

Legislative History for Connecticut Act

PA 14-118

SB394

House	7090-7092	3
Senate	2199-2218	20
Insurance	1080-1091, 1122-1123, <u>1171-1184</u>	28
		51

H – 1201

**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 21
6912 – 7260**

Will the Clerk please announce the tally.

THE CLERK:

Senate Bill 55 as amended by Senate "A" in
concurrence

Total Number Voting	145
Necessary for Passage	73
Those voting Yea	95
Those voting Nay	50
Those absent and not voting	6

SPEAKER SHARKEY:

The bill, as amended, passes in concurrence with
the Senate.

SPEAKER SHARKEY:

Mr. Clerk, please call Calendar 517.

THE CLERK:

On page 27, Calendar 517, favorable report of the
joint standing committee on Appropriations, Substitute
Senate Bill 394, AN ACT CONCERNING REQUIREMENTS FOR
INSURERS' USE OF STEP THERAPY.

SPEAKER SHARKEY:

Representative Megna.

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, I move acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate.

SPEAKER SHARKEY:

Question's on acceptance of the joint committee's favorable report and passage of the bill in concurrence with the Senate:

Will you remark, sir?

REP. MEGNA (97th):

Thank you, Mr. Speaker.

Mr. Speaker, this bill simply empowers a health care provider when an insurer wants to use prescription drug step therapy. It's a good bill and ought to pass.

Thank you, Mr. Speaker.

SPEAKER SHARKEY:

Thank you, sir.

Would you care to remark? Would you care to remark further on the bill before us? Would you care to remark further?

If not, staff and guests 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.

The House of Representatives is voting by roll. Will members please return to the chamber immediately. The House of Representatives is voting by roll.

SPEAKER SHARKEY:

Have all the members voted? Have all the members voted? Will the members please check the board to make sure your vote is properly cast. If all the members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

Senate Bill 394 in concurrence with the Senate.

Total Number Voting	146
Necessary for Passage	74
Those voting Yea	118
Those voting Nay	28
Those absent and not voting	5

SPEAKER SHARKEY:

The bill passes in concurrence with the Senate.

Will the Clerk please call Calendar 543.

THE CLERK:

Calendar 543, favorable report of the joint standing committee on Energy and Technology,

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**CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
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THE CLERK:

On page 37, Calendar 211, Substitute for Senate Bill Number 394, AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY, favorable report of the Committee on Insurance and Real Estate.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Thank you, Madam President. Madam President, I move for acceptance of the joint committee's favorable report and passage of the bill.

THE CHAIR:

Motion is on acceptance and passage. Will you remark, sir?

SENATOR CRISCO:

Yes, Madam President.

This is an -- well, they're all important, but this addresses step therapy, and members of the circle, Madam President, may say what is "step therapy"? Well, step therapy is a tool that many health insurers use to contain pharmacy benefit costs. It requires patients to try and fail on less costly medication before he or she can step up to the medication recommended by their doctor. What Senate Bill 394 does, it gives practitioners the ability to override step therapy protocol under specific circumstances when the practitioner believes it is in the best interest of the patient, established guidelines to ensure practitioners have an expeditious process to override step therapy protocols under certain circumstances if the practitioners believes it is medically, medically in the best interest of the patient. And also limits the time a patient can be subjected to step therapy to the (inaudible)

team necessary by prescribing a practitioner to determine the treatments clinical effectiveness over a period no longer than 30 days. Step therapy is extremely important, and the healthcare provider can override a health plan Steps protocol when he or she can demonstrate that the required step therapy regimen has been ineffective in the past for treatment of the insurer's medical condition, is expected to be an ineffective, based on the known relevant fiscal or mental characteristics of the insured and the known characteristics of the drug regimen, it will cause or will likely cause an adverse reaction by fiscal harm to insurer if that should occur and if it's not in the insurer's best interest based on our definition, a medical necessity. Senate Bill 394 does not eliminate the use of step therapy. Insurers will retain the ability to contain costs with appropriate step therapy protocols, Madam President.

THE CHAIR:

Will you remark? Will you remark?

Senator Kelly, good afternoon, again, sir.

SENATOR KELLY:

Thank you very much, Madam President.

I have a couple of questions, through you to the proponent of the bill.

THE CHAIR:

Please proceed, sir.

SENATOR KELLY:

Thank you.

You indicated, Senator Crisco, that the -- the current step therapy protocol and process that insurance companies' carriers have would stay in place. Is that a fact?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, I'm sorry. Neither Senator Kelly and I are becoming silver tsunami candidates or there's noise, I really didn't hear the second part of his question.

THE CHAIR:

Senator Kelly, can you repeat that please, a little louder? Thank you.

SENATOR KELLY:

Certainly, Madam President.

As I understand what you said as you introduced the bill, the current insurance carrier has -- I'm going to -- if they have a step therapy protocol already in place that that protocol is not going to be displaced by this bill.

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you, yes, unless it can't be (inaudible) otherwise that it's an adverse reaction to the individual, the patient.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Okay. So basically the carrier would have a

protocol in place, that protocol remains in place but what this bill would do is provide a mechanism whereby you could override the -- the step therapy protocol. Is that correct?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the good senator, yes, the healthcare provider can override the health -- the health plan Step protocol when it can be demonstrated for -- under the required step therapy that there are negative effects.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Okay. So could you explain how the current step therapy protocol would occur, like what's the current law? What would happen if a patient had to conform with a -- a step therapy protocol? Can you give me an example?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the good senator, well, I can't -- through you, Madam President, through the Senator, I can't give specific medical cases with certain medical applications because, you know, the practice apply to prescription drugs treating a wide range of diseases and conditions include autoimmune diseases, cancer, diabetes, HIV, AIDS, mental

health and pain, so I -- I don't think I'm qualified to, unless I misunderstood the good senator, a specific answer to his question.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

What I am -- I'm trying to -- to get at and drill down on is the need for this -- this change in law and I want to understand how the current, like, what would be a current example of somebody going through step therapy and, then, how this would change that individual's situation if they meet one of these certain circumstances in which they could override the carrier's step therapy protocol.

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you, in my layman's knowledge, if a patient is on a medication which is less costly and it's not working effectively, then this would allow the patient to step up to recommendation to the medication recommended by the doctor if the doctor finds that it will help the patient as compared to the present medication that they're on.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

Would -- I guess what -- would this be something -- that would be a -- considered where a physician would prescribe a certain drug, maybe a name brand drug, of let's say a -- a pain medication and there was not only a less affordable but -- or less expensive but also generic that may not be as -- as -- I don't want to use the word "potent" but as strong as the originally prescribed medication. Is that what this would do is that you'd have to start at maybe a generic lower dose and work your way into the prescribed medication or is it just looking at an alternative generic that's the same dose?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the good senator, right now step therapy is already allowed. What this will do for the patient, if whatever therapy they were on now is not working and another medication is needed and it may be a little more costlier, this will allow the doctor to prescribe the new medication to help that individual patient.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Okay. That might be where I'm having a little bit of a misunderstanding here, because what I -- I think is that in order to override what's occurring you need a -- a -- some sort of a recommendation that it's medically necessary. And if the prescribed drug isn't working, you know, I would believe that that would be the way it was framed there that the physician had already recommended that prescription and it's not working so now we're going to go to another

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prescription that may work better, but I thought it was -- I thought step therapy was different from that. Am I incorrect in that -- that belief?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator. As I stated before that the healthcare provider can override a health plan step protocol when he or she can demonstrate several things (inaudible) required step therapy regimen, that the present regimen is ineffective in the past, now in the past or treatment of the insurer's medical condition is expected to be ineffective based on the known relevant physical or mental characteristics of the insured and the known characteristics of the drug regimen, it may cause or will likely cause an adverse reaction by or physical harm to the insurer, or if it's not in the insurer's best interest, based on medical necessity. So it's basically an approach to improve care, medical care to individuals that presently is not effective.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

Through you, who makes that determination as far as the ineffectiveness? Is it the -- the physician or the provider?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, I believe it's the provider.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Could Senator Crisco please repeat the answer?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Again, Madam President, --

THE CHAIR:

Ladies and gentlemen in the back --

SENATOR CRISCO:

We have competition.

THE CHAIR:

-- the dialogue between the two Senators, they're having some problems. If you could move from behind them I'd appreciate it. Thank you.

SENATOR CRISCO:

Madam President, through you to the Senator, the provider.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

And the mechanics of this override, if I were prescribed a -- a prescription that is ineffective, I've -- I'm taking it, it's ineffective, what do I do? Do I go back to my doctor and get information or do I just request a change through my provider?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you, according to my knowledge, to the good senator, the patient, you know, or the doctor determine if it's being ineffective and then the doctor can make the information available to the provider and to see if there's a different therapy that could be utilized.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Okay. So when we look at those certain circumstances and we seek to override, we would work in conjunction with our own physician or medical provider and come up with the necessary information that would create the medical necessity medically necessary documentation to prove the ineffectiveness and warrant the override. Am I correct in that statement?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

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Madam President, through you to the Senator, yes.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

Now in the bill it indicates that it -- it increased the time from 30 to 60 days. Do we know what the -- the average protocol in Connecticut is for those carriers that provide step therapy protocol?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, what has transpired in our process when the bill was before the Appropriations Committee it was changed from 30 to 60 days.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

While we changed that at the Appropriation Committee level, do we have any knowledge of what the current practice in the industry is with regards to the length of time for a step therapy protocol?

Through you, Madam President.

THE CHAIR:

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Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, I don't believe there is a standard definition or time because of the numerous illnesses that are being treated on the step therapy, so they vary, you know, whether it's, you know, pain versus cancer versus some other disease. So I think it varies upon not only the -- the medical condition but also how an individual tolerates certain medications.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

And now the 60-day period, is that a base minimum that the step therapy has to be engaged in or is that the -- the outlying maximum?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to Senator, I believe it's the base.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Senator Crisco. So if I understand that correct, I'd have to engage in the use of the initial prescription for 60 days before we deem it to be ineffective and could warrant it an

override?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, I believe there are current statutes in place where you can submit it -- the appeal before that that time.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

And if I did submit an appeal, what would that be for if I disagreed with what the -- the protocol was?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, yes, I believe for the protocol.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

So what's the difference between that appeal and the -- the current bill that would override the current step therapy protocol?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, I believe it just -- what the bill does is create uniformity and gives the practitioner an opportunity to see if his recommended therapy or medication is being effective and also of trying follow the provider guidelines that just provides a -- more opportunity if they step therapy is not effective.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

So then the appeal period that would be in current law would really be in accordance with the carrier and the step therapy protocol that they -- they currently would have internally?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, according to my knowledge, yes.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Through you, Madam President, are there any carriers that do not have step therapy protocols

that you're aware of?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, since there is such a great number of -- of providers in pharmaceuticals, but I believe that I think our state health plan does not provide for state step therapy.

THE CHAIR:

Senator Kelly.

SENATOR KELLY:

Thank you, Madam President.

And thank you, Senator Crisco, for answering my questions and clarifying a lot of areas of this bill that I had, obvious certain doubts and questions on. I have no further questions at this time and I do thank the Senator for his patience. Thank you.

THE CHAIR:

Thank you.

Senator Witkos.

SENATOR WITKOS:

Thank you, Madam President.

What an enlightening debate between the two Senators. You know, this is a classic case of making sure that nobody comes in between the doctor and its patient and if a doctor prescribes a medication -- well, let me back up. You go to the doctor because something is wrong with you, you don't feel well, and the doctor prescribes you a medication, and maybe they prescribe you a

generic to start off with, and it's just not doing the job that it was meant to or the doctor thought that it might be, so you go back to your doctor and you say it's not working. If we pass this bill, the doctor will be able to say, well, let's get a jump right to the -- the brand name rather than using the generic, and then hopefully the person's on -- on the road to a even greater speedier recovery. So I stand in strong support of the bill. This is something that we shouldn't allow because something is cheaper to be -- force a patient to suffer for 60 days because it's outside of the -- because of the Step program when it's not working. I think this is the -- the type of legislation that should we -- we should be discussing in -- in this chamber as medications are developed for various different reasons and the patients are better off, and I think in the long -- in the long run they're healthier, and we save money because they're back to work or they're out of -- they're not in the infirm stage and it's something that I'm certainly looking forward to support.

Thank you, Madam President.

THE CHAIR:

Thank you.

Will you remark?

Senator Frantz. Good afternoon, sir.

SENATOR FRANTZ:

Good afternoon, Madam President.

I think I have a question -- I think I have a question on the bill.

THE CHAIR:

Will you proceed, sir?

SENATOR FRANTZ:

Thank you.

Through you, Madam President, Senator Crisco, while I completely understand the intent of this bill, I think I do anyway, my question revolves around the kind of drugs that we're talking about, prescription drugs that we're talking about, are we talking about allergy medicines or are we talking about the full spectrum going up to more serious drugs where we all know for a fact that if you don't have the right kind of drug or the highest quality drug, that you can find in the marketplace, you may be asking for -- for trouble with that particular individual and I'm thinking specifically of things like schizophrenic drugs, anti-seizure drugs and the likes. So through you, Madam President, what are we talking about?

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, as I mentioned earlier, this practice is provide to prescription drugs treating a wide range of diseases and conditions, including autoimmune diseases, cancer, diabetes, HIV, AIDS, mental health and pain. And may I add to the good senator while step therapy can be an effective tool in some instances, it can also have significant negative consequences for the patient if the duration and effectiveness of the required Step protocols are not carefully managed. So what we are trying to do is participate in the appropriate management of step therapy for the best possible care for the patient.

THE CHAIR:

Senator Frantz.

SENATOR FRANTZ:

Thank you for that answer, through you, Madam

President, I suppose I'll have to listen to the rest of the debates to figure out which way to go on this bill. But it's clearly the -- it's the struggle between cost management and -- and quality, which there seems to be a direct correlation between -- or an inverse correlation, I should say -- I should say between saving money and having a high quality drug that's available on the market. So thank you for that clarification. We know that we're talking about some very, very serious drugs in addition to other drugs that are less -- that are designed to deal with less serious health problems. So thank you, Madam President.

Thank you, Senator Crisco.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

Good afternoon, Senator Welch.

SENATOR WELCH:

Good afternoon, thank you, Madam President.

I struggle with this bill and I struggle with it for a few reasons because, one, I can see the benefit, but two, I guess I question as to is there not already a process in place to address the situation that we're talking about and that be, you know, the adverse determination process. And -- and so I wonder -- I guess, a loud, Madam President, why would not one use that process that's in place, and so for instance, Madam President, if -- if I were prescribed a generic drug and let's say there was a name-brand drug out there by a company like Pfizer or something like that, and I'm not happy with the drug that was prescribed to me, why wouldn't I then approach the insurance company and go through -- and go through the process that's already in place, kind of skipping the whole step therapy thing?

Through you, Madam President.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, if I heard him correctly, to manage an illness, particularly the serious illnesses that I mentioned, there are times when an individual's system may react differently from different medications. This is just one Step -- step therapy to try to get it right. And many of the times, you know, they do get it right, but the same time we have to be fair, not only to the provider and the insurance company and to the doctor, but mostly to the patient. I believe this addresses all the possible good parts of step therapy and the negative parts of step therapy.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

And I can appreciate the statement, and I can appreciate the intent, I guess I just wonder aren't there already mechanisms in place to kind of circumvent say the bad parts of step therapy if there is an adverse reaction, if there truly is a better drug out there that a doctor certifies as medically necessary. That's my question, Madam President.

Through you.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO:

Madam President, through you to the Senator, there may be processes in place but they may be cumbersome and even more costly. And this is an attempt to make the most effective process applicable to the individual patient.

THE CHAIR:

Senator Welch.

SENATOR WELCH:

Thank you, Madam President.

And thank you, Senator Crisco, for your answers.

THE CHAIR:

Thank you.

Will you remark? Will you remark?

If not -- Senator Crisco.

SENATOR CRISCO:

If there's no objection, Madam President, I guess Senator Kelly has objection.

THE CHAIR:

Never mind, there will be a roll call vote.

SENATOR CRISCO:

Roll call vote, thank you.

THE CHAIR:

At this time, Mr. Clerk, will you please call for a roll call vote and the machine will be open.

THE CLERK:

There will be an immediate roll call vote in the

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Senate. An immediate roll call vote in the
Senate. All Senators report to the chamber.

THE CHAIR:

I'm going to ask you to please (inaudible) call
the roll call again.

THE CLERK:

Immediate roll call vote in the Senate.
Immediate roll call vote in the Senate.

THE CHAIR:

If all members have voted, all members have
voted, the machine will be closed.

Mr. Clerk, will you please call the tally.

THE CLERK:

Senate Bill Numbers 394.

Total number voting 35

Those voting Yea 28

Those voting Nay 7

Absent not voting 1

THE CHAIR:

The bill passes.

Mr. Clerk.

THE CLERK:

On page 4, Calendar 234, Senate Bill Number 196,
AN ACT CONCERNING GROUP-WIDE SUPERVISION FOR
INTERNATIONALLY ACTIVE INSURANCE GROUPS,
favorable report of the Committee on Insurance
and Real Estate. There are amendments.

THE CHAIR:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**INSURANCE AND
REAL ESTATE
PART 3
896 – 1294**

2014

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March 13, 2014

law/gbr INSURANCE AND REAL ESTATE
COMMITTEE

1:00 P.M.

REP. SAMPSON: Thank you, Mr. Chairman.

Scott, I just wanted to thank you for your testimony. You've certainly planted -- cleared the air tremendously for me because you answered the one concern that I had which is really protecting unit owners from, you know, the arbitrary changes that kind of are alluded to and why this legislation before us -- or this proposal will be. And I did look up online that the FHA did loosen those guidelines up to 50 percent for investor-owned units which I find amazing and I will -- glad I learned that fact, so thank you.

SCOTT SANDLER: Thank you. It's been my pleasure.

And, of course, we are -- the organization CAI, as well as myself as Chair of the legislative action committee, we're at your disposal ready and willing to provide whatever information we have.

Thank you for your time.

SENATOR CRISCO: Thank you very much.

WENDY FOSTER: Good afternoon. Thank you, Senator Crisco, Representative Megna and the committee for allowing us to speak. My name is Wendy Foster, and I am here to urge your support for S.B. 394, AN ACT CONCERNING REQUIREMENTS FOR INSURERS USE OF STEP THERAPY.

Senate Bill 394 ensures that patients with commercial insurance coverage have access to the same step therapy protections that the General Assembly extended to Medicaid enrollees in 2013.

As a representative of U.S. Pain Foundation, I am aware of other patients' experiences with step therapy. As a patient, I have personally dealt with the practice, as I have no definitive diagnosis I am treated symptomatically.

One of my symptoms is a compromised respiratory system having both restrictive lung disease and asthma. For this reason, I trust that my primary care physician or specialist will make the right treatment decisions based on his or her knowledge of my condition.

At one point, I was given a prescription for a pain medication by my doctor but my insurer required me to try a different medication first before filling the prescription my doctor wrote. As can happen with narcotics, I had increased difficulty with my breathing and required additional medication to improve. Had I been able to fill the initial prescription my doctor had written for me, the additional medication would not have been necessary, I would not have incurred the additional expense or office visit nor experienced increase distress that was caused.

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COMMITTEE

1:00 P.M.

Another time my pulmonologist prescribed a medication for my gastro esophageal reflux disease, GERD. Because reflux can exacerbate asthma it is important for me to keep mine in check. Once again, I was required by my insurance company to try a different medication first. The delay of the prescribed medication chosen for me by my physician who knows me and understands my condition, delayed treatment of the reflux and thereby delayed treatment of my asthma. This delay meant that an additional medication was necessary to control my asthma episodes.

These are just two examples of unnecessary complications that can arise when healthcare decisions are taken out of the hands of a patient's physician and put into the hands of an individual with neither the personal experience nor contact with the patient. For these reasons I urge you to ensure that patients with commercial insurance coverage have access to the same step therapy protection that the General Assembly extended to Medicaid enrollees in 2013 by supporting Senate Bill 394.

Thank you.

SENATOR CRISCO: Thank you, Wendy.

Any questions? Any questions of Wendy?

Thank you very much.

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COMMITTEE

March 13, 2014
1:00 P.M.

Marialanna is next.

MARIALANNA LEE: Good afternoon.

SENATOR CRISCO: Marialanna, please proceed.

MARIALANNA LEE: Thank you, Chairman.

Good afternoon to members of the committee as well. My name is Marialanna. I'm here today with the Leukemia Lymphoma Society representing our Connecticut chapter and the thousands of blood cancer patients and their caregivers, people that we're serving all throughout the State of Connecticut.

Thank you, of course, for the opportunity to comment on S.B. 394 concerning the use of step therapy. You know, this is -- it's a really important to our patients. I mean we're talking about people who are living every day just hoping and praying that they're going to have real access to the treatments that have been identified by their medical teams as offering the greatest chance of survival.

Chairman, you will remember that are your hearing back in February on S.B. 7 myself and many of the other patients advocates encouraged the committee to consider substituting for S.B. 7 language that would mirror the Medicaid provisions, those protections for step therapy that are already in place, in the law, in Connecticut.

Those, as you know, were passed by the General Assembly last year. They're fair. They're reasonable. The one negative was that they apply only to the Medicaid space. They don't apply to the commercial market. And so you know I want to -- I want to be clear in saying LLS supports this legislation.

We applaud the committee for raising it because you are, in effect, creating an opportunity for some consistency in the patient protections that are out in the market. Right. We think it's important that all of our patients regardless of the source of their coverage have access to the same protections under the law.

Now I've submitted written testimony, and I hope that you'll have an opportunity to look at it further but for now I just want to quickly mention three points in particular that -- that come up around this issue. One of them is cost.

You know step therapy as you know, it's been established as a -- as a cost-savings mechanism. At LLS, we feel that step therapy if used in tandem with the patient protections that again, already exist in Connecticut for Medicaid, step therapy done in that way can really help facilitate a better, stronger bottom line. That's because allowing clinical considerations and medical expertise to play their intended role in treatment decisions will only help prescribers, patients and

payers to collaborate to avoid the costly episodes of care that come about in those exceptional cases where the medical data indicates that a patient is not going to fair well on an insurers preferred treatment.

Also remember that we're talking about exceptional cases here. We're not talking about override being granted in every single scenario. We're talking about override being granted only when a provider can demonstrate medical necessity and that is defined very clearly in the bill language.

Second, the ACA mandates regarding State enacted mandates. That would not apply in this case. This is another -- another point of pushback that I hear a lot. That ACA provision applies only to State laws that are requiring coverage for new benefits or services. S.B. 394 would not mandate any new coverage. It's simply commenting on the use of utilization management techniques that's used for benefits that already exist.

And then, finally, with regard to the current appeals processes that exist, you know, what we hear from our patients is that they're inadequate; that they're very difficult to navigate; that they're time consuming; that they're ending -- they're resulting in delays in their care. You know, whether that's our patients needing to be better informed or whether it's you know the insurers have opaque processes, I think we can put that aside and

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agree that at the end of the day all prescribers having access to a clear and direct process for addressing step therapy requests that would really benefit the likelihood of achieving strong patient outcomes.

So I'll end there. Thank you again.

SENATOR CRISCO: Thank you.

Any questions?

Thank you very much for your time.

MARIALANNA LEE: Thank you.

SENATOR CRISCO: Continue on, Darth Vader. Only kidding. Only kidding. Only kidding.

Susan.

SUSAN HALPIN: Senator Crisco, Representative Megna, members of the committee. For the record, my name is Susan Halpin and I'm here today on behalf of the Connecticut Association of Health Plans to testify in opposition to Senate Bill 394, AN ACT CONCERNING REQUIREMENTS FOR INSURERS USE OF STEP THERAPY.

I changed my testimony a little bit this time which may be refreshing for some of you. I think you've all heard our concerns about the costs that are associated with prescription drugs.

But what I did was try to respond a little bit to some of the questions that you've -- you've asked previously.

The bill that's before you would set up a separate process for pharmacy utilization review and -- and appeals outside the purview of the current utilization review statute which is very prescriptive.

I think if you set up a separate process for drugs it would prove to be pretty cumbersome and confusing. I put down the section of the Statute 38a-591 which establishes the process for urgent care utilization review requests.

And the statute states that any benefit request is determined to be an urgent care request if it's made by a healthcare professional with knowledge of the covered person's medical condition or for a situation that's very clearly defined, as you'll see below, which I think gives a lot more specificity even than what's -- what's contemplated currently in the bill before you.

The carrier may offer the -- the healthcare professional of an urgent care request the opportunity to have a peer-to-peer discussion. That's what we talked about last time I testified on the previous step therapy bill that's also under consideration in the committee, which provides the opportunity for an exchange about information -- clinical

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information that may make an insurer you know see the wisdom of approving that second bill. But the -- but the insurer has to have the opportunity to get that information. Oftentimes that's what happens, that's where the lag is is they don't get the information from the provider.

And the law provides that a carrier must make a determination for an urgent-care request as soon as possible, and that's actually in the law, taking into account the person's medical condition but not later than 72 hours after receiving the request.

As the insurance statutes go, they repeat for utilization review, average determinations, external appeal, and there are similar parameters that exist for those statutes for urgent-care requests throughout the current law.

So we believe there are multiple points of access currently that are there to address the problems that are envisioned under 394. And we would submit to you that the -- the bill before you is unnecessary and we, hopefully, urge your rejection of the bill.

And then I went on to give you the -- you know the cost consequences around passage of the legislation which we hope you will continue to consider.

SENATOR CRISCO: Thank you.

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Any questions? Any questions?

Thank you very much.

SUSAN HALPIN: Thank you, Senator.

SENATOR CRISCO: Brian.

BRIAN QUIGLEY: Thank you, Chairman Crisco,
Chairman Megna and members of the committee.
And thank you for not referring to me as Darth
Vader.

For the record, I'm Brian Quigley,
representing Express Scripts, the pharmacy
benefit manager to indicate our opposition to
Senate Bill 394. Fully agree with Susan's
comments on behalf of the association. We
also think that it -- this legislation is
unnecessary for the commercial market because
we do have, in Connecticut, the most stringent
urgent appeal requirements in the country
following the passage last year of Public Act
13-3.

In addition, all PBMs have exception processes
built in now that are required by the
Department of Insurance so that people can
apply for an exception to the step therapy
program.

There are computer programs in place to
identify those who've already been on a

medication so they don't have to go through step therapy again.

I've mentioned in testimony on other bills of this type the potential costs that are coming from new drugs. One drug, solvaldi is \$84,000 for a 12-week treatment.

Since I testified last week on that a panel of experts in California have recommended that these -- that that drug only be used for patients with severe hepatitis complications because of the potential costs. So state governments, Medicaid/Medicare and -- and private carriers are going to have to look at all of these new drugs and see how step therapy and prior authorization, genetic -- generic substitution work to control the costs of these coverages.

As Susan said, you can't achieve consistency with the passage of this bill because the majority of the population would not be covered by this bill.

So we're very concerned that unlike Medicaid which is -- it's probably the wrong word but a captive population. You've got a stable population. You know who they are. People can move from large group coverage where this protection would not be available to a small employer coverage.

You get coverage for very expensive drugs and that type of vanity selection will make

coverage much less affordable for small employers and for those purchasing coverage on the exchange. So we would urge you to oppose this bill. I'd be happy to answer any questions.

SENATOR CRISCO: Thank you, Darth Vader, Jr.

Any questions? Any questions?

Thank you very much.

BRIAN QUIGLEY: Thank you.

SENATOR CRISCO: Proceeding to House Bill 5501,
Donna, to be followed by Stacy.

DONNA KARNES: What's the opposite of Darth Vader?

SENATOR CRISCO: Well, we could call you Mother
Theresa.

DONNA KARNES: I don't know. Okay.

Good afternoon, Senator Crisco, Representative Megna and members of the committee. It's been awhile since I've seen you. What since Tuesday in New Haven. Thank you for coming.

My name is Donna Karnes and I'm a realtor in Norwalk, and the immediate past chair of the legislator committee of Connecticut Realtors. I appreciate the opportunity to speak in support with amendments to H.B. 5501.

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REP. SAMPSON: Okay. That was really the only question.

RALPH BIONDI: Representative Sampson, I don't know.

REP. SAMPSON: Okay. Thank you.

SENATOR CRISCO: Any other questions?

Thank you so much, sir.

We will return now to the legislative part of the public hearing.

Representative Orange.

REP. ORANGE: Thank you, Mr. Chairman. For the record, my name is Linda Orange, State Representative from the 48th Assembly District. And thank you once again for giving me the opportunity to testify this time in support of Senate Bill 394, AN ACT CONCERNING REQUIREMENTS FOR INSURERS USE OF STEP THERAPY.

I have heard from constituents that they sometimes have to take prescriptions that are not what their doctor has -- has prescribed but what the insurer requires in order to get coverage and payment from their plan.

If that drug fails to be effective the patient may be able to then get coverage for the drug originally prescribed by his or her physician. Patients may be required to fail repeatedly on

the same drugs over any length of time before this happens under current law.

This bill establishes a simple and necessary override process that in cases of medical necessity a physician may override an insurer's step protocol. This bill is similar to legislation that we passed last year for Medicaid beneficiary and would apply a similar override process for privately-insured individuals. I believe this bill strikes a reasonable and balanced approach that will allow step therapy to better realize its cost-savings goals and to do so without causing the patient harm. I urge this committee to favorably report the bill.

SENATOR CRISCO: Thank you. Thank you, Representative.

REP. ORANGE: Thank you, Mr. Chairman.

SENATOR CRISCO: Are there questions? Any questions?

Thank you so much.

REP. ORANGE: Thank you for allowing me to run in last minute. I appreciate it.

SENATOR CRISCO: Any time.

REP. ORANGE: Thank you.

SENATOR CRISCO: All right.

March 13, 2014

Raised Senate Bill No. 394

Good afternoon. My name is Wendy Foster. Thank you for allowing me to speak on SB 394: An Act Concerning Requirements for Insurers Use of Step Therapy.

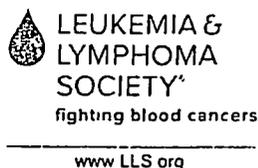
Senate Bill 394 ensures that patients with commercial insurance coverage have access to the same step therapy protections that the Gen. Assembly extended to Medicaid enrollees in 2013.

As a representative of US Pain Foundation, I am aware of other patient's experiences with step therapy. As a patient, I have personally dealt with the practice. As I have no definitive diagnosis, I am treated symptomatically. One of my symptoms is a compromised respiratory system, having both restrictive lung disease and asthma. For this reason, I trust that my primary care physician or specialists will make the right treatment decisions based on his or her knowledge of my condition. At one point, I was given a prescription for a pain medication by my doctor but my insurer required me to try a different medication first before filling the prescription my doctor wrote. As can happen with narcotics, I had increased difficulty with my breathing and required additional medication to improve. Had I been able to fill the initial prescription my doctor had written for me, the additional medication would not have been necessary, I would not have incurred the additional expense or office visit, nor experienced the increased distress that was caused. Another time, my pulmonologist prescribed a medication for my gastroesophageal reflux disease. Because reflux can exacerbate asthma it is important for me to keep mine in check. Once again, I was required by my insurance company to try a different medication first. The delay of the prescribed medication, chosen for me by my physician who knows me and understands my condition, delayed treatment of the reflux and thereby delayed treatment of my asthma. This delay meant that an additional medication was necessary to control my asthma episode.

These are just two examples of unnecessary complications that can arise when healthcare decisions are taken out of the hands of a patient's physician and put into the hands of an individual with neither the personal experience nor contact with the patient.

For these reasons I urge you to ensure that patients with commercial insurance coverage have access to the same step therapy protection that the Gen. Assembly extended to Medicaid enrollees in 2013 by supporting Senate Bill 394.

Thank you



Written Testimony in Support of Step Therapy Reform (SB 394)
Insurance and Real Estate Committee
Public Hearing – March 13, 2014

Chairmen Crisco and Megna, and Members of the Committee:

On behalf of the Leukemia & Lymphoma Society (LLS) and the thousands of blood cancer patients we serve throughout the state of Connecticut, we thank you for the opportunity to comment on Raised Senate Bill No. 394, concerning the use of step therapy. LLS applauds the committee for raising this bill, as it would ensure that patients with commercial coverage have access to the same step therapy protections that the General Assembly extended last year to Medicaid enrollees.

Step therapy is a widely-used technique that insurers use to control drug costs. Under step therapy, an insurer places a coverage restriction on certain prescription medications. Before the plan will authorize coverage for those medications, the patient must first try other, generally less expensive drugs to see if they will be effective. In 2010, almost 60% of commercial insurers were utilizing step therapy nationally.¹ In Connecticut, the practice is applied to drugs used to treat a wide range of diseases and conditions, including cancer, diabetes, HIV/AIDS, mental health, multiple sclerosis, and other rare diseases.

While step therapy can be an effective tool in some instances, it can have significant negative consequences for a patient if the duration and effectiveness of the step therapy is not managed carefully. Note that the drug sequences required under step therapy are not based on a patient's specific medical profile or a physician's assessment of that patient's best treatment option. Rather, sequences are based on cost and on general expectations about potential treatment responses. Also, note that patients with commercial coverage may be required to try the same drug(s) repeatedly over any length of time, as the law does not place any constraints on the duration of a step therapy protocol.

If not managed carefully, step therapy can lead to delays in access to the medication offering the greatest medical benefit. Other patients may find themselves with no alternate therapy for an extended period of time. According to one recent study, 67% of patients whose specialty drugs were rejected under step therapy did not receive an alternate drug within a 30 day window.³ In these cases, patients may experience disease progression, a serious risk for patients dealing with life-threatening conditions. While Connecticut took an important first step last year by protecting Medicaid patients from inappropriate use of step therapy, those with commercial plans do not have access to the same protection.

For many cancer patients, every day is a battle. From the moment of diagnosis, patients rightfully want to know that they will have access to the treatment plan determined by their medical team to offer the greatest clinical benefit. Data from 2012 shows that an increasing percentage of plans are applying step therapy programs specifically to oncology products: 54% of plans, up from only 36% the year before.⁴ This trend is deeply worrying to the cancer community, given that recent treatment breakthroughs are driven by the principles of "precision medicine": today, oncologists have access to more diagnostic information than ever before, allowing them to make treatment decisions based on a patient's specific profile. Yet those advantages can be diminished by step therapy, given its reliance on generalizations about large patient populations.

Fortunately, the Medicaid rules in Connecticut offer a common-sense, balanced solution that – if applied to the commercial space – would enable insurers to continue using step therapy for cost-savings purposes while *also*

ensuring that treatment decisions are left to the patient and his/her medical team. Medicaid does this by providing the prescriber with a process to request an override of the relevant step therapy protocol, when medically necessary. This override is granted *only* if the provider can demonstrate the presence of certain clinical characteristics – namely, that the preferred treatment required under the step therapy program:

1. Has been ineffective in the treatment of the patient's condition in the past;
2. Is expected to be ineffective, based on relevant characteristics of the patient and the drug regimen;
3. Will cause or is likely to cause an adverse reaction or other physical harm to the patient; or
4. Is not in the best interest of the patient, based on considerations of medical necessity.

Also, in cases where step therapy is appropriate for use, the bill would limit the amount of time a patient could be subjected to step therapy so that patients cannot be obligated for an indefinite period of time to risk treatment delays or adverse reactions. That limit would be thirty days, after which point the healthcare provider may deem the treatment clinically ineffective for the patient at hand.

These simple protections can help facilitate a strong bottom line, as more effective cost-control can be achieved by allowing clinical considerations and medical expertise to play their intended role in treatment decisions. This will help avoid the costly episodes of care that arise from unnecessary delays in treatment and/or side effects.

Also regarding cost: we would like to clarify that the Affordable Care Act provision requiring states to defray the cost of recently enacted insurance mandates would not apply to SB 394. According to federal regulations,¹ this requirement applies only to state laws that require the coverage of *new* benefits and/or services. SB 394 does not require insurers to add drugs to their formularies or to make any other additions to a plan's covered benefits and services. Rather, SB 394 addresses the way a utilization management technique is applied to drugs that are already on formulary.

Finally, it's important to understand that currently available appeals processes do not offer sufficient patient protection when it comes to step therapy. Navigating these processes is typically difficult and time-consuming for patients, caregivers, and prescribers alike, which can delay care anywhere from days to weeks. This is often due to a lack of transparency in an insurer's internal appeals process, which itself must be exhausted before a patient's claim would be eligible for external appeals. Simply put, the likelihood of strong patient outcomes would be greatly enhanced if all prescribers – not just those treating Medicaid patients – have access to a procedure for requesting a step override that is less opaque and more direct and efficient.

With questions, please contact.

Marialanna Lee
 Director, State Government Affairs, NE Region
 Leukemia & Lymphoma Society
 Office of Public Policy
marialanna.lee@lls.org
 (215) 232-2763

Jennifer McGarry
 Senior Manager, Patient Access, Education & Advocacy
 Leukemia & Lymphoma Society
 Connecticut Chapter
jennifer.mcgarry@lls.org
 (203) 427-2046

¹ Motheral, Brenda. *Journal of Managed Care Pharmacy* Vol 17, No 2 March 2011.

² Report from Health Strategies Group, published by *Managed Care Oncology* during the 4th quarter of 2012.

³ Department of Health and Human Services "Patient Protection and Affordable Care Act, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" 45 CFR Parts 147, 155, and 156 Available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>



Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, March 13, 2014

Connecticut Association of Health Plans

Testimony Submitted in Opposition to

SB 394 AAC REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 394 AAC Requirements for Insurers' Use of Step Therapy which would seriously compromise the efforts of health plans to contain costs and use practices designed to ensure cost-efficient and effective prescription drug use.

SB 394 would prohibit carriers from requiring that members try a less costly prescription drug for "more than 30 days" if a provider at the end of the 30 days indicates that the drug is clinically ineffective. In addition, the bill requires that carriers establish and disclose a process by which an insured's treating provider may request at any time an override of the step therapy regimen and requires "expeditious" approval by the health insurer upon such request.

Passage of SB 394 would set up a separate process for pharmacy utilization review and appeal outside the purview of the current utilization review statute that would not only prove duplicative and costly but could also prove cumbersome and confusing.

Section 38a-591d already establishes a process for urgent care requests that requires carriers to maintain written procedures for an expedited review relative to prospective urgent care requests. The current statute states that any benefit request "is determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition OR for a situation as defined under 38a-591a(38)s:

(38) "Urgent care request" means a request for a health care service or course of treatment (A) for which the time period for making a non-urgent care request determination (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (ii) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested, or (B) for a substance use disorder, as described in section 17a-458, or for a co-occurring mental disorder, or (C) for

a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, as defined in section 38a-496, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

The carrier may offer the health care professional filing an urgent care request the opportunity to confer with a clinical peer if a grievance hasn't yet been filed. Unless the provider has failed to provide the information necessary to make a determination, the carrier *must make a determination as soon as possible taking into account the person's medical condition but not later than 72 hours after receiving the request.*

Similar parameters exist for expedited reviews of adverse determinations both internally by the carriers themselves and externally through the Department of Insurance's independent appeals process

Multiple points of access exist currently to address the problems envisioned under SB 394. There is no need for the proposal and the Connecticut Association of Health plans respectfully urges rejection of the bill.

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, generic or over the counter). When no clinical advantage is apparent, cost considerations often warrant moving members and providers to use the more cost-effective drug.

This law would drive up health care costs with no improvement in clinical outcomes and frankly, it contradicts not only the goals of the Affordable Care Act (ACA) which seek to find the least costly effective treatments and encourage their use whenever possible but, it also runs contrary to efforts currently underway by the state itself to control escalating prescription drug costs via the State Employee Plan and the Exchange. 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.

Please also keep in mind also that passage of SB 394 would *only* apply to the approximately 35% of Connecticut residents that are covered by fully insured health plans - typically your small employers who are the most price sensitive. The bill would *not* apply to the 65% of Connecticut residents who are self-insured and thereby subject to federal ERISA requirements rather than state law. Passage of SB 394 would likewise have a detrimental effect on the Health Care Exchange which needs provisions like step-therapy to help keep premiums affordable.

We urge your rejection SB 394. Thank you for your consideration.



Office of the
Healthcare
Advocate
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
State Healthcare Advocate
Before the Insurance and Real Estate Committee
In support of SB 394
March 13, 2014**

Good afternoon, Representative Megna, Senator Crisco, Senator Kelly, Representative Sampson, and members of the Insurance and Real Estate Committee. For the record, I am Vicki Veltri, State Healthcare Advocate with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

Thank you for the opportunity to comment on Senate Bill 394, which addresses an important issue in healthcare delivery. As healthcare costs continue to rise, payors continue to seek means of minimizing expenditures, and the use of step therapy to ensure that cost effective treatments have been exhausted prior to approving alternate medication therapy is one tool to achieve that goal. However, while acknowledging payor's interest in reducing costs, SB 394 appropriately defers to the treating physician's clinical judgement. Although the 30 day requirement for payor preferred medication may delay the beginning of the prescribed course of treatment, this proposed legislation importantly enables the physician to independently make the determination whether the step therapy has had the desired and optimal clinical effect. More importantly, permitting physicians to override the 30 day step therapy requirement if, in their judgment, it would be ineffective or detrimental to the patient respects the physician's experience and clinical assessment.

As the only agency whose primary mission is to advocate for Connecticut's consumers healthcare needs, I thank you for providing me the opportunity to deliver OHA's testimony today. If you have any questions concerning my testimony, please feel free to contact me at victoria.veltri@ct.gov.

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National Multiple Sclerosis Society
Connecticut Chapter
659 Tower Avenue, First Floor
Hartford, CT 06112-1269
Tel +1.860.913.2550
Fax +1.860.761.2466
www.ctfightsMS.org

Insurance and Real Estate Committee Public Hearing – March 13, 2014
Testimony in Support of
S.B. No. 394 (RAISED) AN ACT CONCERNING REQUIREMENTS FOR
INSURERS' USE OF STEP THERAPY

Senator Crisco, Representative Megna, Senator Hartley, Representative Wright, Senator Kelly, Representative Sampson and members of the Insurance and Real Estate Committee,

Thank you for the opportunity to submit written testimony. My name is Susan Raimondo and I am the Senior Director of Advocacy and Programs for the National Multiple Sclerosis Society, Connecticut Chapter.

We are asking that the Insurance and Real Estate Committee pass SB 394, An Act Concerning the Requirements for Insurers' Use of Step Therapy.

Our request is that the legislature pass legislation that will do two things:

1. limit the number of medications required to be tried to only one and the maximum amount of time needed to try a medication should be only 30 days.

2. establish a method for health care providers to exempt any patient from a step therapy requirement if:
 - The drug required by the insurance company has been ineffective previously
 - The drug is expected to be ineffective
 - The drug will or will likely cause adverse events or harm to the patient, or
 - It is in the best interest of the patient to be exempted

Over the past few years, health plans have increased efforts to control costs by instituting tactics including step therapy, increasing enrollee cost-sharing and creating specialty tiers. For those patients in health plans subject to these practices, the rising cost of MS disease modifying therapies and other medications can jeopardize access to treatments. We realize that steps must be taken to contain costs; however critical time can be lost when insurers require that an individual must fail on multiple medications.

Multiple sclerosis is an aggressive disease, it can progress rapidly. Disability can occur within a short amount of time. In the case of MS, it is not merely a period of trying medication to see if it works; there often is a "wash-

out" time that must happen before a new medication can be used. In addition, there may be the need to objectively measure the size and number of MS lesions in an individual' s brain, spinal cord and optic nerve to see if a medicine is working. The MRI can provide this measure; however getting insurance approval for an MRI can take valuable time, where disability may be increasing.

The Mandell Center for Multiple Sclerosis at Mount Sinai Rehabilitation Hospital has an example of how difficult it is to obtain needed medication. They are treating a 26 year old female who was diagnosed with MS in July 2013 after onset of ataxia, leg heaviness, and significant double vision. Her MRI showed involvement in the brain stem, hemisphere, and spinal cord. She was treated with two courses of steroids. Another MRI showed new lesions. She responded to the second course of steroids, and her neurologist recommended Tysabri to treat her aggressive MS. Tysabri is the only medication to show significant results for people with aggressive MS.

A request for Tysabri was made to her insurance, it was denied, appealed and the neurologist interviewed with the plan' s medical director to plead for a trial of Tysabri. The medication was still denied and the plan required step therapy. The company requires that the individual fail two injectable medications prior to Tysabri being approved. She took Copaxone and was unable to tolerate it. She has now initiated Rebif. Clinical concerns are that this individual will have ongoing aggressive MS. Unfortunately, as of late February 2014, this patient has not started Tysabri due to insurance steps. This could lead to increased levels of disability for a young member of

society. She had been out of work for several months as a result of her severe presentation of symptoms.

Individuals with MS and other chronic debilitating diseases do not have time to wait to determine if multiple medications will work. Physicians are the best determinants of clinical treatments and their recommendations must be promptly available to all patients.

Please pass SB 394, An Act Concerning the Requirements for Insurers' Use of Step Therapy.

Thank you.

For more information, contact the National MS Society, Connecticut Chapter at 860.913.2550 or email programs@ctfightsms.org.



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serving Connecticut, Maine, Massachusetts, New Hampshire Rhode Island & Vermont

35 Cold Spring Road, Suite 411
 Rocky Hill, CT 06067-3166
 TELEPHONE: (860) 563-1177
 TOLL-FREE: (800) 541-8350
 FAX: (860) 563-6018
 EMAIL: infosne@arthritis.org

March 15, 2014

Senator Joseph J. Crisco, Co-Chair
 Representative Robert W. Megna, Co-Chair
 Insurance and Real Estate Committee
 Room 2800, Legislative Office Building
 Hartford, CT 06106

WRITTEN TESTIMONY ON RAISED BILL 394-AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY.

Senator Crisco, Representative Megna, and Member of the Insurance and Real Estate Committee

The Arthritis Foundation favors the provisions on step therapy in Raised Bill 394 that extend to those with commercial health insurance the same protections afforded Connecticut Medicaid patients. This bill protects people from having to fail a prescription drug more than once and limits the trial of a step therapy to 30 days.

Doctor-diagnosed arthritis affects one-fourth or 654,000 of our state adult population, according to the Centers for Disease Control and Prevention (CDC).¹ CDC also estimates that arthritis affects 3,400 children in our state.²

Step therapy is a practice that insurers sometimes use to control costs by requiring patients to fail less expensive prescription medications before receiving more expensive medications.

The Arthritis Foundation has no issue with requiring those newly diagnosed to fail preferred medications before trying non-preferred medications, where such sequencing is in concert with published medical guidelines for best practices for disease control. For instance, in arthritis, the American College of Rheumatology published guidelines for recognized therapies and recommended sequencing of therapies.

We are especially pleased that this bill includes an exemption provision, since in medicine there is no one size fits all. This provision allows a doctor to request an override of step therapy in one of three instances. These include: the medication has been ineffective in the past; is expected to be ineffective in the patient based on current research; or may cause adverse effects or other physical harm.

We encourage the committee to add the following two additional provisions:

- 1 Those stable on a therapy should not be required to switch to a preferred drug and fail it before getting back on a therapy that meet established criteria for disease control. Our state's Pharmacy and Therapeutics Committee has in the past grandfathered Medicaid patients

Arthritis Foundation Testimony on Raised Bill 394-page 2

stable on an existing therapy in the interest of maintaining disease control. Disease control is particularly important in arthritis to avoid permanent damage to joints.

2. Step therapy provisions should follow currently accepted and published medical guidelines for progression of treatment for chronic diseases.

For instance, the American College of Rheumatology (ACR) recommendations for the treatment of rheumatoid arthritis starts with disease-modifying anti-rheumatic drugs, most of which as available in generic form. These agents are given singularly then in combination before adding treatment with the more expensive biologic therapies.

In the last several years, we have seen insurers require patients to fail two or more self-injectables before getting access to an infusible therapy, such as Remicade. Infusible therapies are often chosen when a patient can't inject because of hand deformity or in children where the dose needs to be adjusted for body weight.

The choice of an individual agent is complex and is undertaken with many variables in mind, including the diagnosis, the proximity of the patient to the physician's office, the patient's preference for mode of administration, the patient's ability to be mobile, and the physician's experience.

In summary, physicians, not insurers, should prescribe the most appropriate treatment for their patients. Thank you for your consideration.

Susan M. Nesci, MS, MA
Vice President, Public Policy & Advocacy
35 Cold Spring Road, Suite 411
Rocky Hill, CT 06067
860-563-1177
860-563-6018 FAX
snesci@arthritis.org

¹CDC, Division of Adult and Community Health, 2010 (cdc.gov).

²Sacks J, Helmick CG, Luo YH et al. Prevalence of and annual ambulatory health care visits for pediatric arthritis and other rheumatologic conditions in the United States in 2001-2004. *ArthRheum* (Arthritis Care and Research) 57:8 1439-1445 2007

SENATOR MARTIN M. LOONEY
MAJORITY LEADER

Eleventh District
New Haven, Hamden & North Haven



State of Connecticut

SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

March 13, 2014

FTR

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I would like to express my support for SB 394 AN ACT CONCERNING REQUIREMENTS FOR INSURERS' USE OF STEP THERAPY. Under this bill, if an insurer requires the use of step therapy in its policies, the use of step therapy for any prescribed drug would be limited to 30 days. If at the end of the thirty day period, the insured's treating health care provider deems such step therapy drug regimen clinically ineffective for the insured, the insurer must provide the drug requested in the original prescription. In addition, the treating healthcare provider may make a request to override the step therapy requirement even before the 30 days have elapsed. These time limits on the use of step therapy by private insurers are similar to the policy regarding step therapy enacted under Connecticut's Medicaid plan. I believe that this bill would improve the quality of care in our state and ensure that physicians rather than insurance companies practice medicine. Thank you for raising this important legislation.

P. 1
Linda

State of Connecticut
HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE LINDA A. ORANGE
DEPUTY SPEAKER OF THE HOUSE
48TH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 4012
HARTFORD, CT 06106-1591

HOME: 860-537-3936
CAPITOL: 860-240-8585
TOLL FREE 1-800-842-8267
FAX: 860-240-0206
E-MAIL: Linda.Orange@cga.ct.gov

MEMBER
APPROPRIATIONS COMMITTEE
GENERAL LAW COMMITTEE
LEGISLATIVE MANAGEMENT COMMITTEE
PUBLIC SAFETY AND SECURITY COMMITTEE

March 13, 2014

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

Senator Crisco, Representative Megna, and members of the Insurance and Real Estate Committee:

Thank you for giving me the opportunity to testify in support of Senate Bill 394, An Act Concerning Requirements for Insurers' Use of Step Therapy.

I have heard from constituents that they sometimes have to take prescriptions that are not what their doctor has prescribed but what the insurer requires in order to get coverage and payment from their plan. If that drug fails to be effective, the patient may be able to then get coverage for the drug originally prescribed by his or her physician. Patients may be required to fail repeatedly on the same drug(s) over any length of time before this happens under current law.

This bill establishes a simple and necessary override process that, in cases of medical necessity, a physician may override an insurer's step protocol. The bill is similar to legislation that we passed last year for Medicaid beneficiaries and would apply a similar override process for privately insured individuals. I believe the bill strikes a reasonable and balanced approach that will allow step therapy to better realize its cost-savings goals and to do so without causing patient harm.

I urge this committee to act favorably on SB 294.

Sincerely,

Linda Orange
Deputy Speaker, 48th District