

Insurance and Real Estate Committee JOINT FAVORABLE REPORT

Bill No.: HB-6096

AN ACT LIMITING CHANGES TO HEALTH INSURERS' LISTS OF COVERED
Title: OUTPATIENT PRESCRIPTION DRUGS.

Vote Date: 3/19/2019

Vote Action: Joint Favorable Substitute

PH Date: 2/14/2019

File No.:

***Disclaimer:** The following JOINT FAVORABLE Report is prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and does not represent the intent of the General Assembly or either chamber thereof for any purpose.*

SPONSORS OF BILL:

Insurance and Real Estate Committee

REASONS FOR BILL:

The bill addresses the disruption in treatment and higher out of pocket costs to insured caused by changes to the drug formulary occurring during the plan year. The bill does this by limiting mid year changes to the formulary to drugs found to be unsafe by the FDA or approved by the FDA for non-prescription use and restricts the reclassification of drugs to cause a greater co-pay, or larger deductible to the plan holder.

SUBSTITUTE LANGUAGE:

The Substitute Language rewrites the pertinent sections for clarity and continuity. It also makes clear that drugs may be added to the formularies at any time.

RESPONSE FROM ADMINISTRATION/AGENCY:

[The State of Connecticut Insurance Department](#) took no position on the bill as written at the time of the Public Hearing and indicated they would comment and advise when the particulars of implementation were laid out.

NATURE AND SOURCES OF SUPPORT:

[Rep. Michelle Cook, 65th Assembly District](#), supported the bill's intent for several reasons and presented a draft substitute for consideration. She said that under prevalent negotiating protocols insurers lock in prices for a particular drug from a pharmaceutical company when it is accepted to the formulary and there is no overriding financial need for insurers to move a

drug to a higher cost tier mid plan year or to remove a drug's availability. She said she could think of no other example where terms of a contract could be unilaterally and substantially changed by one side without the other side's consent and without recourse to seek a contract with a different provider. She highlighted the ability to discontinue a treatment/drug mid plan year if it was deemed unsafe by the Federal Drug Administration and did not challenge the insurers ability to change terms of the formulary at the time of open enrollment. She said the bill still allowed the substitution of generic formulas that did not have adverse medical or financial impacts with consultation of the healthcare provider. She provided the Committee with information from 50 State Network illustrating the negative health impacts on those who had experienced non-medical switching of treatments and drugs.

Sen. Martin Looney, 11th District, President Pro Tempore, supported the bill because of the underlying issue of drug formularies changing a patient's access to a prescribed drug mid contract is "unfair". He expressed caution on basing necessary changes to the formulary on non FDA criteria as too broad and subjective.

Mariam Hakim Zagar, President , CT Orthopaedic Society supported the bill because it would protect patients from have treatments and treatment regimens substantially altered at a time when the insured is unable to seek and purchase other healthcare plans.

Ted Doolittle, Healthcare Advocate for the State of Connecticut supported the bill. He noted that consumers often make their healthcare plan choice based on promised drug coverage and that changes to that coverage, outside of the enrollment period, should to be limited. He also stressed his support of insurance carriers having the ability to add, move and remove drugs on the formulary as a way to pressure pharmaceutical companies towards lower, competitive pricing. However, those negotiations should not affect consumers mid contract and mid treatment.

Kathleen Flaherty, Esq. of Connecticut Legal Rights Project, Inc., supported the bill emphasizing that many people pick their plans based on the drug formularies and to change those drugs and their out of pocket costs mid year was not in the consumer's interest and the insurers should be required to provide the coverage that they put forth at the time the plan was selected.

NATURE AND SOURCES OF OPPOSITION:

April Alexander, on behalf of the Pharmaceutical Care Management Association (PCMA), opposes the bill stating that eliminating the ability of insurers to move or remove drugs from the formulary at any given time negates the insurer's capacity to hold down prices and thus costs to the consumers. Limiting this flexibility would also discourage the use of new, more effective and lower cost alternatives.

Christine Cappiello, Anthem Blue Cross and Blue Shield, opposed the bill pointing out that the inability of insurers to move a brand drug to a higher tier or off the formulary, especially when an equally effective new brand comes on line, depresses the incentive for drug makers to offer their products at a competitive price, costing consumers. An example was given about very costly drugs to treat Hepatitis C. When a lower cost alternative came on the market, the move to higher tiers encouraged the lower cost treatment, not only saving the individual consumer but consumers as a whole.

The [Connecticut Conference of Municipalities](#) opposed the bill focusing on the impact to municipality costs in the form of higher premiums, a cost that is passed on to residents in the form of higher property taxes.

[Janice Perkins from Connecticare](#) opposed the bill and gave testimony detailing the process whereby insurers submit their proposals to the state in the May before the open enrollment period, thus placing the price freeze for eighteen months and not just twelve. Another aspect to consider was that Large and Small group clients don't renew on January 1st when Exchange formulary changes would be allowed. Confusion would result from the posting of changes for one group and not the others. Current law notifies the insured at their pharmacy and allows for a 60 day period for the patient and healthcare provider to appeal the change, protecting the consumer from adverse changes.

[The Connecticut Association of Health Plans](#) encouraged opposition to the bill because protections for the consumer are already in law. They cited the 60 day appeal process and the protections in place for drugs and treatment for chronic illnesses when the attending healthcare providers attest their medical necessity. They felt that further regulation would not protect the consumer but in fact would cost the consumer in higher premiums and deductibles

[The Universal Health Care Foundation](#) opposed the bill because it did not ban any and all changes to the formulary during a plan year, with the exception of those found to be unsafe, but proposes a 60 day appeal window. They say that moving drugs mid year to higher tiers just moves the cost to the consumers who are unable to seek enrollment in different plans for a year. They likened the practice to "bait and switch".

Reported by: Elizabeth Gillette

Date: March 25, 2019