NAMI Connecticut
National Alliance on Mental Illness

FTR

Testimony before the Insurance and Real Estate Committee
March 15, 2012
HB 5485

Good afternoon, Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Daniela Giordano, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here today on behalf of NAMI-CT to testify in opposition to section 3(b) of HB 5485 – An Act Concerning the Connecticut Health Insurance Exchange.

This section of the bill prevents Connecticut from taking advantage of the opportunity under federal health care reform to create a Basic Health Program for a very vulnerable population, i. e., individuals under the age of 65 who earn between 133% and 200% of the federal poverty level (FPL), and instead specifies that the state's new Health Insurance Exchange is to make health plans available to them. This is not a good idea.

People in this income range are not eligible for Medicaid coverage but still have low incomes – between $1,250 and $1,900 a month. At this income level, individuals will have a very hard, if not impossible, time paying premiums and cost-sharing required in the Health Insurance Exchange. The Mercer Study for the Connecticut Health Insurance Exchange Board estimates that 50% of eligible people with incomes between 133%-200% of the federal poverty level will not enter the Exchange and will be uninsured. Additionally, individual private insurance plans provide only limited and inadequate coverage of mental health treatments.

A State Basic Health Program modeled on Medicaid promotes effective and efficient administration of mental health services. Medicaid offers coordinated and comprehensive mental health services via its Behavioral Health Partnership. The goal of the Behavioral Health Partnership (BHP) is to provide access to a more complete, coordinated, and effective system of community-based behavioral health services and support. Improved coordination of care through enhanced communication and collaboration within the behavioral health delivery system and with the medical community will provide quality care to consumers and savings to the entire system.

Continuity of care is crucial. This will be facilitated if the State Basic Health Program is modeled on Medicaid, administered by the same entity that administers the state's Medicaid program, and has the same provider networks and benefits. Connecticut's Medicaid program is administered by four non-risk Administrative Service Organizations (ASOs), one specifically for behavioral health. *Placing all Medicaid and SBHP enrollees under one efficient administrative system with a unitary enrollment system will avoid the administrative costs of people with*

incomes at about 133% of the federal poverty level churning between two different systems and different sets of providers as individuals' incomes fluctuate slightly. People's lives don't change as they cross 133% of the federal poverty line, and neither should their health care. No one thinks that having DSS review and re-enroll people at this level will save money or improve or accelerate care.

Designing a State Basic Health Program that mirrors Medicaid would also benefit the state budget. The SBHP proposed in the bill would be funded entirely with federal funds, thus being cost-neutral to the state. Additionally, by approaching the interconnected issues of medical and mental health in an integrated manner, **consumers would have access to early and continuous integrated medical and mental health services instead of costly crisis interventions such as emergency rooms or hospitals**. This is essential as individuals with mental health issues face severe medical issues. People with major mental illness have, on average, a life expectancy that is 25 years shorter than the general population. This life expectancy discrepancy can be mitigated if both mental and medical health services are provided in an adequate and coordinated fashion. Three out of every five people with serious mental illnesses die from preventable, co-occurring chronic diseases such as asthma, diabetes, cancer, heart disease and cardiopulmonary conditions.

Another important benefit of modeling the SBHP on Medicaid is its supportive wrap-around services which are crucial to people having access to health care services including being able to get to their appointments. About fifty percent of medical transportation services are used for appointments to behavioral health services, forty percent for medical services and ten percent for dental services. People's care will be interrupted if they do not have the means to get to their appointments.

A State Basic Health Program MUST be adopted *this session.* Planners of the Health Insurance Exchange need to know who will be eligible for the Exchange and who will be in the SBHP as they are planning the Exchange this year. Residents with income up to 200% FPL need affordable, good quality health care.

Thank you for your time and attention. I am happy to answer questions you may have.
Respectfully yours, Daniela Giordano