



National Alliance on Mental Illness

Testimony before the Appropriations Committee

February 18, 2009

Good evening, Senator Harp, Representative Geragosian, and members of the Appropriations Committee. My name is Kate Mattias, and I am the Executive Director of the National Alliance on Mental Illness, CT (NAMI-CT). I am here to testify on the Governor's proposed budgets for the Department of Social Services (DSS) and the Department of Children and Families (DCF).

NAMI-CT strongly opposes the Governor's recommendation to subject mental health related medications to the state's Preferred Drug List (PDL). This will greatly and disproportionately restrict access to psychiatric medications for low-income people with serious mental illnesses. Currently the state is required to make *all* mental health related drugs available. This policy is based on the common understanding that barriers to medication access for people with serious psychiatric disabilities most often lead to an interruption in their treatment and can have serious life-threatening consequences (please see attached). Psychiatric medications are often the only form of treatment that a person with a mental illness receives, and it can take years for an individual to find a medication that he or she responds to or a combination of medicines that work. Individualized clinical decision-making must be protected. Finding the right medication regimen is often dependent on the individual's relationship with the prescriber, and responses to medications vary tremendously.

The Governor also proposes to eliminate the Medicare Part D state wraparound that covers the co-pays for people who are dually eligible for Medicare and Medicaid and non-formulary drugs for those who are on Medicaid or ConnPACE. In 2006, the state made a promise to continue its obligation to these populations and to hold them harmless from changes in their drug coverage imposed by Part D. The state has and continues to save substantial amounts of money from the cost shifts to Part D, and the Governor is now trying to take away protections that preserved the stability of these vulnerable populations. For most people with Medicaid and ConnPACE, buying a medication outright is simply not an option, so they go without their vital prescriptions. Low income individuals on Medicaid and ConnPACE often face chronic diseases, mental illness, dementia, lack of phones and transportation, limited English proficiency, and the use of outpatient clinics with a rotating set of doctors, all of which dramatically increase the difficulty of working with their pharmacy and doctors to get their medications and navigating complicated utilization management processes. Again, this would disproportionately hit those with the least resources.

In a study of dual eligible Medicare Part D recipients with mental illness, over half had problems accessing needed medications. **The results: nearly one in five had an emergency room visit and over one in ten were hospitalized.**¹ Among the most commonly reported problems were *not being able to access medication refills; discontinuing or temporarily stopping medications as a result of prescription drug plan management or coverage issues, or because patients could not afford copayments.*

¹ WEST, WILK, MUSZYNSKI, ET AL. Medication Access and Continuity: The Experiences of Dual-Eligible Psychiatric Patients During the First 4 Months of the Medicare Prescription Drug Benefit, *Am J Psychiatry* 164:5, May 2007

Similarly, the Governor's proposals to restrict access to high cost drugs, reduce state supplement benefits, and eliminate Medicaid coverage for all dental services other than emergency – *are all extremely short sighted*. The loss of general dental services will lead to an increase in serious diseases and conditions related to poor oral health, such as systemic infections, heart disease, and diabetes, and it will further overwhelm emergency rooms and community clinics with dental emergencies. We are not going to resolve this budget crisis by taking from the most low-income and chronically ill people in our state. The costs of these decisions will spill out in other uncontrollable ways and as yet unforeseen damage will be the result.

In addition, the state should use existing DCF funds to establish a pilot program for youth and young adults with the most intensive mental health needs who require age-appropriate housing and services allowing them to transition between both Department of Children and Families (DCF) and the Department of Mental Health and Addiction Services (DMHAS) without mandated changes in their housing or services (as outlined in the bill HB 5230). DCF has substantial resources that can be directed toward this critical service need, and has outlined the extent of this need in their own budget options to the Office of Policy and Management (OPM).

Lastly, we urge the state to move forward with the funding necessary for on-time implementation of the new law that will raise the age of adulthood in Connecticut courts to 18 years old. Many of these youth have significant mental health and other needs that are being not addressed by the adult system. Rather, they should be in a structure that offers age-appropriate treatment, and helps them to become productive adults. Instead, these youth are placed directly into a gap within the services system making them ineligible for services in the juvenile system and inappropriate for services suitable for adults.

Thank you for your time and attention. I would be happy to answer any questions.

PROTECT ACCESS TO PSYCHIATRIC MEDICATIONS

REDUCE MENTAL HEALTH CARE COSTS

According to the National Institute of Mental Health, individuals have unique responses to psychiatric medications and need more, not fewer, choices. Noting the vulnerability of individuals with mental illness who are on Medicaid, the Kaiser Commission on Medicaid and the Uninsured recommends exemptions from restrictions for all psychotherapeutic and anticonvulsive medications. CT currently protects open access to psychiatric medication by exempting psychiatric drugs from the state's Preferred Drug List (PDL), and providing Medicare Part D wraparound coverage for those dually eligible for Medicaid and Medicare, or on ConnPACE. It is critical that the state continues these protections to ensure that patient treatment is not compromised and health care costs to the state don't skyrocket as a result.

Access is Vital for the Patient and the State's Economy

Psychiatric drugs are among Medicaid's most costly and commonly prescribed drugs, and are thus targets for cost-containment policies. But many studies have shown that attempts to cut costs at the pharmacy level will reduce appropriate care, adversely affect health status, and cause shifts to more costly types of care.

- The National Bureau of Economic Research indicates that the utilization of newer and more costly drugs reduces non-drug medical expenditures 7.2 times more than it increases drug expenditures
- Of 579 psychiatric patients experiencing access barriers or discontinuity of medications, 19.8% visited Emergency Rooms; 11% required psychiatric in-hospitalization care; and 3.1% became homeless as compared to those without access barriers
- According to the American Psychiatric Association, atypical (and more costly) antipsychotics should be considered as first-line medications for patients in the acute phase of schizophrenia. Costs associated with non-adherent patient with schizophrenia are 160% higher than those able to take the medications prescribed.

Cost-containment Strategies used to discourage use of high cost psychiatric medications

- **Preferred Drug Lists (PDL)** means that only certain drugs will be covered by insurance, often resulting in medication disruption, crisis care, and administrative burdens for physicians:
 - Patients may be required to seek "**Prior Authorization**" from their physicians for medications not on the formulary, thus endangering the patient and increasing physician administrative burden. Often times, patients aren't even aware of the PA until they're at the pharmacy.
 - In some cases, patients must undergo a "**fail-first**" policy forcing them to fail on a lower-cost treatment, even when not clinically indicated, before a more expensive agent is approved.
- **Capping coverage for Medicare Part D co-pays** could mean co-pays of up to \$20 per month. The RAND study found that cost-sharing caused a 41% reduction in medical visits for low-income adults and concludes that co-payments harm the health of low-income adults.
- The American Journal of Psychiatry shows that patients with medication access problems required nearly twice as much administrative time per hour as patients without access problems.

