

The logo consists of the letters 'FTR' in a bold, black, sans-serif font.

**Insurance and Real Estate Committee
Testimony
February 5, 2015**

Re: S.B. No. 24 An Act Establishing Standards and Requirements for Insurers' Drug Formularies, Requiring Disclosure of Certain Health Insurance Plan Information for Consumer Comparison Purposes, And Requiring The Connecticut Health Insurance Exchange and Insurance Department To Evaluate Health Insurers' Compliance With the Affordable Care Act

The American Heart/Stroke Association believes all formulary decisions should be made based primarily on the recommendations of the healthcare team after considering the scientific evidence in the specific patient or patient groups to be treated and the ratio of risk/balance in that setting. These decisions should be widely and proactively promulgated to prescribing physicians and include provisions for appeals both at the policy level and for individual patient exceptions. Economic considerations, although of substantial importance, should only be addressed after those other considerations have been fully evaluated.

For this reason, The American Heart/Stroke Association supports the concept of ensuring drug formularies that are prescribed by patients' physicians are not placed in specialty tiers that are cost prohibitive to patients. SB 24 addresses this issue and ensures patients have access to drugs formularies that are prescribed by their physicians and are medically appropriate for their condition. Access to medically appropriate drugs is critical and having a tiered system where medicines are not represented in a tier is not in the best health interest of the patient.

Patients who participate in Exchanges deserve the most accurate and up to date information when making decisions in consultation with their physicians. It is vital for drug formulary plans be easily understood and easily accessible so patients can compare them properly before choosing a plan. The plans offered by the Exchange should provide information that can be accessed with little difficulty and provide basic information like the hospitals and providers in a plan's network, the drugs in the formularies, copayment information, process for appealing a denial in service, and the steps available to seek an exception for services that a patient and their physician deem necessary.

Finally, because patients are bound to an insurance plan for a year, drug formulary changes that remove drugs from a tier or are shifted to an increased cost sharing tier should not be permitted because of the negative impact to the patient.

SB 24 is a good first step in ensuring patients are treated justly, can make knowledgeably decisions with their physicians with picking plans that offer access to medically necessary drugs, and are assured that changes do not occur to plans mid-stream that limit access to proscribed drug treatments.

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