



Office of the
Healthcare
Advocate
STATE GOVERNMENT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Appropriations Committee
Concerning HB 6350
February 22, 2013**

GOOD EVENING SENATOR HARP, REPRESENTATIVE WALKER, SENATOR KANE, REPRESENTATIVE MINER AND MEMBERS OF THE APPROPRIATIONS COMMITTEE. For the record, I am Victoria Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed healthcare consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

OHA opposes removing parents and caretaker relatives between 133-185% from HUSKY A. There is insufficient evidence that individuals in this income range will be able to purchase and avail themselves of coverage under the plan standard plan design that has been developed. We do not know what other plan options will be available. At the same time, spending per Medicaid member has grown only at a rate of 1.8 % despite a substantial increase in enrollment. This is due, in part, to DSS' efforts to model an integrated care model.

As a member of the Exchange Board, I can assure you that the board is committed to doing its best to temper the cost of healthcare coverage on the Exchange. Even under the best possible

scenario, the Exchange itself is not projecting that it will be able to cover all of the uninsured in our state on January 1, 2014. It will take us several years to achieve a rate of uninsurance comparable to Massachusetts (~2%), the figure that appears to have been used to develop the budget assumptions in the proposed budget.

As a matter of full disclosure, OHA is administering the Navigator and In-Person Assister program, an intensive outreach and education program to assist people in enrolling in healthcare coverage, including public programs and the Exchange. We will do our absolute best to reach underserved communities and people who might not otherwise enroll on their own via the Exchange. Some will be persuaded by the need to have coverage for chronic conditions and by the prospect of facing emergency care versus a having primary care treatment provider if covered by a health plan. Some will be drawn to the broader provider networks available through commercial insurance coverage.

However, we cannot force people to enroll in coverage. The Affordable Care Act allows for people not to enroll in coverage, and the penalty for not enrolling in year one (2014) is \$95, and even that penalty might be waived under a hardship exemption for those of low income. It's important to state that: 1) the Exchange Board never made, nor does it have the power to make, a policy decision that the Exchange should assume the HUSKY A adults between 133-185% FPL in year one, and 2) there has been no demonstration to support the assumption of this budget that everyone who is cut off of Medicaid at 133-185% FPL will be able to enroll in the Exchange.

Another important issue that OHA must address is the impact on access to behavioral health services for the individuals who might be removed from HUSKY A.

By way of background, on October 17, 2012, OHA held a hearing on barriers to access for preventive and treatment services for behavioral health. The purpose of that hearing was to level set the current delivery system of mental health and substance use services in

Connecticut. Behavioral health is OHA's number one type of clinical case, and it has been for some time. In 2012, OHA handled over 500 new behavioral health cases.

OHA's hearing made it clear that we have a tremendous amount of work to do to address the problems in our system, particularly in our private insurance system. Our findings, detailed in a report on our website, are based on our years of work and witness to the struggles of children, adults and families to access needed services. The report is available online at http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.)

In our report, we discuss the fact that individuals who receive their services under the Connecticut Behavioral Health Partnership experience a process that integrates mental health and substance use services into overall healthcare. The CTBHP approves services at a higher rate than private insurance plans do. (See above report.) (OHA is pursuing grant funding to conduct an independent study of the CTBHP to determine whether the CTBHP and some of the associated evidence-based community-based services it offers might be model of behavioral health service delivery to all residents of the state.) Further, Community Health Network of CT (CHNCT) conducts mental health assessment of its members, which includes screening for depression resulting in early intervention.

According to the CTBHP, for the 190,817 HUSKY A adults over 18 in HUSKY A, in the first three quarters of 2012, there were: over 1200 psychiatric inpatient admissions; nearly 1,000 inpatient detoxification admissions; 2700 day treatment admissions, and; over 18,000 outpatient admissions. Lengths of stay in the day treatment programs such as partial hospitalization and intensive outpatient exceed the lengths of stay traditionally allowed by commercial private insurance plans. The utilization over three quarters of 2012 of inpatient (1.15%) and day treatment programs (1.41%) for HUSKY A adults far exceeds utilization of such treatment

options in private plans over the full calendar year of 2011,¹ which ranges from 19% to 0.42% for inpatient services and 0.06% to 0.30% for day treatment programs in fully insured plans in Connecticut. (See

http://ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf at 33.)

Outpatient behavioral health services for HUSKY A adults through the first three quarters of 2012 also exceed outpatient services on a per enrollee basis for all but one fully insured plan. These data raise concerns about barriers to accessing medically necessary services for HUSKY A adults if those adults seek behavioral health services through private fully insured plans on the Exchange.

OHA also discovered other issues that raise concerns about access to behavioral health services in private plans. We understand that the legislature is addressing some of these issues for which we are grateful. However, we believe any changes we make this year need some time to work before we assume that current Medicaid enrollees would gain much improved behavioral health access in the Exchange. Importantly, the medical necessity definition in the Medicaid program is stronger—for a reason—than that in the insurance statutes. The protection of that medical necessity definition will be lost for those HUSKY A adults if they are removed from the Medicaid program.

OHA also opposes the elimination of the Behavioral Health Partnership Oversight Council (BHPOC). The BHPOC is a true stakeholder council that oversees the operation of the CTBHP. OHA serves on this council. The BHPOC exercises its authority under a statute that appropriately allows for a level of independent monitoring and stakeholder involvement in the delivery of mental health and substance use services that is unprecedented in our state. Such oversight is critical to continued stakeholder participation and the success of the CTBHP. There are minimal savings associated with the elimination of the BHPOC. The savings are far outweighed by value that the BHPOC brings to an integrated behavioral health delivery system

¹ The use of the previous calendar year does not alter these percentages. A review of previous reports shows that the percentage of utilization in fully insured plans is consistent over the last few years with the percentages reported above; therefore, it is reasonable to assume that utilization was similar in 2012 since there were no major policy changes for behavioral health benefits.

for Medicaid enrollees. Elimination of the BHPOC is inconsistent with efforts to improve our state's mental health and substance use services delivery system and ensure accountability of that system.

The reality of eliminating coverage for these adults in Medicaid, even if all of them will not be removed from Medicaid in the first fiscal year, is there may be a substantial number of people going without coverage. Individuals going without coverage will have a cascading effect; individuals without coverage will seek care in hospitals, FQHCs and other locations that are also facing cuts in the proposed budget. This in turn increases overall healthcare costs, which further jeopardizes both the state's ability to provide appropriate healthcare coverage in its public programs, and premiums will again increase to compensate for increasing costs. And those costs will be felt by the state.

Finally, I want to thank the committee for its commitment to all residents of the state. I appreciate the difficult task you have in front of you in developing a sound and balanced budget. Please let me know how OHA can provide you with any assistance in your deliberations over these very important issues. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.