



**National
Multiple Sclerosis
Society**

November 6, 2017

**Legislation: LRB-3119, Representative Kolste
Position: SUPPORT**

Dear Representative Sanfelippo, Chair of Assembly Health Committee:

We are writing to submit comments on behalf of the National Multiple Sclerosis Society's Wisconsin Government Relations Advisory Committee regarding LRB-3119, a bill draft introduced by Representative Kolste, which aims to prevent non-medical switching of prescriptions or devices during an insurance plan year. This legislation would be an important step towards comprehensive solutions that will improve access to medications that people—including those living with multiple sclerosis (MS)— need to live their best lives. Thus, the National MS Society supports this legislation, and urges that it be introduced and given a public hearing in committee.

Multiple sclerosis is an unpredictable, often disabling disease of the central nervous system which interrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. While everyone with MS is impacted differently by the disease, a growing body of evidence indicates that early and ongoing treatment with a disease modifying therapy (DMT) is the best way to modify the course of the disease, prevent the accumulation of disability, and protect the brain. However, some folks have trouble accessing DMTs. People with MS report high and rapidly escalating medication prices, increasing out-of-pocket costs, confusing and inconsistent formularies, complex approval processes, and non-medical switching of prescriptions and devices that stand in the way of getting the treatments they need.

Non-medical switching refers to changes health insurers make to prescription drug benefits during the plan year, for reasons that are unrelated to patients' health or safety. Such changes can force stable patients to switch drugs or even stop taking a needed medication. These insurance changes may include 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. When out-of-pocket costs increase or additional utilization management requirements are added to a formulary, a patient may be forced to change medications due to financial constraints or access barriers, rather than for medical reasons.

It is also inherently unfair for one party to a 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 base their decision to enroll in a particular health plan based on the available information about the medications they need. Changes to plan design or drug tiers in the middle of the plan year leave patients with limited options: pay more for their medications, find an alternate therapy, or forego treatment altogether. Health plans usually make formulary changes with the goal of lowering costs, which can result in stable patients losing access to their medications. Changing medicines for non-medical reasons can cause adverse reactions, side effects, or diminished response to medication treatment. This can lead to disease progression, reduced functional capabilities and a lower quality of life for patients, as well as higher overall healthcare costs due to increased ER and physician visits and hospital admission.

People with MS or other conditions that depend on high-cost "specialty" drugs are especially vulnerable when insurers make formulary changes in the middle of a plan year. Moving a high-cost drug to a higher cost-sharing



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tier is common among private insurers, but can make critical prescription drugs unaffordable for people who rely on them. These changes are even harder on plan enrollees when formulary changes occur after the open enrollment period has ended and the plan year has begun, when changing health plans is not an option until the following open enrollment period. Increased medical debt, non-adherence to treatment and medical bankruptcy can all result from sudden increases in out-of-pocket costs.

In closing, we commend Representative Kolste for working on the issue of non-medical switching. The National MS Society supports legislation that would prohibit non-medical switching. Non-medical switching can have negative outcomes on patients' physical health and financial security. This bill draft should be introduced, and assigned to a committee where its merits can be properly debated in front of the public. In the future, the Society looks forward to partnering with you to champion this issue. The Society is here to serve as a resource, so I hope you will feel free to contact us if you have any questions about our position or non-medical switching.

Respectfully,

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Cc:

Representative Kolste
Representative Bernier, Vice-Chair of Assembly Health Committee
Representative Petersen, Chair of Assembly Insurance Committee
Representative Duchow, Vice-Chair of Assembly Insurance Committee, Chair of Assembly Committee on Consumer Protection
Representative Tittl, Vice-Chair of Assembly Committee on Consumer Protection
Assembly Speaker Robin Vos
Assembly Majority Leader Jim Steineke