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Testimony to the Senate Public Health and Welfare Committee

February 11, 2015

Madam Chairwoman and members of the Senate Public Health and Welfare Committee thank you for allowing me to provide this testimony on Senate Bill 123.

My name is Mike Garrett and I am the CEO of Horizons Mental Health Center in Hutchinson. We provide services in 5 south central counties, Pratt, Barber, Harper, Kingman, and Reno. I am also the President of the Board of Directors of the Association of Community Mental Health Centers of Kansas.

I understand there are concerns regarding the use of mental health medications and their associated cost. I also understand some believe that without SB123, their ability to manage the use of these medications is limited.

I want to provide testimony to express my concerns of the possibility of unintended consequences if this bill is passed.

I think it is important to initially start by reporting the average life expectancy of an adult with a Severe and Persistent Mental Illness is 53. The average length of life is 53. These are individuals that typically suffer from other serious illnesses, in addition to their mental illness.

I believe we can have a significant impact on the overall health of a person suffering from mental illness if we are able to achieve effective symptom management of their mental illness.

In other states, the use of a Preferred Drug List and/or prior authorization has been referred to as a 'fail first' policy. That is when an individual with a severe and persistent mental illness must fail treatment on a less expensive medication prior to being allowed to receive a more costly medication.

I think there are several areas we need to consider as a State when making a decision as to whether a PDL for mental health medications make sense. A first area is **clinical outcomes**. Do the medications on the PDL manage the symptoms of a person's illness as effectively as the medications not on the preferred list? A second area is **economics**. That is, does it make good economic sense to have a PDL beyond the fact that there is a reduction in medications costs for a single line item? A third area is **ethical**. Is it ethical to have a PDL for individuals with an illness whose life expectancy is 53 years of age?

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In regards to the first area, **clinical outcomes**, we need to look at symptom management and treatment compliance. This involves an issue frequently referred to as 'bioequivalence' or 'interchangeability'. These terms assume the medications on the PDL and the medications not on the list due to their cost are equivalent and produce the same treatment outcomes. My understanding of the research indicates this continues to be an area of controversy in the research literature as to whether these medications are actually equivalent, except where there are generic versions of brand name medications.

Central to the area of clinical outcomes is treatment compliance. That is, does the patient take the medication as prescribed. The number one reason identified by our patients for treatment non-compliance is side effects. People discontinue medications when the side effects are severe and in their eyes not worth experiencing in order to see if, the medications work. The use of 'fail first' medications are likely to increase non-adherence due to these medications having more numerous and more severe side effects, than the newer medications.

Probably the easiest way to increase treatment compliance is to prescribe medications that manage symptoms effectively and have the fewest side effects. So, using the right medicine from the initiation of treatment could actually be viewed as a treatment best practice.

Within their efforts to manage the disease experienced by their patients, psychiatrists need to have better access to research that will assist them in making a better medication selection in regards to treatment effectiveness, severity of side effects and research as to which medications are truly clinically interchangeable. The selection guidelines cannot be based solely on price.

If clinical outcomes are compromised, the entire cost of the health care episode increases.

The second area I identified as needing to be considered in adopting a PDL is whether it makes good **economic sense**. If we take a narrow focus, the use of a PDL consisting of lower cost medicines, makes sense due to the impact on a single line item in a budget. The cost of that line item goes down. We have to be careful not to make the mistake of seeing the cost of a person's medication as the only cost incurred in the management of their disease.

I understand it is very difficult to quantify cost avoidance and yet that is what I am asking you to do. Many believe a PDL will result in is actual cost savings. They are able to demonstrate that with a PDL they would be able to save a significant amount of tax dollars. I think focusing on medications costs alone is too narrow of focus. I believe as taxpayers we need to focus on the total cost of a patient's disease rather than just the cost of their medications. The most expensive cost for the care of an individual with mental illness is inpatient treatment. Research indicates a person with schizophrenia will experience inpatient treatment approximately once every two years.

If the outcome of a PDL reduces the cost of medicines by reducing treatment options, but these medications are less effective in managing the person's symptoms, the patient is at risk of more frequent relapses. If relapse occurs, there will be referral to more intensive Levels of Care and possibly readmissions. If we are able to reduce even a few of the inpatient stays for a person over the course of a lifetime by avoiding treatment failures, the health care savings is significant.

Another factor, as mentioned earlier, is treatment compliance. If the patient is non-compliant due to the side effects of their prescribed medication, this puts them at greater risk for relapse and readmission into the most expensive level of care provided, readmission to a hospital.

Another variable in the questions as to whether a PDL makes good economic sense is whether the costs are actually not incurred, or whether they are only shifted to others. As we are all aware, an individual experiencing a mental health crisis can have contact with law enforcement, emergency rooms, the court system and crisis intervention services through a mental health provider. The outcome of these contacts may result in a readmission, court proceedings, and possibly even incarceration for the patient. As a result, the cost of care for this individual is shifted from one entity to the other without any real cost avoidance to the taxpayer.

I do not believe it is cost effective to have a policy that may result in a health care crisis, especially when we look at total health care resources used over a lifetime, rather than just the cost of a medicine at a point in time.

Again, I believe as we think about the total cost of disease management, the provider's need to have better access to research focusing on medication selection, that takes into account treatment outcomes, side effects and research as to which medications are truly clinically interchangeable. The selection guidelines cannot be based solely on price.

I also believe there is an **ethical issue** related to SB123. Is it ethical to require treatment failure in order to be able to receive a more effective medication? I think all of us would be hard pressed to say this would be appropriate for an individual battling cancer, or the patient recovering from a heart attack, or the patient experiencing kidney disease.

Remember, people with a severe and persistent mental illness have an average life expectancy of 53 years.

A very daunting task would be the task of defining what constitutes treatment failure. I believe it is an ethical issue as to whether we have a policy that would define treatment failure as a person experiencing suicidal behaviors, or a psychotic episode comprised of hallucinations and delusions or being taken into protective custody by a law enforcement official before we consider their current treatment regimen a failure and then are willing to provide them access to more effective medications.

My concern is that with a fail first policy, that to begin treatment with failure in view is harmful to our patients and the damage that is done by a mental health crisis or relapse may not be overcome with corrective actions in the future.

Throughout my testimony, I have repeatedly made note of individuals with a severe and persistent mental illness have an average life expectancy of 53. Our goal as providers of health care is to not only help these individuals manage their mental illness, but to help them develop a healthier lifestyle and a disease management outlook not only for their mental illness but their physical illnesses as well. In order for us to achieve this goal, and consequently reduce their overall cost of their healthcare, their mental illness symptoms must be managed effectively first. If they are not, we will not be successful.

It is my opinion that SB 123 will have a negative impact on the lives of those we serve with a mental illness and will contribute to the overall cost of their health care over the course of their lifetime rather than reducing the cost. In order to have a meaningful impact on the lives of those suffering from a mental illness we need to look at how we can achieve the most desirable clinical outcomes, while making the most economic sense while at the same time making sure we treat their illness as we treat other life impacting illnesses. I do not believe SB 123 accomplishes that.

Again, thank you for the opportunity to provide you with this testimony.