



**Testimony of Kevin Lembo, State Healthcare Advocate
Before the Appropriations Committee, Connecticut General Assembly
On the Governor's Proposed Budget for the Department of Social Services, HB 6365
February 18, 2009**

Good morning Senator Harp, Representative Geragosian, Senator Debicella, Representative Miner, and members of the Appropriations Committee. For the record, I am Kevin Lembo, the State Healthcare Advocate. My office is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Your job this year is an unenviable one. As always, we offer you our assistance in analyzing healthcare issues affecting Connecticut residents, including healthcare proposals in the budget. While the Office of the Healthcare Advocate (OHA) could submit testimony on numerous components of the Governor's proposed budget for the Department of Social Services, we focus on only a few issues which warrant your very careful attention.

It is critical that we take opportunities to maximize federal revenue when it is consistent with our program goals, can offset state expenditures and preserve much needed programs. In this dark economic time when we need to scrutinize our expenditures for value and efficiency, we have to be careful that we do not jeopardize the best components of counter cyclical programs like Medicaid, which can help families stay together and remain economically stable until a brighter economy restores jobs and healthcare coverage.

Related to that concern, we believe the committee needs to parse the proposed expenditures in the biennial budget for the Charter Oak Program. The Governor's budget allocates about \$55 million for the program over the next two years. The budget projects an enrollment of 20,000 in the biennium. While we applauded the Governor's effort to begin a healthcare program, most of the concerns we expressed initially are unresolved. Our primary concern is the lack of participating providers in the program. Our office has handled many cases, some directly with the health plans and some by referral to DSS. The most often cited problem is the lack of primary doctors and specialists. Given the relatively low reimbursements, we understand why provider participation is low.

However, the state is paying the full premium for a majority of Charter Oak enrollees. That is \$259.00 per month, with very little reported information on how that money is spent each month. Perhaps the most important scrutiny the program could face is some detailed reporting to this committee on actual utilization of varying services in the program, accompanied by data on the number of unique primary care and specialists providers, the number of people who have max-ed out their benefits, etc. Much more needs to be done to justify the kind of expenditures requested for Charter Oak for the biennium. It may turn out there is room in the premium for the addition of more comprehensive services that would attract more enrollees.

Many advocates will testify on the impact of the multiple proposals to eliminate services under Medicaid as well as the imposition of certain requirements. So as not to be repetitive, I list here the eliminations that I think will have immediate consequences that will only prove to exacerbate the wider healthcare crisis:

- The elimination of SMANC (state medical assistance for non-citizens)
- The reduction of services through mechanisms like a revised medical necessity definition, elimination of certain cost-effective services and over-the counter medications
- The elimination of funding for essential and independent monitoring of the program
- The elimination of self-declaration of income, prolonging delays in access to care and increasing administrative burdens
- Eliminating the automatic thirty day supply of medications when a medication requires prior authorization

There are numerous cuts which may also have severe implications for the healthcare of our poorest and most chronically ill residents, including: the imposition of cost-sharing via premiums and co-payments, which may also result in the departure of some providers from the program; the elimination of the Medicare Part D wrap-around for dual eligibles and ConnPACE recipients, which in concert with the proposal to pay only for the least expensive benchmark plan, will almost certainly result in the loss of needed prescription drugs for seniors.

It is not an easy task to decide what, if any, programs may have to be eliminated. It will be important to weigh these proposals against the actual necessity of some of these cuts. The committee in some cases may have been presented with a false choice on some of these cuts. We simply ask that you analyze each and every budget proposal in this very complicated Human Services budget to ensure accountability in the accuracy of the presented numbers.

Notwithstanding the difficulties of the HUSKY and Medicaid budgets, there may be more room under the Charter Oak program line. Savings that can be generated there could be used to replace possible cuts to HUSKY and Medicaid.

Thank you for your attention to my testimony. Please contact me or our general counsel, Vicki Veltri at 297-3982 or Victoria.Veltri@ct.gov, with any questions you may have or any requests for assistance.