/06 at
http://www.ct.gov/ohca/lib/ohca/common_elements/household06_summary_single_pages_for_pdf.p
[9] Ibid.

Improve provider rates, data and outreach. H.B. 6332 would raise reimbursement rates for providers. We support this because it would help to create capacity and stability in the health care system as a whole. National data illustrate a lack of available providers for women, especially specialty care providers. We also support efforts to ensure quality health care in Connecticut through improved data collection, advanced electronic medical records and disease management, while supporting safety net providers. Data collection should analyze gender, race and ethnicity to be meaningful for this population. Likewise, we support measures which would increase funding for HUSKY outreach. This would enable more uninsured eligible residents to obtain and maintain coverage.

Tax incentives for consumers and small businesses are key. H.B. 6332 allows tax deductions for the health care costs borne by consumers. While we support allowing premiums to be deducted pre-tax for consumer affordability, we also believe that small business tax credits are essential.

The average cost of insurance for a small employer in Connecticut was $3,944 in 2003 according to the Agency for Healthcare Research and Quality. According to information from the Connecticut Business and Industry Association, the current cost estimate is between $4,654 and $4,930 per enrolled employee.[10]

Microenterprises employ twice as many people as the top 25 largest employers in our state. The Microenterprise Resource Group conducted a recent survey[11] which found:

- 85% of small business felt that health insurance was a necessity for themselves and their employees, but the vast majority do not offer insurance.
- Over three quarters are willing to contribute to insurance premiums.
- Respondents said that they would prefer to buy insurance through 1) a state pool or 2) buy individual policies if tax credits were available. State subsidies for coverage were also favored.

We urge you to support the small business tax credit in H.B. 6332.

Cardiovascular Disease Prevention. Both the PCSW and the CWHC support increased education and awareness, early intervention and treatment, and equal access to health care to address racial and ethnic disparities in healthcare as proposed in HB 6843.

In Connecticut, the leading causes of death for women are major cardiovascular disease, cancer, diabetes, chronic lower respiratory, and HIV/AIDS.[12] There is a clear racial and

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[10] Kaminski, Janet L. Connecticut Office of Legislative Research. "Cost Of Health Insurance For Small Employers," October 19, 2005 (2005-R-0706).
[11] Micro-Enterprise Resource Group-Universal Healthcare Survey Project Results. December 2006.

ethnic disparity as African-American and Hispanic women are at a greater risk for these diseases than White women.[13] African-Americans are at greater risk for heart disease, stroke and other cardiovascular diseases than Caucasians. The prevalence of these diseases in Black females is 49%, compared to 35% in White females.[14] The risk of heart disease and stroke increases with physical inactivity. Physical inactivity is more prevalent in women, African-Americans and Hispanics. For all of these reasons, we applaud and support H.B. 6843.

We thank you for your attention and we look forward to working with you on these issues.

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[12] 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.

[13] The extent of the problem with Asian populations is unknown due to lack of sufficient data.

[14] American Heart Association. *Heart Disease and Stroke Statistics – 2007 Update (based on 2004 figures).*

CONNECTICUT WOMEN'S HEALTH CAMPAIGN

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Universal Health Care: What it Means for Women

The Connecticut Women's Health Campaign (CWHC) supports universal coverage. We believe that coverage cannot be truly and completely universal without recognizing the special needs of women. In the context of health care, "equal" cannot mean "the same"; women's special needs and concerns must be addressed to ensure that they have truly equal access to health care. Universal health care for women must be:

- Gender appropriate;
- Culturally competent;
- Comprehensive and preventive; and
- Confidential.

These basic principles inform the CWHC's position on specific aspects of any plan for health care reform.

Coverage must be both comprehensive and preventive. High quality care should be available to all under a universal plan. Coverage must include specialty care, mental health and substance abuse treatment, access to prescription medication, vision and oral health care, preventive care, acute and long-term care, and rehabilitative care. The CWHC believes that any plan for universal health care must include the full panoply of reproductive health services, including coverage of family planning, contraceptives, abortion, cancer detection and treatment, prenatal care, and inpatient overnight stays for child-birth and mastectomy when needed. Indeed, the CWHC has been at the forefront of advancing such consumer protections when the "market" failed to address gender appropriate care in these areas.

Violence against women must be seen as a public health epidemic with emphasis on and resources for early education, prevention and unlimited treatment. Hospitals participating in any universal health care plan must offer and provide emergency contraceptives for all sexual assault victims. The full dosage must be offered and provided in the emergency room.

Preventive care must include health promotion and education. Maintaining wellness and building good health habits must be part of the universal health care design. This includes nutrition and physical education and activity at all stages of life, mental health services, substance abuse treatment, tobacco prevention and cessation as well as treatment of eating disorders.

Consumers must be able to access an array of practitioners, including midwives and nurse-practitioners. Settings should include community and school-based health centers, family planning clinics, and others that provide a safety net to underserved populations, including women and girls. Women must be able to identify a gynecologist or other specialist as their primary care

provider if reform builds on a managed care system.

Health care should be responsive to and inclusive of diverse populations and differences among clients. Proposals should strive to eliminate racial and ethnic disparities by design. This would include proactive recruitment of bilingual and multicultural health professionals and improved health data by collecting information gender, race and ethnicity. In particular, this means that medical interpreters must be provided and paid for as a covered service in order to ensure that those with limited English proficiency are able to communicate effectively with their providers.

Support unpaid family caregivers as well as the health care workforce. Women who are caregivers to disabled and/or terminal family members must be able to access respite care in the form of home health care. Low-income women of color are also disproportionately represented among paid caregivers for those with chronic conditions. Home health professionals, nurses aides and other workers form the backbone of our health care system and should be insured and paid fairly. Unpaid family caregivers without employer-sponsored coverage should also be made eligible for public insurance programs.

Protect the confidentiality of women and girls. Current state statutes protecting the confidentiality of services for all minors, including reproductive and behavioral health care, must be integral to any universal plan. For example, patients with HIV infection, survivors of sexual violence and domestic abuse, and those who seek behavioral health care must be confident that seeking care will not result in disclosure of their health condition.

Health care and insurance must be affordable so that true universality is accomplished. This means that low-income households should be exempt from cost-sharing while higher income households should pay no more than 5% of family income on total health care costs.

The CWHC urges decision-makers to ensure that these elements are included in any plan for universal or other health care reform. Only by doing so will health care reform address the needs of women and girls.

The Connecticut Women's Health Campaign is a broad coalition of groups who have been committed to and working for the health and well-being of Connecticut women and girls for over ten years.

Our mission is:

- to achieve access to health care for all women and girls in Connecticut;
- to advance the representation of women at all levels of decision-making, research and service delivery;
- to promote awareness of women and girls' health care needs; and
- to educate the public, especially state policymakers, about these needs.