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TESTIMONY OF SHELDON TOUBMAN BEFORE THE APPROPRIATIONS COMMITTEE IN OPPOSITION TO PROPOSED CUTS TO THE HEALTH SAFETY NET AND IN SUPPORT OF INCREASED DSS STAFFING

Members of the Appropriations Committee:

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association. I have represented Medicaid enrollees for over two decades. I am here to testify in opposition to the proposed cuts to Connecticut's essential medical assistance program for low income residents contained in the Governor's social services budget and HB 6367, and in support of additional funding to increase DSS's sorely depleted eligibility staffing.

Specifically, I am opposed to section 21 of HB 6367 which would end all Medicaid coverage for parents of minor children between 133 and 185% of the federal poverty level starting on January 1, 2014, and the proposal to impose "step therapy" on Medicaid enrollees in need of certain drugs.

Opposition to Elimination of Medicaid Coverage for Parents Over 133% of FPL

The proposal to end coverage for these parents flies in the face of the Governor's stated commitment to preserving the health safety net-- it would do just the opposite, throwing many of these vulnerable parents into the rolls of the uninsured.

The stated theory behind this draconian proposed cut is the assumption that these low income parents can instead buy private insurance on the new health insurance exchange intended to go into effect on January 1, 2014. That assumption defies logic because right now HUSKY A involves no cost sharing at all for all participants up to 185% of poverty. The health insurance plans on the exchange, by contrast, will be **unaffordable for individuals at these income levels**, with unaffordable premiums as well as high deductibles and copays—even *after* factoring in the subsidies from the federal government. Most of these parents will just go uninsured as a result.

As just one example, according to one of the available calculators estimating the approximate premium costs **with** the federal subsidies, the one run by the Kaiser Family Foundation (http://healthreform.kff.org/subsidycalculator.aspx), a 4-person family at 150% of the poverty level (annual income of about $35,300) will have to pay monthly premiums of about **$118**. The final premium may be a little different but this gives some idea of what these individuals will be facing, even with the subsidies.

But that is just to get into the gate. Then, according to the documents specifying the cost-sharing for the "Silver alternative" plan for individuals at 150 to 200% of poverty already adopted by Connecticut's Health Insurance Exchange (http://www.ct.gov/hix/lib/hix/Board_Approved_Standard_Plan_Designs_%2801242013%29.pdf), there is then:

1. A yearly deductible of **$500** before coverage (other than for drugs) kicks in
2. Many, many copays, including, among others:
    - **$15** per primary care doctor or mental health visit
    - **$30** per specialist visit
    - **$30** per x-ray
    - **$50** per MRI
    - **$100** per ER visit
    - **$250** per outpatient surgery
    - **$5** per generic drug
    - **$15** per preferred name brand drug
    - **$30** per non-preferred name brand drug
    - **50%** copays for all medical equipment and supplies
3. This does not include additional out of pocket payments for services currently covered by HUSKY A Medicaid but **not covered at all** under the standard plans on the exchange, like non-emergency medical transportation and dental services.

Keep in mind that in CT we twice adopted and twice **repealed** very low drug copays of 50 cents and then $1.50 because even **these** copays restricted access. So imagine what copays of $15, $30 and $250 will mean, even for those who can manage to pay the high premiums to get any coverage.

Here is a chart of the families on HUSKY A affected by this proposal (those between 133% and 185% of the federal poverty level):

Family Size	Annual Income
2	Between $20,628 and 28,694
3	Between $25,975 and 36,131
4	Between $31,322 and 43,568
5	Between $36,668 and 51,005
6	Between $42,015 and 58,442

While maybe going to an exchange for people at these income levels could make sense in **other** states, in CT, with its high cost of living for everything, it can't work. For these families, what going to the exchange instead of HUSKY ***really*** means is that the parents will lose all their health insurance because they can't afford it—and studies have shown that when parents lose their Medicaid coverage, the kids often drop off of Medicaid too, so the whole family becomes uninsured. This will undermine the whole point of

"ObamaCare," which was to reduce the number of uninsured, not to increase those numbers.

Section 21 makes clear that these cuts begin January 1, 2014, with all new applicants denied Medicaid coverage if their incomes are over 133%. OPM has suggested that parents already on will have a year's grace period, until January 1, 2015, before they will be cut off, because of their eligibility for one year of Transitional Medical Assistance (TMA) under federal law. But this provides very little solace for three critical reasons:

1. TMA only helps parents with EARNED income- if a parent has only SSDI, alimony or some other non-wage income, they don't get TMA at all, so they would be cut off of Medicaid on July 1, 2014 with no grace period.

2. TMA under federal law is currently slated to end entirely on **December 31, 2013**, and, in light of the federal government's own budget problems, it is questionable whether it will be extended at all into 2014 or, if so, how limited the TMA benefits will be.

3. Even if TMA is extended by Congress, about 40,000 low income parents will by January 1, **2015** lose all of their Medicaid coverage, and it will be very difficult to reverse the cut once already made.

It has been suggested that these parents could get some kind of "wraparound" for the high cost-sharing, perhaps partly paid by the federal government. That solution isn't going to work either, for several reasons, including:

a. The indications are that, at best, the federal Medicaid agency, CMS, will partially reimburse a wraparound for **premiums** only, not co-pays and deductibles, and even that only where a pre-existing waiver is present in the state governing an expansion population. Most of the unaffordable cost-sharing is actually on the copay and deductible side. So it looks like the wraparound would be entirely state-funded, whereas HUSKY A parent coverage is reimbursed 50 cents on the dollar.

b. If CT did this, the wraparound would be precarious politically, with the next budget crisis likely resulting in a lowering or elimination of the wraparound (this is what happened with the disappearing Medicare Part D wraparound for dual eligible individuals).

c. Apart from the copays, the **covered benefits under exchange plans would be substantially less than under our Medicaid program** (e.g., no medical transportation, no dental coverage absent separate payment, much skimpier behavioral health services, a small number of PT, OT visits/year). The proposed wraparound won't help with these new, unaffordable expenses.

d. Parents would also be thrown back to mostly for-profit MCOs to get all their care with all the negatives that entails (we know that behavioral health will particularly suffer, but every benefit area is likely to see barriers to access beyond state-run Medicaid rules).

e. Having parents and kids in completely separate plans administered by different payers with different provider networks is not good in general, and also will make it less likely that a parent who signs up for insurance also gets it for his or her kids.

Opposition to Medicaid "Step Therapy" Proposal

I also oppose the Governor's proposal to adopt "step therapy" for medications under the Medicaid program.

Prior authorization (PA) has already imposed significant access barriers to prescription drugs for low income Medicaid enrollees. Patients routinely appear at a pharmacy seeking a prescribed drug which requires PA without such authorization have been sought or obtained by the prescriber, resulting in denials of access at the pharmacy. Although we appreciate that the legislature mandated a generic flyer be provided at the pharmacy when this occurs, this has not solved the problem because this system is dependent on pharmacies having the flyers available to hand out, and the flyers are in any event not specific to the individual or the drug for which there is a problem.

But step therapy would impose an entirely new obstacle. "Step therapy" is a euphemism. What this really means is that prescribed drugs will absolutely be denied at the pharmacy unless you previously tried and **failed** on the cheaper drug or drugs in the same therapeutic class (because the cheaper drug either was ineffective or caused serious side effects). The drug will only be dispensed if the Medicaid electronic pharmacy system identifies an earlier paid prescription for the cheaper drug **or** the prescriber knows to request PA explaining the past unsuccessful use of the cheaper drug under a different plan and does so.

This turns low income residents into guinea pigs, forcing them to try a drug not intended by their doctor. Worse, in the meantime while the doctor tries to figure out what happened and the need to prescribe the alternative drug or request PA, there will be no access to **any** drug.

Need for Increased DSS Eligibility Staffing

I also wanted to make sure that members of the committee were aware that the severe delays in processing Medicaid applications are continuing at DSS due to ongoing short-staffing. Although about 220 new eligibility workers were hired last year and that may sound like a lot, this brings DSS only up to about **880** eligibility workers. This needs to be put in context:

- 11 years ago, DSS had **845** eligibility workers and then the numbers dropped as successive administrations took no action to replace departing or transferring workers

- 11 years ago, there were about 326,000 Medicaid enrollees; today there are about 612,000 enrollees, an approximate **88% increase**

- 11 years ago, there were about 13,000 Medicaid applications per month; today, there are about 23,000 applications per month, about a **77% increase**

- So just to keep up with the level of processing in 2002, DSS would need to hire about 677 (77% of 880) new eligibility processing employees on top of the 880 current such employees

- Although DSS is working on a modernization program (ConneCT) which we all hope will be successful, even its most optimistic estimate shows an efficiency savings, when modernization is ultimately completed, of 395 employees, **leaving a deficit of about 282 eligibility employees, just to get us to where we were in 2002 before the large drops in staffing began to occur**

- The 395 figure also is wildly high; even DSS acknowledges the likely efficiency gains to be more modest -- in the mid 200s range.

So new hiring at DSS is clearly necessary, notwithstanding the Governor's order to all Commissioners that they are prohibited from asking for new staff. I therefore urge this committee to include an increased appropriation for DSS eligibility staffing, beyond what the administration has requested.

Need for Increased Revenues

Finally, I would like to note that, rather than making these harmful cuts, we should be looking at the revenue side of the equation, such as making the state income tax more progressive and asking the well off in the state to pay marginal tax rates comparable to those paid in our neighboring states.

Thank you for the opportunity to speak with you this evening.