May 24, 2021

Via Electronic Communication

Clay Schexnayder
Speaker of the House
Louisiana House of Representatives
schexnayderc@legis.la.gov

Chad Brown
Chairman, House Committee on Insurance
Louisiana House of Representatives
brownc@legis.la.gov

Re: In Opposition to SB 181

Dear Speaker Schexnayder and Chairman Brown:

The undersigned patient advocacy groups write to you in opposition to Louisiana SB 181. Given that this bill provides express authority to health plans to engage in activity that would result in nonmedical switching of stable patients, we ask that you vote against this legislation.

I. Overview of Nonmedical Switching

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. The undersigned groups do 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.

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, HIV/AIDS, cancer, mental health disorders, and autoimmune diseases, must try multiple medications before finding one that is well tolerated and effective. Additionally, generic alternatives may not be available. Forcing these stable plan enrollees to switch medications simply to save on cost can disrupt that carefully achieved equilibrium.

II. Summary of SB 181

While many states have begun enacting legislation to prohibit negative midyear formulary changes, SB 181 expressly allows such activity. These negative formulary changes can include

increasing out-of-pocket costs, adding additional prior authorization or step therapy restrictions, or dropping a medication from coverage altogether. Such changes are tied to increases in a medication's wholesale acquisition cost that occurred at any point in the past 365 days. The plan must simply notify the plan enrollee that the change will occur 30 days before the modification is set to take effect. These changes can take place regardless of the patient's disease or health condition and would apply to patients who are stable on their current medications. The bill provides for no exception process for patients to access their prescribed medication once these negative formulary changes are implemented.

III. SB 181 Is Harmful to Patients

This bill creates consumer protection issues and places patients in the middle of the drug pricing battle between insurers and drug makers. Individuals often sign up for health plans under the belief that their medication will be covered at a fixed, out-of-pocket rate. Yet, this bill sets a 365-day lookback period for price increases. Presumably, the insurer could make a midyear formulary change even if it had knowledge of such increases before the plan year 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. While patients will receive 30 days' notice, it is unclear what good such notice would do. The bill does not include a mechanism to allow a patient to request an exception to any formulary changes. Individuals with serious, complex, and chronic conditions, such as epilepsy, diabetes, immunodeficiency, HIV/AIDS, cancer, mental health disorders, and autoimmune diseases, could be left with no access to their prescribed medication resulting in interruptions in care, disease progression, increased adverse events, and hospitalization. As such, this bill provides insurers with a mechanism to engage in bait-and-switch activities.

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 a contract (i.e., the health plan), especially in light of unequal bargaining power between the insurer and plan enrollee.[1] Yet, this legislation would expressly permit such activity.

Finally, midyear formulary changes may increase health care 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

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[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).

[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.

hospitalization.[4] As such, midyear changes can be quite costly.

Based on these concerns, we strongly oppose Louisiana SB 181, which would expressly allow nonmedical switching practices and encourage you to vote against the bill. Please contact us at policy@aimedalliance.org if you have any questions. Thank you for your consideration in this matter.

Sincerely,

The AIDS Institute
Aimed Alliance
Alliance for Patient Access
American Chronic Pain Association
The Bonnell Foundation
Bridge the Gap – Syngap Education and Research Foundation
Chronic Care Policy Alliance
Coalition of State Rheumatology Organizations
Community Liver Alliance
Dravet Syndrome Foundation
Global Healthy Living Foundation
The Headache and Migraine Policy Forum
HealthyWomen
HIV+Hepatitis Policy Institute
Infusion Access Foundation (IAF)
Lupus and Allied Diseases Association, Inc.
Miles for Migraine
National Infusion Center Association (NICA)
National Organization of Rheumatology Managers
Patients Rising Now

Cc: Members of the House

[4] *Id.*