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Testimony of Sheldon Toubman before the Human Services, Public Health and Insurance and Real Estate Committees in Opposition to SB 990, in Support of a Substitute Version of SB 988, and in Opposition to Section 21 of HB 5172, Which Would Place Elderly/Disabled Medicaid Enrollees into Problematic HUSKY HMOs

Good morning, Members of the Committees. My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association, mostly working on matters involving access to health care for low-income residents.

Opposition to Section 21 of HB 5172

I am here to testify in opposition to Section 21 of HB 5172 before the Insurance Committee, which would open up the problematic HUSKY HMOs to the vulnerable elderly and disabled Medicaid population, effectively causing the movement of the most confused among this population into HMOs with too few doctors and a direct financial incentive to deny needed health care, at a probable greater cost to the taxpayers.

The statement of purpose for HB 5172 reads that it is a bill "to expand the availability and affordability of health insurance benefits to all Connecticut residents." In the case of Section 21, however, the passage of this bill would have the exact opposite effect.

Although couched in language about "*allow[ing]* aged, blind or disabled Medicaid beneficiaries to voluntarily enroll in the managed care plans available to HUSKY Plan, Part A and HUSKY Plan, Part B beneficiaries," this bill would, as a practical matter, cause confused elderly and disabled Medicaid recipients to be moved to restrictive HMOs based on promises from these financially interested HMOs. This would occur because of the recipients' susceptibility to the slick advertizing campaigns of these HMOs, which present a rosy picture of access often unrelated to reality. Based on what we know from Medicare HMOs marketed to basically the same population, when confused seniors and people with disabilities sign up for restrictive plans with few doctors and restrictive policies regarding access to care, they often have no idea they did so.

Based on the ongoing experience with the HUSKY HMOs for the generally healthy family and child population already enrolled in them, these HMOs have severely inadequate provider networks. But this reality will go unmentioned by the HMO marketers. And, because of the obvious financial incentives, even if the HMO the enrollee chooses includes his or her current doctor, the HMO will often deny access to care when that participating provider requests it. Given the access problems these HMOs already create for low- income HUSKY families, this clearly can't be a good thing for the

even more vulnerable elderly/disabled Medicaid recipients with complex and multiple medical conditions.

There is another commonly-stated myth that proponents of HMOs routinely invoke in support of moving this population to HMOs: that these HMOs coordinate care which would not otherwise occur. But this rarely occurs now-- under the HUSKY contracts which already require it. Similarly, in the case of Oregon, which has experimented with HMOs for its elderly and disabled population, the reality has been quite the opposite. As one Oregon advocate, Attorney Timothy Baxter of the Lane County Legal Aid and Advocacy Center, recently explained:

> In our collective experience serving many hundreds of elderly and disabled OHP participants over the years, true case management via ENCC, and bona fide advocacy through an ombudsman, have been, not just ineffective, but generally nonexistent.
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> The officers of commercial health plans have, quite literally, a legal *duty* to their corporate shareholders or other owners to maximize profits to the fullest permissible extent. The conflict of interest in assuming the role of public servant invades the innermost core of the health plan's mission. To have any hope of keeping the health plan from unchecked fulfillment of its own corporate nature, the most rigorously faithful oversight must be maintained without letup.
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> My own county served as a truly catastrophic illustration of how badly things can go wrong. In 2000 and later years, the state's oversight of Lane County's MCO failed -- totally. As a result, the Lane County MCO ran wild over the rights of its disabled and elderly [Medicaid] members. Improper, unexplained denials of requests for medical equipment and supplies became the norm. Delay, stonewalling, and other hardball private insurance tactics, became standard operating procedure.

In sum, the movement of elderly and disabled Medicaid enrollees to the HUSKY HMOs, whether on a "voluntary" basis or otherwise, cannot serve the stated goal of HB 5172 to "expand the availability and affordability of health insurance benefits to all Connecticut residents."

While Section 21 is not good for access to care for this population, it is possible that the proponents of this section believe it will at least save money. But this is a myth too. It is not at all clear that having moved the HUSKY population into HMOs will save money relative to the well-functioning non-risk system most of them were in before February 1st. Moreover, based on the years of experience with Medicare Advantage HMOs enrolling essentially the same population, placing the elderly and disabled Medicaid population in capitated HMOs will be **more** expensive than continuing to administer health care directly to this population under the DSS-run Medicaid fee for service program.

In the 1990s, when the Clinton Administration sought to save money by moving elderly/disabled Medicare recipients into HMOs, under the "Medicare+Choice" program, the HMOs could not make money on the program and so, in Connecticut as elsewhere, Medicare plans left in droves. Indeed, Bruce Vladeck, the Administrator of CMS (then called the Health Care Financing Administration or HCFA) during these years, who oversaw this program, said: "Managed care did not save Medicare a nickel."

Although the Bush Administration has managed to bring HMOs into the Medicare program and keep them, this has only been possible at a frightful price to the taxpayers: HMOs have been willing to stay in the program because of the profits made possible through heavy subsidization of these plans by the federal government, such that they **on average cost the taxpayers 14% more than it would cost to provide the same care under the traditional government-run Medicare program.** President Obama has specifically identified this excessive cost as an example of waste in the health care system which must be eliminated. Once the subsidy is removed, it is unlikely that the HMOs will be able to continue providing services under Medicare, given their much higher administrative costs than under traditional Medicare.

Last year, when essentially the same bill as HB 5172 came up before the Insurance Committee, I testified against this particular provision, but it was passed by the committee without amendment. Fortunately, the bill never came up for a vote and died. If this provision is not removed this time, it will contain the same threat to access health care for our most vulnerable elderly and disabled population and advocates will again oppose it for this reason.

I therefore urge you, on behalf of the tens of thousands of elderly and disabled Medicaid recipients who will not know what is in store for them if they are persuaded to sign up with the HUSKY HMOs, to delete Section 21 if you are to pass favorably on HB 5172.

Opposition to SB 990

I am also here to testify in opposition to SB 990, before the Human Services Committee.

SB 990 is entitled "An Act Concerning Expanding the HUSKY Formulary." While this sounds at first blush to be a positive thing, since it refers to "expansion," it is clearly not good for vulnerable enrollees in the HUSKY, Medicaid and SAGA programs. It would restrict access to psychiatric medications for enrollees in these programs-- both adults and **children**-- by REMOVING the critical exemption from the operation of the restrictive preferred drug list (PDL or formulary) for "mental health-related drugs." Currently, all such drugs are exempted from this, meaning that no such drugs are subject to prior authorization simply because they are not on the PDL, a process which restricts, and in fact is specifically intended to restrict, access to these drugs. This is a critical exemption followed by many other states.

If the bill is passed, then DSS's Pharmaceutical and Therapeutics Committee will review all psychiatric medications and some of them, most likely the more expensive ones, will be kept off the list and thus be available only through prior authorization, resulting in denials of access. This will even apply to children in DCF custody in need of psychiatric

medications to control their behaviors. And although the title of the bill only refers to HUSKY, the removal of the exemption will also apply to elderly and disabled Medicaid recipients, as well as those on SAGA, as the statute which will be amended applies to the PDL administered by DSS for **all** of these programs.

The medications needed to treat severe brain disorders, e.g., major depression, schizophrenia, bipolar disorder, and other disorders, in particular patients cannot always be easily identified. Finding the medication that addresses the symptoms of the disorders with the least side effects requires patience, diagnostic skill, and often trial and error over many months. Unfortunately, our knowledge of brain disorders and the neurobiology of mental illnesses is still developing.

A physician's judgment, and the patient's knowledge of his or her own functioning, is central to the successful amelioration of these disorders, not the distant judgment of a bureaucrat or even a medical professional who has no knowledge of, or responsibility for, the treatment of this person. Imposing the additional obstacle of prior authorization will have the inherent effect of making some of the medications which these conscientious physicians prescribe difficult to obtain, such that some patients will have their access blocked to the one medication which will provide appropriate treatment for their psychiatric condition.

Psychiatric medications, even the newer atypical anti-psychotic drugs, often have unpleasant side effects, and the motivation to secure the medication, even when the individual knows it is in their best interest, is often conflicted. To have delays of any kind is not acceptable, and may discourage the individual from taking this or any other psychiatric medication. It is not cost-effective to interfere bureaucratically with anyone's chance for recovery by subjecting their prescribed psychiatric medications to prior authorization. For all these reasons, our statutes have long had a total exemption from the operation of the PDL for all mental-health related drugs, along with all anti-retroviral drugs used to treat HIV/AIDS. I urge you not to remove that exemption.

Support for Substitute Version of SB 988

I am also here to testify in support of a substitute to S. 988 before the Human Services Committee, which would require DSS to submit a request to the federal government for permission to run a demonstration project under Section 1115 of the federal Social Security Act to place the SAGA and Charter Oak programs under a Medicaid waiver, so as to obtain partial federal reimbursement. Although the concept of obtaining federal reimbursement for existing state-funded programs is laudable, the language in this bill is no longer current, in light of the change in federal administration, and it does not contain essential protections for existing Medicaid clients or ensure that the legislature will have control over the waiver negotiated with the federal government. Attached is substitute language to Section 1 of the bill which will accomplish all of these things.

First, the term "Health Insurance Flexibility and Accountability demonstration initiative" is a term that was developed by the Department of Health and Human Services under the Bush Administration to encourage states to undermine the Medicaid program by having them apply to cover new populations under Medicaid under Section 1115, but only if the

inclusion of the new population was cost-neutral for the federal government **and** the state cut back substantially on benefits or services for populations **already** covered under their respective Medicaid programs. The goal of the Bush Administration was effectively to remove requirements under federal Medicaid law which protected Medicaid recipients, under the stated principle of "state flexibility." States which chose these waivers ended up harming vulnerable Medicaid populations by restricting their access to health care.

It is expected that the Obama Administration will be rejecting this concept and therefore would not approve any waivers invoking it, as the current draft of SB 988 currently does. Accordingly, the draft substitute language removes this in favor of the statutorily appropriate language that DSS shall seek a "waiver of section 1902(a)(10)(A) of the federal Social Security Act (and such other sections of federal law as the Secretary may require)."

Second, to ensure that the submission of a waiver request under this bill does not harm the over 400,000 current (and new) Medicaid recipients in Connecticut, protective language must be included which ensures that eligibility, coverage and services are not in any way reduced for these individuals as the price for obtaining the waiver to cover new populations under Medicaid. Although the Obama Administration is likely to reject the cost-effective test which was applied by the Bush Administration under demonstration project waivers under Section 1115, it is too soon to know this for certain. While the advocates share the goal of the legislature to obtain federal reimbursement for state-funded programs wherever we can safely do so, this should not be done at the price of diminished access to services for the vulnerable existing Medicaid populations. The attached substitute language addresses this concern.

Third, because the Department of Social Services has on occasion acted on legislative committee approval by negotiating with the federal government in a manner at odd with that legislative intent, it is important that DSS come back to the two legislative committees of cognizance—this one and the Appropriations Committee—after the waiver is approved by the federal government so that the committees have a final opportunity to review and approve it. This might be of particular concern if the federal government will not approve the part of the waiver request regarding the Charter Oak program without substantial changes to it, which is likely given the problematic design of that program. The draft substitute language ensures that the two committees will have a final opportunity for review (and approval or disapproval) before implementation.

Finally, we expect that, with the approval from the federal government of this proposed waiver for the SAGA population, not only will there be no harm to existing Medicaid recipients but the SAGA benefits will be increased to the Medicaid level, which is where they were a few years ago, before the Rowland Administration began a campaign to eliminate this essential safety net program. We in fact intend to advocate on this point at the federal level, when the waiver request is submitted, and expect little resistance because SAGA is still a fully state-administered entitlement program structured essentially like the Medicaid program, so bringing it up to the Medicaid level should not be that difficult.

On the other hand, bringing the Charter Oak program up to the Medicaid level will present a major problem because of the design of that program as a bare-bones limited benefit program administered through fully capitated contracts with HMOs. The Obama Administration is not likely to approve placing a new population under the Medicaid program unless they actually are given the benefits of Medicaid coverage and protections. Since this would require the substantial renegotiation of the capitated contracts under which the Charter Oak HMOs obtained, either at DSS's initiation or as a necessary concession by DSS to have the HMOs agree to contract with the state, such non-Medicaid compliant limitations as an annual $7500 cap on prescription drugs and an annual $100,000 cap on all benefits, there is a serious question whether this part of the waiver will be approved by the federal government.

PROPOSED SUBSTITUTE LANGUAGE FOR S.B. 988, Section 1
(proposed additional language shown in bold letters)

"Section 1. (NEW) (Effective from passage) (a) Not later than January 1, 2010, the Commissioner of Social Services shall apply **to the Secretary of the United States Department of Health and Human Services** for a waiver of **section 1902(a)(10)(A) of the** federal **Social Security Act (and such other sections of federal law as the Secretary may require) in order to operate a** ~~law under the Health Insurance Flexibility and Accountability~~ demonstration **project** ~~initiative~~ **under section 1115 of that Act** for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under (1) the state-administered general assistance program, and (2) the Charter Oak Health Plan, established pursuant to section 17b-311 of the general statutes**, provided, however, that no such waiver shall be submitted which would permit or require any reduction in eligibility, coverage or amount, duration or scope of services under the existing Medicaid programs for the aged, blind and disabled and HUSKY, Part A, in effect at the time of the approval of the waiver, in order to gain approval from the Secretary.** The commissioner shall submit the application for the ~~waiver~~ **demonstration project** to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations prior to submitting the application to the federal government in accordance with section 17b-8 of the general statutes.

(b) If the proposed demonstration project is approved by the Secretary, the commissioner shall submit the demonstration project, as so approved, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations, in accordance with section 17b-8 of the general statutes, for consideration and approval, prior to implementation of the demonstration project.

(c) If the commissioner fails to submit the application for the waiver to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by January 1, 2010, the commissioner shall submit a written report to said committees not later than January 2, 2010. The report shall include, but not be limited to: (1) An explanation of the reasons for failing to seek the waiver; and (2) an estimate of the cost savings that would result from the approval of the waiver in one calendar year.