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TESTIMONY OF SHELDON TOUBMAN IN OPPOSITION TO THE HARMFUL HEALTH CARE CUTS CONTAINED IN S.B. 32 AND IN SUPPORT OF EXPANDING PCCM IN THE HUSKY PROGRAM AS AN ALTERNATIVE MEANS TO SAVE MONEY

Good morning, Members of the Human Services Committee:

My name is Sheldon Toubman, and I am an attorney with New Haven Legal Assistance Association. I am here to speak in opposition to most of the Governor's bill, S.B.32, which would cut health care benefits for low-income residents under Medicaid, HUSKY and SAGA programs. A better solution is to modestly increase taxes on those best able to afford them. Another good solution is to invest in the short term in the statewide roll-out of primary care case management (PCCM) for both the HUSKY A and HUSKY B populations, to reap big rewards in a matter of months.

I call your attention to just some of the draconian proposals reducing or eliminating access to health care for low-income residents contained in S.B. 32:

- (1) implementing unaffordable copays for Medicaid enrollees, such that they will simply forego treatment until their conditions require expensive emergency room intervention
- (2) increasing the already unaffordable drug copays for dual eligible Medicare/Medicaid recipients from \$15 to \$20 per month
- (3) ending eyeglass coverage for adults under Medicaid and SAGA
- (4) eliminating most medical transportation under SAGA
- (5) increasing HUSKY B cost-sharing
- (6) imposing prior authorization for psychiatric medications on which individuals have been stabilized
- (7) eliminating the Medical Inefficiency Committee, which is carefully crafting a new Medicaid definition of medical necessity which will not reduce access to care, per a statute passed last year, and instead imposing the restrictive SAGA medical necessity definition which the Governor has been attempting to impose on the far larger Medicaid population for several years

And this is on top of the cuts already adopted last year, in response to the Governor's demands, such as ending the wraparound for dual eligible (Medicare/Medicaid) recipients unable to get needed drugs under their Medicare Part D plans.

All of these cuts are taking us in the wrong direction, as more people find themselves needing to turn to the Medicaid and SAGA programs due to the prolonged recession. However, there is one good proposal by the Governor in S.B. 32: to replace the current system for providing health care under the HUSKY program through capitated HMOs with a non-risk system run through one or more administrative services organizations (ASOs). After many years of denying the advocates' assertions that there are better ways of providing health care which also save money, the Governor has acknowledged that the capitated model is indeed more expensive and that the state saved money when the existing HUSKY HMOs in 2007 were turned into ASOs for about 14 months.

Although the details of her ASO proposal have not yet been fleshed out, and advocates will be watching this proposal carefully, assuming that there are adequate consumer protections and that there really is no risk imposed on the ASOs-- which DSS unfortunately has proposed for the even more vulnerable elderly/disabled Medicaid population -- the move to ASOs to save \$29 million is a good idea for both HUSKY enrollees and the taxpayers. We also would urge that only one ASO be contracted with on a competitive basis, as there are substantial efficiencies from having only one entity administer a non-risk contract and there is no benefit from having multiple contractors.

However, even more money can be saved by moving the HUSKY population to PCCM, under which primary care providers, rather than a contracted insurance company, is responsible for coordinating health care. Under the PCCM model already rolled out by DSS last year, but in a very anemic way, primary care providers are paid \$7.50 per member per month for providing this service, in addition to any health services they provide which are reimbursed on a fee for service basis. By contrast, when we last had ASOs administering the HUSKY program, in 2008, they were paid \$18.18 per member per month just for administrative services, with all medical costs being covered by DSS, which in turn had to incur its own administrative costs to pay those claims.

Although the Governor's proposed move from capitated HMOs to ASOs is welcome, moving to PCCM will save more money, put care in the hands of those most able to coordinate it—the treating primary care providers—and provide a stable alternative to the ever-changing set of risk and non-risk corporate contractors which have moved in and out of the HUSKY program over the last three years. Even when the HMOs acted as ASOs in 2008, they did not do a good job of coordinating care from corporate offices. And unlike companies which will not hesitate to terminate a contract if it is not in their bottom line interest, individual doctors coordinating care under PCCM are committed to their patients and are not likely to go anywhere. At the very least, we need a statewide alternative to compete with the ASO-administered model.

There also is a very relevant precedent from Oklahoma, where that state in 2003-2004, under pressure from capitated HMOs demanding more state money, went from 3 Medicaid HMOs to statewide PCCM—and saved millions of dollars for the taxpayers right away. In Oklahoma, the HMOs were removed less than 2 months after the decision was made to remove them; the period of time for the transition to statewide PCCM was just 4 months; the expenditures for medical services and cash flow actually dropped about \$85.5 million in the first fiscal year; and, even with the increased administrative costs for the state in rolling out the new program, which are particularly high at start-up time, the net savings were \$4.3 million in the first few months and \$3.9 million in the first full fiscal year.

At a legislative forum on February 5th before this Committee, DSS attempted to explain why, despite the experiences of states like Oklahoma, the PCCM program it is charged by statute with implementing with “not less than one thousand individuals who are otherwise eligible to receive HUSKY ...A” has essentially been stuck in neutral, with only 322 enrollees for 228 providers. For example, DSS's Medical Director, Dr. Robert Zavoski, said it is “hard to explain” to enrollees why they should sign up and that is why few have signed up. Actually, it easy to explain. For example, DSS could say:

“This program will allow you to get the same health care but **without** an insurance company getting between you and your doctor, and you will have someone at your doctor's office to call for help, unlike the insurance company's call center which you often can't get through to, let alone get an answer or help from.”

But DSS apparently is loath to promote a program when every person who signs up for it is money taken out of the pockets of the HMOs, which the agency is trying to keep happy (as either HMOs or ASOs) so they will continue running both the HUSKY program and the governor's deeply-troubled Charter Oak program—even if running HUSKY through PCCM would be much cheaper for the taxpayers, as well as better for enrollees and providers. Absent outside intervention, the PCCM program is going nowhere—in opposition to the clear legislative goal of implementing a very robust program of PCCM to run parallel to the HMOs, at least during a meaningful test period.

I therefore urge you to reject the governor's proposed harmful health care cuts contained in S.B.32, accept the proposal to move to a single non-risk ASO, and invest in the **statewide** rollout of PCCM without delay, for both HUSKY A and HUSKY B populations, to get us going on an established model for providing quality care at a lower cost to the taxpayers.

Thank you for the opportunity to speak with you today.