# Insurance and Real Estate Committee
# HOUSE FAVORABLE REPORT

**Bill No.:** HB-5361
**Title:** AN ACT LIMITING CHANGES TO PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS.
**Vote Date:** 3/10/2020
**Vote Action:** Joint Favorable
**PH Date:** 3/3/2020
**File No.:**

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**SPONSORS OF BILL:**

Insurance and Real Estate Committee

**REASONS FOR BILL:**

To prohibit insurers from altering formulary coverage, with limited exceptions concerning safety of certain medications, during a formulary contract year. This will protect consumers from a "bait and switch" tactic sometimes used by insurers that causes them to be locked into an insurance plan for a year that does not cover, or exponentially raises the price of, the medications that they need.

**RESPONSE FROM ADMINISTRATION/AGENCY:**

**Kevin Lembo, Comptroller, State of CT:** "We are here today because one half of Connecticut's population is worried about affording their prescriptions. This fear of prescription costs spans across all insurance statuses – commercial, employer, Medicaid, Medicare, and no insurance. Connecticut residents have reported taking extreme measures because they struggle to afford their prescriptions. Fifteen percent did not refill a prescription, 13 percent cut pills in half or skipped a dose, and 20 percent did one or both of these. Connecticut is one of the wealthiest states in the wealthiest country in the world! Our residents should not sacrifice their health because they cannot afford their medication and that is why I support H.B. 5366. The health of our residents must be a priority - and that means ensuring that monthly drug prices are manageable and predictable. Allowing anyone to be deprived access to life-saving medications due to cost does not align with Connecticut values. This aggressive set of policies are a signal that the state is tired of the old way of doing things, and that we are ready for a change to keep Connecticut residents healthy."

**NATURE AND SOURCES OF SUPPORT:**

**Representative Michelle Cook, CT General Assembly:** "Presently, CT insurers are not required to honor the terms of the prescription coverage contract they advertise and sell to consumer… Insurers are free to change or adjust their formularies during open enrollment, when consumers have a fair chance to review and compare their options… Not only do contracts with pharmaceutical manufacturers mean insurers likely pay less than the public price of medications, but most have cost caps and even cover multiple years—making it even more unfair that a consumer's pharmacy benefits can currently be reduced within the plan year."

**Representative Jason Doucette, CT General Assembly:** "Currently, health care insurers are allowed to add or remove drugs from plans' formularies at any time or change the coverage tiers for drugs with 60 days' notice. This bill would place limitations on insurers' ability to make those changes in the middle of a plan year without giving consumers the option to potentially switch their coverage plan. These changes can be devastating to vulnerable patients who are faced with the choice of coming out of pocket to make up the difference, accepting a less effective alternative medication, or perhaps even discontinuing their medication when coverage is lost. Furthermore, I see this bill as an important piece of our efforts generally to control the price and accessibility of life saving prescription drugs."

**Senator Martin Looney, CT General Assembly: "**The costs of potentially life-saving prescription drugs are out of control.... Price gouging affects every Connecticut resident. According to the CT Health Policy Project, Connecticut is second in most spent per person on prescription drugs. We must be committed to finding common-sense solutions to ensure Connecticut residents have access to affordable prescription drugs, and that is why I support H.B. 5366. The aggressive policy initiatives in the bill include capping the monthly out of pocket cost of prescription drugs, as well as a cap on the cost of prescription drugs tied to the consumer price index. …. Section 11 of the bill adopts the same provisions in H.B. 5361, a bill I strongly support because it would protect patients from formulary changes during the term of their health insurance policies. 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 then change the formulary during the policy term and exclude that drug."
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**NATURE AND SOURCES OF SUPPORT:**

**AARP:** "On average, older Americans take 4.5 prescription drugs per month,3 and they rely on their health insurance to help them access the medications they need to improve or maintain their health. When individuals buy health insurance, they choose plans that make the most sense for their budgets and, more importantly, for their health needs. With few exceptions, when consumers enroll in a health plan, they are locked in until the termination of the plan year, and they do not have the ability to make changes to the terms of that plan. Unfortunately, the same rules do not apply to insurers. Under current Connecticut law, there is little to stop a health insurance provider from marketing a plan as providing expansive formulary coverage and then significantly changing the benefit package once an individual is enrolled in the plan. AARP believes that a health insurance provider should be held to the drug formulary it markets to consumers, absent limited circumstances such as the availability

of a new FDA-approved prescription drug or when prescription drugs are withdrawn for safety reasons."

**Michael Aranow, M.D, President, CT Orthopaedic Association:** "We are writing to share our Society's support of both bills and to extend the orthopaedic community's collective thanks to the Committee for initiating this bill seeking to protect consumers from health insurers' egregious practices of changing the terms of a health care insurance contract during a coverage period. Both of the bills being heard before you today are pro-consumer, patient-centered bills that will benefit our patients and relieve them of the burdensome insurance practices and policies that are harmful to their care and treatment. Connecticut citizens purchase health insurance and agree to pay monthly premiums for a year's worth of coverage promised and detailed in the benefits package. Currently an insurance company can change the formulary mid-year, but the consumer is not allowed to switch insurance companies. Why is the insurance company allowed to make changes during the contracted period, taking away a covered benefit, while the consumer is still expected to pay the same monthly premium? This constitutes a "bait and switch" tactic by a powerful industry that needs to be stopped immediately and penalized appropriately. Insurance companies that sell health insurance coverage in our State should only be able to change the formulary and/ or coverage for prescription at the time of open enrollment with 90 days prior notice."

**Lesley Bennett, CT Volunteer State Ambassador, NORD Rare Action Network:** "Health insurers and PBMs should have to honor their contracts with consumers like any other business in our state. The insurer/PBM practice of non-medical switching (which includes midyear formulary changes and pushing a patient's medication to a higher cost tier) often harms patients and their families who are trying to manage complex medical conditions and keep the patient stable (out of the hospital). It is a practice that undermines the doctor-patient relationship and makes it difficult for physicians to keep a patient on the most appropriate treatment plan."

**David Benoit, MHP, RPh Vice President, Patient Care Services Northeast Pharmacy Service Corporation** : "This legislation proposes to put all insurance plans in line with sound formulary principles as in most of the Medicare Part D plans. For an insurance company to change a co-pay tier or completely remove a prescription drug from their drug formulary within a plan year, can cause interruption in therapy for a patient, which depending on the patient's condition, could be extremely detrimental."

**Ruth Canovi, Director, Advocacy in CT, American Lung Association: "**Mid-year formulary changes can reduce a patients' access to needed medications. Patients need to be able to receive the medications and other treatments that their medical providers believe would be best for them. Navigating burdensome formulary changes for life-saving medication can also be challenging for both patients and providers. This can lead patients to delay or discontinue treatment, which ultimately leads to higher health care costs. The Lung Association supports the improvements that HB5361 will make it easier for patients to get the medications they need to breathe. HB5361 would limit mid-year formulary changes for medications and shield patients from increased prescription drug cost-sharing during a plan year."

**Michael Finley, Government Relations Advocate, Epilepsy Foundation of CT:** "The Epilepsy Foundation appreciates that cost-control is a worthy goal and, in general, it

enthusiastically supports providing patients with greater access to generic medications. The Foundation is committed to the welfare of people with epilepsy and their families, and the high cost of many name-brand medications is a particularly significant issue for people with epilepsy, many of whom will take medication on a daily basis for the remainder of their lives. The Foundation welcomes the opportunity that generic medications present to lower the overall costs of delivering effective healthcare to individuals and society. But the Foundation believes equally that short-sighted cost considerations should never be allowed to trump efficacy or take precedence over patient welfare."

**Kathleen Flaherty, Esq., Executive Director, CT Legal Rights Project Inc:** "People choose their health plans based on the information that the plans share about what drugs are included in coverage, at which level of cost-sharing. Once someone has signed a contract for coverage, the insurer should not be permitted to unilaterally change the terms of that coverage during the plan year, except in limited circumstances. No one should show up to the pharmacy to pick up a prescription, expecting the cost to be a particular dollar amount, only to be told by the pharmacist that the drug is no longer covered and therefore is only available to the individual if they can pay a significantly higher price. I have had that experience personally. I was lucky enough to have a credit card to cover the cost and bring my medication home. I was able to write a letter to my insurer, win that first level appeal, and get that money refunded. Not everyone is fortunate enough to be able to do that."

**Pamela Greenberg:** ."I am also a person living with multiple sclerosis (MS). As a person living with several chronic conditions, I rely on a good number of medications daily. Unfortunately, I also must spend a large amount of money on co-pays to control my conditions each year. Non-medical switching is the practice of insurance companies removing a drug from a covered formulary or moving it to a higher cost-sharing tier during the plan year. I have been subject to this several times in the past. As an example, I have had my cholesterol medication changed from a tier 2 to a tier 4 without notice from my insurance company. A prescription that I paid $30.00 a month for went up to $125.00 a month. I ask that you pass HB5361 which would guarantee that insurance companies stick to the contracts we sign up for at the beginning of the plan year."

**Laura Hoch, Manager of Advocacy, National Multiple Sclerosis Society:** "The National MS Society supports limiting the use of non-medical switching during an insurer’s policy term and we therefore support HB5361. Interference with a person’s course of treatment poses dangerous threats to their health and safety. We do encourage the committee to amend this bill to require that insurers provide notice if they plan to remove a drug from a covered formulary at the end of the policy term. This notice should be given before open enrollment begins so that the insured is aware of changes and can make an informed decision moving forward. We urge you to protect the residents of Connecticut, including those living with MS."

**Debbie Osborn on behalf of Connecticut Society of Eye Physicians, CT ENT Society, CT Dermatology and Dermatologic Surgery Society and the CT Urology Society:** "The burden of selecting health insurance programs is difficult. Even after wading through “legalese” and confusing contracts, patients and their families face high deductible policies, and restrictive formularies with high co-pays. Furthermore, even after signing the contract, unilateral changes can be made at the whim of the insurer. Tell me is it fair that a medication that has been covered for years can be suddenly and unexpectedly unavailable? Or that a medication that had preferred tier status may be moved to a higher tier with higher co-pays,

and burdensome “prior authorization” requirements? The medical community thinks not!... Patients are not the only victims. Practicing physicians in Connecticut must take precious time away from patient care to do endless appeals, prior authorizations, or even re-shuffle a medical regimen that has been stable (with potential for adverse reactions and side effects) because someone, or some committee, that never saw the patient has made disruptive medication changes. This undermines the doctor-patient relationship and can lead to instability and less favorable outcomes."

**Jill Zorn, Senior Policy Officer, Universal Health Care Foundation of CT: "**When individuals as well as employers choose a health plan, they often closely examine the drug formulary to inform that choice. In fact, consumers are constantly encouraged to “shop” for a plan that best meets their needs and those of their family. A prescription drug formulary, particularly for those who rely on medication to maintain their health or stay alive, is often a decision-making factor. An insurer should not be allowed to make a detrimental formulary change to a health plan after a consumer or employer has chosen to enroll. A change like this is akin to breaking a contract and is inherently unfair. Changes like this also contribute to unaffordable out-of-pocket costs. Alarmingly, a study of Connecticut residents who take prescription drugs regularly found 88 percent are worried they won’t be able to afford their medications. Worse, 20 percent said they either did not fill a prescription, cut pills in half, or skipped a dose due to concerns about cost."

**NATURE AND SOURCES OF OPPOSITION:**

**CT Association of Health Plans:** "The bill runs counter to other efforts aimed at reducing the price of pharmaceuticals. Prohibiting health insurers from removing a drug from, or changing a drug tier within, a formulary during a plan policy term would remove any leverage that carriers have to negotiate lower prices with pharmaceutical companies when prices spike or new drugs come to market. This legislation would prevent carriers from encouraging patients to use new lower costs alternatives, brand or generics, once introduced even if the new drug has fewer side effects and better outcomes. Such policies also run counter to supporting the practice of evidence-based medicine… Rather than further regulating plan formularies, we believe consumers would be better served by the legislature looking into ways they can prevent drug companies from arbitrarily increasing prices throughout the calendar year."

**Sam Hallemeier, Director, PCMA:** " Although health plans use formularies, if a patient needs to access a non-formulary drug, health plans and PBMs have in place appeals processes for patients to request coverage. The health plan or PBM works with a patient and their provider to provide access to non-formulary drugs where medically necessary and/or likely to create the best outcome. State legislations that seeks to disallow mid-year formulary changes eliminates an important tool in the fight against rising pharmaceutical costs."

**Reported by: Kaity Marzik** **Date: 5/1/2020**