DISABILITY RIGHTS CONNECTICUT
Justice. Community. Inclusion.

Disability Rights Connecticut
"Connecticut's protection and advocacy system"

846 Wethersfield Avenue
Hartford, CT 06114

March 17, 2022

Re: Testimony before Insurance and Real Estate Committee Regarding SB 415 (Exceptions to "Step Therapy" and Shifting of Burden of Proof to Insurers) and SB 416 (Anti-Competitive Hospital System Practices)

Good afternoon, Rep. Wood, Sen. Lesser and distinguished members of the Insurance and Real Estate Committee:

My name is Sheldon Toubman and I am the Litigation Attorney at Disability Rights CT. We are the Protection and Advocacy System for CT, serving individuals with a full range of physical, behavioral, intellectual and developmental disabilities. I am here to testify about the impact of **SB 415** and **SB 416** on people with disabilities.

First, regarding **SB 416**, disabled people not on Medicaid face significant costs due to higher and higher hospital-based prices, and anti-competitive practices by large hospital systems serve to drive up those prices. The consolidation of hospitals and providers into large health systems allows prices to rise largely unchecked and has reduced consumer choice.

The impact on people with disabilities is partly through higher premiums if they contribute to those costs. But even if they are insulated from premium increases due to employer or exchange subsidies, they still are saddled with paying coinsurance for a lot of hospital charges, i.e., they pay a direct percentage of the charge, so as hospital prices go up, their own costs go up. And, overall, people with disabilities use more hospital-affiliated services than do non-disabled people.

There are several anti-competitive practices used by large hospital systems, as has been well reported. One of them is the system requiring that all of its facilities en mass be placed on a best tier of value even when an insurer's tiering system is supposed to be designed to encourage consumers to select what in fact are high value providers. This subversion of efficiency ratings only serves to benefit the

large hospital systems seeking to manipulate the tiering system. To the extent this drives up the prices of individual hospital-based services, people with disabilities pay the freight in terms of a percentage of that charge.

Regarding **SB 415, Sections 1 and 2**, exempting from "step therapy" any drugs for treatment of "a behavioral health condition or a chronic, disabling or life-threatening condition or disease," this would significantly benefit individuals with a wide range of disabilities who currently find their access to treatment blocked.

First, the term "step therapy" is not about concerns that a person get the right kind of therapy, or even about "therapy" at all, but rather it is a tool used by insurers to **control costs** by requiring patients to first try and **fail** on cheaper drugs before they are allowed to obtain payment for a more expensive drug. Insurers don't interfere "therapeutically" unless it will be **cheaper** for them. (It is like calling "capitation" "prepayment" and pretending it is no longer "capitation.") A far more appropriate term for this cost-cutting technique is "*fail first*."

While problematic for everyone, this is particularly problematic for people with mental health disabilities for several reasons, as painfully laid out before the Public Health Committee on Monday in testimony on **SB 331** and **HB 5275**, which would prohibit "fail first" for all behavioral health drugs. The reasons include: (1) it is already such a challenging situation for providers trying different drugs which cannot be fully known in advance will work for which individuals, and have very serious side effects, (2) some behavioral health drugs are capable of causing not just serious but also **permanent** side effects which persist after the experiment is ended, (3) some patients are understandably reluctant to take these powerful drugs, such that this experimentation for the insurer's benefit may reasonably cause some of these individuals to give up on any medication therapy entirely, (4) in any event, fail first will likely delay crucial medically necessary treatment, (5) with the result of the person's mental health condition worsening, placing them at risk of harm and costly, restrictive institutionalization, or even suicide.

The Connecticut State Medical Society in its testimony on Monday urged a prohibition on **ALL** failed first requirements. But recognizing the reality for providers of patients with behavioral health and other disabling conditions in a difficult pharmacological environment, the severe side effects some of these drugs, and the results of delays in appropriate treatment, exempting at least

these drugs from fail first will significantly improve access to appropriate therapy for people with disabilities.

I did also want to address the false claim by the insurance industry representative at the Monday hearing that the supposed existing protections from fail list in law are sufficient. Specifically, she relied upon the fact that a person may be experimented on for ***only*** 60 days, and also claimed that anyone can get an "**automatic override"** to avoid this experiment.

First, 60 days can be a lifetime on the wrong medication, with the time to stop a disabling condition from turning into a suicide ticking away and/or the patient having to suffer from terrible side effects for two months. Second, what the statute says is just that a provider "may *request* at any time an override of the use of any step therapy drug regimen" and "an override request shall be expeditiously granted when an insured's treating health care provider *demonstrates*" one of several circumstances. *See* C.G.S. 38a-510(a)(b)(1) and 38a-544(b)(1). By its terms, this is hardly automatic. What this means in the real world was made clear by Monday's testimony from a long-time treating psychiatrist, M.D.S. Nissanka:

> "Step Therapy may slow down the process of starting a new medication. I have had difficult times finding which medications were tried and which dosage, and length of the treatment by going through the charts. In spite of sophisticated electronic health records, *the information is not readily available to a busy practitioner. Patients often cannot tell us accurately the information, which is needed for documentation*." 2022HB-05275-R000314-Nissanka, M.D.S., CRMHC-TMY.PDF (ct.gov) (emphasis added).

Finally, **Sections 4 and 6 of SB 415** will address the related burden of insurance companies' routinely second-guessing the judgement of treating providers regarding what is best for their patients, by requiring a rebuttable presumption in favor of the provider in prior authorization reviews: the insurer will need to prove **lack** of medical necessity. This is already the case under Medicaid law but applying this principle to commercially-insured individuals will significantly benefit people with disabilities, especially those with multiple conditions.

Thank you for the opportunity to speak with you today.