U.S. PAIN FOUNDATION

April 26, 2018

Hon. Robert W. Godshall
150 Main Capitol Building
PO Box 202053
Harrisburg, PA 17120-2053

Hon. Thomas R. Caltagirone
106 Irvis Office Building
PO Box 202127
Harrisburg, PA 17120-2127

RE: U.S. Pain Foundation Testimony in Support of HB 2113

Dear Chairmen Godshall and Caltagirone:

U.S. Pain Foundation is the leading pain patient advocacy group in the nation, representing the interests of the 100 million Americans living with chronic pain. We seek to address the many challenges chronic pain patients face, ranging from social stigma to barriers to treatment. One major obstacle to care is the practice of non-medical switching. U.S. Pain is submitting this testimony in support of House Bill 2113 that would amend Pennsylvania's Unfair Insurance Practices Act and ensure residents remain stable on their medically necessary treatment options, without interruption, for the duration of the health plan year.

Currently, Pennsylvania insurers are not required to honor the terms of the prescription coverage they advertise and sell to consumers. Taking advantage of this loophole, insurers frequently reduce coverage for medications midyear, forcing patients who are stable on a medication, even for years, onto an insurer-preferred medication. Because the coverage reductions happen after open enrollment, patients have no way to change plans and are locked into coverage that doesn't meet their needs.

Studies show that forced switches for non-medical reasons may lead to increased symptoms, side effects and even relapse of a patient's health condition. Research also demonstrates that these negative health consequences may actually increase overall utilization costs, as patients require additional medical care.

When a person living with a chronic pain or another chronic condition is subjected to non-medical switching practices, the outcomes can be devastating. For example, one study found that rheumatoid arthritis patients who were taken off of their medication experienced 42 percent more emergency room visits and 12 percent more outpatient visits.[1] In addition, because of the negative health effects, patients with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis or Crohn's disease who were switched experienced 37 percent higher medical care costs and 26 percent higher total costs than patients who weren't switched.[1]

With all this in mind, the tide is turning against permitting midyear formulary changes. Last summer, a consumer workgroup of the National Association of Insurance Commissioners published a report recommending states prohibit major formulary changes.[2] It also should be noted that this report found that Medicare protects patients from non-medical switching. Negative formulary changes must be approved by the Centers for Medicare and Medicaid Services, and even if approved, affected enrollees are exempt from the change for the remainder of the year. In addition, Medicare patients must receive 60 days of advanced written notice of approved negative changes.[2] If Medicare can offer these protections, why can't commercial insurers?

Insurers are free to adjust their formularies during open enrollment, when consumers have a fair chance to review and compare their options. In addition, this bill would not prohibit generic substitution; non-medical switching involves patients being switched to an entirely new drug, not just a generic. Furthermore, health plans are still permitted to add new drugs to the formulary during the current plan year or remove drugs for safety reasons as dictated by the Food and Drug Administration.

On behalf of U.S. Pain Foundation and the one in three Americans living with chronic pain, and as a chronic pain patient myself, I respectfully ask that you support House Bill 2133 so that Pennsylvania ensures access to fair, reliable prescription insurance coverage.

Respectfully,

Shaina Smith
Director of State Advocacy & Alliance Development
U.S. Pain Foundation

CC: Members of the Consumer Affairs Committee

Sources:

1. http://www.uspainfoundation.org/wp-content/uploads/2016/01/costs-of-non-medical-switching-infographic.pdf
2. http://www.uspainfoundation.org/wp-content/uploads/2017/01/NAIC-Midyear-Formulary-Changes.pdf

THE TRUE COSTS OF NON-MEDICAL SWITCHING

Pharmacy benefit managers and health insurers are increasingly making coverage changes aimed at forcing stable patients onto treatments other than those their physicians recommend.

This intrusion into the physician-patient relationship, known as "NON-MEDICAL SWITCHING," erodes patient health and drives up monetary and societal costs.

ERODING PATIENT HEALTH; DRIVING UP HEALTH CARE & SOCIETAL COSTS

DEVASTATING HEALTH CARE OUTCOMES

- One way insurers can force a non-medical switch is by raising patient co-pays, making a treatment financially inaccessible.
  - For each 10 percent rise in patient co-pays, **medication use falls between 2 percent and 6 percent.**[i]
  - Doubling copays **reduces treatment adherence by 25 percent to 45 percent.**[i]
  - The consequences of medication nonadherence include **disease progression, reduced functional abilities, and a lower quality of life.**[ii]
- Switching treatments, even those the FDA deems "equivalent," can lead people with epilepsy to experience **breakthrough seizures.**[iii]
- For Crohn's Disease patients, even voluntary switching from one therapy to another is associated with **loss of effectiveness** within one year.[iv]

HIGHER HEALTH CARE COSTS

- Rheumatoid arthritis patients who incurred non-medical switching experienced the following over six months:
  - **42% more ER visits**
  - **12% more outpatient visits**[v]
- The **risk of hospitalization** for patients suffering from diabetes mellitus, hypercholesterolemia, hypertension, or congestive heart failure doubles with nonadherence – one potential outcome of raising out of pocket costs.[vi]
- People with epilepsy who recently switched **sought more in-patient and emergency care** than those that did not.[vii]
- Patients with rheumatoid arthritis, psoriasis, psoriatic arthritis, ankylosing spondylitis, or Crohn's disease who switch treatment due to a formulary change incur **37 percent higher all-cause medical costs** (which include hospitalizations, ER visits, and outpatient visits) and **26 percent higher total costs** than patients who are not switched.[viii]

NEGATIVE SOCIETAL IMPACTS

- Nonadherence to treatment medication regimens contributes direct annual costs of **$100 billion** to the U.S. health care system. Indirect costs **exceed $1.5 billion annually in lost patient earnings** and **$50 billion in lost productivity.**[ix]
- Psychiatric patients who stop taking their medications because of prescription drug coverage changes, utilization management, or copayment issues are **3.2 times more likely to be homeless.** Psychiatric patients who discontinue or temporarily stopped their medications are **more than twice as likely to be incarcerated in prison or detained in jail.**[x]

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ii. Jimmy B, Jose J. Patient Medication Adherence: Measures in Daily Practice.Oman Medical Journal. 2011;26(3):155-159. doi:10.5001/omj.2011.38.

iii. Epilepsy Foundation. (2009). In Their Own Words: Epilepsy Patients' Experiences Changing the Formulation of the Drugs They Use to Prevent Seizures. Available at http://www.epilepsy.com/sites/core/files/atoms/files/In-Their-Own-Words.pdf

iv. Van Assche, Gert, Vermeire, Severine, et al. Switch to adalimumab in patients with Crohn's disease controlled by maintenance infliximab: prospective randomized SWITCH trial. Gut Online. 10.1136/gutjnl-2011-300755. 2011

v. SWITCHING FROM ADALIMUMAB TO OTHER DISEASE-MODIFYING ANTIRHEUMATIC DRUGS WITHOUT APPARENT MEDICAL REASONS IN RHEUMATOID ARTHRITIS: IMPACT ON HEALTH CARE SERVICE USE [AB1395]. Signorovitch et al. Ann Rheum Dis 2012;71(Suppl3):717

vi. Anon. Poor medication adherence increases healthcare costs.PharmacoEconomics and Outcomes News. 2005;480:5

vii. Zachry III WM, Doan QD, Clewell JD, Smith BJ. Case-control analysis of ambulance, emergency room, or inpatient hospital events for epilepsy and antiepileptic drug formulation changes. Epilepsia. 2009;50(3):493-500.

viii. Chao, J., Lin, J., Liu, Y., & Skup, M. (2015). Impact of non-medical switching on Healthcare costs: a claims database analysis. Value in Health, Volume 18 (Issue 3), pp. A252.

ix. Goldman D.P., et al. (2004). Pharmacy benefits and the use of drugs by the chronically o;:/ JAMA., 291(19). 2344-2350.

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