

**Written Testimony of Stephen R. Smith, M.D., M.P.H. on the Health Care
Cabinet Recommendations on Restraining the Cost of Prescription Drugs
January 12, 2018**

My name is Stephen Smith. I reside at 899 Montauk Avenue in New London and I am a family physician practicing at the Community Health Center in New London. I also serve on the board of directors of the Connecticut Health Advancement and Research Trust (CHART), the parent organization of the Universal Health Care Foundation of Connecticut and serve as president of the board of directors of the Eastern Area Health Education Center (AHEC). I am professor emeritus of family medicine of the Warren Alpert Medical School of Brown University.

The high cost of prescription drugs erects financial barriers to the patients I serve and undermines my ability to provide the best care possible. Just this week, I saw a middle-aged man, whose diabetes had been relatively well controlled, but on Thursday, I found it badly out of control. He had lost his job and with it his health insurance. To make matters worse, his brother-in-law had died and no one else in the family could pay for the funeral expenses, so my patient emptied his bank account to bury his brother-in-law. Unable to afford the high cost of insulin, he simply stopped taking it. This patient had also had a heart attack in his early 40s and was at high risk of having another unless his blood sugar was well controlled. Fortunately, he has just started a new job that includes health insurance, though it's uncertain what his out-of-pocket costs for drugs will be.

My patient's story is hardly unique. According to a recent survey by *Consumer Reports*, 1 in 7 patients don't fill their prescriptions because of the cost. That's why the recommendations of the Health Care Cabinet are so timely and so desperately needed. I heartily endorse all the recommendations and urge the legislature to take speedy action to adopt them. I also suggest that the cabinet consider another action that wasn't included on your list of recommendations, but could save patients money on their prescriptions, namely, therapeutic substitution, which I explain below.

One way I try to help my patients afford their medications is to write prescriptions for generic drugs whenever possible. You are probably familiar with generic substitution in which a pharmacist can substitute a less-expensive generic version of a drug for the brand name, for example, substituting amoxicillin/clavulanate for Augmentin. This practice has been around since the 1980s and has proved both safe and economical. About 70 percent of prescriptions are filled using generic substitution.

While I'm sure you are familiar with generic substitution, you may not be familiar with a related concept called therapeutic substitution, which a number of states—but not Connecticut—permit. If I write a prescription for a drug for which no generic drug is available, then the pharmacist cannot substitute another drug that does the

same thing but is not chemically identical. For example, if I write a prescription for the cholesterol-lowering drug Livalo, the pharmacist must fill the prescription for that drug, which costs \$223.50 for a month's supply, even though an equally effective drug, simvastatin, is available that costs only \$3.40 a month.

Therapeutic substitution could save billions of dollars if applied nationally. A study published in 2016 in *JAMA Internal Medicine* by Johansen and Richardson showed that up to \$73 billion could be saved in this manner. And that's not just savings for insurance companies—\$24 billion was in excess out-of-pocket spending for patients. (1)

And it's more than just saving money. Patients have to pay different amounts out-of-pocket for drugs in different tiers set by the insurance company. If a doctor prescribes a drug in a tier with a high copayment when an equivalent drug exists in a lower tier with less or even no cost sharing, there is a higher likelihood that the patient will stop taking the drug. In a recent study in the *Journal of the American Heart Association*, Li, Schwartz, and Doshi showed that patients prescribed either Lipitor or Crestor showed a drop in the monthly use of these cholesterol-lowering medications compared to patients who were prescribed a generic statin like lovastatin or simvastatin. (2) The result could be higher cholesterol levels and higher rates of strokes and heart attacks.

Therapeutic substitution is not a brand-new, untried concept. It's already happening even here in Connecticut though not in private pharmacies. This is the time of year when all my fellow prescribers at the Community Health Center bemoan the fact that our Husky Medicaid program has switched the acid-indigestion drug that it will pay for. One year it's Nexium, the next year it's Protonix—whatever drug the state can buy less expensively. The drugs work exactly the same, but they're not generic equivalents. Therefore, the pharmacist can't simply switch the patient from one to the other. I, and all my prescribing colleagues, have to spend time switching our Husky patients over. This is a waste of time and a big headache.

A similar thing happens when my patients are admitted to the hospital. The hospital pharmacy has a limited formulary of drugs it keeps in stock. If one of my patients is on atenolol for high blood pressure and the hospital pharmacy only stocks metoprolol, they will substitute one for the other.

Other states, like Washington, have therapeutic substitution laws that allow pharmacists to make these substitutions following prescribed guidelines. I asked a colleague of mine who practices in Washington state what benefit or harms he had experienced as a result of that state's therapeutic substitution laws. Here's what he wrote:

“For me it is a huge benefit because if I prescribe something that is not on the patient's insurance formulary, the pharmacist can substitute a similar drug that is on the formulary. Rather than wait for my approval, clogging up my inbox or

bothering my staff, they simply do it and then send me a note that they did. It is super easy! I have found the pharmacists to be professional and have had no problems.” (3)

Sometimes, I may not want a similar drug substituted. For example, if I prescribe the antidepressant sertraline (Zoloft), I don't want the pharmacist to substitute fluoxetine (Prozac) for it. While the two drugs work equally well for depression, they have different side effect profiles and interact with other drugs differently. All I need to do is tick off the “no substitution” box on my electronic or hard copy prescription pad and the pharmacist would not attempt to switch drugs.

If done thoughtfully and carefully with good evidence-supported protocols to guide pharmacists and prudent prescribing by physicians (4), therapeutic substitution can be beneficial both financially and medically. Connecticut should join Washington state and other states to permit therapeutic substitution in Connecticut. I urge the cabinet to consider adding this to its excellent list of recommendations.

References

1. Johansen ME, Richardson C. Estimation of potential savings through therapeutic substitution. *JAMA Intern Med.* 2016;176(6):769–775.
2. Li P, Schwartz JS, Doshi JA. Impact of Cost Sharing on Therapeutic Substitution: The Story of Statins in 2006. *J Am Heart Assoc.* 2016 Nov. 11:5
3. Personal communication. David Evans, M.D., Associate Professor of Family Medicine, Rosenblatt Family Endowed Professor in Rural Health, University of Washington School of Medicine. February 3, 2017.
4. Ross JS. Therapeutic Substitution—Should It Be Systematic or Automatic? *JAMA Intern Med.* 2016;176(6):776.