The Honorable Tim Murphy

Statement for the Record – H.R. 2646

June 15, 2016

Over the past three years this Committee has worked tirelessly to elevate the issue of mental health in general, and the treatment of those suffering from serious mental illness specifically, to the attention of the Congress. Over that period of time, we have witnessed a meaningful and substantive conversation across the Congress on the need for mental health reform. To that end, I thank the Chairman and the Committee for their hard and valued efforts to bring H.R. 2646 to the Committee for markup.

One issue that was included in the original text of H.R. 2646, but which had to be dropped for a number of reasons, was access to mental health medications – particularly in the Medicare and Medicaid programs. When I first introduced H.R. 2646, the legislation included Section 502 which would have preserved mental health medications as "protected classes" within the Medicare Part D Program, and would have extended such protection to the Medicaid program as well. The provision met with widespread bi-partisan support, and both Democrats and Republicans praised the provision as a needed bulwark of support to treatment of those suffering from mental illness. The opening statement by Subcommittee Chairman Pitts during this hearing, and the supporting statements from other Committee members, only reinforce the bipartisan support for ensuring that those with mental illness have access to needed medications which can control their illness.

The protected classes were put into place in 2006 to ensure Medicare beneficiaries in the Part D program had access to life-saving doctor-prescribed medication. At the time, CMS designated six such classes based upon the correct understanding that medications in each class were chemically distinct and not interchangeable. In fact, the current Part D Manual states that "CMS instituted this policy because it was necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans, as well as to mitigate the risks and complications associated with an interruption of therapy for these vulnerable populations." Several years later, Congress fixed the Protected Classes into the Part D statute, leaving the Secretary discretion to add or remove the classes after development of appropriate criteria.

Many in Congress were deeply troubled when, in January 2014, CMS proposed to remove the anti-depression class, and suggested it would shortly remove the anti-psychotic medication class, from protected class status. Indeed, in both this House and in the Senate, dozens of members signed bi-partisan letters to CMS urging the Agency to drop its proposal, and thanks to this Committee's leadership CMS withdrew the proposal during the comment period. Yet, the Medicare policy remains at risk, and there are no protections for mental health medications in Medicaid.

Numerous studies have demonstrated that not only is patient care improved when those suffering from mental illness have access to needed medications, but the costs of care are also reduced when appropriate medication therapy is accessible. I have attached to this statement a list of

select journal articles and publications which amply demonstrate the importance of unrestricted access to mental health medications.

Although the medication access provisions introduced in the original legislation have not been able to be included in today's legislation, the need for legislative clarity has not abated. I thus commit to continuing to pursue legislation to address this important issue, and call upon my colleagues to join me in that effort. Mental health reform, and access to needed medications to treat those suffering from this serious illness, is simply too important.

Again, I thank the Chairman and all Members of the Committee for their support of H.R. 2646, and I look forward to joining with my colleagues in the near future to address access to medication treatment.

Ensure Access to Mental Health Medications

Select Studies Demonstrating the Importance of Open and Robust Access to Antipsychotic Medications

Blumberg, *et al., Marketplace Antidepressant Coverage and Transparency,* Robert Wood Johnson Foundation/Urban Institute, November 2015.

- Recognized that patients with depression "often have to try multiple medications to achieve remission of depression symptoms", but that broader coverage was still needed to ensure access (studying Exchange Plan access).

- Addresses problems with step therapy requirements for mental health medications, noting that they can be "problematic for consumers who move to a different insurer and may have to interrupt effective treatment regimes."

***How Do Health Plans Manage Access to Mental Health Prescription Drugs?,* Open Minds Market Intelligence Report, August 2015.**

- Documenting that 25 states and the District of Columbia utilize mental health medication formulary restrictions, including step therapy, in Medicaid programs, and 15 states limit the number of prescriptions for mental health medications.

Wu, *et al.*, *The Economic Burden of Schizophrenia in the United States in 2002*, Journal of Clinical Psychiatry, Sept. 2005.

- A study of 2002 data, conducted by a prominent research team including health economics and policy experts from the Analysis Group, Tulane University, and Harvard Medical School.
- Found that total excess U.S. costs associated with schizophrenia were $62.7 billion. Less than one-tenth (about $5 billion) of those costs were associated with drugs**.**
- The $5 billion in drug spending for schizophrenia in 2002 was lower than all but one category of direct health care costs for schizophrenia that year—and was dwarfed by the indirect costs.
- Underscores that open access to antipsychotic medications—as is provided for under the Part D *All or Substantially All* policy—is not just good medicine, but also smart fiscal policy.

Lang, *et al.*, *Medication Adherence and Hospitalization Among Patients with Schizophrenia Treated with Antipsychotics*, Psychiatric Services, Dec. 2010.

- A study of Florida Medicaid eligibility and claims data, which studied medication adherence and hospitalizations in just under 16,000 patients with diagnoses of schizophrenia.
- Findings confirm that medication interruptions / non-adherence increase the risk of hospitalizations.
- About 1/3 of the Florida Medicaid patients coded with a schizophrenia diagnosis had a psychiatric hospitalization. Maintaining those patients on medication therapy would save significant costs as compared to the price tag of the hospitalizations.

Sallee & Agemy (Anderson Economic Group, LLC), *Costs and Benefits of Investing in Mental Health Services in Michigan*, 2011.

- Findings included that "The State Government Currently Spends 20 Times More on Emergency Mentally Ill Adult Cases Than Early/Moderate Cases" and that "Better Access to Mental Health Services Reduces Other Governmental Costs."

- Further found that, despite some short-term cost increases associated with providing mental health services to all Michigan residents, State costs decline over time when these patients receive treatment.
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Driscoll & Fleeter, *Estimate of the Net Cost of A Prior Authorization Requirement for Certain Mental Health Medications*, Aug. 2008.

- Estimated the net cost of a proposal by the Ohio Department of Jobs and Family Services to impose a prior authorization (PA) requirement for certain antipsychotics for patients with schizophrenia, bipolar disorder, and other serious mental illnesses.
- These findings mirror results of a recent study by Law (*Psychiatric Services*, May 2008), which found that PA policies in West Virginia and Texas do not appear to reduce pharmacy costs.

Soumeral, et al., *Use of Atypical Antipsychotic Drugs for Schizophrenia in Maine Medicaid Following a Policy Change*, Health Affairs, Apr. 2008.

- Found that patients who initiated therapy with atypical antipsychotics following a new prior authorization policy experienced a 29% greater risk of treatment discontinuity than patients initiating therapy with atypical antipsychotics before the policy took effect.
- In a comparison state, no such change in continuity of care was observed, and **both** states saw a slight decrease in spending for atypical antipsychotics.
- Concluded that "[o]bserved increases in treatment discontinuities without cost savings suggest that [atypical antipsychotics] should be exempt from PA for patients with severe mental illnesses."

***Questions and Answers about the NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study — All Medication Levels,* National Institutes of Mental Health, November 2006.**

- Documenting need for mental health patients to be able to shift between medications given that only one third of patients respond to first line treatment.