Kate M. Nicholson, JD
Executive Director and Founder
kate@nationalpain.org
800-735-0818

December 7, 2023

The Honorable Bernard Sanders
Chairman
Senate Committee on Health, Education, Labor and Pensions
United States Senate
428 Senate Dirksen Office Building,
Washington, DC, 20510
Chairman Sanders

The Honorable Bill Cassidy, M.D.
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
United States Senate
428 Senate Dirksen Office Building,
Washington, DC, 20510

Dear Chairman Sanders and Ranking Member Cassidy:

We write in strong support of the Advancing Research in Chronic Pain Act, legislation introduced by Senators Bob Casey (D-PA), Marsha Blackburn (R-TN), Tim Kaine (D-VA), and Kevin Cramer (R-ND) to close existing critical gaps in chronic pain research, centralize data, and propel essential research into this prevalent, disabling condition forward.

The National Pain Advocacy Center (NPAC) is a 501c3 nonprofit organization that accepts no industry funding and advocates for the health and human rights of people in pain. NPAC is an alliance of clinicians, scientists, public health experts, and people with lived experience of pain, as well as people in recovery from an opioid use disorder. NPAC promotes equitable and effective pain management. This bill is of critical importance to our community.

More than 50 million Americans live in pain every day or nearly every day of their lives, and between 17 and 19.6 million have pain so severe that it regularly interferes with their ability to work or perform the most basic life activities. We know these critical statistics about the prevalence of chronic pain and high-impact chronic pain because of research conducted by the Centers for Disease Control and Prevention (CDC). This research was previously funded at the CDC, yet much more must be done to accomplish the population research goals of the National Pain Strategy (NPS) (pp. 17-22). A key objective of the NPS is to “Develop a system of metrics for tracking changes in pain prevalence, impact, treatment, and costs over time to assess progress and evaluate the effectiveness of interventions at the population health level.” The CDC does not have a discretionary budget, so this bill is essential to ensuring that vital research continues.

We know from other sources that chronic pain is consequential; just one type, low back pain, is the leading cause of disability. And chronic pain is growing in

P.O. Box 4172
Boulder, CO 80302

info@nationalpain.org
(303) 909-3175

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the U.S.: reported cases in 2019-2020 grew at a much faster rate than other major conditions -- more than seven times faster than diabetes and more than three times faster than mental health conditions, both of which are also on the rise. An aging population in America and long COVID are critical additional considerations for the impact of chronic pain on our healthcare system and the economy.

The economic costs of chronic pain are similarly staggering. A 2011 report (based on 2009 data) showed annual costs of $635 billion, which should be adjusted for inflation and the recent uptick in chronic pain. Another study showed that Americans spend $87.6 billion in a single year on low back and neck pain alone on treatments that are often ineffective.

Chronic pain involves many underlying conditions and stems from various sources and body systems. Our members include people with pain from conditions like cancer, sickle cell disease, multiple sclerosis, and many other chronic conditions. The pain may be neuropathic, inflammatory, or nociceptive. Given the breadth and significance of chronic pain, numerous gaps in research still need to be addressed. The Advancing Research in Chronic Pain Act addresses those gaps.

Moreover, because there is no centralized national institute on chronic pain, current research efforts are scattered across various federal government offices – centralizing data in a single hub that provides essential information to those who suffer is needed and addressed by the Advancing Research in Chronic Pain Act.

Including the Advancing Research in Chronic Pain Act as an amendment in the reauthorization of the SUPPORT Act makes sense. Congress has already recognized the importance of dealing with both pain and addiction in its funding of the NIH Helping to End Addiction Long-term (HEAL) initiative. However, to date, funded research has not been divided equally between pain and addiction. The inclusion of chronic pain in the SUPPORT Act is appropriate because one of its goals is to stem rising overdoses, and a subset of people with chronic pain, the 5 to 8 million who use opioids to manage it, are now at risk of overdose and suicide.

Specifically, people who have been using opioids medically – often for many years – are being subjected to dangerous tapering and cessation practices that federal agencies from the Food and Drug Administration to the CDC have warned against and that numerous studies detailed in the resources section below show increase their risk of overdose and suicide by three to five times.

People with chronic pain who use opioids medically are facing unconscionable barriers to healthcare: half of the primary care clinics in the U.S. will refuse to see them (See additional resources below). As public health agencies have also acknowledged, these barriers and risks result partly from policies that overreach or have been applied in a one-size-fits-all manner, which is inappropriate given the variety of conditions involved in chronic pain.

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Despite a remarkable nationwide decline in the total prescribing of opioids in the United States, drug overdose deaths continue to rise. A recent national study by IQVIA reported that while per capita *prescription* opioid use is down 64% since the peak of prescribing in 2011, opioid overdose deaths have increased by 253% in the same period. People living with chronic pain are suffering from this reduction in the medical supply and are at increased risk for overdose.

In sum, the Advancing Pain for Chronic Pain Act is one aspect of addressing the larger tragedy facing people with chronic pain in the U.S. Additional research into chronic pain proposed by this Act will provide evidence for optimal treatment strategies that preserve quality of life and prevent disability.

We strongly urge you and the other members of the Senate Health Education Labor and Pensions (HELP) Committee to take up the act and consider integrating it by amendment into the SUPPORT Act, which we understand the Committee will be considering in the coming weeks.

We thank you for your time and consideration.

Respectfully submitted,

Kate M. Nicholson

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Resources

On barriers to care:

- Two surveys found that half of all primary care clinics are unwilling to take on a new patient who uses opioids to manage pain.
- The original study is of clinics in Michigan (Lagisetty, JAMA Netw Open 2019).
- A follow-up study looked at primary care clinics in 9 states (Lagisetty, PAIN 2021). *On risks associated with disruption, discontinuation, and tapering of opioid medication:*
- Just changing a patient's dose resulted in a three-fold increased risk of overdose death. (Glanz, JAMA Netw. Open 2019).

On risks related to medication disruption, cessation, and tapering:

- In a study of Medicaid patients on opioids for more than 90, discontinuation resulted in hospitalization or an ER visit in nearly half of patients (Mark, J Subst. Abuse Treat. 2019).

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- Opioid disruption in primary care settings is associated with an increased risk of death (James, J Gen Intern Med 2019).
- Veterans who were tapered experience a higher risk of death from overdose or suicide (Oliva, BMJ 2020).
- Opioid tapering is associated with termination of healthcare relationships (Perez, J Gen Intern Med 2020).
- Discontinuation of opioids in patients stable on opioids is on the rise and often happens abruptly (Neprash, J Gen Intern Med 2021).
- Dosage reduction is associated with mental health crises and overdose events. (Agnoli, JAMA 2021).
- The heightened incidence of overdose and mental health crises from tapering continued two years post-taper. (Fenton, JAMA Netw. Open 2022).
- There is a heightened risk of overdose and suicide in patients with no prior use disorder or risk of opioid misuse, and these risks occur regardless of the pace of tapering. (Larochelle, JAMA Netw. Open 2022).
- Tapering is associated with an increase in emergency department visits and hospitalizations, fewer primary care visits, and lower medication adherence for other chronic conditions (diabetes, hypertension). (Magnan, JAMA Netw. Open 2023).
- Going from over 90 morphine milligram equivalents (MME) to 0-29 within 30 days was associated with a four-fold increased risk of overdose death. (Henry, J Gen Intern Med 2023).