

**Testimony before the Human Services Committee
February 23, 2010
Opposition to SB 32**

Good evening, distinguished chairs and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). NAMI-CT is the largest member organization in the state of people with psychiatric disabilities and their families.

NAMI-CT is strongly opposed to the following proposals in SB 32 (An Act Implementing the Governor's Budget Recommendations Concerning Social Services):

- Removing the protection for people with mental illnesses on Medicaid/SAGA who are stable on psychiatric medications (the Legislature wisely chose to protect people who have been stable on a psychiatric medication at any point in the previous 12 months by exempting them from the new prior authorization requirements).
- Imposing co-pays of \$3.00 on certain medical services and prescription co-pays of up to \$20.00 on certain individuals enrolled in Medicaid.
- Increasing the newly imposed co-pays on prescriptions for people enrolled in Medicaid and Medicare Part D from \$15 to up to \$20 per month.
- Bypassing the Medical Inefficiency Committee process and eliminating the requirement that any changes in the Medicaid Medical Necessity definition not reduce the quality of care for Medicaid recipients by allowing DSS to implement the harmful SAGA medical necessity definition.

These new cuts are on top of numerous cuts agreed to in the budget adopted last year that have already begun to impact the same population of very low-income seniors and people with physical and psychiatric disabilities, including:

- New restrictions on psychiatric medications for people receiving drug coverage through Medicaid or SAGA.
- New co-pays for people on Medicare and Medicaid receiving drug coverage through Medicare Part D. This will subject them to co-pays up to \$15 per month.
- The elimination of drug coverage for medications not on person's private Medicare Part D plan (the state used to pick up the cost of these drugs for people who also have Medicaid or ConnPACE).

The cumulative affect of these cuts will have a devastating impact on some of Connecticut's poorest and most vulnerable population with incomes on average between \$500 and \$600 per month or about a \$140 per week.

We understand the fiscal crisis facing the State and appreciate all your efforts to preserve the safety net, but there are significant human and economic costs associated with these policies.

Multiple studies show that restricting access to psychiatric medications leads to higher costs through increased emergency room use and hospitalization. Lack of access to treatment and medications also leads many to incarceration and homelessness (please see attached). Further, studies confirm that "prescription drug co-pays, in particular, have an adverse effect on consumer use of medication as prescribed".¹

¹ National Council for Community Behavioral Healthcare, State Policy Focus: Medicaid Copays, April 2007.

Evidence shows that such co-pays -- **result in across the board reductions in all service usage, not just less important services or products.**² While this might not harm the average person, research demonstrates that **people at risk of poor health are adversely affected by co-pays; people at risk of poor health who are also low-income face an even greater chance of being harmed by co-pays.**

In short, co-pays are proven to lead to people not getting their medications. In fact, Medicaid co-pays have been twice repealed and rejected in our state because the harm and costs are so well-documented.

Lastly, Section 36 of this bill implements the restrictive SAGA definition of Medical Necessity for Medicaid recipients, a policy that DSS has been pushing for years and the Legislature has consistently rejected. In fact, this Section will effectively eliminate the Medical Inefficiency Committee that the Legislature just put in place to ensure that the change in definition sought by the Governor and DSS does not reduce quality of care, and to advise DSS on the amended definition and the implementation of the amended definition and to provide feedback to the department and the General Assembly on the impact of the amended definition.

The Committee is comprised of physicians, attorneys, and advocates, and has worked diligently for the past several months to develop balanced recommendations for DSS and the state. The Committee will soon be producing a report with an alternative Medicaid Medical Necessity definition designed to comply with last year's legislative mandate.

The consequences of untreated mental illness are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives. The economic indirect cost of mental illness is well over \$79 billion per year in the United States.³

As the state continues to grapple with the budget deficit, please remember that low-income people with disabilities and seniors have already been disproportionately affected. We cannot rely on further spending cuts in this budget, which already outweigh revenues raised by 3:1.⁴ We need a balanced approach with a revenue solution. Further short-sighted measures will continue to exacerbate the need for services and result in even more job loss.

² J. Gruber, "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond," Kaiser Family Foundation (2006): 4.

³ Mental Health: A Report of the Surgeon General, 1999.

⁴ Budget passed in the fall had \$3 billion in cuts according to Senate President Don Williams and about \$1 billion in revenue increases.

PRESERVE ACCESS TO MENTAL HEALTH-RELATED MEDICATIONS

The Impact of Mental Illness

Unlike many illnesses, missed doses, discontinuation, or changes in doses or specific medications can result in devastating relapses. Too often, medication disruptions result in emergency department visits, hospitalization, homelessness, incarceration, or even suicide.

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The Impact of Restricted Access

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.

Barriers to Accessing Medications

In a 2007 study of Medicare Part D recipients with mental illness, over half had problems accessing medications. The consequences:¹

22% suffered an increase in **suicidal thoughts or behaviors**

20% required an **emergency room visit**

11% required **hospitalization**

3.1% became **homeless**

Prescription Co-pays decrease use of needed medications and shift costs

Medicaid co-payment policies **decreased drug utilization** by 17%; antipsychotic use by 15.2%²

In the Oregon Health Plan, co-pays for prescriptions reduced pharmacy expenditures, but **resulted in cost shifts (increased inpatient care), not cost savings**³

Prior Authorization requirements place considerable administrative burdens on doctors, nurses, state agencies and pharmacists. Many people are not even aware that they need prior authorization to pick up their medications until they're at the pharmacy, often resulting in them walking out without their medications.

Protect Individuals with Mental Illness in Connecticut

Last year, the Legislature wisely chose to protect people who have been stable on a psychiatric medication at any point in the previous 12 months by exempting them from prior authorization requirements when they are picking up a medication that is not on the state's Preferred Drug List.

NAMI-CT thanks our legislators for providing this protection and urges them to continue ensuring that our most vulnerable citizens access medications that are essential to their health and stability, and necessary to relieve multiple state systems.

Please Reject the Governor's Proposal to Remove this Critical Protection!

¹ West, Joyce C., 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*; 2007;164(5):789-796.

² Hartung D.M., et al. *Medical Care*. 2008;46(6):565-572.

³ Neal, Wallace T., et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. *Health Services Research*, Volume 43 Issue 2, pp. 515-530, January 31, 2008. Accessible at <http://www3.interscience.wiley.com/journal/119390808/abstract?CRETRY=1&SRETRY=0>.

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