AIMED ALLIANCE

June 1, 2020

Via Electronic Communication

Health Committee
The Ohio House of Representatives
77 S. High Street
Columbia, OH 43215

Re: In Support of H.B. 418

Dear Chairman Lipps, Ranking Member Boyd, and House Health Committee Members:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. On behalf of Aimed Alliance, I am writing to you in support of Ohio H.B. 418. Given the importance of this bill to patients, we ask that you bring the bill to the floor for discussion and pass the bill.

Nonmedical switching occurs when an insurer removes a medication from a formulary list, moves the medication to a higher cost tier, or increases the out-of-pocket costs owed after the plan year has begun. As a result, a patient can no longer afford his or her medication and is forced to switch to a different medication. Aimed Alliance does not oppose switching plan enrollees from a brand medication to a generic version of a drug that exhibits the same levels of effectiveness and safety. However, we are against insurance policies that force stable plan enrollees to switch to a therapeutic equivalent medication (*i.e.*, an entirely different medication) for nonmedical reasons, thereby interfering with the health care practitioner-patient relationship after the plan year has begun.

Nonmedical switching is a consumer protection issue. Individuals often sign up for health plans under the belief that their medication will be covered at a fixed, out-of-pocket rate. Yet, health plans often make negative formulary changes after the plan year has begun. While the insurer is free to make such changes, patients are locked into their plans for the entire year and have no alternative option for coverage if they lose access to their medication. As such, these midyear formulary changes effectively serve as a bait-and-switch. Some courts have even found that these unilateral modifications are a breach of duty of good faith and fair dealing, which requires both honesty and reasonableness in the enforcement of the contract, especially in light of unequal bargaining power between the insurer and plan enrollee.[1] Yet, most plan enrollees lack the resources to sue a health plan to enforce such a duty, and therefore, legislation is needed to protect consumers and strengthen this duty.

[1] *E.g.,* Florence Urgent Care v. Healthspan, Inc., 445 F.Supp.2d 871 (S.D. Ohio 2006); *E.g.*, Badillo v. Mid Century Ins. Co., 121 P.3d 1080 (Okla. 2005); Christian v. Am. Home Assurance Co., 577 P.2d 899 (Okla. 1977). In the Fifth Circuit, an insurer breaches the duty of good faith and fair dealing if it "has no reasonable basis for denying or delaying payment of a claim." Therefore, in the Fifth Circuit, a breach of the duty of good faith and fair dealing against an insurer will likely fail if there was any reasonable basis for denial of that coverage. Henry v. Mutual of Omaha Ins. Co., 503 F.3d 425 (5th Cir. 2007).

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In some instances, nonmedical switching may negatively impact some plan enrollees' health. Health care providers often work with plan enrollees for years to find a therapy that helps stabilize their conditions, manage their disease, or prevent re-emerging symptoms or the development of new side effects. Often, people living with chronic or complex conditions, such as epilepsy, diabetes, immunodeficiency, AIDS, cancer, mental health disorders, and autoimmune diseases, must try multiple medications before finding one that is well tolerated and effective. Forcing these stable plan enrollees to switch medications simply to save on cost can disrupt that carefully achieved equilibrium.

While health plans often make midyear formulary changes with the intent to cut costs, such a practice may increase costs in the long run. Health care providers, pharmacists, and administrators have reported that nonmedical switching increases administrative time, side effects or new unforeseen effects, and downstream costs to plans.[2] This is because when a stable plan enrollee is switched for nonmedical reasons, his or her care is more likely to be interrupted by a switch.[3] He or she may experience flare-ups, disease progression, and relapse, leading to increased health care utilization, including more doctors' visits and hospitalization.[4] As such, midyear changes can be quite costly.

Based on these concerns, we strongly support Ohio HB 418, which would limit nonmedical switching practices. Thank you for your efforts to improve the health care system and to protect patients from the dangers of nonmedical switching.

Sincerely,

Stacey Worthy
Counsel

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[2] *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).

[3] *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.

[4] *Id.*