

## Ohio House of Representatives– Insurance Committee

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Chairman Brinkman, Vice Chairman Lampton, Ranking Minority Member Miranda and Members, thank you for the opportunity to provide testimony on House Bill 153, an act limiting midterm changes to drug formularies to protect patients. We offer our appreciation to Representatives Liston and Carruthers for their efforts in drafting this bill and for how it may assist those who live with multiple sclerosis (MS) and their families.

The National Multiple Sclerosis Society's vision is a world free of MS. We believe that people affected by MS can live their best lives when we work together to stop MS in its tracks, restore what has been lost and end MS forever.

Multiple sclerosis is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. When someone is diagnosed with MS, their clinician will typically prescribe a medication referred to as a disease-modifying therapy (DMT). DMTs are used to modify the disease course, treat relapses, and manage symptoms. Growing evidence indicates that early and ongoing treatment with DMTs is the best way to prevent the accumulation of disability and protect the brain from permanent damage due to MS.

“Mid-year formulary changes” are changes that health insurers make to prescription drug benefits during the plan year, for reasons that may be unrelated to patients' health or safety. Another commonly used phrase to describe this practice is “non-medical switching.” Insurers can currently make several types of changes to their drug formulary during the plan year, such as moving a prescription to a higher cost-sharing tier, increasing out-of-pocket costs by moving from co-pay to co-insurance, adding utilization review requirements (such as step therapy or prior authorization) or removing a prescription from a drug formulary.

Movement from one DMT to another should only occur for medically appropriate reasons. When a person living with MS loses access to the treatment that best controls their disease progression, they may experience loss of function and possibly irreversible increase in disability. Managing MS can be a difficult process that requires several “trial and error” changes to medication before finding the one that is most effective at controlling disease progression with the least number of negative side-effects. Once a patient living with MS finds a DMT that works for them, treatment with that medication should continue without interruption unless determined otherwise by the individual or his or her healthcare provider. Switching for any

reason other than medical necessity could lead to hospitalization or lengthy stays at rehabilitation centers, both of which are much costlier than the difference in drug prices.

It is also inherently unfair for one party under contract to make changes during a contract period. When patients enroll in a health plan, they sign a contract for an entire year. People with chronic conditions like MS often base their decision to enroll in a health plan based on the available information about the medications they need. MS DMTs are very costly. In 2013, the average price of MS DMTs was around \$60,000; in 2018 the median price of brand DMTs increased to \$80,000 and just two years later in 2020, the brand median price is \$91,835. Five MS DMTs are priced at more than \$100,00 per year. Placing any medication that is part of a DMT on a higher cost-sharing tier during a policy term can create either unmanageable expenses or worsening symptoms and side effects for individuals living with MS due to lack of adherence.

A poll by the Alliance for Patient Access reported that more than two-thirds of chronic disease patients have been driven to change medications due to reduced insurance coverage and higher out-of-pocket costs. 95% of respondents reported worsening symptoms, 89% reported worse side effects following a switch to a new medication, and 48% were switched to a medication they had previously tried and discontinued due to side effects, ineffectiveness, or cost. Allowing health insurers to remove coverage of a prescription drug or reclassify it to a higher cost-sharing tier during a policy term conflicts with treatment recommendations of leading experts in the treatment of MS.

Experts in the treatment of MS advocate for early, ongoing and uninterrupted treatment with a DMT following careful assessment by specialists. This cannot occur if patients and doctors are subject to a process that is not transparent. Lack of transparency on costs and barriers to the drug increase the risk that a patient may not be able to afford or access their medication. The National MS Society supports limiting the use of non-medical switching during an insurer's policy term. Interference with a person's course of treatment poses dangerous threats to their health and safety. We encourage the bill sponsor and this committee to require insurers to cover prescription medications for the remainder of a policy term, allowing individuals to remain stable on the medications prescribed to them by their physicians. Thank you for your time and consideration.

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