



Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, March 13, 2014

Connecticut Association of Health Plans

Testimony Submitted in Opposition to

SB 394 AAC REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 394 AAC Requirements for Insurers' Use of Step Therapy which would seriously compromise the efforts of health plans to contain costs and use practices designed to ensure cost-efficient and effective prescription drug use.

SB 394 would prohibit carriers from requiring that members try a less costly prescription drug for "more than 30 days" if a provider at the end of the 30 days indicates that the drug is clinically ineffective. In addition, the bill requires that carriers establish and disclose a process by which an insured's treating provider may request at any time an override of the step therapy regimen and requires "expeditious" approval by the health insurer upon such request.

Passage of SB 394 would set up a separate process for pharmacy utilization review and appeal outside the purview of the current utilization review statute that would not only prove duplicative and costly but could also prove cumbersome and confusing.

Section 38a-591d already establishes a process for urgent care requests that requires carriers to maintain written procedures for an expedited review relative to prospective urgent care requests. The current statute states that any benefit request "is determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition OR for a situation as defined under 38a-591a(38)s:

(38) "Urgent care request" means a request for a health care service or course of treatment (A) for which the time period for making a non-urgent care request determination (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (ii) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested, or (B) for a substance use disorder, as described in section 17a-458, or for a co-occurring mental disorder, or (C) for

a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, as defined in section 38a-496, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

The carrier may offer the health care professional filing an urgent care request the opportunity to confer with a clinical peer if a grievance hasn't yet been filed. Unless the provider has failed to provide the information necessary to make a determination, the carrier *must make a determination as soon as possible taking into account the person's medical condition but not later than 72 hours after receiving the request.*

Similar parameters exist for expedited reviews of adverse determinations both internally by the carriers themselves and externally through the Department of Insurance's independent appeals process.

Multiple points of access exist currently to address the problems envisioned under SB 394. There is no need for the proposal and the Connecticut Association of Health plans respectfully urges rejection of the bill.

Carriers use step therapy (requiring the use and failure of one drug before another drug may be covered) because some drugs are very expensive, and yet they have no better clinical track record for outcomes than less expensive medications (brand, generic or over the counter). When no clinical advantage is apparent, cost considerations often warrant moving members and providers to use the more cost-effective drug.

This law would drive up health care costs with no improvement in clinical outcomes and frankly, it contradicts not only the goals of the Affordable Care Act (ACA) which seek to find the least costly effective treatments and encourage their use whenever possible but, it also the runs contrary to efforts currently underway by the state itself to control escalating prescription drug costs via the State Employee Plan and the Exchange. Without a formulary, pharmaceutical sales and marketing practices could play too large a role in prescription choices. Formularies are critical if we are serious about controlling health care costs.

Please also keep in mind also that passage of SB 394 would *only* apply to the approximately 35% of Connecticut residents that are covered by fully insured health plans - typically your small employers who are the most price sensitive. The bill would *not* apply to the 65% of Connecticut residents who are self-insured and thereby subject to federal ERISA requirements rather than state law. Passage of SB 394 would likewise have a detrimental effect on the Health Care Exchange which needs provisions like step-therapy to help keep premiums affordable.

We urge your rejection SB 394. Thank you for your consideration.