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**Ohio Hematology Oncology Society**  
**House Bill 153 Proponent Statement**  
**House Insurance Committee**  
**May 26, 2021**

Chairman Brinkman, Vice Chair Lampton, Ranking Minority Member Miranda, and Members of the House Insurance Committee, thank you for the opportunity to provide written testimony in support of House Bill 153 regarding non-medical switching of drugs. The Ohio Hematology Oncology Society represents nearly 200 oncologists and hematologists in Ohio who treat cancer patients in the private office (community) setting. Community oncology practices treat the majority of patients facing cancer. Our members are located in rural, suburban, and urban settings. Practices range in size from 1 to 35 physicians, with most being in the 3-4 physician range.

Non-medical switching occurs when a patient's effective current therapy is switched between therapies for economic or other non-medical reasons. Non-medical switching is defined as switching to a clinically similar but chemically distinct medication for reasons apart from lack of effectiveness, tolerability or adherence. Health plans and 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.

As you would imagine, non-medical switching can be particularly perilous for the patients we see facing cancer. Cancer treatments are very individualized and many patients are facing side-effects and other health issues along with their cancer. Finding the right cancer treatment drug and supportive drug combinations is a delicate balancing act. Disruption in the care plan can increase side-effects and negatively impact the efficacy of treatment.

House Bill 153 addresses medication switching that is happening during the middle of a plan year and provides increased patient protections through:

- Placing restrictions on 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).

When coverage is restricted in the middle of the plan year, patients become locked into their plan, unable to enroll in a different plan for the rest of the year. Because of this, they often cannot afford to stay on their treatments.

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Cost should not be the primary driver of utilization management policies. Policies that attempt to incentivize, force, or coerce patients to accept anti-cancer therapy alternatives that are not recommended by their oncologist can threaten the outcomes for patients. Thus, individuals with cancer should have full access to the anti-cancer therapy most appropriate for their disease when used in accordance with current clinical and scientific evidence. Cost-containment strategies should not limit the ability for patients to receive access to appropriate care, or for providers to prescribe such care. They should also be transparent and without conflicts of interest.

Treatment decisions should arise from the course of the doctor-patient relationship. HB 153 increases protections for patients with chronic and complex diseases by allowing them to remain stable on their current course of treatment prescribed by their provider. Please support HB 153 when it comes before you for a vote.

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