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Memorandum in Support

S.2282 (Cleare)

ACT to amend the insurance law, in relation to prohibiting the application of fail-first or step therapy protocols to coverage for the diagnosis and treatment of mental conditions

MHANYS supports S.2282 (Cleare), which would prohibit the application of fail-first or step therapy protocols to coverage for the diagnosis and treatment of mental health conditions.

Psychopharmacology is a highly individualized prescribing practice that is most effective when left to the judgment of prescribing physicians (most often a psychiatrist) and their patients. We believe that Step Therapy is not in the therapeutic best interest of patients and often unnecessarily prolongs the search for the right medication for the individual. Many psychiatric medications require weeks and sometimes months to begin showing efficacy. Others have complex side effect profiles that are particularly challenging to prescribe when other illnesses or disorders are co-morbid. Subjecting patients to sequential trials of medications in a step therapy fashion can unnecessarily post-pone recovery.

Antidepressants - Nearly 1 in 5 people will receive a diagnosis of a depression or anxiety disorder at some time in their life. People with severe depression and/or anxiety are at risk of suicide or hospitalization especially if left untreated or undertreated. The medications used to treat these disorders, primarily Selective Serotonin Reuptake Inhibitors (SSRIs), can take as long as 4 to 8 weeks to begin showing efficacy. Because of this delay, it is imperative that prescribing physicians are able to select medications that in their clinical judgment have the greatest chance of working for particular patients. When subjected to Step Therapy protocols and sequential trials of failed SSRIs, it can take months before the right medication is ultimately found, leaving patients vulnerable to distressing symptoms, hospitalizations, substance abuse and even suicide.

Antipsychotics – The efficacy and side effect dynamics of this class of medications is highly patient specific. Discerning the best antipsychotic for a patient that will effectively treat the symptoms of their disorder and minimize side effects that might otherwise cause a patient to stop taking a medication altogether is critical. It is well established that patients who live in states that impose restrictions on atypical antipsychotics are 11.6 percent more likely to stop all treatment. Patients with Schizophrenia in these states are more likely to experience a hospitalization, have 23 percent higher inpatient costs and 16 percent higher total healthcare costs; and patients with bipolar disorder were also more likely to experience a hospitalization, with 20 percent higher inpatient costs and 10 percent higher total costs.ⁱ The imposition of Step Therapy in these situations undermines the optimization of medication selection and often

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results in treatment non-compliance and the resulting consequences of relapse such as re-hospitalizations, substance abuse and even homelessness.

Co-morbidity – Utilization reviewers are blind to overall patient profiles including other illnesses or disorders (both mental and physical) that may be co-morbid with the particular diagnosis for which a medication is prescribed. A common example would be when a physician is prescribing certain antipsychotics to a patient with co-morbid diabetes or obesity since the side effect profile of some antipsychotics is weight gain. Prescribing psychiatrists and physicians should make the final medication selection decisions in concert with the patient, taking into account the patient’s full medical profile and history.

For these reasons MHANYS urges the Legislature to pass S.2282.

ⁱ - Formulary Restrictions on Atypical Antipsychotics: Impact on Costs for Patients with Schizophrenia and Bipolar Disorder in Medicaid. February 24, 2014, (Seth A. Seabury, PhD; Dana P. Goldman, PhD; Iftekhar Kalsekar, PhD; John J. Sheehan, PhD; Kimberly Laubmeier, PhD; and Darius N. Lakdawalla, PhD).