Testimony submitted on October 20th, 2015 to the Joint Committee on Financial Services in support of HB 800 An Act promoting continuity of care for multiple sclerosis treatment.

Dear Chairman’s Eldridge & Michlewitz and committee members:

Thank you for the opportunity to offer testimony verbally and in writing on behalf of the more than 12,000 individuals with multiple sclerosis in the Commonwealth.

Testimony and supporting documents
Please find enclosed written testimony from our public hearing panel in addition to two other letters of support, The Use Of Disease-Modifying Therapies in Multiple Sclerosis Principles and Current Evidence: A Consensus Paper by the Multiple Sclerosis Coalition-March 1995 and the MS Society publication What is Multiple Sclerosis? Your committee received in advance the NMSS publication The MS Disease-Modifying Medications. It is a reader friendly document I strongly urge this committee to review in lieu the complexity and variety of treatment options as subject in this bill.

In my role as Director of Public Policy for the Greater New England Chapter I serve as a voice for individuals affected by multiple sclerosis and their families. Ensuring access to care in all its forms is a high priority throughout our organization. MS is a chronic disease of the central nervous system with a wide range of symptoms from mild to severe. MS is not the same disease in any two people and can fluctuate over time. There is no cure but at present the disease modifying treatments known as DMDs are currently one of the frontline approaches to slowing the progression of the disease and reducing the likelihood of disability. The complexity and uncertainty of MS makes identifying an effective treatment following diagnosis accompanied by comprehensive medical care essential.

MS Disease modifying treatments
The National MS Society currently supports use of all 12 current disease-modifying treatments approved by the FDA. They are Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Lemtrada, Novantrone, PLEGRIDY, Rebif, Tecfidera, and Tysabri. Additional treatments are in the research pipelines. There are no treatments for primary progressive MS to date. When individuals are newly diagnosed or not experiencing exacerbations or flare-ups for the disease remaining on treatments that are not always easy to administer or convenient such as with self-injections or infusions can be a challenge. Individual treatment decisions are made between the physician and patient based on multitude of factors. It can also be a period of trial and error based on clinical tests, MRI results and changes in ones functioning status. Each DMD has potential risks and benefits. Each DMD is distinct and not effective or safe for each patient. According to The Use Of Disease-Modifying Therapies in Multiple Sclerosis Principles and Current Evidence: A Consensus Paper, “once a disease-modifying treatment is initiated, evidence suggests
Treatment needs to be ongoing for benefits to persist. Cessation of treatment has been shown to negatively impact clinical and MRI outcomes. Treatment with a given medication should be continued indefinitely unless there are contradictions”.

Why is the National MS Society supporting HB 800 and why MS only language?

HB800 is consistent in ensuring access to care and The Use Of Disease-Modifying Therapies in Multiple Sclerosis Principles and Current Evidence: A Consensus Paper. The National MS Society has a lengthy history of funding biomedical research and as a vital partner to bring new treatments to market. This investment is realized when all treatments are available help people with MS live their best lives.

While our organization did not initiate this legislation, we do support the objective ensuring “continuity of care” for current individual patient treatment regimens. To clarify the bill does limit the focus to “continuity”, thereby any patient who needs to change treatments for any reason would not be guaranteed access to a new prescribed therapy per this language. While access to different treatments can be problematic for this other target population, we recognize the rationale in creating this minimum standard of treatment care continuity. This bill however should not be construed as a requirement or permission by insurers to only cover current treatments patient are currently taking. That interpretation would be an unintended consequence of this bill. The National MS Society maintains all FDA approved DMDs should be made available in health plan drug formularies. As more treatments have come to market this is not the reality. Physician autonomy in the treatment decision making process must be upheld in the best interest of the patient’s wellbeing.

Interruptions in continuity of coverage can occur for many reasons- changes to a new health plan, changes within an existing health plan’s formulary such as exclusion of one or more DMDs by a health plan or a pharmacy benefit manager plan, differing out of pocket costs for a drug based on the status in a formulary tier, the practice of designating one or more drugs in this calls “preferred” or utilizing a step therapy approach. Ensuring continuity of care will not only benefit the physician and patient but should aim at controlling health care costs resulting from disease progression, hospitalizations and rehab admissions. We support MS specific language vs. including other conditions or biologics because MS is truly a unique disease in its complexity and treatment specificity.

Thank you for consideration of this testimony and those on the MS testimony panel. Please contact me if I can provide additional information.

Sincerely,

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