Written Testimony in Opposition to Senate Bill 123

Kansas Senate Public Health and Welfare Committee
Chairperson: Mary Pilcher-Cook

Wednesday, Feb. 12, 2015

From: Anne Owen, PhD
Licensed Psychologist in Kansas
Mother of a son with schizophrenia

Madame Chair and members of the Public Health and Welfare Committee: I appreciate the opportunity to voice my opposition to Senate Bill 123 to you today. My testimony reflects my own professional and personal views and not those of any organization.

The former representative, David Crum, stated that his purpose in proposing Bill 123 was to reduce the inappropriate over-prescription of antipsychotic drugs to Kansans with dementia living in nursing homes.[1] Placing psychiatric medications on restrictive preferred-drug lists in order to address this complex problem will have unintended negative consequences for Kansans who don't have dementia but suffer from serious and persistent mental illnesses such as schizophrenia and bipolar disorder, and who require access to these medications in order to attain any quality of life or return to productivity. In addition, if another goal of the bill is to reduce the cost burden of these medications on the state's Medicaid budget, this too is a strategy that will backfire by costing the state more due to an increase in hospitalizations, incarcerations, and diminished productivity.

Who would determine the new limitations and who would administer them?
Bill 123 proposes withdrawing the exemption for psychiatric drugs, and thereby implicitly proposes the institution of an as-yet-undefined method for utilization control, prior authorization, and restricted access. Who is going to develop this methodology? We no longer have a sitting committee of experts to address this question. We used to. In 2009, the Kansas Mental Health Prescription Drug Advisory Committee (consisting of 14 experts in the field of psychiatry, psychology, and psychopharmacology) reviewed this very issue. This committee of nonpartisan experts agreed that the unique natures of psychiatric medications and psychiatric patients warranted the protection afforded through open access to medications prescribed by their physicians. Sadly, this committee was disbanded during Kansas Health Policy Authority reorganization. Among the proponents of Bill 123, who has the commensurate professional expertise to assess the broad implications of the bill's passage on one of our state's most vulnerable populations?

Restricting access to the full armamentarium of antipsychotic medications costs more than it saves.
Numerous studies have shown that placing limitations on access to antipsychotic medication leads to increased costs due to poorer outcomes from treatment discontinuity, and results in increases in the use of other health services such as inpatient treatment of schizophrenia.[2]

---

[1] Marso, A. (2014, Nov. 24). *New Effort to Tighten Regulation of Mental Health Drugs Concerns Advocates*. Retrieved from www.khi.org.

[2] Thieda, P. et al. (2003, April). *An Economic Review of Compliance with Medication Therapy in the Treatment of Schizophrenia.* retrieved from www.ps.psychiatryonline.org

The costs associated with inpatient treatment are significant. According to 2006 data from 418 hospitals, the average Medicaid cost per hospitalization was $8,335 for patients with schizophrenia, $6,583 for patients with bipolar disorder, and $5,181 for patients with depression,[3] and those costs have not fallen in the ensuing nine years. Conversely, a recent review of the data regarding the consequences of limiting prescription drug coverage found twenty-three studies demonstrating that unfettered prescribing policies led to improved patient outcomes and a reduction in use of other health care services.[4]

One hundred thousand unintended victims in Kansas

Prevalence studies indicate that the lifetime prevalence of psychotic disorders is 3.48 percent.[5] This translates into over one hundred thousand Kansans suffering from schizophrenia, bipolar disorder, and other psychotic illnesses. Looking at schizophrenia alone, research has repeatedly proven that persons with schizophrenia are a heterogeneous group, with idiosyncratic responses to medication.[6] Until ongoing brain research progresses, finding effective medication is complex and can include trial-and-error. These complex determinations cannot be conducted if forces external to the individual and his or her physician impose limits on medication choice or timely intervention. Without individualized and timely ability to receive medication, persons with schizophrenia suffer from incalculable negative consequences, including exacerbation of symptoms, decrease in medication adherence, increase in costly hospitalizations, and a further decrease in their already diminished quality of life.[7],[8],[9],[10],[11]

A program to reduce excessive antipsychotic use in nursing homes already exists and is showing results.

In 2011, the Centers for Medicare and Medicaid Services established the National Partnership to Improve Dementia Care in order to address this national problem that Senate Bill 123 purports to address. In just 21 months, the national prevalence of antipsychotic use in long-stay nursing homes decreased by 15.1 percent. In Kansas, the prevalence decreased by 11.4 percent.[12] This change was not accomplished through external limitations placed on

---

[3] Stensland, M., et al. (2012). *An Examination of Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals. Psychiatric Services*. 63(7), pp. 666-671.

[4] Kesselheim, A. (2014). *Prescription Drug Insurance Coverage and Patient Health Outcomes: A Systematic Review*. American Journal of Public Health. 105(2), pp. e17-e30.

[5] Perala, J., et al. (2007). *Lifetime Prevalence of Psychotic and Bipolar I Disorders in a General Population.* Archives of General Psychiatry, 64(Jan), pp. 19-28.

[6] Leucht, S. (2013). *Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis.* The Lancet, 382(9896), pp 951-962.

[7] Chakos, M., et al. (2004, January). *Effectiveness of Second-Generation Antipsychotics in Patients with Treatment-Resistant Schizophrenia: A Review and Meta-Analysis of Randomized Trials*. Retrieved from www.ps.psychiatryonline.org.

[8] Vogt, W., et al. (2011, Dec.) *Medicaid Cost Control Measures Aimed at Second-Generation Antipsychotics Led to Less Use of All Antipsychotics*. Retrieved from www.content.healthaffairs.org.

[9] Menzin, J., et al. (2003, May). *Treatment Adherence Associated with Conventional and Atypical Antipsychotics in a Large State Medicaid Program*. Retrieved from www.ps.psychiatryonline.org.

[10] Leucht, S., et al. (2009*). Second-Generation Versus First-Generation Antipsychotic Drugs for Schizophrenia: A Meta-Analysis*. The Lancet, 373(9657), pp31-41.

[11] Voruganti, L., et al. (2000). *Comparative Evaluation of Conventional and Novel Antipsychotic Drugs with Reference to their Subjective Tolerability, Side-Effect Profile and Impact on Quality of Life.* Schizophrenia Research. 43(2-3), pp 135-145.

[12] *Fact Sheets: Data show National Partnership to Improve Dementia Care exceeds goals to reduce unnecessary antipsychotic medications in nursing homes*. (2014, Sept 19). Retrieved from www.cms.gov.

prescribers, but through education, training, and utilization measurement. Why is it assumed that this program will not continue to be effective in reducing excessive use and its concomitant cost?

We must stop blaming the victims of mental illness for their problems.
Research has shown that many people still believe that persons with mental illness are responsible for their illness.[13] Moreover, research has demonstrated that perceptions of personal responsibility are the single greatest correlate of the values that guide where resources are allocated by politicians.[14],[15] Politicians (as humans!) are not uniquely immune to this bias against persons with mental illness, but we must make sure that our political policy decisions are not fueled by stigma or ignorance. It is imperative that our legislators in Topeka guard against disproportionately harming our citizens with mental illness through inappropriate and restrictive programs that limit their access to the proper medication.

I urge the committee to reject Bill 123. To do so is fiscally sound and medically informed. It is also the humanitarian thing to do.

---

[13] Corrigan, P., et al. (1999). *Predictors of participation in campaigns against mental illness stigma*. Journal of Nervous and Mental Disease. 187, pp 378-380.
[14] Sitkka, L. (1993). *Of Ants and Grasshoppers: The Political Psychology of Allocating Public Assistance.* Psychological Perspectives on Justice: Theory and Applications. Cambridge Series on Judgment and Decision Making, Cambridge University Press.
[15] Sitkka, L., & Tetlock, P. (1993). *Providing Public Assistance: Cognitive and Motivational processes Underlying Liberal and Conservative Policy Preferences*. Journal of Personality and Social Psychology. 65, pp. 1205-1223.