

**Testimony Regarding
H.B. No. 6350: AAC the Budget for the Biennium Ending June 30, 2015, and Other
Provisions Relating to Revenue**

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Appropriations Committee
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Senator Harp, Representative Walker, and members of the Appropriations Committee:

I am testifying today on behalf 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.

Connecticut Voices supports the Governor's proposals to:

Maintain Medicaid income eligibility limit for pregnant women at 250% of the federal poverty level. We note that the budget maintains coverage for children in the HUSKY (Medicaid) and HUSKY B (CHIP) as required by federal law.

Expand coverage to individuals on HUSKY D (Medicaid for low-income adults without children) to 133% of the federal poverty level under a state option in the Affordable Care Act. The income limit is currently only 56% of the federal poverty level. Beginning in January 2014, the federal government will reimburse the state for the full cost of coverage for all HUSKY D enrollees. As a result, the state is expected to save hundreds of millions of dollars over the next decade in costs associated with this Medicaid expansion.

Connecticut Voices opposes the proposal to eliminate coverage for more than 40,000¹ HUSKY parents with income between 133% and 185% of the federal poverty level (\$25,975 to \$36,131 for a family of three)² beginning January 1, 2014, with the expectation that instead they will purchase coverage through the state's new health insurance exchange.

Many HUSKY parents are likely to join the ranks of the uninsured.

The overarching goal of the Affordable Care Act is to increase the number of individuals and families with insurance coverage and access to needed health care. This will come from both the Medicaid expansion and the opportunity of the *currently uninsured* population in Connecticut to purchase insurance through the exchange, beginning in 2014. It runs counter to the purpose of the Act to end insurance coverage for low-income parents, and create an unnecessary risk that many of them will join the ranks of the uninsured. Research *and common sense* demonstrate that even with subsidies many of these parents will forego coverage and/or care due to unaffordable costs of the exchange plans.³⁴

HUSKY coverage is tailored to the needs of low-income families.

Currently, HUSKY A parents pay no premiums or other out-of-pocket costs, and have access to medically necessary transportation, dental and behavioral health, and substance abuse services, as well as prescriptions without co-pays. Transportation to medical appointments is not a covered service provided by an exchange health plan, dental coverage may be available through the exchange,

but at an additional and unsubsidized cost, and access to behavioral health services is limited or too expensive under many commercial plans. There is tremendous concern that individuals whose mental health conditions are controlled with psychiatric medications will forego those drugs if they have to pay even nominal amounts. It is very likely that many of these parents, struggling to pay rent, utilities, food, clothing, and other essential items for their children, will forego paying for their own health insurance coverage, rather than skimp on supports for the family as a whole.

Children on HUSKY may lose coverage or access to care if their parents lose coverage.

Children on HUSKY with family income up to 185% of the federal poverty level remain eligible for HUSKY A until 2019 under the Affordable Care Act. We are, however, very concerned about the effects of the parent's loss of coverage on their children's access to coverage and care. Research demonstrates that when whole families are covered together the number of children who are insured and have access to care is much higher.⁵ Insured children with uninsured parents are nearly 2.5 times more likely to experience an insurance coverage gap than insured children with insured parents.⁶ Insured children with uninsured parents are at greater risk of having unmet health care needs and having never received at least one preventive counseling service.⁷ A child with publicly insured parents is about 8 times more likely to be enrolled in public coverage compared to a child whose parent is uninsured.⁸ Moreover, whether children get health care is related to parental use of health care, and – not surprisingly but significantly – “the health of parents can play an important role in the well-being of their children.”⁹

Connecticut can be proud of the progress it has made in reducing the number of uninsured children¹⁰ over the last 15 years – due in no small measure to the success of the HUSKY program. This is no time to risk increasing the number of uninsured children and parents.

We also oppose the following proposals:

1. Reduction in funding for the 2-1-1/United Way HUSKY Infoline by 52% in FY14 and elimination of all funding in FY15. HUSKY Infoline provides one-on-one assistance with eligibility and access to care issues specifically related to the HUSKY program. Given the anticipated changes to the HUSKY program in 2014 under health reform, the in-depth expertise of the staff of Infoline will be needed more than ever to assist families.

2. Reduction in funding for community-based Healthy Start programs by 60%. Healthy Start assists pregnant women to access health coverage and prenatal care.

3. Elimination of funding for independent performance monitoring in the HUSKY Program (\$219,000 per year, though 50% of this cost is reimbursed by the federal government). Independent performance monitoring has been state-funded since 1995 and is conducted by Connecticut Voices under a contract between DSS and the Hartford Foundation for Public Giving. This project provides information on enrollment patterns¹¹, long-term trends in the use of children's health services, including well-child, dental, emergency, and asthma care.¹² This information is not reported by the Department's administrative services organization (“ASO”) contractor. The project also provides data on maternal health and birth outcomes in the HUSKY Program, including low birthweight, preterm births, prenatal care, births to teen mothers, and smoking among mothers.¹³ This research is based on linked birth-HUSKY enrollment data that is not available to the Department's ASO contractor.

During the next biennium when the HUSKY program will be undergoing major changes due to the Affordable Care Act and other initiatives, it is more important than ever that the state maintain its cost-effective investment in oversight and program improvement – a program that serves over 425,000 children, parents, and pregnant women.¹⁴

4. Elimination of the Behavioral Health Partnership Oversight Council. I am a member of the Council and co-chair of the Coordination of Care Committee. This proposal is set forth in H.B. 6367, *An Act Implementing the Governor's Budget Recommendations for Human Service*. I bring it to the attention of the Appropriations Committee since it has little impact on the state budget (the only appropriated funding is for a legislative staff person), but could have a deleterious effect on the great work of the Partnership. The Partnership has only recently expanded to potentially cover all 600,000 individuals – children and adults – on Medicaid and CHIP (HUSKY B). This is no time to reduce transparency, oversight, and consumer input with regard to mental health services in our state. We need to build on the success of the Partnership and that can only be done in collaboration with the many stakeholders on the Council – providers, state agencies, consumers, their family members, and advocates. We urge you to support the continuation of the Council.

Thank you for this opportunity to testify regarding H.B. 6350. Please feel free to contact me if you have questions or need additional information.

¹ Statement of Ben Barnes, Secretary, Office of Policy and Management at the meeting of the health insurance exchange board (February 21, 2013). Estimate by the Office of Fiscal Analysis last year in its analysis of S.B. 425 was 31,000.

² Annual Update of the Poverty Guidelines, 78 Fed. Reg. at 5153 (January 18, 2013).

³ Between 133% and 185% FPL, individuals will be expected to pay between 3% and 5.61% of their income for premiums and as much as \$2,250 for an individual (\$4,500 for a family plan) toward deductibles, co-pays and other out-of-pocket costs depending on the plan and the health of the consumer. Patient Protection and Affordable Care Act "Affordable Care Act", P.L. 111-148 as amended by P.L. 111-152. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule, 77 Fed. Reg. at 73173 (December 7, 2012). Even if the parents pay the premiums, they may be discouraged from receiving necessary care due to other out-of-pocket costs, such as co-pays.

⁴ See, for example, Ku, L, and Wachino, V, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings*, Center on Budget and Policy Priorities, July 7, 2005, available at <http://www.cbpp.org/cms/?fa=view&id=321>.

⁵ Dubay, L, and Kenney, G, "Expanding public health insurance to parents: effects on children's coverage under Medicaid," *Health Serv Res* 38(5): 1283-1301 (2003).

⁶ DeVoe, JE, Tillotson, CJ, and Wallace, LS. "Children's Receipt of Health Care Services and Family Health Insurance Patterns," *Ann Fam Med* 7(5): 406-413 (2009).

⁷ *Id.*

⁸ GAO, *Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families*, GAO-11-264, February 4, 2011, available at <http://www.gao.gov/products/GAO-11-264>.

⁹ Committee on the Consequences of Uninsurance, Institute of Medicine, *Health Insurance Is a Family Matter*, Washington, DC: National Academy Press, 2002.

¹⁰ See, e.g., Lee, MAL, *Uninsured Children in Connecticut: 2011*, Connecticut Voices for Children, October 2012, available at <http://www.ctvoices.org/sites/default/files/h12uninsuredchildren11a.pdf>.

¹¹ See, e.g., Lee, MAL, *Trends in New Enrollment in the HUSKY Program: 2011*, Connecticut Voices for Children, December 2012, available at <http://www.ctvoices.org/sites/default/files/h12newenrollees2011.pdf>; Lee, MAL, *Children in the HUSKY Program Experience Gaps in Coverage: An Update*, Connecticut Voices for Children, May 2012, available at <http://www.ctvoices.org/sites/default/files/h12huskycoveragegaps.pdf>.

¹² See, e.g., Lee, MAL, *Children's Dental Services in the HUSKY Program: Program Improvements Led to Increased Utilization in 2009 and 2010*, Connecticut Voices for Children, November 2011, available at <http://www.ctvoices.org/sites/default/files/h12newenrollees2011.pdf>.

¹³ See, e.g., Lee, MAL, *Births to Mothers with HUSKY Program and Medicaid Coverage: 2010*, Connecticut Voices for Children, February 2013, available at <http://www.ctvoices.org/sites/default/files/h13birthsreport10.pdf>.

¹⁴ See, Langer, S and Lee, MAL, *The HUSKY Program for Children and Families: The Impact of the Governor's FY 2014 and FY 2015 Budget Proposals*, Connecticut Voices for Children, February 21, 2013, available at <http://www.ctvoices.org/sites/default/files/h13huskybudgetfy1415.pdf>.