CRAWFORD BECK
VINEYARD

February 9, 2015

House Committee on Health Care
Oregon State Legislature
900 Court St. NE, Salem Oregon 97301

To the Members of the House Committee on Health Care:

I am sending this letter today in opposition to HB 2421. I am the mother of a 42-year-old woman who is living with bipolar disorder. She was diagnosed at age 30 and began a treatment regimen, which has involved over time several mental health medications: a mood stabilizer, antidepressants, antipsychotics, antianxiety medications, and a sedative. Following her initial diagnosis, working with a psychiatrist, it took several years before she was stabilized and able to manage her symptoms. But maintaining stability requires constant adjustments. I am fortunate that she is compliant and I do not have to be concerned about her discontinuing her medication. The critical point here is that a stable pharmaceutical program for mental illness is a complex calculus of balancing drugs and their dosage with their therapeutic effect, with counterbalancing their side effects, and modulating their use with alterations in the disease.

I would like to make several points about mental health medications and then address the specifics of the legislation.

Firstly, given the fact that it can take some time to find the right medication, we need to have these medications openly available through the prescribing physician. Even with access, it may be difficult to find the appropriate medication and dose for each individual. The medication and dosages for one individual living with bipolar disorder illness, for example, will not necessarily work for another. It is not as simple as replacing the insulin not being synthesized by a diabetic's pancreas.

Secondly, we cannot limit access to the medications, since one individual may require two or three, and another individual may require more and different pharmaceuticals.

Thirdly, many of these medications require a considerable amount of time to be effective, e.g., lithium, a mood stabilizer, may take up to three weeks to have its full effect. Other mood stabilizers and antidepressants also take several weeks to begin working. We cannot expect results instantly as one might with insulin or pain relievers. Then, once the effective dosage is found, the blood level must be maintained at a steady state. If it fluctuates significantly, the

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therapeutic effect may be lost and much additional work invested to reestablish the correct dosage.

I am entirely sympathetic with the premise in HB 2421 that coordination of all of a person's care will assure the best outcome healthwise and economically. The legislation requires that the cost of mental health drugs to be included in global budgets of coordinated care organizations. It also permits each individual coordinated care organization to develop its own formulary and restrict access. While we appreciate the State's concern to control costs for drugs, limiting access to those drugs may be detrimental to the health of individuals living with mental illness. What one might save in the cost of the drug could end up costing much more in hospitalizations. Additionally, persons living with mental illness can be fragile, particularly those living with bipolar disorder. Approximately 47% of those living with bipolar disorder think about suicide, while 25% actually attempt suicide, compared to the entire US population where 4.6% of individuals attempt suicide. Given this fragility, it is very unwise to limit access to medications which are vital to maintaining stability.

SECTION 2 of HB 2421 requires coordinated care organizations **to temporarily** continue to provide the mental health drug to a member who is in course of treatment with the drug without imposing prior authorization to January 1, 2017. But the establish treatment regimen may be summarily withdrawn or altered after that date. Once an individual has been stabilized on a mental health drug, suspending treatment is dangerous at best. If a coordinated care program can be established and agreed upon for the patient prior to that deadline, why should it be necessary or why should the CCO be permitted to alter it after that deadline? The patient's treating physician should be the sole arbiter of the patient's regimen. Is it truly fair to set such an opportunity for the CCO to override both the physician and the patient?

In summary, I am not in favor of turning over the management and approval of the protected mental health medications to the coordinated care organizations which might restrict access by excluding certain drugs from their forumlaries, possibily requiring prior authorization, or demanding a "fail first" policy which could cause the patient's condition to deteriorate. The current system with its protections ensures that mental health medications are available to those who need them. This must be continued.

Thanks you for permitting me to provide this testimony.

Sincerely,

Jeanne C. Beck

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