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February 10, 2021

Iowa State Capitol
1007 East Grand Avenue
Des Moines, Iowa 50319

Re: Support for HF 372

The Coalition of State Rheumatology Organizations (CSRO) is a national organization composed of over 30 state and regional professional rheumatology societies, including our member society that represents providers of rheumatology care in Iowa. CSRO was formed by physicians to ensure excellence and access to the highest quality care for patients with rheumatologic, autoimmune, and musculoskeletal disease. It is with this in mind that we write to you in support of HF 372.

As you consider HF 372, CSRO would like to convey its support for providing continuity of care to stable patients.

Non-medical switching occurs when health plans and Pharmacy Benefit Managers (PBMs) force a stable patient to switch from their currently effective medication by restricting coverage for that medication. Health plans and pharmacy benefit managers accomplish this by: removing the drug from their formulary, moving the drug to a more restrictive formulary tier, or using other prevailing means to increase the patient's out-of-pocket costs for the drug or restrict access.

Patients that suffer from complex chronic conditions, such as rheumatoid arthritis and many others, require continuity of care to successfully manage their condition. The aforementioned conditions are extremely complex and present unpredictably, necessitating a high degree of individualized and attentive care.

Physicians may spend months or years of trial and error finding a treatment regimen that properly manages their condition. The resulting course of treatment must carefully balance each patient's unique medical history, co-morbid conditions, and side-effect balancing drug interactions. This equilibrium is carefully chosen and tenuous. Even slight deviations in treatment and variations between drugs, even those in the same therapeutic class, can cause serious adverse events. Aside from needless suffering, the resulting disease progression can be irreversible, life threatening, and cause the patient's original treatment to lose effectiveness. It cannot be assumed that a treatment that works for *one patient* will work for *each patient*. Non-medical switches are one-size fits all decisions that disrupt physicians' ability to exercise their medical expertise in concert with their patients.

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It must be noted that CSRO is not unconcerned with the cost of pharmaceuticals in the United States. However, non-medical switching is a poor way to control costs for the patient populations in question, and can lead to larger follow-on costs that swamp any up-front savings. Physicians, pharmacists, and other healthcare administrators have reported that nonmedical switching increases administrative time, increases side effects or new unforeseen effects, and increases downstream costs to plans.[1] Moreover, when a stable plan enrollee is switched for nonmedical reasons, their care is more likely to be interrupted by a second switch.[2] These cost-motivated switches increase plan enrollees' health care utilization, disrupt the course of care, and, as a result, increase related health care costs.[3]

For these reasons we urge you to support HF 372.

Respectfully,

Madelaine Feldman, MD, FACR
President, CSRO

[1] *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).

[2] *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.

[3] *Id.*