Revised

SENATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
New Haven, Hamden & North Haven

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

Thursday, February 7, 2019

Good Afternoon Senator Lesser, Representative Scanlon and members of the Insurance and Real Estate Committee. I would like to testify in support of several bills today. I hope and expect that many of these proposals will have bipartisan support; some of these ideas are new this year while others have been before the General Assembly in past sessions. All of them would provide important patient protections.

SB 42, AN ACT CONCERNING COST-SHARING UNDER HEALTH INSURANCE POLICIES, would protect patients from practices in which insurance carriers bill an insured at a copayment or coinsurance rate that is higher than the rate that an uninsured person would be billed for the same service. I became aware of this issue, in which an insurer manipulates the amount billed such that an insured can actually be charged more than 30 times the charge to an uninsured patient, because there is a pending class action suit against Cigna on this matter. Included in the Judge's order that denied (on most counts) Cigna's motion for summary judgment is this example of the insurer's fraudulent behavior[1]:

[1] https://www.docketbird.com/court-documents/Neufeld-v-Cigna-Health-and-Life-Insurance-Company-et-al/ORDER-granting-in-part-and-denying-in-part-a-class-internal-cross-reference-link-href-55-55-a-Motion-to-Dismiss-Signed-by-Judge-Warren-W-Eginton-on-8-30-18-Ladd-Smith-I/ctd-3:2017-cv-01693-00097

"As one example of Cigna's fraudulent scheme as it relates to plaintiff Srednicki, on June 19, 2017, she obtained a blood test from Laboratory Corporation of America Holdings (doing business as "LabCorp"), an in-network provider. **The cash price for this test to an uninsured customer of LabCorp was only $449.00**. Nevertheless, Cigna listed on the EOB that the provider was "HLTH DIAG LAB"—not the actual provider, LabCorp—and that the "**Amount Billed" was an astounding $17,362.66,** almost 40 times greater than the uninsured cash price. Cigna claimed on the EOB that it had provided a "Discount" of $14,572.66, over 32 times greater than the cash price, and that the "Covered Amount" for the test with a cash price of $449.00 was $2,787.00, more than 6 times greater than the cash price. Cigna further stated on the EOB that of the "Covered Amount" of $2,787.00, the plan paid $471.02 (roughly the cash price) and plaintiff Srednicki was required to pay an additional $2,315.98 in deductible and coinsurance payments. Id. at ¶ 14.

These laboratories also appear some affiliation with the insurer[2] Clearly this practice is extraordinarily unfair to patients and thus should be prohibited.

SB 39, AN ACT LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES DURING THE TERM OF CERTAIN HEALTH INSURANCE POLICIES, 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

[2] Upon information and belief "HLTH DIAG LAB" is a doing-business-as pseudonym for Cigna-affiliate Cigna Healthcare of Arizona, Inc. Cigna, through yet another business name, "Cigna Medical Group," wrongfully and fraudulently "balance-billed" plaintiff Srednicki $2,315.98. According to a statement at the bottom of its bill, Cigna Medical Group "is the medical group practice division of Cigna HealthCare of Arizona, Inc." When contacted by plaintiff Srednicki's doctor, the actual lab provider, LabCorp, confirmed orally (but would not do so in writing) that it had been paid in full by Cigna with a payment of $471.02."

would like to suggest that the bill be drafted to create a new statute section rather than amending current statute sections 38a-492f and 38a- 518f. Nevada law prevents this non-medical switching with clear language. [3]

SB 36, AN ACT PROHIBITING HEALTH CARRIERS FROM REQUIRING THE USE OF STEP THERAPY FOR CERTAIN PRESCRIPTION DRUGS, would strengthen patient protections vis a vis insurers use of step therapy. While there are legitimate uses of step therapy, too often it is implemented in a manner that interferes with patient care.

---

[3] **NAC 689A.425 Coverage for prescription drugs: Removal from approved formulary prohibited; exception; movement to different tier in formulary; addition of drug to formulary.** (NRS 679B.130, 687B.120, 689A.710)

1. Except as otherwise provided in this section, an individual carrier that offers a health benefit plan which provides coverage for prescription drugs and uses a formulary that has been approved by the Commissioner pursuant to NRS 687B.120 shall not:

(a) Remove a prescription drug from the formulary; or

(b) If the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance,

during the plan year for which the formulary was approved by the Commissioner.

2. An individual carrier described in subsection 1 may:

(a) Remove a prescription drug from a formulary at any time if:

(1) The drug is not approved by the United States Food and Drug Administration;

(2) The United States Food and Drug Administration issues a notice, guidance, warning, announcement or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) The prescription drug is approved by the United States Food and Drug Administration for use without a prescription.

(b) If the individual carrier's formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a brand name prescription drug to a tier with a larger deductible, copayment or coinsurance if the individual carrier adds to the formulary a generic prescription drug that is approved by the United States Food and Drug Administration for use as an alternative to the brand name prescription drug at:

(1) The benefit tier from which the brand name prescription drug is being moved; or

(2) A benefit tier that has a smaller deductible, copayment or coinsurance than the benefit tier from which the brand name prescription drug is being moved.

3. This section does not prohibit an individual carrier from adding a prescription drug to a formulary at any time.

4. This section does not apply to a grandfathered plan.

5. As used in this section:

(a) "Health benefit plan" has the meaning ascribed to it in NRS 687B.470.

(b) "Individual carrier" has the meaning ascribed to it in NRS 689A.550.

(Added to NAC by Comm'r of Insurance by R074-14, 12-21-2015, eff. 1-1-2016)

Public Act 14-118 ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY created certain patient protections regarding insurance carriers' use of step therapy. However, patients and providers continued to have situations in which the carriers' step therapy policies prevent the patients from receiving the treatment that their health care providers have decided is the most appropriate. In some cases this has delayed effective treatment which can leave patients with diminished health outcomes. In 2017 PA 17-228, AN ACT CONCERNING STEP THERAPY FOR PRESCRIPTION DRUGS PRESCRIBED TO TREAT STAGE IV METASTATIC CANCER, recognized these continued patient struggles and further regulated the use of step therapy in certain cancers. However, the use of step therapy continues to be particularly problematic for chronic disease and cancer patients. SB 36 would ensure that the physician is able to provide the best treatment for patients.

SB 28, AN ACT CONCERNING REIMBURSEMENTS UNDER CERTAIN HIGH DEDUCTIBLE HEALTH PLANS, would require that health carriers that issue certain high deductible plans directly reimburse participating providers. Currently under these plans the provider must bill the patient and then the patient must submit the bill to the insurer. The current status forces providers to become bill collectors which isn't a rational system.

SB 43, AN ACT PROHIBITING HEALTH CARRIERS FROM DENYING COVERAGE FOR CERTAIN COVERED BENEFITS PROVIDED IN HOSPITAL EMERGENCY ROOMS would address a fairly new policy being used by some health insurance carriers. There have been numerous news stories about insurance carriers retrospectively refusing to cover emergency room costs. While it makes to encourage patients not to seek unnecessary treatment in an emergency department, it is dangerous to expect laypersons to

decide if a condition requires emergency treatment. What if a patient has chest pain and goes to an emergency department. That is obviously a reasonable choice under the prudent layperson standard as defined in federal law[4]; the patient cannot be expected to know if this chest pain is caused by a heart attack (clearly an emergency) or gastric reflux (not an emergency). It seems entirely unreasonable for an insurer to retrospectively decide it will not pay because the insurer decided that what the patient had wasn't time sensitive. Also this policy could be dangerous; it could cause a patient with a deadly condition to forego or delay a trip to the emergency room because of fear of being stuck with the bill[5].

SB 30, AN ACT PROHIBITING COPAYMENT ACCUMULATOR PROGRAMS, would prohibit insurers from implementing Copay Accumulator programs. These programs use patients as hostages in the battle of insurers and pharmacy benefits managers versus pharmaceutical companies. While the high price of prescription drugs is an enormous problem, the answer to this problem is NOT taking more money from patients.

According to Geoffrey Joyce, a pharmaceutical economist at the University of Southern California:"There are no good guys here," "This is about control of the market."

The only thing that's clear is who loses. The loser is the patient,[6]"

Under Copayment Accumulator programs, any copayment assistance that a patient receives (whether directly from a pharmaceutical manufacturer or from coupon cards such as Good RX) does not count toward the patient's deductible. An article in Health Affairs describes it this way:

---

[4] https://www.law.cornell.edu/cfr/text/42/438.114

[5] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/
https://www.cbsnews.com/news/anthem-among-health-insurers-refusing-to-pay-er-bills-doctors-say/

[6] said Geoffrey Joyce, a pharmaceutical economist at USC.

"These programs change the calculus for patients by no longer applying the copay coupons to patient deductibles and out-of-pocket maximums. Patients must spend more out of pocket to reach their deductible; sometimes thousands of dollars more. For too many patients, this makes the drugs they depend on unaffordable[7]"

The PBMs claim that these drug coupon cards incentivize the use of brand name drugs; however, 87% of the cards are used for drugs that have no generic equivalent[8]

It appears that these programs may allow insurers to double dip because they get their full co-pays while also extending the duration of patients' deductibles. Connecticut should protect its residents from this practice.[9]

SB 29, AN ACT CONCERNING THE BURDEN OF PROOF DURING ADVERSE DETERMINATION AND UTILIZATION REVIEWS, would create a presumption that treatment that is ordered by a physician is medically necessary treatment. Generally in law, the burden of proof in any case is placed on the party who has the relevant information and knowledge. SB 29 would bring appeals of adverse determinations in line with most areas of the law. Here, the insurer is the only party with knowledge as to why a claim was denied. In appeals of adverse determinations, neither the patient nor the provider know why the payer declined to cover a service. Despite this reality, under the current framework the burden of proof in these appeals is on the patient and the provider. In fact prior to PA 12-102 the patient and provider didn't even have the right to access the record that the insurer used to make the decision. In

---

[7] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/

[8]

[9] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/ http://www.latimes.com/business/lazarus/la-fi-lazarus-healthcare-copay-accumulators-20180427-story.html

addition, an insurer is not licensed to practice medicine and its judgment as to what is medically necessary for a patient should hold far less weight than that of the treating physician. The insurer could still, of course, deny claims under this framework; it would simply have to prove that the treatment was not medically necessary.

SB 31, AN ACT CONCERNING SURPRISE MEDICAL BILLS FOR LABORATORY SERVICES, would strengthen the protections from surprise billing that were included in PA 15-146. That act (which has become a model for other states[10])[11] reformed many aspects of our healthcare system but as is often true, once enacted, legislation may require small adjustments and we have heard from constituents and read in the literature[12] that lab services can still be an issue. PA 15-146 gave patients protection from surprise billing and SB 31 would simply ensure that laboratory services are included in these protections. Under this bill, if a patient's samples are sent to an out of network lab without the patient's knowledge, then the patient would be required to pay only the in-network cost sharing and the lab would have to accept the in-network rate as payment in full. Our intent had always been that laboratory services should have been covered under PA 15-146 and this bill will make that a reality. In fact Sec. 38a-478q would appear to already require that Managed Care Plans send samples to covered labs.[13].

[10] https://www.fiercehealthcare.com/practices/physician-coalition-takes-aim-at-surprise-medical-bills-physicians-for-fair-coverage

[11] http://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-consumer-protections-states

[12] For example, we want to avoid this https://khn.org/news/liquid-gold-pain-doctors-soak-up-profits-by-screening-urine-for-drugs/

[13] **Sec. 38a-478q. Use of laboratories covered by plan required.** Each provider, as defined in section 38a-478, in utilizing laboratories or testing facilities for enrollees in managed care plans that provide coverage for laboratories and testing facilities, shall utilize laboratories or testing facilities covered by the enrollee's managed care plan or notify the enrollee if the provider intends to utilize a laboratory or testing facility not covered by the plan.

SB 33, AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED PRESCRIPTION DRUGS, would create greater equity in our healthcare system by extending to all patients the protections that we previously extended to cancer patients. In 2010, the Connecticut General Assembly passed PA 10-63, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS (now Sec. 38a-504) which addressed the fact that many current therapies can include oral rather than intravenous chemotherapy. Unfortunately, this provision applies only to cancer therapy and there are a number of other diseases that are now best treated with these types of medications. The oral medications can include biologics/biopharmaceuticals which have revolutionized care for some diseases and have offered many patients literally a new lease on life. However, these drugs are often extraordinarily expensive. Many of the drugs come in pill form and thus are covered as prescription drugs rather than as medical expenses. Many health plans would cover 100% of an IV infusion but only a percentage of a prescription drug. Thus, if the biologic/biopharmaceutical cost was $5000 per month and the patient had a plan that paid 80% of prescription drug costs, that patient would have to pay $12,000 per year out of pocket, while the out of pocket cost if the procedure was an IV infusion would be $0. This seems an absurd result since oral drugs would seem to save the healthcare system time as well as money. These new drugs are making many diseases manageable but it would appear that the practice of medicine, our healthcare system, and the insurance industry have not caught up with the power and convenience of these new drugs

SB 37, AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF PRESCRIBED DRUGS DURING ADVERSE DETERMINATION REVIEWS AND

EXTERNAL REVIEW PROCESSES, would 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.

SB 38, AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS, would decrease the timeframe for expedited reviews; this time frame was unfortunately lengthened in PA 11-58. Under the current system, the insurer has 72 hours to respond to an urgent care request; in some cases 72 hours can put a patient in serious danger. I have in past years proposed and still prefer a 24 hour timeframe which is the current requirement for mental health urgent care requests. The American Medical Association and the American Hospital Association have included among their joint policy goals[14] a 24 hour time frame for urgent care requests. Clearly 24 hours represents a superior policy; however, even 48 hours would be a significant improvement from current state law.

SB 40, AN ACT REQUIRING SITE-NEUTRAL PAYMENTS FOR HEALTH CARE SERVICES, would establish site neutral payment policies in Connecticut. SB 811 (PA 15-146) originally had contained a provision to create site neutral payment policies between physician owned practices and hospital owned outpatient practices. The site neutral reimbursement

[14] https://www.ama-assn.org/health-care-coalition-calls-prior-authorization-reform

provision was ultimately removed in order to facilitate passage of the bill. The disparity in pricing for the same procedure at different sites of service goes beyond any rational explanation. One of the arguments used against including site neutral payment policies in that bill was that this policy had never been implemented anywhere. However, since then this policy has been included by Congress (regarding Medicare) in budget deals since 2015. There are a variety of ways to move towards site neutral payment policies and I would be pleased to work with you on them.

SB 34, AN ACT CONCERNING SHORT-TERM HEALTH INSURANCE, would require that short term health insurance plans cover essential health benefits, thus protecting patients who, for whatever reason, choose to purchase these plans.

SB 87, AN ACT PROHIBITING DISCRETIONARY CLAUSES IN DISABILITY INCOME INSURANCE POLICIES, and SB 41, AN ACT PROHIBITING DISCRETIONARY CLAUSES IN HEALTH INSURANCE AND DISABILITY INCOME POLICIES, would protect residents who have purchased disability insurance policies. Many disability insurance policies contain clauses that grant discretionary authority to the insurance company. These clauses require that the court reviewing the decision must give deference to the insurance company's decision applying what is called an "arbitrary and capricious" standard of review[15]. However, many states have prohibited these clauses because an insurance company has a conflict of interest in both making the decision whether a person is "disabled" and then paying the

[15] The clauses read something like "The plan administrator has sole discretionary authority to determine eligibility for benefits or to interpret the terms or provisions of the policy or contract."

monetary benefit. A number of states have made it illegal to enforce such discretionary clauses[16]. The National Association of Insurance Commissioners has model language on this issue.

Thank you for hearing these bills of extraordinary importance and I look forward to working with you on these issues.

[16] https://www.erisadisabilitybenefits.com/longtermdisability/discretionaryclausesbannedinerisapolicies.html "The plan administrator has sole discretionary and authority to determine eligibility for benefits or to interpret the terms or provisions of the policy or contract."

SB 42 AN ACT CONCERNING COST-SHARING UNDER HEALTH INSURANCE POLICIES.
SB 36 AN ACT PROHIBITING HEALTH CARRIERS FROM REQUIRING THE USE OF STEP THERAPY FOR CERTAIN PRESCRIPTION DRUGS.
SB 39 AN ACT LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES DURING THE TERM OF CERTAIN HEALTH INSURANCE POLICIES.
SB 28, AN ACT CONCERNING REIMBURSEMENTS UNDER CERTAIN HIGH DEDUCTIBLE HEALTH PLANS
SB 43 AN ACT PROHIBITING HEALTH CARRIERS FROM DENYING COVERAGE FOR CERTAIN COVERED BENEFITS PROVIDED IN HOSPITAL EMERGENCY ROOMS.
SB 30 AN ACT PROHIBITING COPAYMENT ACCUMULATOR PROGRAMS.
SB 29 AN ACT CONCERNING THE BURDEN OF PROOF DURING ADVERSE DETERMINATION AND UTILIZATION REVIEWS.
SB 31 AN ACT CONCERNING SURPRISE MEDICAL BILLS FOR LABORATORY SERVICES.
SB 33 AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED PRESCRIPTION DRUGS.
SB 34 AN ACT CONCERNING SHORT-TERM HEALTH INSURANCE.
SB 37 AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF PRESCRIBED DRUGS DURING ADVERSE DETERMINATION REVIEWS AND EXTERNAL REVIEW PROCESSES.
SB 38 AN ACT REDUCING THE TIME FRAME FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS.
SB 40 AN ACT REQUIRING SITE-NEUTRAL PAYMENTS FOR HEALTH CARE SERVICES.
SB 87 AN ACT PROHIBITING DISCRETIONARY CLAUSES IN DISABILITY INCOME INSURANCE POLICIES.
SB 41 AN ACT PROHIBITING DISCRETIONARY CLAUSES IN HEALTH INSURANCE AND DISABILITY INCOME POLICIES.