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JOINT
STANDING
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INSURANCE AND
REAL ESTATE
PART 8
2295 – 2657

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CHRISTINE CAPIELLO: Yeah, they make the distinction in preservice determinations and post service determinations and the appeals are different.

REP. SCHOFIELD: Yeah, they have different timelines.

CHRISTINE CAPIELLO: So now to make them -- this purports to make them the same on the appeals side. And that's why the state has a conflict. We believe it has a conflict on (inaudible).

REP. SCHOFIELD: Okay. Thank you.

SENATOR CRISCO: Thank you, Representative Schofield. Any other questions? Any questions? Thank you very much. Appreciate it.

No one to speak on House Bill 6472, 1085. We're now proceeding to Senate Bill 1083, Susan Halpin.

SUSAN HALPIN: Good afternoon again. Susan Halpin on behalf of the Connecticut Association of Health Plans. And if you don't mind while I'm up here I'll also just add my comments to Senate Bill 1084 as well as 1083 in the interest of your time.

The Connecticut Association respectfully urges your opposition to both bills. We believe they would seriously compromise the efforts of health plans to contain costs by using UR practices to help insure cost effected -- cost efficient and effective prescription drug use. 1083 that's before you would prohibit carriers from requiring that members try one brand name prescription pain drug before using another brand name prescription drug -- pain drug.

We don't know of any medical rationale for this approach. Carriers use step therapy -- requiring the use and failure of one drug before another may be covered because some drugs are very expensive. And yet they have no better clinical track record for outcomes than

some of the less expensive medications, brand or generic.

We believe that when no clinical advantage is apparent, any considerations -- cost considerations often warrant them moving members and providers to use the more cost effective drug. We believe there are provisions in place already.

Yet if the member needs to access that drug -- and we believe frankly without a formulary in these kinds of cost controls, pharmaceutical sales and marketing practices could play too large of a role in prescription drug choices.

Formularies are critical to controlling health care costs. It's also important to note within the context of this bill that drugs can be used for more than one purpose. And when that is the case pharmacists would not know -- for instance if a particular drug is being prescribed for pain management or some other purpose.

Many of the issues that I just describe also pertain to Senate Bill 1084, which kind of applies the same philosophy to tiered benefits. And tiering of benefits is something that's encouraged under health care reform. And its focus is on value based insurance design. And we believe that this legislation is simply contrary to PPACA and should not be made law.

Again, we believe tiered benefits are critical if we're serious about controlling health care costs, and we would urge your opposition to both bills.

SENATOR CRISCO: Thank you, Susan. Any questions of Susan? Thank you very much.

SUSAN HALPIN: Thank you.

SENATOR CRISCO: Eric George, to be followed by Brian.

HB6472
SB1085

ERIC GEORGE: Good afternoon, Senator Crisco, members of the Insurance and Real Estate committee. For the record, my name is Eric George, Associate Counsel for the Connecticut Business and Industry Association. And I'm here to ask for your opposition to Senate Bill 1083.

I've come before you multiple times asking you to reject mandates, and we've gone through all of the rigmarole. I will say this, you have in place now an analysis process through the University of Connecticut and the Department of Insurance, which is slated to look at all of the mandates, giving you what their costs are and what their benefits are.

I would urge you to do that prior to passing mandates. And to have a -- a body that will give you such data, rather than just passing laws because we don't yet quite have the information on them.

I can tell you that the counsel will -- Counsel for Affordable Health Insurance says that mandates increase costs by over 50 percent. I can tell you that the Centers of Policy and Analysis say that 25 percent of our uninsured are priced out for mandates alone.

But I think that you need to process the exact information from the Department of Insurance prior to passing any mandates. Thank you, I'd be happy to answer any questions.

SENATOR CRISCO: Thank you, now are you -- I respect your position on the cost end analysis, but we don't seem to be receiving most -- an analysis on the benefits, but that's something we're working on. But we see the costs from the -- and this is timelined, but if there's any suggestions you have in the future for how we could expedite the process we'd love to talk to you.

ERIC GEORGE: My suggestion would definitely be have -- be to have the data on the front end before policy decisions are made.

SENATOR CRISCO: Well, you know, general sales will change -- committee changes it's difficult to -- no, project what bills we will be hearing next year. But, you know, if you're interested we'll gladly talk to you about it.

ERIC GEORGE: I'm always interested.

SENATOR CRISCO: Thank you. Any questions of Mr. George? Yes, Mr. D'Amelio.

REP. D'AMELIO: Thank you, Mr. Chairman. Eric, as you know, I've been on this committee a long time and we've been always dealing with this issue of mandates.

I'm just curious, you know, when you sit on this side you're -- you're trying to balance what is right to keep the, you know, premium levels down, because as a self-employed individual I -- I know the burden that that places on you. But then you hear the other side of the issue where there are needs, and insurances are not meeting those needs.

So, you know, how do you -- how do you strike the balance?

ERIC GEORGE: Let me flip it a little bit. When you're on this side of the table, and you're looking at the premiums that come at you each month. And you're trying to do well by your employees. And you're trying to provide insurance. And the costs keep on ticking up. And more and more mandates are being added to the requirements, there's a frustration level there as well.

You guys have the -- you have a balancing act that you have to play. Employers have a balancing act, too. Either pay the amount for the premium or don't provide the benefit. It's a hard decision to make. Some employers are forced to make that decision.

And it's unfortunate that they are in the position where they can no longer afford to

provide insurance coverage to -- and a lot of these small businesses, we're talking about dear friends of theirs. And they can't afford it anymore. So it's a balancing act on both sides.

I would say that to the extent that you can limit increasing premiums, that's a good thing to get access to people for insurance.

REP. D'AMELIO: And, you -- you know, you're absolutely correct. I mean I -- I live that every single day. I -- I know what -- I know what those costs are and I know the burden that it places on -- on businesses, especially small business owners. Some -- some go without insurance because they simply can't afford it.

However, some of the stuff that comes before us -- I mean legislation that's proposed on this committee is because there was an issue that caused it to be -- to be, you know, forced upon us -- don't you think at some point the insurance companies have to kind of make a common sense decision when to cover something and not cover something so it doesn't come to this level?

Because it seems like sometimes, you know -- you know, when you're dealing with some really horrific issues and, you know, we're hearing the testimony on this side, it's really hard to say no.

ERIC GEORGE: Well, you know, I completely hear what you're saying. I can't imagine what it would be like to be in your position. I can only speak for the payer position.

And when the insurance companies will price it out to the payers, being the employers being the individual's personal health care, we have to foot the bill.

We're not making the decisions on what to cover, what not to cover. What we are doing is we are paying the bill. And we're trying to provide coverage to our employees and their

families. The more expensive it is the less likely employers will be able to provide any coverage at all.

So it's really -- it comes down to, is some insurance better than none at all? That's a decision that everybody has to come to in their own mind. In my opinion, you're not going to be able -- you're not going to be able to have like the perfect Cadillac utopian plan. But you will be able to have something that's affordable that is still comprehensive.

And making insurance affordable so that it is -- is accessible should be everybody's goal.

SENATOR CRISCO: Thank you. Representative Coutu.

REP. COUTU: Thank you, Mr. Chairman. I know that many nonprofits who have smaller payrolls had substantial health care coverage X amount of years ago. And every year, they're making it less and less coverage. And the goal is really to provide payroll so then the people can go home and feed their families, clothe their families, and provide housing.

I've seen this in my family. We had a certain level of health care coverage. And then as the premiums were going up, our -- the employer was slowly decreasing the quality of the plan -- what I would consider the quality, the amount of coverage, higher deductibles, which I actually think are a good thing.

So this is a big debate. And I know it's important, but I always have concern when legislative body turns things into an emotional reason. And I see that time and time again. People in various communities come in and they bring the emotional aspect of it out. And we have to make decisions based on sound numbers and statistics.

So I guess I'm sort of lecturing. Maybe I shouldn't be. But do you -- is there studies out there showing the states comparatively with other states? Which have the most mandates?

Because we're like, number five in the country, or three or five, somewhere around there.

ERIC GEORGE: Yeah, we're in the top five. It's a report that I referred to in the past.

REP. COUTU: But I meant the cost. Like the correlation between the number of mandates and the total cost.

ERIC GEORGE: In that report I was referring to does talk about costs.

REP. COUTU: Yeah, I started to --

ERIC GEORGE: It talks about -- it talks about it in a -- in a spectrum amount. It is not to the level of detail that the Department of Insurance would be able to give you looking at the demographics of -- of a given state, of the state of Connecticut.

What this would -- Counsel for Affordable Health Insurance does is gives a range. It will give -- take a given mandate, say mental health parity, say prosthetic, say, you know, name the mandate. And they'll say in general what that will impact premium by, you know. Is it X percent? Is it Y percent? What is it?

And then you can go and look at all the mandates for your state to see how much is this impacting premium. It also tells you how many mandates one state has in relation to the rest. So yes, it does. I -- I provided this committee with that report. I'd be happy to do it again. I can -- I can give you the Web site. It's --

REP. COUTU: The book, right? The book --

ERIC GEORGE: You know, it's -- it's only -- if it's 15 pages I'd be surprised.

REP. COUTU: Oh, okay.

ERIC GEORGE: It's not that extensive. It's produced every year. It's been updated through 2010.

REP. COUTU: Yeah, I'll take that -- a couple copies of that.

ERIC GEORGE: Okay, I can bring it up to you after I get done.

REP COUTU: And thank you, Mr. Chairman.

SENATOR CRISCO: You're welcome, (inaudible). Representative Schofield.

REP. SCHOFIELD: Thank you, Mr. Chairman. I have kind of a couple questions about these two bills. On ostomy supplies, do you -- this is -- probably you don't have an answer, but do you have any idea what a typical person with a colostomy needs to spend on an annual basis on ostomy supplies? Because they get $1000 worth of coverage now, and what's proposed is $5000. What's the typical cost?

HB 6472

ERIC GEORGE: I can do some research for you. I do not have that information now, but I can do research for you if you would like.

REP. SCHOFIELD: Yeah, if someone could get that for us, that would be helpful. I mean, one thing that occurs to me is, you know, there's certain sectors that -- if you're buying toilet seats for the military, they're going to cost you $5000. If you're buying them for your home at Lowe's, you know, they're 15 bucks.

And it's kind of the same thing in health care. And it's in part because we are insulated from the real cost and so there isn't real competitions. I wonder if these things are -- can you buy them on the internet at a cheaper price these days?

ERIC GEORGE: Right. You're scratching at an issue that is huge in the entire health care debate. And that's the data. And that's, you know, not only quality data, that's cost data as well.

Where you comparatively can look at different providers, look at different avenues to get care and make a determination.

I mean, I will tell you if I -- if it was a huge issue that I was dealing with, I'm not necessarily going with the cheapest. I want to know, you know, quality data as well. And comparative quality data in terms of who are those providers treating? What was the populations that they were treating?

But that -- that's a difficult issue to get -- for everybody to get their arms around. But it's as important as anything that we discuss in the health care debate. It is one of the kinds --

REP. SCHOFIELD: If you could get some pricing data --

ERIC GEORGE: Yeah, I can do -- I will get you whatever I can, Representative Schofield.

REP. SCHOFIELD: -- not only on, you know, what -- what it costs through insurance these days, but if you were to buy colostomy supplies elsewhere where you don't have it covered where there's a little more competition, what would the pricing be like?

SB1085

And then I had a question on the -- the colonoscopies as well. You know, the United States Preventive Services Task Force is working on identifying tests, extreme tests and preventive services that should be offered without a co-pay. And that will be a federal standard.

And I'm wondering if -- because this is proposing that all colostomy -- colonoscopies done without a co-pay would -- is that on their list as well?

ERIC GEORGE: I -- I don't think we know what their list is (inaudible) at this point.

REP. SCHOFIELD: I think their list is developed somewhat.

ERIC GEORGE: Okay, you've got more information than I do. I -- I don't believe -- well it's not finalized. Whether or not it's on the list, again I don't know. I apologize for that.

REP. SCHOFIELD: I think that'd be -- if someone can get us that information.

ERIC GEORGE: Sure.

REP. SCHOFIELD: You know, is it on the early draft of the list? That would be helpful, as well.

ERIC GEORGE: And I -- you know I think the point that you're getting at is very important. Whatever Connecticut does to determine what is preventive care need to be in compliance and on all fours with the federal government since the federal government has said that, you know, PPACA is going to address, you know, no co-pays for preventive care services, what those are.

Just like the mandates that we've had. So are they going to be in compliance with the essential benefits package? And if not, what's going to happen to the market place that's inside the exchange and the market place that's outside of the exchange?

I think it's everybody's will that the rules be the same inside the exchange and outside the exchange. I believe that's the only fair system to have.

But if you were going to have mandates that are required outside but not inside, then you don't have a level plan. So, you know, so much of what's going on right now is in -- still in a state of flux because the federal law, while passed, has not been fully implemented.

We -- there's so many huge holes there that still need to be addressed by agencies like HHS and others.

REP. SCHOFIELD: Okay, thank you.

SENATOR CRISCO: Any more questions of Eric? Thank you very much. Brian, and followed by Wendy.

BRIAN QUIGLEY: Thank you, Chairman Crisco, and members of the committee. I'm Brian Quigley. I'm here with -- today representing Express Scripts, a pharmacy benefit manager, to indicate our opposition to Senate Bill 1083. This bill would severely limit step therapy for pain medications.

Step therapy is a standard benefit tool designed to address both cost and safety issues, to initiate the most clinically safe and cost effective level of medication. In terms of how this operates, I do want to state that plans normally grandfather people who are already on a higher level medication. The system identifies that and they are permitted to stay on the level of medication where they are.

The prescriber of the medication always has the opportunity under health benefit plans to ask for an exception if the first drug is an oral medication and their patient can't tolerate oral medication. That would be an easy granted exception.

If they're -- have shown an adverse reactions to other medications that were -- again that would be an easily granted exception. And to the extent that they don't fall in the regular parameters of exceptions, they would also have the right to appeal to external review.

So the idea that they are always and in every circumstance forced to start at a lower level medication or a different brand medication is -- is simply not true. The cost implications of this interference with step therapy are pretty significant.

There was a 2004 study by the American Journal of Managed Care that indicated for three drugs; ulcer, depression and arthritis -- one of those

obviously being major pain medication -- that the savings from step therapy were roughly 38 percent on the cost of those drugs. That cost gets translated into the cost of coverage.

And since this bill cannot apply to self-insured plans, that cost like so many of these bills would be shifted entirely to small employers. And the drug benefit is not necessarily an optional benefit. But small employers can purchase their health benefits without a drug benefit to the extent that bills like this and 1084 drive up the cost of the drug benefit.

Employers may choose not to provide a drug benefit, or they may choose an option which increases the co-pay and/or institutes the deductible for the drug benefit.

So by eliminating a standard tool, this bill could have a significant impact on small employers and their members. And for that reason, we oppose it.

If you'd like, Senator, I can comment on the 1084 or take questions now on this one.

SENATOR CRISCO: Yeah, let's get back to you on 1084. Okay?

BRIAN QUIGLEY: Okay.

SENATOR CRISCO: Any questions of Brian? Thank you. Wendy? Is Wendy here? Wendy? Ginger? Ginger? Anyone? They're not here. Christine Capiello will now go to 1084.

CHRISTINE CAPIELLO: I've got (inaudible). For the record, my name is Christine Capiello. I'm the Director of Government Relations for Anthem Blue Cross Blue Shield. And I'm here to speak on Senate Bill 1084, an Act Concerning Out-of-Pocket Expenses for Non-Preferred Named Drugs.

We oppose this bill because it's not needed. The Department of Insurance already prohibits

I'd also like to mention that this would limit our ability to coordinate prescription drug coverage. Thank you for the ability to speak to you today and answer any question you may have.

SENATOR CRISCO: Thank you, Christine. Any questions? Questions? Thank you very much. Brian? (Inaudible).

SB1084
SB1083

BRIAN QUIGLEY: Thank you again, Senator Crisco. Again, for the record Brian Quigley for Express Scripts. Just to reiterate what Christine said, this bill would interfere with one of the basic elements of pharmacy benefit management, which is the ability of the pharmacy benefit manager to bring their size and ability to negotiate with manufacturers to get a discount on brand drugs.

And that discount is generated by the fact that -- well, there's Express Scripts which has 50 million people covered or Medco which has 80 million people covered. But those manufacturers want to get access to the people that they cover, and they're willing to provide a discount if -- if the preferred formulary creates a greater market share for them.

By saying that you can no longer have a differential co-pay, you eliminate the basic tool by which the insurer or pharmacy benefit manager moves people to that preferred brand drug, which is a lower co-pay. That -- and these drugs are biologically equivalent. They're -- they're medical effectiveness is the same or they wouldn't be differentiated.

So what you're doing is eliminating the ability of the PDM or the insurer to negotiate those discounts. You're increasing your cost of coverage. You're eliminating the ability of the member who's covered to get a lower co-pay, because they're -- if you can't differentiate between drugs, there's no incentive to give a lower co-pay.

And again, as I said with 1083 the cost of this benefit -- of this bill, the limitation on the ability to control cost is only on small employers, not on large employers, not on the state of Connecticut. And -- and we think this makes no sense at all. And again, interferes with the basic tool of management. I'd be happy to answer any questions.

SENATOR CRISCO: Thank you, Brian. Any questions? Any questions? No? Thank you very much.

BRIAN QUIGLEY: -- for your patience.

SENATOR CRISCO: Wendy, and Ginger from the Pain Foundation? Are you here? All right, they're not here then this will conclude our public hearing for today. Thank you all --

Connecticut State Medical Society
160 St Ronan Street New Haven CT 06511-2390 (203) 865-0587 FAX (203) 865-4997

Connecticut State Medical Society
House Bill 6472 An Act Concerning Insurance Coverage for Ostomy Supplies
Senate Bill 1085 An Act Concerning Health Insurance Coverage for Colonoscopies
Senate Bill 1083 An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Management
Insurance And Real Estate Committee
March 1, 2011

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, on behalf of the more that 7,000 physicians and physician in training members of the Connecticut State Medical Society, thank you for the opportunity to present this testimony to you today on House Bill **6472 An Act Concerning Insurance Coverage for Ostomy Supplies, Senate Bill 1085 An Act Concerning Health Insurance Coverage for Colonoscopies** and Senate Bill **1083 An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Management.** Without a doubt, passage of these bills would provide a tremendous benefit to certain patients. They would strengthen an individual's health status and/or increase quality of life. These benefits cannot be compared or contrasted to the financial cost of their implementation.

House Bill **6472 An Act Concerning Insurance Coverage for Ostomy Supplies** increases the annual limit on ostomy supplies from one thousand dollars to five thousand dollars. The cost of such supplies has increased dramatically since original passage. The one thousand dollar limit is no where near adequate for patients requiring ostomy supplies annually

Senate Bill **1085 An Act Concerning Health Insurance Coverage for Colonoscopies** prohibits the imposition of a co-payment or deductible for additional colonoscopies required in a benefit year. The cost of colonoscopies on an individual can be significant. The determination by a physician that a second colonoscopy is medically necessary indicates that there is potential for a severe medical condition. Unaffordable co-payments and deductibles could cause those in need to delay seeking treatment; causing an increase in costs to the healthcare system should a complicated or advanced problem arise.

Senate Bill **1083 An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain** simply prevents an insurer from requiring the use of over-the-counter medications when a physician using professional judgment has determined that such medications would be ineffective. It does not, however, impact the ability to provide generic equivalents for name brand medications.

While we support these bills, we must once again stress that the position of the CSMS is that none would be necessary if a rational determination of a medically necessary service by a physician to improve health or increase a patient's quality of life was the trigger for insurance coverage and payment.

TESTIMONY SUBMITTED REGARDING CONNECTICUT SENATE BILL 1083

COMMITTEE on INSURANCE and REAL ESTATE

Submitted by:

Andrew Friedell
Director, Government Affairs
Medco Health Solutions, Inc.

March 1, 2011

Mister Chairmen, and members of the Committee, my name is Andrew Friedell and I am Director of Government Affairs for Medco Health Solutions, Inc., which is a leading health care company that is advancing the practice of pharmacy and serving the needs of approximately 65 million people. I would like to thank you for this opportunity to testify today regarding our opposition to Senate Bill 1083. If enforced as written, this bill could actually prevent identification of serious safety issues for some patients and drive up the cost of pharmacy care for employers in the state.

Medco provides clinically driven pharmacy services designed to improve the quality of care and lower total health care costs for private and public employers, health plans, labor unions, government agencies of all sizes, and for individuals served by Medicare Part D Prescription Drug Plans. About one third of the companies on the Fortune 500 list are Medco clients.

Medco provides drug benefits to roughly 18 percent of the Connecticut population. We mail approximately 990,000 prescriptions to state residents annually and we also operate a specialty pharmacy in Vernon, Connecticut.

As drafted, SB1083 currently stipulates that a plan which provides coverage of prescription drugs shall not "require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs." There is an exemption for therapeutically equivalent generic alternatives.

Pharmacy benefit programs frequently implement a variety of guidelines & programs that are designed to ensure that patients receive clinically appropriate and cost effective therapies. Sometimes, this can involve programs that promote a generic drug or lower-cost brand-name alternative drug before higher cost non-preferred drugs are covered. Because the "treatment of pain" is a very broad description which implicates numerous different conditions and treatments, there are also many important pharmacy

management programs that could be affected by this legislation. Without these programs in place the cost of the benefit will increase while the quality would be reduced.

I'd like to highlight three specific examples of how this bill could result in a more expensive and lower quality drug benefit for patients in Connecticut.

First, NSAIDs or non-steroidal anti-inflammatory drugs such as ibuprofen, naproxen and others are among the most commonly prescribed drugs to treat pain. These drugs are available in a pill form for oral administration at a fairly low cost. However, there are other non-oral formulations in the same class as these drugs (such as topical treatments like a patch or a gel) that are available at a much higher cost. As a result, plans often implement guidelines that require patients to initiate therapy on a lower cost oral formulation of an NSAID, and if treatment is not tolerated or ineffective, then the brand drug is covered. Yet SB1083 would require plans to cover the more costly formulations right away -- without any ability to request that patients and prescribers consider lower cost formulations of these drugs on the initial fill. This could ultimately cause plans to exclude all coverage of higher cost products as there would no longer be a process to assess when lower cost oral NSAIDs might be an option for some patients. In that way, SB1083 could actually result in less coverage of these medications -- an unintended consequence completely at odds with the bill's intent.

Second, it is safe to assume that the "treatment of pain" includes drugs used to treat migraine headaches. In this class of drugs, there are several different options available to prescribers, including brands and generics. There are some higher cost and lower cost options; some options include opioid controlled substances, others are non-controlled substances. Because of these variations in price and potency, some plans choose to implement policies -- based on the best scientific treatment guidelines for these medications -- that call for the patient to initiate therapy on the most clinically safe and cost effective alternatives. In many instances, these guidelines often recommend one of the non-controlled substances (one of the so-called triptan drugs which are available as brands and generic versions) as the gold standard first-line treatment for patients with migraine headaches. But if SB1083 were enacted, plans would be prohibited from implementing this sort of "step therapy" program (i.e., to use a triptan prior to a controlled substance-opioid). In this way, SB1083 could actually have the unintended effect of allowing greater use of controlled substances as well as more expensive drugs within this class.

Finally, it is also common for a plan to implement guidelines -- particularly for drugs used in the treatment of severe pain -- whereby certain drugs may not be covered on an initial fill *for safety reasons*. For example, the Food and Drug Administration instituted a so-called black box warning on the drug fentanyl which cautions that the drug should not be used in opioid non-tolerant patients. To quote from the warning posted on the drug's website: "Deaths occurred as a result of improper patient selection (e.g., use in opioid non-tolerant patients) and/or improper dosing."[1] Under SB1083, if a prescriber wrote an initial prescription for this drug, the plan would be prohibited by state law from implementing these sort of safety guidelines to ensure the patient was opioid tolerant

prior to use of fentanyl-- which are recommended by the FDA as being in the best interest of the patient.

It should be noted that there are avenues through which the patient can obtain coverage of a non-preferred product on the initial fill in the presence of existing coverage review programs. For example, some plans may have coverage determination logic in place that utilizes prescription claims history to identify situations where other preferred alternatives (beyond the exact brand alternative) have been tried first (i.e., claims for these alternatives are in the patient's medication profile). In these circumstances, the coverage review program could immediately adjudicate the non-preferred drug as covered. In situations where the patient's claim history lacks this information, the non-preferred prescription generates a coverage review process. This process often includes other exceptions for covering the non-preferred drug (e.g., for the topical more costly branded NSAID) such as determining whether or not the patient is able to use oral NSAIDs (if they cannot, the non-preferred topical NSAID is covered) or determining if the patient experienced intolerance to treatment with preferred NSAIDs. In situations where none of these exceptions is identified by the coverage review process and a denial of coverage is rendered, an appeals process exists to consider unique circumstances for a patient that could result in coverage approval for the non-preferred drug.

It is also important to point out that because state laws of this sort apply only to fully-insured plans in the state and not to those self-insured plans that are subject to federal rules, SB1083 will disproportionately affect those smaller employers who typically do not have the resources to self-insure. These are the same employers who not only drive job creation but who are also most vulnerable to added health care costs of the sort that would be levied by this bill.

In summary, because this legislation would force plans to cover higher cost alternatives as an initial choice -- if they are to provide coverage of these drugs -- this will accelerate the rate of increase in prescription drug spending. At a time when coverage is eroding, when overall healthcare costs are going up and when employees and retirees' out-of-pocket costs are on the rise, we urge you to oppose legislation of this sort that will further drive up costs. I appreciate the opportunity to submit our concerns with this legislation and I look forward to answering any questions you may have on my testimony.

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[1] www.actiq.com

Anthem.

March 1, 2011

Statement
Of
Anthem Blue Cross and Blue Shield
On
SB 1083 An Act Concerning Health Insurance Coverage Of Prescription Drugs For Pain Treatment.

Good afternoon, Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut. I am here today to reluctantly speak on SB 1083 An Act Concerning Health Insurance Coverage Of Prescription Drugs For Pain Treatment.

We oppose this bill because, similar to SB 1084, it is not needed. The Department of Insurance already prohibits mandatory or closed formularies in Connecticut. Thus, physicians are already free to prescribe any drug they feel is medically justified for their patient. While it is true that Anthem like most managed care plans has a formulary, and encourages physicians and patients to use the drugs on the formulary, the physician is always free to prescribe any drug he feels is necessary for the patient's well being. If the drug is not on the formulary, the physician may be asked to justify why the prescribed drug should be paid for, but he is never prohibited or penalized for prescribing a non-formulary drug.

Prescription drugs are the fastest growing expense line in all of health insurance. Between 1993 and 1998, prescription drug costs increased 84% while total benefit payment grew only 26%. Even more startling, private third party expenditures on prescription drugs grew 130% during this period while total benefit payments grew only the 26% already cited. Prescription drugs are clearly the fastest growing cost segment in this market. Interestingly, during this same period, consumer out-of-pocket spending on drugs grew only 17%. Thus, as a share of total private spending on prescription drugs, consumer direct spending decreased from 51% in 1993 to only 35% in 1998.

This is not a bad thing, prescription drugs are increasingly effective in curing illness and in relieving symptoms, and we are happy that more and more people are having prescription drug coverage provided to them in their group health insurance coverage. However, as spending increases dramatically, we are asked to find ways to hold down costs, so that employers can afford to provide this type of coverage. We are increasingly concerned that if we are not allowed to provide some structure to this benefit, employers will simply stop covering prescription drugs all together.

I would also like to mention that one of the problems of this bill is that it would limit our ability to coordinate prescription drug coverage. To work with physicians to find the best, most effective drug for their patients. The first drug prescribed by a physician may not be the best drug for every patient. There are often interactions possible with another drug that has been prescribed by a different physician without the knowledge of the new doctor. One of our most effective quality improvement measures is the checking of prescriptions for drug interactions, and for efficacy of alternative medicines.

Thank you for the opportunity to speak to you today and I welcome any questions you might have.

American Cancer Society

Insurance and Real Estate Committee
March 1, 2011
Testimony of the American Cancer Society

RE: SB 1083, An Act Concerning Health Insurance Coverage Of Prescription Drugs For Pain Treatment.

Pain remains one of the most feared and burdensome symptoms for cancer patients and survivors. Pain associated with cancer can almost always be relieved, yet it is a problem in at least 60% of patients in active treatment.

When a patient is prescribed an expensive or risky, branded drug, a payer may determine that the patient will not be allowed coverage on that drug until other, less expensive or less risky protocols have been tried, first. If it works well for the patient, then no more steps are needed. However, if the patient does not have the desired outcomes with the first drug, then a second drug, the next least expensive or risky drug in the same class, will be tried until the patient takes a drug that is effective and costs the least amount of money.

The rationale behind step therapy is that it ensures that patients receive appropriate medications in a cost effective manner, while reducing waste, error and unnecessary drug use. However, this can lead to delays in proper treatment as well as unnecessary discomfort to the patients themselves and potential increased costs in the form of unplanned emergency room, doctor visits or other health complications.

SB 1083 seeks to prohibit individual and group health insurance policies that provide coverage for prescription drugs from requiring insureds to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs. ***While we do not have a formal position on this legislation, we view the physician-patient decision-making process as a critical component of proper care and prefer to avoid policies that may not be in the patient's best interest in that regard.***

Cancer-related pain can interfere with patients' ability to complete scheduled treatments, and can devastate quality of life – affecting work, appetite, sleep, and time with family and friends. Open communication with healthcare professionals about pain, the medications for it, and other methods available to treat it is essential to relieve symptoms and improve quality of life.

Thank you.

Global Healthy Living Foundation
515 North Midland Avenue
Upper Nyack, New York 10960 USA
+1 845 348 0400
+1 845 348 0210 fax
www.ghlf.org

February 28, 2011

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106
Phone: 860-240-0510

RE: Senate Bill No. 1083 – AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT.

Senate Bill No. 1084 – AN ACT CONCERNING OUT-OF-POCKET EXPENSES FOR NONPREFERRED BRAND NAME DRUGS.

Dear Committee Members,

I am writing to you today on behalf of the more than 44,000 members nationwide of CreakyJoints.org, a part of the Global Healthy Living Foundation, to express our support for SB 1083 and SB 1084, an act concerning health insurance coverage of prescription drugs for pain treatment and an act concerning out-of-pocket expenses for non-preferred brand name drugs. More than 1,200 members of CreakyJoints live in Connecticut, and I write to you on behalf of those residents living with chronic pain.

CreakyJoints is an arthritis patient advocacy organization dedicated to building, sustaining and educating people with all forms of arthritis. Nearly 75 percent of our members have Rheumatoid Arthritis, and I would like to specifically address their concerns regarding two access-to-care issues: specialty tier medications, and step therapy for the treatment of their RA or chronic pain.

About 1.3 million people in the United States are believed to have Rheumatoid Arthritis. Rheumatoid Arthritis is a painful condition that affects all ages, races, and social and ethnic groups. Although there is no cure for Rheumatoid Arthritis, the disease can be controlled in most people. Early, aggressive therapy to stop or slow inflammation in the joints can prevent or reduce painful symptoms, prevent or reduce joint destruction and deformity, and prevent or lessen disability and other complications. Biologics have changed the world for people with Rheumatoid Arthritis, but they are also new and high-cost treatments that insurance companies tend to place on specialty tiers within drug plan formularies. From an RA patient perspective, the

Continued on Page 2

difference between paying a co-payment and paying the coinsurance rate for a medication could be hundreds of dollars a month.

Here are just a few more examples explaining why both specialty tier and step therapy strategies are problematic for RA patients and doctors:

- Specialty tier mechanism violates the basic principal of insurance whereby individuals and employers purchase health insurance plans so that they are protected from the risk of needing to pay for highly expensive medical treatments.
- Specialty tier coinsurance rates can change unpredictably. This makes it impossible for patients to anticipate and budget for health care costs. It also impedes them from having informed discussions with their doctors about containing the cost of their treatment.
- Step therapy is time-consuming from a physician and patient standpoint, is more expensive from a direct and indirect out-of-pocket cost perspective, it denies patients the drugs they need when they need them, and creates additional barriers leading people to forgo needed medications

Because of the recession, high unemployment, and an erosion of employer-based insurance, now more than ever, patients with Rheumatoid Arthritis need access to affordable prescription drugs coverage. I urge all the members of the Insurance and Real Estate Committee to consider this carefully and vote in support of SB 1083 and SB 1084.

The Global Healthy Living Foundation recently launched a national campaign, "Fail First Hurts" (http://www.FailFirstHurts.org), to provide personal perspective on step therapy, or fail first practices by insurance companies. People living with pain associated with RA, chronic or acute pain need to efficiently and adequately address their needs through the medication intended by their physician. We hope that you will consider these people – many of whom live in Connecticut – when voting for SB 1083 and SB 1084.

If you have questions or wish to discuss this further, please call me or our Executive Director, Lou Tharp at 845-348-0400 or email me at sginsberg@ghlf.org or Lou at ltharp@ghlf.org

Thank you for caring about patients and their need for quality access to care in Connecticut.

Sincerely,

Seth Ginsberg
President, Global Healthy Living Foundation

Shelly Olivadoti
14 Balsam Circle
Shelton, CT 06484

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

Dear Co-Chairman Joseph Crisco and Co-Chairman Robert Megna:

I am writing to you please ask you to, support Raised Bill 1083: *An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Treatment.* This bill would prohibit individual and group health insurance policies that provide coverage for prescription drugs from requiring insurers to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs. Legislation such as this would help to alleviate the problem of unused (failed) pain medications building up in home medicine cabinets; potentially reduce the prescribing of opioids; potentially help to reduce/minimize health care expenditures; and minimize the suffering of patients and the administrative burdens for prescribers.

Step therapy (also referred to as fail-first) is one of many tools employed by health care payers to manage utilization of health care services. In the case of medications, the process usually requires a patient to try medicines for his or her conditions in a series of steps. While the goal of step therapy policies makes sense, the practical reality is often different.

- Step therapy policies can result in increased healthcare costs
- Step therapy policies contribute to the administrative burden in medical offices
- Step therapy policies often require patients to endure monetary, physical and psychological distress
- Step therapy policies may lead to the accumulation of unused medicines in home medicine cabinets

Step therapy policies override a treatment decision between a health care provider and a patient. Even when a health care provider thinks the treatment may not work, these policies can unnecessarily force patients to: pay cost-sharing for the first steps of therapy and for additional medical visits; suffer physically because effective treatment is delayed; and, tolerate side effects from inadequate medicines.

I respectfully urge you to support Raised Bill 1083.

Respectfully Submitted

Shelly Olivadoti

Members of the Insurance and Real Estate Committee
Legislative Office Building, Room 2800
Hartford, CT 06106

Monday, February 28, 2011

Christopher Zurcher
101 Bishop St. 2R
New Haven, CT 06511
(203) 886-5905
cjzurcher@yahoo.com

Dear Co-Chairman Joseph Crisco and Co-Chairman Robert Megna:

I am writing to you to request that you support Raised Bill 1083: *An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Treatment.* This bill would prohibit individual and group health insurance policies that provide coverage for prescription drugs from requiring insurers to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs. Legislation such as this would help to alleviate the problem of unused (failed) pain medications building up in home medicine cabinets; potentially reduce the prescribing of opioids; potentially help to reduce/minimize health care expenditures; and minimize the suffering of patients and the administrative burdens for prescribers.

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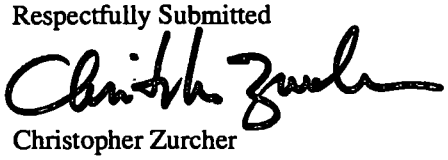
I respectfully ask you to support Raised Bill 1083.

Respectfully Submitted



Christopher Zurcher

U.S. PAIN FOUNDATION

Insurance and Real Estate Committee
Room 2800, Legislative Office Building
Hartford, CT 06106

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I am writing to you please ask you to, support Raised Bill 1083: *An Act Concerning Health Insurance Coverage of Prescription Drugs for Pain Treatment.* This bill would prohibit individual and group health insurance policies that provide coverage for prescription drugs from requiring insurers to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs. Legislation such as this would help to alleviate the problem of unused (failed) pain medications building up in home medicine cabinets; potentially reduce the prescribing of opioids; potentially help to reduce/minimize health care expenditures; and minimize the suffering of patients and the administrative burdens for prescribers.

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I respectfully urge you to support Raised Bill 1083.

Respectfully Submitted

Paul Gileno Founder/President

info@uspainfoundation.org
www.uspainfoundation.org

Main: (800) 910.2462
Fax: (800) 929 -4062

P.O. Box 2182
Shelton, CT 06484

CBIA

CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

TESTIMONY
BEFORE THE
INSURANCE AND REAL ESTATE COMMITTEE
LEGISLATIVE OFFICE BUILDING
MARCH 1, 2011

My name is Eric George and I am Associate Counsel for the Connecticut Business & Industry Association (CBIA). CBIA represents approximately 10,000 businesses throughout Connecticut and the vast majority of these are small companies employing less than 50 people.

While the federal government has passed health care reform, more needs to be done to lower costs. More needs to be done to improve the health of our citizens. Employers find health care costs rising faster than other input costs. Some providers are unable to generate sufficient patient revenue to cover costs. Some patients cannot get timely access to optimal care. And too many individuals remain without health insurance, engage in unhealthy behaviors and live in unhealthy environments.

For the business community, the issues of health care quality, cost and access are critical. After numerous years of double-digit and near-double-digit increases, health insurance has quickly become a product that many people and companies find they can no longer afford. In addition, the cost of health care directly affects businesses' ability to create new jobs.

Therefore, CBIA asks this committee to reject **SB 1083, AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS FOR DRUG TREATMENT.** The business community and other stakeholders are calling for significant reforms to Connecticut's costly and inefficient health care system. As you consider the various proposals to reform the state's health care system, CBIA asks you to refrain from making the already high cost of health care even more unaffordable for the state's companies and residents.

The recent federal health reform law, the Patient Protection and Affordable Care Act, requires that if a state adopts any mandated benefit that exceeds the benefit levels of the "essential benefit plan" then that state must pay for the cost of that mandate. The federal government has not yet defined what constitutes an "essential benefit plan." So, the State of Connecticut is rolling the dice with each new or expanded mandate that it adopts because if that mandate goes further

than the "essential benefit plan" then the state will be paying the bill – further stressing our already strained state budget.

Every health benefit mandate, while providing a benefit to the individuals who utilize those services, increases health insurance premiums for all state-regulated group and individual policies. In fact, the Council for Affordable Health Insurance (CAHI) has reported that health benefit mandates increase health insurance premiums between less than 20% to more than 50%. According to CAHI, Connecticut's mandates increase group and individual health insurance premiums by as much as 65%.

Connecticut's employers are already struggling to afford health insurance for their employees. The hardest hit among these companies are small employers whose revenues and operating budgets make affording employee health insurance extremely difficult. However, when the legislature adopts new health insurance mandates, it makes affording health insurance particularly difficult for these small employers. This is because state mandated benefits only impact plans that are subject to state regulation. If a company has the financial ability to self-insure, then that company's health plan is governed solely by federal law, including the Employee Retirement Income Security Act (ERISA), and does not have to comply with state health benefit mandates. Companies that are able to self-insure (and therefore not subject to Connecticut's health insurance mandates) are typically larger companies that can afford taking on such risk. Smaller companies usually cannot and are forced to be fully insured and subject to state regulation.

So, Connecticut's health insurance mandates impact smaller employers in the state to a greater degree than larger employers. When the legislature either creates a new mandate or expands an existing mandate, it is making health insurance less affordable for those small companies that can least afford to shoulder these cost increases.

CBIA asks this committee to reject all new or expanded mandate proposals and to enact a moratorium on health insurance mandates. It is crucial that as the state moves forward toward major health care reform, that the General Assembly refrain from taking any actions that would increase the cost of already skyrocketing health insurance premiums.

Again, please reject **SB 1083** and thank you for the opportunity to offer CBIA's comments on this legislation. I look forward to working with you on this and other issues related to the reforming Connecticut's health care system.

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L. 8

Quality is Our Bottom Line

Connecticut Association of Health Plans

Testimony Submitted in Opposition to

SB 1083 AAC Health Insurance Coverage of Prescription Drugs for Pain Management
SB 1084 AAC Out of Pocket Expenses for Nonpreferred Brand Name Drugs

Insurance Committee Public Hearing
Tuesday, March 1, 2011

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 1083 and SB 1084 which would seriously compromise the efforts of health plans to contain costs by using utilization review practices to help ensure cost-efficient and effective prescription drug use.

SB 1083 would prohibit carriers from requiring that members try one brand name prescription pain drug before using another brand name prescription pain drug. We know of no medical rationale for this approach. Carriers use step therapy (requiring the use and failure of one drug before another drug may be covered) because some drugs are very expensive, and yet they have no better clinical track record for outcomes than less expensive medications (brand or generic). When no clinical advantage is apparent, cost considerations often warrant moving members and providers to use the more cost-effective drug.

Any member who does not respond to treatment with the first-required drug or who cannot take that drug may then proceed to the next "step" and try the less preferred drug. This law would drive up health care costs with no improvement in clinical outcomes and frankly, it contradicts not only the goals of federal health care reform which seek to find the least costly effective treatments and encourage their use whenever possible but, also the efforts currently underway by the state itself to control escalating prescription drug costs. Without a formulary, pharmaceutical sales and marketing practices could play too large a role in prescription choices. Formularies are critical if we are serious about controlling health care costs. It's also important to note within the context of the bill, that many drugs are used for more than one purpose, and when that is the case, the pharmacist does not know if a particular drug is being prescribed for pain management or some other purpose.

SB 1084 would essentially "compress" the permissible levels of drug plan tiers so that all brand name drugs would have to be in the same tier. Members and providers can always choose and receive coverage for drugs on a higher tier, but members must pay a higher cost-share to make that choice. Tiering of benefits is something that is encouraged under federal health care reform's focus on value-based insurance design. This legislation is simply contrary to the aims of PPACA and should not be made law. Again, without tiered formularies, pharmaceutical sales and marketing practices could play too large a role in prescription choices. Tiered benefits are critical if we are serious about controlling health care costs.

While every mandate under consideration by the legislature is laudable in its intent, each must be considered in the context of the larger debate on access and affordability of health care and ***now must also be viewed in the context of federal health care reform and the applicability of the Patient Protection and Affordable Care Act of 2010 (PPACA).***

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com

Please consider recent testimony submitted by the Department of Insurance relative to another proposed mandate under consideration which urges the Committee to understand the future financial obligations that new or additional health insurance mandates may place on the State of Connecticut and taxpayers stating that:

> ***In simple terms, all mandated coverage beyond the required essential benefits (as will be determined by HHS) will be at the State's expense. Those costs may not be delegated to the individual purchaser of insurance or the insurer.***

Both the General Assembly and the Administration have pledged again this year to address the needs of the approximately 400,000 Connecticut residents who lack health insurance coverage. As we all know, the reasons people go without insurance are wide and varied, but most certainly cost is a major component. In discussing these proposals, please also keep in mind that:

- Connecticut has approximately **49 mandates, which is the 5th highest** behind Maryland (58), Virginia (53), California (51) and Texas (50). The average number of mandates per state is 34. (OLR Report 2004-R-0277 based on info provided by the Blue Cross/Blue Shield Assoc.)

- For all mandates listed, the total cost impact reported reflects a range of **6.1% minimum to 46.3% maximum.** (OLR Report 2004-R-0277 based on info provided by the Dept. of Insurance)

- State mandated benefits are not applicable to all employers. Large employers that self-insure their employee benefit plans are not subject to mandates. **Small employers bear the brunt of the costs.** (OLR Report 2004-R-0277)

- The National Center for Policy Analysis (NCPA) estimates that **25% of the uninsured are priced out of the market by state mandates.** A study commissioned by the Health Insurance Assoc. of America (HIAA) and released in January 1999, reported that "...a fifth to a quarter of the uninsured have no coverage because of state mandates, and federal mandates are likely to have larger effects. (OLR Report 2004-R-0277)

- **Mandates increased 25-fold over the period, 1970-1996, an average annual growth rate of more than 15%.** (PriceWaterhouseCoopers: The Factors Fueling rising Healthcare Costs- April 2002)

- National statistics suggest that **for every 1% increase in premiums, 300,000 people become uninsured.** (Lewin Group Letter: 1999)

- "According to a survey released in 2002 by the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), employers faced an average **12.7% increase in health insurance premiums** that year. A survey conducted by Hewitt Associates shows that employers encountered **an additional 13% to 15% increase in 2003.** The outlook is for more double-digit increases. **If premiums continue to escalate at their current rate, employers will pare down the benefits offered, shift a greater share of the cost to their employees, or be forced to stop providing coverage."** (OLR Report 2004-R-0277)

Thank you for your consideration.

H – 1120

CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2011

VOL.54
PART 29
9635 – 9973

The bill passes.

Will the Clerk please call Calendar 565.

THE CLERK:

On page 25, Calendar Number 565, Senate bill number 1083, AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT. Favorable report of the Committee on Appropriations.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Megna of the 97th.

REP. MEGNA (97th):

Thank you, Mr. Speaker. I move the Committee's Joint Favorable Report and passage of the bill in concurrence with the Senate.

DEPUTY SPEAKER ARESIMOWICZ:

Question is on acceptance of Joint Committee's Favorable Report and passage of the bill.

Representative Megna, you have the floor, sir.

REP. MEGNA (97th):

Thank you, Mr. Speaker. This -- Mr. Speaker, this bill eliminates step pain therapy protecting patients and helping them in their state of pain and I urge my colleagues to support the bill. Thank you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, sir.

Representative Carter of the 2nd, you have the floor, sir.

REP. CARTER (2nd):

Thank you, Mr. Speaker. I'm going to recuse myself for a potential conflict of interest.

DEPUTY SPEAKER ARESIMOWICZ:

The Chamber will stand at ease while Representative Carter leaves the Chamber.

(Chamber at ease.)

DEPUTY SPEAKER ARESIMOWICZ:

Chamber will return to the Call. Representative Schofield of the 16th, you have the floor, madam.

REP. SCHOFIELD (16th):

Thank you, Mr. Speaker. I have concerns about this bill and have a question for the proponent of the bill as well as some comments.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Megna, please prepare yourself. Representative Schofield, please proceed, madam.

REP. SCHOFIELD (16th):

Thank you, Mr. Speaker. To my esteemed colleague whom I hold in great affection but still have to ask a question. Why are we singling out treatment of pain for this change in how drugs are managed when we're not doing the same thing to drugs for hypertension, for diabetes, for heart disease, for depression, for any of many, many other equally important chronic illnesses? Through you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Megna.

REP. MEGNA (97th):

Thank you, Mr. Speaker. Mr. Speaker, this issue came forward to us with people suffering in pain, chronic pain, and we just -- it just became an issue dealing with pain. I don't know about the -- these other things that the good Representative is speaking about. Through you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Schofield.

REP. SCHOFIELD (16th):

I will just express my concern. There really is no good reason that I can see to single out one particular condition or diagnosis for a different way of managing the medical costs of those drugs. When a

patient comes to a physician with any condition and there's an array of drugs to choose from, it's extraordinarily rare that a physician would know which specific drug is going to work and which one isn't, and that's true for pain as well. So there's no reason to start with the most expensive drug and in the case of pain medication certainly not to start with the most addictive drug either. We should start with step therapy process where we look at less expensive medication because that might work just as well as a more expensive medication.

This is going to result in increased medical costs at a time when we're all trying to control medical costs. It's going to result in an increase in premiums, and I also worry that it's going to result in an increase in illicit drug use or abuse of prescription medications. There are physicians who are known to be script writers and it will be that much easier for them to go give someone who has a headache Dilaudid or Oxycontin right off the bat rather than having them try aspirin or a much less --

DEPUTY SPEAKER ARESIMOWICZ:

Madam, just hang on for one moment. The gentlelady is trying to get her comments into the

record. Please keep the noise in the Chamber to a quiet roar so she can proceed.

Please proceed, madam.

REP. SCHOFIELD (16th):

Thank you, Mr. Speaker. I appreciate that. I'm actually done with my comments, but again urge my colleagues to oppose this bill. I think it's bad for medical care costs and bad for patients. It sets a very dangerous precedent. Thank you.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, madam.

Will you remark further? Will you remark further on the bill before us? If not, staff and guests please come to the Well of the House, members take your seats, the machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the Chamber. The House is voting by roll call. Members to the Chamber, please.

DEPUTY SPEAKER ALTOBELLO:

Have all the members voted? If all the members have voted, please check the board to ensure your vote has been properly cast. If all members have voted,

the machine will be locked, Clerk will take a tally.

Clerk will announce the tally.

THE CLERK:

Senate Bill Number 1083, in concurrence with the Senate.

Total Number voting	145
Necessary for passage	73
Those voting Yea	100
Those voting Nay	45
Those absent and not voting	6

DEPUTY SPEAKER ARESIMOWICZ:

The bill passes in concurrence.

Representative Olson.

REP. OLSON (46th):

Thank you, Mr. Speaker. Mr. Speaker, I request that Item 604 be removed from the Consent Calendar and that the Clerk call Calendar 604. Thank you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Clerk, please call Calendar 604.

THE CLERK:

On page 30, Calendar 604, substitute for Senate Bill Number 1103, AN ACT CONCERNING EARLY CHILDHOOD EDUCATION. Favorable report of the Committee on

S – 621

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2011

VOL. 54
PART 10
2971 – 3322

Those absent or not voting 1.

THE CHAIR:

The bill passes.

Mr. Clerk.

THE CLERK:

Calendar page 30, Calendar Number 166, File Number 226, Senate Bill 1083, AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT, Favorably Reported, the Committee on Insurance and Real Estate and Appropriations. Clerk is in possession of amendments.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Thank you, Mr. President. Mr. President, I move for acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

On acceptance and passage, will you remark?

SENATOR CRISCO (17th):

Yes, Mr. President. Mr. President, I am not calling any of my amendments that I submitted before.

Basically what we're trying to accomplish here is to prohibit individuals and group health insurance policies that provide coverage for prescription drugs from requiring insurers to use -- prior to using a brand name prescription, any other brand name.

This is a strong principle that I believe in, Mr. President and members of the Circle, is that when a physician prescribes a specific drug or a pharmaceutical or medication, that's what should dominate what is given to the insured, Mr. President.

THE CHAIR:

Thank you, Senator Crisco.

Will you remark further?

Senator Kelly.

SENATOR KELLY (21st):

Thank you, Mr. President. I have a few questions for Senator Crisco.

THE CHAIR:

Please proceed.

SENATOR KELLY (21st):

Under this bill would this require additional use of pain medications or would it reduce the use of pain medications?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, I don't think there is an answer to that. Basically, you know, under our own state health insurance plan there is-- we have coverage for brand name medication in this situation. Whether an individual who receives that particular type of brand medication will use more or less when it's switched, I can't -- I don't believe I can answer that.

THE CHAIR:

SENATOR KELLY (21st):

Could the bill reduce waste? In -- let me back up. Does this bill prohibit physicians from using generic drugs in pain medication, in pain treatment?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Through you, Mr. President to Senator Kelly. No, under the specific insurance plan.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Could you -- Thank you, Mr. President. Could you explain to us how the step therapy works?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Yes, Mr. President. While I'm not qualified but in listening to public hearings and individuals, step therapy is like a trial and miss -- process that certain pharmaceuticals are recommended. If it works, it's fine. If it doesn't work then you go to another medication. If that doesn't work you go to another medication. If that doesn't work then you -- if you're still alive -- you go to another medication.

What has been ascertained is that there has been a period of time when people have gone through unnecessary pain because of this process of trying different medications while not -- you know, fulfilling the family physician or physician's recommendation based upon all their training and knowledge for a specific brand name.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Through you, Mr. President. Each time the patient would go through a different medication, would that necessitate an additional office visit to a physician?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kelly, not only would it necessitate another cost in visiting the physician because I don't believe that a physician would send a prescription to a pharmacist without -- without -- looking at the individual and seeing what the repercussions are, the difficulties are because it could be unrelated.

In addition, by using this particular process there would be considerable amount of waste of pharmaceuticals that you can't use. So you would have to dispense it, you know, get rid of it and if you multiply this, you know, time and time again, there is considerable amount of waste and cost and

excessive pain experienced by the patient that is unnecessary.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Through you, Mr. President. The delay improper treatment and the additional pain that an individual sustains, does that impact the treatment? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kelly, I would assume yes.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Now, this issue will present itself as I understand it as part of the physician who has prescribed a certain treatment with their patient, but then the insurance industry comes in and says that there's an alternative drug and we would like you to try it. Is that correct?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Keely, yeah. It depends if the insurance company is using a therapeutic alternative or a generic. It depends upon the substitute that's used.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

But under this bill I don't think what we're trying to do is require a generic. I think it would be an alternative form of pain medication, correct? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

(Inaudible) to Senator Kelly, yes, what the bill states is that you have to use the brand that is prescribed by your doctor. And you know, also, there are situations, I believe, that certain plans, I believe like the state plan, that will allow for an alternative of a generic equivalent. But it has to be generically equivalent.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

But as I understand it under this bill we're not saying that the generic equivalent is prohibited. What we're saying is that if a -- as I understand the bill as written -- that if a physician prescribes a certain pain medication that that pain medication would be paid for, correct?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

To Senator Kelly -- you know, my apologies to his previous question the answer should have been yes and to this question it's also yes.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Thank you, Senator Crisco.

So would this -- I mean -- as I understand the current practice, presently a physician could prescribe a certain medication for pain treatment that the insurance industry is now saying we want you to try another drug for whatever reason, getting

between the doctor and their patient. Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to the Senator Kelly, he is absolutely correct.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Also under present law and under this bill, a physician would be free to prescribe whatever drug they believe was necessary to alleviate their patient's pain. Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kennedy (sic), I hope that's what the physicians would do.

THE CHAIR:

Senator Kelly.

SENATOR KELLY (21st):

Okay. Thank you, Mr. President. Thank you, Mr. -- Senator Crisco. I have no further questions at this point.

THE CHAIR:

Thank you, Senator.

Will you remark further? Senator Prague.

SENATOR PRAGUE (19th):

Mr. President, thank you. I rise to strongly support the bill. It has been my experience that the only thing the insurance industry is concerned about is the price.

You know, I'll give you a perfect example. I was sick a few weeks ago. And instead of getting the brand name drug, I got the generic. And instead of being out one or two days, I was out four days. I strongly believe that the insurance industry should not be playing doctor. That if a doctor orders what the doctor thinks the patient needs that's what the patient should get, not the substitute that the insurance company wants to provide you because it costs less.

So I strongly support this bill and I hope that members of this Circle, when you think of getting

sick yourself, you want what your doctor orders, not something else. Thank you.

THE CHAIR:

Thank you, Senator.

Will you remark further?

Senator Witkos.

SENATOR WITKOS (8th):

Thank you, Mr. President. Good afternoon. THE CHAIR:

Good afternoon, sir.

SENATOR WITKOS (8th):

I also rise on strong support of the bill before us. You know, on the last bill that was here, I voted against it. And I voted against it because although it has to do with a medicinal mandate through your insurance company, I view that as -- as an extra. We weren't denying anybody anything, we're just saying you're going to get your prescription and that's it. And this is extra and above that.

But this bill specifically speaks to the pain and suffering that a patient must endure in order to get that prescription from their doctor. And it also states that you're only covered if your

insurance policy provides that provision. So you're paying for it already through the premiums that you pay to your health insurer. And your doctor has a say in it and your doctor is saying that you must have this certain prescription to alleviate the pain and suffering. And if there is an equivalent generic, you can do that. Why should we make a patient who is enduring pain and suffering go through a trial and error stage to say, "Well, let's try this one. If that doesn't work we'll go back and we'll try this one." And then the loved ones are sitting around saying, "My God, I wish I could help you but I can't."

The only thing that's preventing them from being helped is legislation that, if we don't pass this, when we know that there's something possibly out there that can help them. It is beyond our power. We as individuals can't do anything to reach into them to help them. They need the medication. They're paying for the medication. Let's give the folks exactly what they're paying for and what they need to make sure that they can get better.

Mr. President, there is a provision we've always talked about a generic equivalent. It says

in here if there is a generic equivalent, you can try that but we're not going to do a trial and error on patients through pain and suffering.

And I applaud Senator Crisco for bringing the bill forward and I look forward to voting in favor. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

Senator Kane.

Momentary lapse, technological lapses here. Are you all set, Senator?

SENATOR CRISCO (17th):

Mr. President, I only accept questions within a time span and that time has expired, I'm sorry.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

I don't know -- something -- obviously my microphone is not working, Senator Crisco. I apologize. I have been told I have a loud voice, but I'll use the microphone for recording purposes.

A few questions, through you, Mr. President, to Senator Crisco.

THE CHAIR:

Please proceed.

SENATOR KANE (32nd):

Senator Crisco, I think currently do we have a type of step therapy? Is that the term they use or type of therapy used for pain medications? Is it increased as time goes by or is it increased for the process of when a patient goes to the doctor and they come to them with their ailments or what have you? Is it increased over that time -- if you're -- Through you, Mr. President, if you can get the gist of my question? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Yes and through you, to Senator Kane, we don't have a step process legislative wise. I believe that some insurance companies, not all, have a process where they apply the step theory, before you receive the adequate medication. And well, there's a lot of pain and suffering sometimes as experienced because of that.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. And through you, in the doctor's or medical profession professional treatment where the patient wouldn't they try any number of medications based on their ailments or based on allergies, based on medical history, there's -- I would imagine there's no proven science that says one drug fits all. They have different ailments, different reactions so they try different drugs. Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane. I am not aware of physicians using a miss or try -- or you know, miss or correct process to get the right medication. I would hope for all of us that the physicians that we are treated by have the background and the education and the knowledge to prescribe the drug that is the proper drug for the ailment.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. Well, I can't believe they would get it right each and every time on the first shot, so to speak. You know, and certainly when it comes to medication and to all of us, there's no one size fits all approach.

This bill says that it prohibits plans from using alternatives before brand names. And so are we allowing doctors to prescribe certain brands? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Thank you, Mr. President. Through you to Senator Kane. We're not allowing -- that's the present law as it exists today. I -- hopefully that Senator Kane has not been to a physician recently but I believe that someone's in excrucial (sic) pain and this is the doctor and the doctor prescribes a specific brand drug -- pharmaceutical, that Senator Kane's going to rush to his nearest pharmacy and get that prescription fulfilled.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

No, I guess my question -- thank you, Mr. President -- no, it is this -- not -- hello?

THE CHAIR:

It's working.

SENATOR KANE (32nd):

There you go.

THE CHAIR:

Senator Kane, please proceed.

SENATOR KANE (32nd):

I think we need to go wireless, Mr. President.

SENATOR CRISCO (17th):

Perhaps Senator Kane would like to use my mike?

SENATOR KANE (32nd):

Perhaps I should come up there, Mr. President. I'm -- I -- I'm working the room as they say.

This bill prohibits the group plans or individual plans from prescribing an alternate if the doctor prescribes a certain brand. Yes? Am I correct in that? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Through you, Mr. President to Senator Kane, yes.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

so then -- Thank you, Mr. President. So then are we now allowing doctors to prescribe certain brands that they may have relationships with? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through to the Senator Kane, I don't think that's a question that can be answered. I would assume under the professional code of ethics for doctors that they prescribe what they feel is the right medication for their patients.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. But every year -- and I don't remember seeing it this year, but every year we see these bills come up about pharmacies, pharmaceutical companies and their ability to do lunches, I think it was, and dinners and being able

to provide doctors with certain dollar figures and that kind of thing.

But aren't we in this bill allowing that relationship? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through to Senator Kane, I'm quite aware of what he's alluded to which has been on the national level particularly, you know, addressed by Congress. I -- from what my knowledge -- my limited knowledge is that there is a professional approach between the pharmaceuticals detailed individuals that visit doctors and inform them of the benefits of their particular product. I'm not aware that what Senator Kane is alluding to exists.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. In this process if -- if this bill goes through, are we raising costs? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane, as stated before, we are perhaps eliminating waste and reducing costs and eliminating extra period of time of pain for the patient.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. But if we are not allowing the insurance company to offer an alternative and they must prescribe the brand that was recommended by the physician, that brand could be more expensive than the alternative? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane, yes and no. it could be more expensive if the substitute is not the appropriate remedy for the patient's, you know, illness. And forgetting the pain, but the other complications that could arise -

- I -- you know -- would -- it would cost us more money than save us money.

Mr. President, through you to Senator Kane, we're talking about a profession of individuals that have an unbelievable amount of education that we all, you know, our lives are dependent upon our physicians. To state or even suggest that physicians act in a unprofessional way, I think is unfair to the profession.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. And I -- I -- again, I'm off the question about the relationship between the doctors and the pharmaceutical companies. I'm strictly now talking about costs. And I'm curious whether to know that this discussion, this evidence, this testimony, did any of this come up in the public hearing process while this bill was going through committee? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane. In reviewing all the public testimony that was presented in our committee, the overwhelming testimony was that using this particular language and legislation would save money and pain.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. So through you, the insurance companies testified as well that they would save money? Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane, if he's aware of the historical history (sic) of presentations before the Insurance Committee, it's obvious that you have one particular view or point and then another view or point. But I personally would trust the physician view or point.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Well, thank you, Mr. President. And the reason I asked that is because typically I think we know that if the costs rise for the insurance companies, that means it's only going to get passed along to the consumer. Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to Senator Kane. It all depends upon the complications that arise from not using the brand name.

THE CHAIR:

Senator Kane.

SENATOR KANE (32nd):

Thank you, Mr. President. I thank Senator Crisco for his answers. I appreciate them and what took place in the committee process. I will be voting in opposition of this bill.

It is yet another unfunded mandate that we are proposing. I do understand that your argument if you will about the savings possibly in regards to the pain treatment. But at the same time I do believe that prescribing a specific drug when there is an alternative will raise costs. And in turn, if

it raises costs for the insurance companies, it raises costs for the consumer. And I believe that all mandates do that. And that's why I'll be in opposition to the bill. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

Senator Welch.

SENATOR WELCH (31st):

Thank you, Mr. President. Thank you, Senator Crisco for your comments so far. And every time I take a look at a mandate, I get concerned. There are truly mandates out there that solve problems. In fact, every mandate solves some problem. But they do create a cumulative effect that is negative and that Senator Kane alluded to, that is driving up the cost of health care, not only in this state but in other states.

But in this state in particular we have a lot of insurance mandates. So anytime a mandate comes across my desk, I spend a lot of time looking at the testimony to see what's driving it. What are people saying? You know, where are they coming from with respect to this. And I did take a look at the testimony. There are ten written submissions with

respect to this bill. And it didn't seem like there was a lot of overwhelming support. In fact, I only saw two from individuals. An individual from Shelton and I think it was an individual from North Haven, and both of them pretty much said the same thing with their letter.

Now, in contrast that to a mandate we had in the Public Health committee on epilepsy. And I'm not sure if that went to Insurance as well, where Senator Crisco sits, but it was -- there was overwhelming testimony as to the importance of making sure that the name brand drugs prescribed by the doctor were indeed the drugs being used. And there was a lot of scientific evidence for that need because epilepsy has a very narrow therapeutic bandwidth. Therefore, any deviation in the drug whatsoever could have very severe consequences for the patient. So I supported that mandate because it made a lot of sense and -- and the costs associated with that are well worth it.

Not to say that that's not the case here. But what this particular mandate causes me to question are the following. The first and this is in the form of a question through you, Mr. President, do we

know, Senator Crisco, if this mandate is an essential benefit under the Patient Protection Affordable Care Act? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to the Senator. First, I think we should clarify what we mean by mandate. According to my experience a mandate is something that is not covered. These prescriptions are covered under many insurance plans, number one. Number two, in regards to the Affordable Health Care Act, while I am quite knowledgeable of many of its components, I'm not aware of this particular question in that plan.

THE CHAIR:

Senator Welch.

SENATOR WELCH (31st):

Thank you, Mr. President, and I appreciate that answer. But it raises a concern. And the concern is this. As the Affordable Care Act moves forward if the state of Connecticut passes a mandate that is not an essential benefit within that Act, then we're paying for it. We're paying for it.

And I looked at the fiscal note, it said nothing with respect to that with regard to this mandate. I was surprised I didn't even see a footnote that mentioned the potential costs to the state of Connecticut depending on what the essential benefits are under the Patient Protection/Affordable Care Act which is another question I had with respect to the process. But obviously not one for here and now.

So that is a big concern I have because this could be a cost that the state of Connecticut will be picking up in the future.

The next question I have --

SENATOR CRISCO (17th):

Mr. President, can I -- can I make

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

- also add to my question to the Senator. We are in the process, we being the Connecticut General Assembly, putting together what's known as an insurance exchange bill that will require to adopt and part of that is the relationship to what mandates exist in Connecticut, and also to what

mandates or preventions, as I prefer to call them, would be covered under Affordable Health Care Act in the year 2014. We will have wording in our insurance exchange bill that would address that issue. Some of the options is that we will go along with our present preventions. And by 2014, when the new list -- because it's issued under the Affordable health Care Act, they may be all one and the same. They may be different and then it will be up to this august body to decide which preventions that we may want to maintain and which ones that we may not want to maintain.

- We may want to eliminate all the additional ones that we have in accordance to the Affordable health care Act or we may want to continue one or two. I think this august body has the intelligence for when that time arrives to make the proper decision.

THE CHAIR:

Senator Welch, you still have the floor.

THE CHAIR:

Senator Welch.

SENATOR WELCH (31st):

Thank you, Mr. President. And with that I would say that's further evidence that we're putting the cart before the horse in this case.

But the question that I have for the proponent of the bill next is this. Can a doctor today write on a prescription that this brand is medically necessary, and that in and of itself is enough to require the insurance company to make sure that that is the script that's filled? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to the Senator. You know, in Connecticut we're very proud that a couple of years ago we defined -- one of the first states, two states in the country -- to define medical necessity. Whether medical necessity is appropriate for all prescriptions I don't think that's very logical. There are a lot of maintenance drugs that are necessary. And to say that it has to be medical necessary, I think one has to allude to what you are referring to, the definition or to the generic term

of where you need this maintenance drug to prove the illness that you have presently.

THE CHAIR:

Senator Welch.

SENATOR WELCH (31st):

Thank you, and again, through you, I'm not sure I understood the answer to that question. If a doctor were to write on a prescription that this particular name brand is medically necessary, would an insurance company then be obligated to pay for that prescription? Through you, Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

Mr. President, through you to the Senator. It is my own experience and since I'm on ten prescription drugs a day I'm not aware of any of my prescriptions stating that this is medical necessary.

And also not being a physician, I'm not aware of how often this practice of writing on your prescription that this is medical necessary. I would assume that a prescription is recommending a medication that it's necessary.

THE CHAIR:

Senator Welch.

SENATOR WELCH (31st):

Thank you, Mr. President. I -- I think -- the good Senator and I might be two ships passing in the night at this point in time. But my understanding is that we have a process, we have a process through which a doctor can make sure that his or her patient is taking exactly the drug that he or she prescribes, and that it would be covered.

So -- so with that and with some of the other issues that I raised, I will not be supporting this bill at this time. Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

SENATOR CRISCO (17th):

Mr. President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17th):

I appreciate the good Senator's (inaudible) but I think if he would only look at the word brand. The word brand means basically is what the physician

feels is medical necessary for his patient or her patient.

THE CHAIR:

Thank you, Senator.

Will you remark further? Remark further? If not, Mr. Clerk, please announce the pendency of the roll call vote.

THE CLERK:

An immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber? An immediate roll call has been ordered in the Senate. Will all Senators please return to the Chamber?

THE CHAIR:

Have all members voted? Have all members voted? If all members have voted, the machine will be locked and the Clerk will take the tally.

THE CLERK:

The motion is on passage of Senate Bill 1083.

Total Number Voting 35

Those voting Yea 27

Those voting Nay 8

Those absent or not voting 1.

THE CHAIR:

The bill passes.

Senator Looney.

SENATOR LOONEY (11th):

Thank you, Mr. President. Mr. President, we have a number of items on our Calendar to refer to other committees at this time.

THE CHAIR:

Please proceed.

SENATOR LOONEY (11th):

And, Mr. President, the first of those items is on Calendar page 11, Calendar 444, Senate Bill 1054. Mr. President, move to refer that item to the Committee on Government Administration and Elections.

THE CHAIR:

So ordered.

SENATOR LOONEY (11th):

Thank you, Mr. President.

Second item is also on Calendar Page 11, Calendar 445, Senate Bill 1056. Mr. President, move to refer that item to the Committee on Finance, Revenue and Bonding.

THE CHAIR:

So ordered.