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Testimony to the Texas House Committee on Insurance
Interim Charge: "*Examine the impacts of changes in prescription drug coverage and drug formularies on patients, particularly those with chronic conditions.*"

About NAMI Texas: NAMI Texas (the Texas alliance of the National Alliance on Mental Illness) is a 501(c)3 nonprofit organization founded by volunteers in 1984. NAMI Texas is affiliated with the National Alliance on Mental Illness (NAMI) and has 27 local Affiliates throughout Texas. NAMI Texas has nearly 2,000 members made up of individuals living with mental illness, family members, friends, and professionals. Its purpose is to help improve the lives of people affected by mental illness through education, support, and advocacy.

About the Alliance for Stable Patients: The Alliance for Stable Patients seeks to:

- Secure legislation that supports patient stability by preventing health insurance plans from switching benefits and coverage and employing utilization management tactics that result in a negative impact on a patient's health;
- Preserve the relationship between patients and their providers to make treatment decisions and to ensure that changes to treatment plans are made for health reasons, not for non-medical reasons without medical rationale.

The Alliance for Stable Patients is working to preserve the relationship between patients and providers to make treatment decisions and to ensure that changes to treatment plans are made for health reasons, not for non-medical reasons without medical rationale. Members include: Alliance for Patient Access | Alliance for the Adoption of Innovative Medicine | Alliance of Independent Pharmacists of Texas | Coalition of Texans with Disabilities | Epilepsy Foundation Central and South Texas | Global Healthy Living Foundation | Keep My Rx | Lone Star Chapter of the National Hemophilia Foundation | Lupus and Allied Diseases Association, Inc. | National Alliance on Mental Illness Texas | National Association of Social Workers, Texas Chapter | National Multiple Sclerosis Society | National Infusion Center Association | Prescription Process | Texas Bleeding Disorders Coalition | Texas Dermatological Society | Texas Medical Association | Texas Nurses Association | Texas Pain Society | U.S. Pain Foundation.

Introduction:

Changes in prescription drug coverage and drug formularies that are made for non-medical reasons can have negative effects on patients, particularly those with chronic conditions.[1]

In my role as Public Policy Director of NAMI Texas and as coordinator of the Alliance for Stable Patients, I've spoken with many patients who have been impacted by what we call "non-medical switching" by health insurance companies. How do they do it? Sometimes, quantity limits are imposed. Or a medication is removed from the formulary altogether, even though the patient was previously covered for that medication by the same health plan. Another way that it happens is that health plans increase the out-of-pocket costs for the patient by hiking the co-pay or placing the medication on a specialty tier.

As I'll describe in my testimony, the consequences of having patients switched off of medications that are working for them can be severe. Furthermore, new research is showing that these switches commonly yield higher average non-drug expenses later on.[2] On behalf of NAMI Texas and the Alliance for Stable Patients, I recommend that the Texas House prioritize legislation that would strengthen protections against health plans switching stable patients off of their medications without cause.

Consequences for Patients:

What has been shown, both anecdotally and in research, is that switching people away from medications that are working for them often results in new side effects, less effective treatment, negative physical impacts, degraded control of disease, and worsening symptoms.[3] Emergency room trips and outpatient visits increase.[4] Subsequent changes to prescription medications increase, as does average non-drug expenses.[5] The evidence is clear: changing the prescription drug coverage for stable patients without any sort of medical reason is harmful for the individual and costly for society.

Chairman Phillips and members of the committee, having a chronic condition and being diagnosed with a chronic condition can be life-changing in the first place. For many patients and their physicians, it takes months or even years of trial and error before finding a therapy that is effective at treating the chronic condition. Their medical stability is hard won, but finding the right treatment can be the key force in stabilizing their condition and allowing them to maintain normal lives. Let's take for example a person with bipolar disorder, which affects roughly 2.6% of the population. Symptoms can include:

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[1] https://www.ncbi.nlm.nih.gov/pubmed/27033747

[2] http://allianceforpatientaccess.org/non-medical-switching-may-increase-health-care-costs-new-study-finds

[3]http://www.businesswire.com/news/home/20170117005588/en/Survey-Finds-Insurance-Companies-Forcing-Floridians-Prescribed

[4] http://ard.bmj.com/content/71/Suppl_3/717.10

[5]http://1yh21u3cjptv3xjder1dco9mx5s.wpengine.netdna-cdn.com/wp-content/uploads/2013/08/IfPA_Non-Medical-Switching-Commercial-Claims-Analysis_Aug-2017.pdf

-manic states
-rapidly changing moods
-unpredictable behavior
-depressed states
-psychotic episodes

Before finding a treatment, life is often extremely difficult for people with this condition. Difficulty with relationships and struggles in school or at work or with life in general are common. Sadly, the symptoms can result in hospitalizations, homelessness, dropouts, and incarcerations. When a diagnosis comes, it is often a challenge to find the right treatment regimen, which can include psychotherapy, medications, and other methods. There is no one-size-fits-all treatment for bipolar disorder, but most people diagnosed with it can and do get better with the right medications.

However, when people have their medications switched on them for non-medical reasons, it drastically complicates the picture. We hear story after story of health plans removing medication from formularies, reducing the coverage amounts, or pricing people out. This can, has, and will continue to result in negative consequences for patients. ***The existing protections against this happening are not strong enough.***

When patients are required to switch from a proven treatment for cheaper alternatives, this is known as non-medical switching.

Patients with chronic diseases are most affected by non-medical switching because they rely upon a stable medication regimen to go about their day-to-day lives. Such patients might include, but are not limited to, those with:

• Arthritis
• Cancer
• Crohn’s disease
• Diabetes
• Epilepsy
• High cholesterol
• Hypertension
• Immunodeficiency disorders
• Mental health conditions
• Pain
• Psoriasis

For example, I know of a Texas patient whose health plan removed her much needed immunotherapy from their formulary after years of covering the treatment. She was notified of the change after renewing her policy – with an increased premium – only after the claim for her

regular treatment was denied, leaving her on the hook for the unexpected expense and without access to the lifesaving treatment she was receiving every two weeks. At one point, it had been eight weeks since her last infusion.

Physicians will often explain that finding the right medication for each patient can take a considerable amount of time and expense. When a patient whose chronic condition is stable loses access to the proper treatment, the results can include a recurrence of symptoms, loss of function, further disease progression, and hospitalization.

Does non-medical switching actually generate the cost savings that health plans envision?

To explore this question, the Institute for Patient Access in August 2017 examined a subset of 2011-2015 data from Truven's MarketScan® Commercial Claims and Encounters and Medicare Supplemental database, which includes information for 3.9 million people.

Their findings[6] were that:
-A potentially cost-motivated change in treatment can yield higher average non-drug expenses later on.
-Patients who did not switch medications had the lowest per-member, per-month spending.
-Switching was indicative of a disrupted course of care. Of patients who made an initial switch, those in eight disease states were likely to make subsequent switches.
-Patients who underwent multiple switches also saw higher average non-drug costs downstream.

Policy Implications:
-Opting for a lower-cost medication does not necessarily reduce overall expenses. Data indicate that lowering medication costs may not be a wise – or effective – long-term strategy for reducing health care expenses. Continuity of care for patients with pre-existing prescriptions for their chronic conditions, on the other hand, could keep costs low.
-Switching can impact patient care and overall expenses. An initial switch may set patients on the path for multiple switches. Patients who undergo multiple switches also see increases in overall healthcare costs later on.

Existing Protections

Insurance Code 1369.0541 and 1369.055 provides a protection against non-medical switching outside of the time of contract renewal. At the time of contract renewal, health plans are free to switch stable patients off of medications without any medical rationale for doing so.

[6] http://1yh21u3cjptv3xjder1dco9mx5s.wpengine.netdna-cdn.com/wp-content/uploads/2013/08/IfPA_Non-Medical-Switching-Commercial-Claims-Analysis_Aug-2017.pdf

Insurance Code 1369.0546(c)(4) requires a health plan issue to grant a written request for an exception to a step therapy protocol if the request includes the prescribing provider's written statement, with supporting documentation, stating that a.) the drug that is subject to the protocol was prescribed for the patient's condition, b.) the patient received benefits for the drug under the plan currently in force or a previous plan and is stable on the drug, and c.) the change in the patient's prescription drug regimen required by the protocol is expected to be ineffective or cause harm to the patient based on the known clinical characteristics of the patient and the known characteristics of the required prescription drug regimen. This protection does not address added prior authorization requirements, newly imposed or altered quantity limits, or the moving of drugs to higher cost-sharing tiers, which increases out-of-pocket costs for consumers and often makes drug financially out-of-reach.

In conclusion

Forcing stable patients to switch medications simply to save costs can disrupt the delicate and arduous process of finding and retaining a therapy that manages the progression of a disease or helps stabilize a complex or chronic condition. Even the slightest variation in treatment can cause a serious reaction, an adverse health outcome, or a decrease in a patient's quality of life. It can also increase out-of-pocket costs and result in subsequent medication switches. We rely on the State having strong statutory protections that ensure a patient has uninterrupted access to the medications they need to continue to stabilize their condition.

Long-term stability is critical for anyone struggling to manage a complex or chronic disease. A switch that occurs at the beginning of a plan year can be just as harmful as one that occurs during the year. Therefore, meaningful patient protections against non-medical switching should protect patients against switches that occur during the re-enrollment period; as well as those within the plan year.