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Testimony of Sheldon Toubman before the Human Services Committee In Support of Restoring Medicaid Services (HB 5794 and 5795) and Increasing the Medicaid Eligibility Guidelines for Elderly/Disabled Recipients (SB 562)

Good afternoon, Members of the Human Services Committee. My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association, mostly working on matters of access to health care. I am here to testify in support of several bills — bills which increase access to Medicaid services such as hospice care, podiatry, chiropractic services, hospital care, and home care services; increase access to federally-subsidized Medicare services; increase the asset limit for State-Administered General Assistance; and, most importantly, increase the final eligibility guidelines for elderly and disabled individuals to 185% of the federal poverty level, so that they match the guidelines for other Medicaid recipients.

First, **HB 5794 and 5795** will restore some important optional services, podiatry and chiropractic services, that were cut from Medicaid several years ago under the Rowland Administration. Just taking the example of podiatry, these services are essential for people with diabetes to detect and treat conditions before they become very serious and expensive to treat— like in the form of foot amputations. These cuts were not wise when they were made and they are not wise now. I urge you to restore these services.

Turning to **SB 562**, I should explain what the process of “spenddown” means for my elderly and disabled clients who are modestly over the current low Medicaid income guidelines. They are told at the beginning of a given six month period what their spenddown amount, usually one or two thousand dollars, is. They then have to incur substantial medical bills from medical providers willing to provide services not knowing for sure if they will get paid. Of course, many providers will not provide services in these circumstances; this is especially the case with home care agencies and some private physicians.

But assuming the provider is willing to provide the services in this situation, the individual must then collect the bills from each of their providers, deliver them to their DSS worker, who likely will be too busy to see them, and then wait to see if the worker says they have or have not met their spenddown. If not, they have to incur and collect still more bills, bring them to their worker, etc.

The process is tedious and difficult even if there is a diligent worker with the time to process the bills; much more so if the worker has a high caseload and is already far behind on their casework. If the individual succeeds in making it through this process, they have to start it all over again for the next six month period.

But what about getting through this process if the individual applying for Medicaid is cognitively impaired, has mental illness or has hearing problems? The process is confusing enough even for someone with a sharp mind, acute senses and an ability to follow through. But for the rest it is hopelessly bewildering. I have clients who bring me a mountain of medical bills, don't know which ones have been submitted and which have not been, and can't figure out if the bill was incurred during the appropriate spend-down period (necessary in order for a bill which has been paid to be used toward meeting the spenddown). They just give up trying to get on Medicaid.

While this is of course bad for them, it is bad for the rest of us too. Without insurance coverage for preventative care or for early treatment of a developing condition, they probably will go without. When they do, small medical problems which could have been addressed easily become major medical crises, which often require treatment in emergency departments and in-patient settings. The good news at that point is that the very high hospital bills will very quickly satisfy the individual's spenddown; the bad news is that the taxpayers will then be paying for this far more expensive treatment, which could have been avoided entirely if earlier care were covered under Medicaid.

Last year, the legislature took the important step of increasing the eligibility of parents under Medicaid to match the income guideline for children—185% of the federal poverty level. This was a very important step. We applaud your action, which has brought benefits to needy families throughout the state.

But left out were the elderly and disabled recipients, whose income guideline is at an abysmally low **60-70% of the federal poverty level**. Not only is this unfair, but the elderly/disabled are statistically more in need of the services covered by Medicaid and yet they are the least capable of navigating the complicated spenddown process to access those services-- which is the only way they can get on Medicaid.

I urge you to increase the income guidelines so that all categories of Medicaid recipients (except pregnant women, who are eligible up to 250% of the federal poverty level) have applied to them the same reasonable income level of 185% of the federal poverty level. **SB 562 will accomplish this.**

In addition, I support **SB 558, 560, 561, and HB 5792 and 5796**, and urge you to pass favorably on each of these bills as well. We need to expand access to hospice services and services necessary to allow individuals to receive cost-effective treatment in the community rather than in institutional settings, as Money Follows the Person (SB 561) will allow us to do. And expanding access to federal subsidies under the Medicare drug benefit is a wise investment because it will reduce our state expenditures under the ConnPACE program. The increase in the SAGA-cash asset limit will simply bring it up to the SAGA-medical assistance asset limit.

Thank you for the opportunity to speak with you today.