



**Ohio Association of Rheumatology
Proponent Testimony to the Ohio House Health Committee
House Bill 418 – Non-Medical Switching**

**Presented by: Stephanie Ott, MD
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Chair Lipps, Vice Chair Manning, Ranking Member Boyd, and members of the Ohio House Health Committee, my name is Dr. Stephanie Ott and I am a practicing rheumatologist in the Lancaster area. Upon my graduation from medical school in 2001, I completed my internship and residency, spent time as a hospitalist, and completed a two-year rheumatology fellowship before going into practice in 2007. I currently serve as the President of the Ohio Association of Rheumatology (OAR), an organization that represents regional and state rheumatology societies. In addition, I serve as a Director, Advocacy Co-chair and Ohio Chapter Leader for the Association of Women in Rheumatology. Thank you for the opportunity to provide testimony today.

In my capacities, I am testifying in favor of House Bill 418, a bill which provides much-needed reform to a utilization management protocol known as non-medical switching. As a rheumatologist, I can attest to the importance of providing a continuum of care to patients with complex, severe and life-threatening autoimmune diseases.

“Non-medical switching” or medication switching, occurs when a stable patient is forced to switch from their currently effective medication for non-medical reasons. Health plans and pharmacy benefit managers (PBMs) accomplish this by: removing the medication from their prescription drug formulary, moving the medication to a more restrictive tier, and through other prevailing means to increase a patient’s cost-sharing or out-of-pocket cost.

Unfortunately, these changes in medication are determined by the plan formulary and without any consideration of the medical repercussions or physicians’ reasoning behind the selection of the original prescription medication. Non-medical switching is based on the presumption that cost savings can be achieved with drugs from the same therapeutic class. However, numerous studies have found this basic principle to be false in terms of both quality of care and actual cost savings as reduced effectiveness of the switched medication or the effects of medication stability disruption can cause adverse reactions and loss of effectiveness, both of which lead to higher cost patient outcomes.

The patient populations that I and other OAR members treat are particularly vulnerable to changes in medication treatment. Disruptions in prescribed treatments which have been effective in treating a patient’s condition can have both short and long-term effects resulting in increased health care costs, hospitalizations, and a host of other potential complications.

Additionally, managing diseases, particularly for certain chronic conditions, is often a difficult process that may require several changes to medication before finding the one that is the most effective for the patient with the least amount of side effects. Many patients with chronic

conditions have been through years of painful trial-and-error with their physician to find the therapy that works for them.

House Bill 418 addresses medication switches that are happening during the middle of a plan year and provides increased patient protections through:

- **Placing restrictions on insurers from removing a medication from a prescription drug formulary during a plan year (health plans and Medicaid).**
- **Prohibiting health plans from increasing patient cost-sharing or from moving drugs to a more restrictive tier during a plan year (does not apply to Medicaid).**

Patients that suffer from complex chronic conditions such as rheumatoid arthritis, epilepsy, cancer, diabetes, mental health disorders, and many others require continuity of care to successfully manage their condition. The aforementioned conditions are extremely complex and present unpredictably, necessitating a high degree of individualized and attentive care.

Physicians may spend multiple years of trial and error finding a treatment regimen that properly manages their condition. The resulting course of treatment must carefully balance each patient's unique medical history, co-morbid conditions, and side-effect balancing drug interactions. This equilibrium is carefully chosen and tenuous. Even slight derivations in treatment and variations between drugs, even those in the same therapeutic class, can cause serious adverse events. Aside from needless suffering, the resulting disease progression can be irreversible, life threatening, and cause the patient's original treatment to lose effectiveness. It cannot be assumed that a treatment that works for *one patient* will work for *each patient*.

Furthermore, physicians, pharmacists, and other healthcare administrators have reported that non-medical switching increases administrative time, increases side effects or new unforeseen effects, and increases downstream costs to plans.¹ Moreover, when a stable plan enrollee is switched for nonmedical reasons, his or her care is more likely to be interrupted by a second switch.² These cost-motivated switches increase plan enrollees' health care utilization, disrupt the course of care, and, as a result, increase related health care costs.³

It is the position of the OAR that:

- Treatment decisions about a patient's medication should be based only upon the patient's history, current response to treatment, and medical judgment of the physician;

¹ E.g., D.T. Rubin, et al., P354 Analysis of Outcomes After Non-Medical Switching of Anti-Tumor Necrosis Factor Agents, EUR. CROHN'S & COLITIS ORGANISATION (2015), <https://www.ecco-ibd.eu/index.php/publications/congress-abstract-s/abstracts-2015/item/p354-analysis-of-outcomes-after-non-medical-switching-of-anti-tumor-necrosis-factor-agents.html>. Bryan R. Cote & Elizabeth A. Petersen, Impact of Therapeutic Switching in Long-Term Care, 14 AM. J. MANAGED CARE SP23 (2008).

² *Cost-Motivated Treatment Changes: Implications for Non-Medical Switching*, Institute for Patient Access (Oct. 2016), http://allianceforpatientaccess.org/wp-content/uploads/2016/10/IfPA_Cost-Motivated-Treatment-Changes_October-2016.pdf.

³ *Id.*

- Physicians and patients, not insurers, should make treatment decisions together;
- Insurers need to be fully transparent about what medications are covered and if a patient will be required to make a switch before choosing their coverage; and,
- Patients who are medically stable on a course of treatment should be allowed to continue their treatment during a plan year unless there is a medical reason to change it.

Non-medical switches disrupt a physicians' ability to exercise their medical expertise in concert with their patients. For these reasons, the Ohio Association of Rheumatology respectfully asks the Health Committee to support the meaningful reforms found in House Bill 418.

Thank you once again for the opportunity to testify today. I would be happy to answer any questions the committee may have.