

# Legal Assistance Resource Center of Connecticut, Inc.

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## **Testimony before the Human Services Committee in Support of RB 5618, An Act Concerning Revisions to the HUSKY Plan and with comments on Bill 34**

by Jane McNichol, Executive Director  
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I am Jane McNichol, Executive Director of the Legal Assistance Resource Center of Connecticut, the advocacy and support center for legal services programs in the state. We represent the interests of very-low income residents of the state.

A number of the bills before you today are of importance to low-income people in Connecticut. I will focus on RB 5618, An Act Concerning Revisions to the HUSKY Plan, but will include brief comments on RB 34 at the end of this written testimony.

### **RB 5618, An Act Concerning Revisions to the HUSKY Plan**

RB 5618 makes two important changes in the way that Connecticut will provide health care through HUSKY A, the Medicaid program for families with children, and HUSKY B, the health care program for children only in families that do not qualify for HUSKY A.

HUSKY A provides health care coverage for about 300,000 children and their parents or caretakers and costs about \$750 million a year. To be eligible, a family's income must be at or below 185% of the federal poverty level. Half the costs of HUSKY A are paid by the federal Medicaid program.

HUSKY B provides health care coverage to about 16,000 children (no adults are covered in HUSKY B) whose families are above the income limit for HUSKY A but still struggle to access health coverage for their children. Much of the funding for HUSKY B comes from federal SCHIP funds.

**Sec. 1 of RB 5618 restores continuous eligibility in the HUSKY program.** This common sense provision, which Connecticut used until 2003, allows children to remain eligible for HUSKY for up to one year after their enrollment or eligibility renewal, regardless of any changes in income or family configuration which might otherwise make them ineligible. This ensures continuity of health care for vulnerable children. The estimated cost of restoring continuous eligibility is \$2.8 million.

**Sec. 2 proposes another common sense improvement in the administration of the HUSKY program.** Under this section, the Department of Social Services would be barred from contracting with Managed Care Organizations (MCOs) to manage HUSKY on an at-risk, capitated basis until July 1, 2009. Currently, DSS intends to return to at-risk, capitated contracts with MCOs to administer the HUSKY program in four months, by July 1, 2008.

**Delaying this switch back would give the administration and the legislature time to examine various methods for administering HUSKY and would save the families in HUSKY from going through two transitions in three months.** In fact, in order to conduct a thorough and orderly review of administrative options, we would propose delaying any contracting with the MCOs on an at-risk, capitated basis until July 1, 2010.

**Background:**

Since January, as a result of the breakdown of contract negotiations between the state and the MCOs, the state changed its HUSKY contracts with the MCOs. Under the revised, short-term contracts, the MCOs are responsible only for administrative services and were not making medical or payment decisions. This is a dramatic change from the history of the MCOs' involvement with HUSKY. Since the mid-1990's, Connecticut has contracted with Managed Care Organizations (MCOs) to run the HUSKY program.

But the program has changed significantly during that time.

- Behavioral health services were "carved out" of the HUSKY services provided by the MCOs a number of years ago.
- The state resumed full authority over pharmaceutical services on February 1 of this year.
- Dental services will be carved out in the near future.
- DSS, under a mandate from the legislature, is developing a pilot primary care case management program to see if this system provides a cost-effective way to provide better health care services to families enrolled in HUSKY.
- On March 31, two of the four MCOs providing HUSKY services will end their contracts with the state altogether. HUSKY A families currently receiving services from Health Net Healthy Options or WellCare of Connecticut/PreferredOne will be required to select a new administrator - either Anthem BlueCare Family Plan, Community Health Network of Connecticut or the Department of Social Services.

On July 1, DSS plans to contract again with MCOs to administer the HUSKY program on an at-risk, capitated basis. Prior to July 1, all HUSKY participants will be asked to select a new MCO to provide their health services. It is highly likely one or more of these new MCOs will never have delivered services to Connecticut HUSKY participants.

**Families in HUSKY should not be required to go through two transitions in three months.** This would create enormous confusion and we can expect that some families will get lost and drop off the program during these transitions.

**As a result of the unanticipated change in the MCO/HUSKY contracts, we are presented with an opportunity to take a serious look at how we are providing health care to families and children in Connecticut.** We should take the time we need to determine the best way to provide these vital services.

(comments on Bill 34 on following page)

**Bill 34 - An Act Implementing the Governor's Budget Recommendations with Respect to Social Service Programs**

**We oppose Section 1, which would eliminate the requirement that the Commissioner of Social Services amend the Medicaid state plan to include foreign language interpreter services as a covered service under the Medicaid.** This is an important initiative adopted in last year's budget. It should not be eliminated before it has even been implemented and tried. Numerous studies document the disparities in health care services and outcomes for racial and ethnic minorities in the state and the nation. This provision is one part of the needed response to these disparities.

**We oppose Section 2, which requires that the Department of Social Services adopt a more restrictive definition of "medically necessary" for use in the Medicaid program** than the one currently used. The rationale for this change is to align the Medicaid program more closely with commercial insurance. But there are important reasons why the Medicaid program does not mirror commercial insurance. The Medicaid program is designed to address the health needs of people who cannot otherwise afford health care coverage. People covered by Medicaid lack the financial ability to supplement coverage. The definition of "medically necessary" in the Medicaid program should remain the same, as the legislature has affirmed in the past two years in rejecting similar proposals.

**We support Section 5, which would increase the child support passed through to families receiving Temporary Family Assistance (family welfare) by \$50 a month.** This is vitally important income to families which currently receive very limited support through TFA. In most of the state, a family of three receives \$560 a month in cash assistance from TFA. The federal government has changed its reimbursement rules so that the proposed \$50 increase in funds passed through to the family costs the state almost nothing.

The new federal rules provide a larger incentive and subsidy for families with more than one child. For a small additional investment, which will be matched by the federal government, the state can do better for families with more than one child. A fact sheet with more details about this issue is attached to my testimony.

# FACTS about Increasing Child Support For TFA Families

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**Under new federal rules effective in October of this year (2008), families receiving TFA cash assistance can receive more child support payments at almost no cost to the state.**

*How the system works now:*

When families apply for cash assistance under the Temporary Family Assistance (TFA) program, they give (assign) the State their right to child support paid by a non-custodial parent. The State collects the required child support from the non-custodial parent and is required to send 50% of these collections to the federal government to repay the federal contribution to family welfare costs.

Connecticut, like most other states, passes \$50 through to the family to supplement the family's TFA benefit and keeps the balance (up to the amount of the family's TFA benefit) to reimburse the State for its share of family welfare costs.

*As of October 1, 2008, the federal government will require less reimbursement from the states:*

Federal law was changed recently to offer an incentive and subsidy for states to increase the pass-through to families. After October 1, the federal government will not require any reimbursement from the states on the first \$100 paid in child support for a family with one child and on the first \$200 for a family with two or more children if the money is passed through to the family. If the State increases the amount passed through to families by \$50, it will not be required to pay the federal government the \$50 in reimbursement previously required. If the State passes through more than \$50 for families with more than one child, the State and the federal government essentially split the cost of the additional pass through.

**Under the new rules, at almost no cost to the state, Connecticut can increase the amount that it passes through to families to \$100 per month.** For a small investment, which will be matched by the federal government, the State can do better for families with more than one child.

*An example of how this works:*

	Parent Pays	Family Share	Federal Share	State Share
<b>Current System</b>	\$400	\$50	\$200 (50%)	\$150
<b>New System</b>			\$150	
family w/ one or more children	\$400	\$100	50% of \$300 (\$400 - \$150)	\$125
family w/ more than one child	\$400	\$150	\$125 50% of \$250 (\$400 - \$150)	\$125

Increasing the pass through to \$100 for all families is included in the Governor's budget proposal. The Governor's budget projects a small cost (\$650,000) in reduced revenue for implementing this important change for families.