Insurance and Real Estate Committee
JOINT FAVORABLE REPORT

Bill No.: HB-6622
Title: AN ACT CONCERNING PRESCRIPTION DRUG FORMULARIES AND LISTS OF COVERED DRUGS.
Vote Date: 3/22/2021
Vote Action: Joint Favorable
PH Date: 3/18/2021
File No.:

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SPONSORS OF BILL:

Rep. Jason Doucette, 13th Dist.
Rep. Michelle L. Cook, 65th Dist.
Sen. Martin M. Looney 11th Dist.
Sen. Saud Anwar, 3rd Dist.

REASONS FOR BILL:

The bill will limit the carriers' ability to remove safe and effective drugs from their formularies in the middle of the plan year and shift a safe and effective drug to a higher cost tier during the plan year. This bill protects patients from formulary changes during their insurance policy terms. I

RESPONSE FROM ADMINISTRATION/AGENCY:

Ted Doolittle, Office of the Healthcare Advocate is in favor of the bill. Under current law healthcare insurers may add or remove drugs from their formularies or shift individual drugs between coverage tiers any time during a plan year. Consumers can be negatively impacted when these changes occur in the middle of the plan year. Consumers spend substantial time and energy reviewing and comparing plans to select and enroll in the coverage that best suits their individual health care and prescription drug needs. When mid-year formulary changes occur consumers often cannot absorb the resulting increases in cost and the financial burden can result in negative medical consequences. This bill will impose reasonable limitations on permissible modifications. The bill will limit the carriers' ability to remove safe and effective drugs from their formularies in the middle of the plan year and shift a safe and effective drug to a higher cost tier during the plan year. Carriers will still have great flexibility to modify their prescriptions.

NATURE AND SOURCES OF SUPPORT:

Senator Martin M. Looney expressed support for the bill. This bill protects patients from formulary changes during their insurance policy terms. It is unfair for a patient to purchase an insurance policy and to have that policy change prescription formulary during the policy. When a physician and a patient choose a drug it may have some dangerous side effects but despite these danger it appears to be the best course of treatment. An insurer could contact a physician to share any safety concerns rather than denying coverage as a first step. I support the variety of coverage requirements as well as patient protections regarding ambulance billing. I applaud the language in this bill.

AARP testified that under current law there is little to stop a health insurance provider from marketing a plan as providing expansive coverage and then changing the benefit package once an individual has enrolled. Health insurance providers should be held to the drug formulary it markets to consumers. States with current policies relating to limiting nonmedical switching include: California, Illinois, Louisiana, Maryland, Nevada, New Mexico Texas, Indiana, Maine and Rhode Island. In 2019 AARP conducted a survey and 80% of older voters take at least one prescription on a regular basis and 72% say they are concerned about the cost and rely on their health insurance to help them access the medications they need.

Kathy Flaherty, Executive Director, Connecticut Legal Rights Project stated that people choose their health plans based on coverage of prescription drugs. It is unfair for a health insurance company to change the tiers of drug coverage in the middle of a plan year.

Connecticut State Medical Society believes that this bill will help solve a long-standing problem. Patients choose insurance plans based on several factors and one is having their medication at an affordable price. When these changes are made during the plan year it may leave a patient without a suitable alternative or a higher cost. The Global Healthy Living Foundation in 2016 surveyed patients in Florida about these changes. Sixty eight percent of those with chronic conditions said when the insurer reduced their coverage they were forced to switch to a different medication, they could not afford the increased cost. Fifty eight percent reported that the new medication was less effective.

Ruth Canovi, American Lung Association's Director of Advocacy appreciates this bill. Lung disease patients having an affordable and quality healthcare is a main priority. Clinical care for lung disease patients should follow evidence-based guidelines and coverage restrictions mid-year can impede access to guidelines-based care. Patients need to be able to receive medication and treatments that are best for them and to delay or discontinue treatment may lead to higher health care costs.

Laura Hoch, National Multiple Sclerosis Society encourages the committee to amend the bill to require insurers provide notice if they plan to remove a drug at the end of the policy term. The notice given before open enrollment gives the insured the ability to make informed decisions before enrollment. MS is often a disabling disease of the central nervous system that vary from person to person. Nearly 1 million people in the United States are living with MS and rely on their disease-modifying therapy medication (DMT). Non-medical switching can be made by insurers during a patient's plan year. Movement from one DMT to another should only occur for medical reasons and not because the insurance plan has

changed. Inference with a person's course of treatment poses dangerous threats to their health and safety.

Universal Healthcare Foundation of Connecticut expressed support of the bill. The bill stops negative changes to private health insurer's prescription during a plan year and permits positive changes. Individuals as well as employers choose a health plan that meets their needs and those of their family. In a 2019 study by the Alliance for Patient Access found:

1. Nearly 40% of patients found new medication not as effective
2. Almost 60% experienced complications from the new medication
3. Nearly one in 10 reported being hospitalized from complications
4. Two-thirds of respondents said the switch impacted their productivity at work
5. More than 40% were unable to care for their children, spouses or family members

Forty percent of Connecticut residents were worried they would unable to afford medication and 19 percent said they did not fill a prescription, cut pills in half and skipped a dose because of the cost.
A similar bill passed the house in 2019 with significant bipartisan support and then in 2020 but died because of the legislative recess caused by COVID-19.

Yale Dems, Josh Guo and Grace Wittington submitted testimony in support. Citizens of Connecticut rely on constant and consistent access to their medication. No person should face obstacles when obtaining healthcare due to a sudden mid-year cost switch by their for-profit insurer. Connecticut is already behind the curve. Several states like Texas have passed similar laws eliminating mid-year formulary changes.

Peter Swartz testified as a multiple sclerosis neuropathy and transverse myelitis patient needs this bill. The practice of non-medical switching is not right. This happened to me when I was on a drug for 13 years and then suddenly during a plan year my insurer removed this medication and told my doctor that I had to take a different medication. This medication had not previously worked in the past and I had to take 5 more capsules a day. When patients enroll in a plan they expect the insurers to live up to their contract.

Pamela Greenberg testified about her personal MS condition and medication. I rely on several medication and send a large amount of money on co-pays to control my condition. I have had my medications switched several times in the past. They have switched me from a tier 2 to a tier 4 without notice at an increase in price from $30 a month to $125 a month. Insurance companies should be made to stick to the contracts people signed up for.

Lauren LeClaire, Kennedy Bennett, Patrick Feeley ,Sarah McKinnis and Evan Roberts sent similar testimony supporting the bill. Connecticut is already behind the curve and needs to catch up with the rest of the nation on this issue

NATURE AND SOURCES OF OPPOSITION:

The Connecticut Association of Health Plans testified against the bill. State law already requires coverage for a drug in an insurer is using the drug for a chronic illness. There are strict step-therapy standards included in state statue. This is just one of many pharmaceutical bills we are opposing. Pharmaceutical prices increase premiums between 15% and 20% yearly. Connecticut's authority only applies to the fully-insured market.

Pharmaceutical Care Management Association thinks this bill would restrict their ability to make drug coverage more affordable. Restricting the ability to make formulary changes will increase health care costs for employers and individuals thru higher premiums and drug costs. This type of policy world cost health care payers $70 million over 5 years.

Reported by: Pamela Bianca **April 8, 2021**