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Good morning Senator Larson, Senator Kelly, Representative Scanlon and members of the Insurance and Real Estate Committee.

First I would like to express my support for SB 378, AN ACT CONCERNING REIMBURSEMENTS UNDER CERTAIN HIGH DEDUCTIBLE HEALTH PLANS, SB 379, AN ACT LIMITING CHANGES TO HEALTH INSURERS' PRESCRIPTION DRUG FORMULARIES, and SB 380, AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES; these are bipartisan bills on which I am proud to be working with Senator Fasano, Senator Gerratana and Senator Somers.

I am also here to express support for HB 5383 AN ACT CONCERNING DISPUTES BETWEEN HEALTH CARRIERS AND PARTICIPATING PROVIDERS THAT ARE HOSPITALS, HB 5384 AN ACT CONCERNING PRESCRIPTION DRUG COSTS, HB 5382 AN ACT CONCERNING CONTINUITY OF CARE AND NETWORK ADEQUACY, HB 5380 AN ACT CONCERNING CLINICAL PEER REVIEW PERFORMED FOR PURPOSES OF A UTILIZATION REVIEW, SB 384 AN ACT CONCERNING MENTAL HEALTH PARITY, DATA REPORTED BY MANAGED CARE ORGANIZATIONS AND THE ALL-PAYER CLAIMS DATABASE, and SB 383 AN ACT CONCERNING ALTERNATIVE TREATMENT OPTIONS.

The concept behind SB 378 is that physicians' are trained to provide medical care; they are not supposed to be bill collectors and administrators for insurers. This bill will require some drafting changes to accomplish its intent which is that insurers offering high deductible plans should allow providers to directly bill the insurer for covered services that are subject to the deductible and that the insurer should bill and collect the amount to be paid from the policy holder. Insurers already have sophisticated billing mechanisms and they are better equipped to perform these functions.

SB 379 would protect patients from formulary changes during their policy terms. It is simply unfair that if a patient buys a health insurance policy that includes prescription drug coverage for a specific drug that the health insurer can change the formulary during the policy term and exclude that drug. I would support stronger legislation that prohibited these formulary changes. This bill does not bar all formulary changes; it will, however, require that if there is a formulary change and the physician states that the specific drug is medically necessary, then the insurer would have to cover the specific medication for the remainder of the policy term. The bill also requires a 60 day notice for formulary changes. Again on this bill I have some drafting suggestions; it should clearly state that if the physician states that the medication is medically necessary then the insurer would have to cover it for the policy term.

SB 380 address the situation in which a patient is prescribed a drug and the insurer defies the physician's order and determines that the drug is not medically necessary for the patient. This proposal would require the insurer to cover the drugs during the course of the appeal. It would provide protection to patients during the

course of the entire appeal process. This legislation would assist patients in receiving appropriate care that has been authorized by a patient's treating physician. In addition, it would encourage the insurer to resolve the appeal with reasonable speed. It is also important to make sure that the ACA's protections for concurrent reviews are included in Connecticut statute.

HB 5383 addresses a major concern, protecting patients during the disputes between insurers and hospital systems(which seem to be occurring with increasing frequency). Contract disputes between health systems and insurers put patient care at risk. Both the hospitals and the insurers have engaged in brinkmanship with a seeming disregard for the wellbeing of the patients. This is an unacceptable situation for patients. Prior to the recent Hartford Healthcare and Anthem dispute, the insurer and provider have reached an agreement in the eleventh hour. These disputes have taken a serious toll on patients who had to (or at least had to consider) rescheduling needed procedures and researching alternative providers. I realize that insurers and the hospitals will claim that the current negotiation process works. I ask, for whom does this process work? Certainly it does not work for the patients who, after having selected a physician and/or hospital, are suddenly told that those providers will no longer be covered. And later after the patient has selected new providers he or she will likely be informed that actually the former provider is back in the network. This brinkmanship puts patient health at risk and exposes the fact that some sectors of our healthcare system put profits ahead of patients. These standoffs clearly illustrate that the current highly consolidated healthcare market requires additional government oversight

to protect patients. Residents of our state deserve better. I have been proposing legislation for a few years that would require a mandatory cooling off period followed by mediation. While not bound to that specific solution, we must be determined to ensure that patients are held harmless during these disputes[1]. Again, if a patient selects an insurance plan that includes treatment by a specific hospital, the patient expects that for the entire policy term treatment at that hospital will be covered as in-network. It is unconscionable that the insurers and the health systems essentially use patients as hostages in order to extort concessions from each other. This bill would require that the health carrier and the participating provider give 90 days notice (current law is 60) and that if they do not come to terms there would be a 60 day "cooling off" period. I do not believe that this is sufficient[2], but it is at least a start.

HB 5384 would require increased transparency regarding prescription drugs; this legislation would increase transparency requirements for Pharmacy Benefits Managers, Insurers, and Pharmaceutical companies. I strongly believe that true transparency can change behavior. While this bill doesn't create a drug review board, it is a very meaningful first step.

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[1] The legislation would ideally[1]

a. Require that physicians cannot become out of network during the patient's policy term. If a patient selects a plan that has the patient's desired physician in-network, that physician shall not become out of network during the term of the policy.
b. Require that during the time that the parties are negotiating after the insurer and the provider are no longer under contract with each other, the patient shall be held harmless and shall not have to pay more than the in-network cost sharing. The provider and the insurer shall follow the reimbursement mechanism set up for out of network emergency services in PA 15-146[1] and the provider shall bill the insurer directly.
c. Require that the parties continue negotiating for a specified time and allow either party to request mediation. If the specified term ends without agreement, require mediation
d. Require that the terms of these agreements be made available to the insureds

HB 5380 would strengthen the definition of "clinical peer" for the purposes of utilization review. This legislation would ensure that the clinical peer reviewing an adverse determination hold a Connecticut license AND practice in the specialty that normally treats the specific condition. This would improve the quality of care in our state.

SB 384 addresses mental health parity which is clearly a crucial need for our state and nation.

HB 5382 would expand the definition of "active course of treatment" in order to increase continuity of care for patients during disputes between health systems and health carriers. This measure would lessen the ill effect of these disputes on patients.

SB 383 would strengthen Connecticut's network adequacy law and also require that patients be offered additional information regarding adverse determinations.

Thank you for hearing all of these bills of extraordinary importance and I look forward to working closely with all of you to enact these meaningful patient protections.