Senator Osten, Senator Formica, Representative Walker, Representative Lavielle, and distinguished members of the Committee, thank you for hearing my testimony today in support of the Medicaid Supportive Housing Benefit through the Department of Social Services.

In many ways we Americans enjoy the best health care in the world. Yet, at the same time, our current system costs more than others around the world and does not deliver world class health outcomes. We are often spending too much and achieving too little with our health care dollars, especially for the very poor.

One reason health care spending is not translating directly into better health outcomes is that medical care alone is estimated to account for as little as 20% of the variation in health outcomes. Much more influential are socioeconomic factors (40%) and health behaviors (30%). It is increasingly clear that it will be impossible to reduce health care costs and achieve better health outcomes, especially for the very poor, without more effectively addressing factors like housing, food insecurity and poverty.

I have seen this first hand in my work at the New London Homeless Hospitality Center. Day after day we see Medicaid paying thousands of dollars for ambulance transports, emergency room care, in patient hospitalizations, treatment programs and prescriptions. The medical care is not the issue and I am proud to live in a state that is committed to providing health care for our poorest neighbors. But in case after case I have seen that, for people experiencing homelessness, the patient’s instability makes it impossible for him or her to take the steps needed to allow these expensive medical interventions to work.

This pattern plays out in dozens of different ways but I share just one all too common situation. Fifty-five-year-old man who in his 20’s, 30’s and 40’s worked hard doing manual labor. Somewhere along the line, an injury—usually to knees or back—takes him out of the labor force. Surgery helps out combined with increasing age not enough to allow him to go back to work. Opioids initially given to treat pain get out of control. Occasional drinking that was no problem when he was younger gets worse as a way of treating growing depression and to dull the chronic pain. Homelessness is not far behind along with multiple emergency room visits, hospital stays, treatment program enrollments and often over a dozen expensive prescription medications. Given the person’s instability, this investment in health care produces very limited health improvement so the cycle of expensive health care interventions is repeated again and again.

Health care alone cannot break this cycle. But national research and our own experience has shown us what can. Housing is key. The stability of a home makes it possible to take medications properly, to follow a diet, to rest, to rebuild a sense of self-worth. Along with
housing we have helped people secure income—even the modest $700/month that SSI provides positions people to better address their health challenges. After housing and income, we have seen the impact of support services that connect a person to primary care, health education, money management and access to healthy food.

With these supports in place, we have seen dramatic reductions in emergency room and in-patient hospital stays. Others will document these savings more scientifically. But I wanted to come today to say I have seen it happen. We do not need to continue spending precious tax dollars for expensive medical care when lower cost common sense steps could have a bigger impact on health outcomes.

The proposed Medicaid housing benefit would allow us to implement these proven interventions for targeted people with the highest health care costs. There will be a return—both financial and human—on this investment and I urge you to support this effort.

Thank you.

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