The Insurance Federation of Pennsylvania, Inc.

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February 18, 2020

To: The Honorable Members of the House Committee on Consumer Affairs

From: Samuel R. Marshall

Re: House Bill 853 – mid-term changes in health policies

We testified on this almost two years ago, and our views and questions remain, as does our commitment to work with all interested parties to assure quality care to our policyholders.

The bill is a broad prohibition of any changes in coverage during the course of a health policy. We're not aware of any insurer raising premiums, copayments, coinsurance or deductibles in the middle of a policy. There may be other types of changes, though, that would happen during the course of a particular policy and could therefore be seen as altering the policy itself:

- For instance, a provider may join (or leave) an insurer's network; or an insurer may drop a requisite of prior authorization and switch to an aggregate limit on visits to a provider; or a new procedure or device may come into being during a policy year. Those are the types of changes that logically could and should be folded into an insured's coverage as a policy year progresses, not wait for the policy's renewal.

The bill's focus seems to be changes in drug formularies, imposing what is commonly known as a "frozen formulary" requisite: An insurer couldn't change coverage of a particular drug that an insured has been getting during the course of that policy – those changes can happen, but only at policy renewal, not during the policy itself.

We don't think that helps individual patients or the broader consumer interest of getting the best prescriptions at the best prices. Changes in the efficacy or cost of a particular drug don't fit neatly into a policy term; they may evolve and change during the policy term, and so might other alternative drugs. Insurance coverage

should reflect that, not wait for the next policy period to stay current with developments in the pharmaceutical world, or to gain savings for our policyholders.

Some examples of the shortcomings of a frozen formulary requisite:

- If a new generic, new brand or new OTC medication is released during the policy year, why not incorporate it sooner than later?

- If there are changes to utilization management, why wait to implement them? Consider opioids as an example where more management has been recognized as necessary – why delay it?

We realize the patient's well-being is paramount, and nobody is suggesting mid-policy changes of medications that might jeopardize that. All health plans provide notice of any change in a drug formulary and allow a doctor to explain why a patient should remain on a particular drug even if less costly alternatives come along.

That might be a better focus: Why not let coverage of a particular drug evolve in real-time along with the science, availability and cost of it and any alternatives – but ensure that the insured not be faced with a switch that may undercut the quality of care being covered, as with assuring notice and appeal rights?

One note: The bill applies to insurance companies, but not to self-insured plans, and not to government programs, as with Medicaid. Why not ask DHS what it does and why?

One drafting concern: The bill amends the Unfair Insurance Practices Act, which is enforced by the Insurance Department. It also makes a violation subject to the Attorney General's enforcement. We're not sure why dual regulation is merited here. That's not only inefficient but potentially inconsistent.

Thank you for the opportunity to be part of this, and we welcome the chance to work with all parties to address concerns.