COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

CONSUMER AFFAIRS COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

MAIN CAPITOL BUILDING
ROOM B-31

MONDAY, APRIL 30, 2018
10:35 A.M.

PRESENTATION ON
HB 2113 (OBERLANDER)
AMENDING THE
UNFAIR INSURANCE PRACTICES ACT

BEFORE:
HONORABLE ROBERT W. GODSHALL, MAJORITY CHAIRMAN
HONORABLE ALEXANDER T. CHARLTON
HONORABLE WARREN KAMPF
HONORABLE CARL WALKER METZGAR
HONORABLE ERIC R. NELSON
HONORABLE MARTINA A. WHITE
HONORABLE THOMAS R. CALTAGIRONE, DEMOCRATIC CHAIRMAN
HONORABLE RYAN A. BIZZARRO
HONORABLE TINA M. DAVIS
HONORABLE ANITA ASTORINO KULIK
HONORABLE PAM SNYDER

ALSO PRESENT:
HONORABLE DONNA OBERLANDER

* * * * *

Debra B. Miller
dbmreporting@msn.com

I N D E X

TESTIFIERS

* * *

NAME — PAGE

REPRESENTATIVE DONNA OBERLANDER
MEMBER, 63RD LEGISLATIVE DISTRICT;
PRIME SPONSOR OF HB 2113.....4

SUZANNA MASARTIS
EXECUTIVE DIRECTOR,
COMMUNITY LIVER ALLIANCE.....9

SARITA BATTISH, MD
REPRESENTATIVE AND ADVOCATE; ON BEHALF OF
NATIONAL PATIENT ADVOCATE FOUNDATION.....10

GRETCHEN KNAUB
REGIONAL DIRECTOR,
EPILEPSY FOUNDATION WESTERN/CENTRAL PA.....11

KATIE KUGLER
PRESIDENT,
PA SOCIETY OF PHYSICIAN ASSISTANTS.....12

SAMUEL R. MARSHALL
PRESIDENT/CEO,
INSURANCE FEDERATION OF PENNSYLVANIA.....18

ARIELLE PHILLIPS
GOVERNMENT AFFAIRS MANAGER,
INDEPENDENCE BLUE CROSS.....20

DOUGLAS FURNESS
SENIOR DIRECTOR OF GOVERNMENT AND
REGULATORY AFFAIRS, CAPITAL BLUE CROSS.....22

MICHAEL YANTIS
VICE PRESIDENT OF STATE GOVERNMENT AFFAIRS,
HIGHMARK, INC.....25

SUBMITTED WRITTEN TESTIMONY

* * *

See submitted written testimony and handouts online under "Show:" at:

http://www.legis.State.pa.us/cfdocs/Legis/TR/Public/trfinder public action.cfm?tr doc typ=T&billBody=&billTyp=&billNbr=&hearing month=&hearing day=&hearing year=&NewCommittee=Consumer+Affairs&subcommittee=&subject=&bill=&new title=&new salutation=&new first name=&new middle name=&new last name=&new suffix=&hearing loc

P R O C E E D I N G S

* * *

(Audio malfunction.)

REPRESENTATIVE OBERLANDER: Good morning, colleagues, and thank you, Chairman Godshall and Caltagirone, for putting House Bill 2113 on the agenda this morning.

I am here today in support of House Bill 2113, "Honor the Contract," which I introduced for two main reasons:

- Protect consumers and patients; and
- Ensure that health insurance businesses "honor the contract" they sell to Pennsylvanians.

This legislation is a commonsense proposal built on a simple concept: If a Pennsylvania consumer purchases a commercial health plan and relies on that coverage for a treatment or service, then the commercial health plan should not be able to reduce or remove that coverage for the duration of the policy. In other words, if individuals or families are locked into a health plan until open enrollment, then that plan shouldn't change.

It is important to have reliable coverage when we need it. House Bill 2113 offers this protection to

consumers.

It would require insurers and their pharmacy benefit managers to honor the contracts that they have with patients during the contract period. This means that after the insurance company and the PBMs design a benefit plan, advertise that plan to their consumers, and the consumers enter into their contract by signing their benefit plan, the consumer cannot have medical services or products taken away from them once they are consuming them. My bill does cover both physical and prescription drug benefits for consumers.

Most Pennsylvanians are surprised to find that their health plan can change its benefits at any time during the policy year, even though the consumer may have carefully researched their plan to ensure that it met the family's health and financial needs and even though consumers are locked into the policy until the next open enrollment period. This unfair scenario is especially true for those living with chronic health conditions such as epilepsy, diabetes, or hemophilia, in addition to mental health diagnoses and those who rely on continuous and consistent treatment plans to manage their health.

I introduced this bill on behalf of patients and provider groups, which have communicated their support for the bill. I modeled it after the American Medical

Association's Prior Authorization and Utilization Management Principle #5, which covers both physical health and pharmaceutical contract terms.

I chose #5 because it was simple and a fair contracting issue, requiring the honoring of contracts with patients throughout the plan year. This bill is just that, simple in its terms and written to promote fair insurance practices to protect the consumer.

I have heard of some of the concerns raised with this bill, and I want to address them at this time. I believe in addressing those concerns, it's important to share what this bill does not do.

- It is not an insurance mandate. The bill does not require anything of insurers or PBMs but to honor the contract that they designed and sold in the marketplace to their patients.
- It does not prohibit generic substitution of prescription drugs.
- It does not stop insurers and their PBMs from changing medical services or prescription drug formularies, as long as the patient isn't already consuming it.
- And it does not stop insurers and their PBMs from removing an unsafe treatment or service

from coverage, as deemed by the FDA.

I have also been asked why this Committee, why Consumer Affairs and not some other Committee, but that's what this bill addresses -- consumer fairness. The intent of House Bill 2113 goes well beyond health care or insurance to requiring the honoring of contracts of businesses doing work in the Commonwealth.

The patient and the provider panel providing testimony to you this morning will be able to paint a clear picture of the negative impact that unfair health coverage changes have here in Pennsylvania.

That concludes my remarks, Mr. Chairman, and I would be happy to answer any questions you may have at this time.

MAJORITY CHAIRMAN GODSHALL: Are there any questions?

If there are no questions, I'm just going to say something. I wanted to ask one thing.

You say they can't change in the middle for certain diseases, and if some new drug comes out, they can't change what I'm on.

REPRESENTATIVE OBERLANDER: They would not be able to change that without you and your doctor having that conversation and making that decision.

MAJORITY CHAIRMAN GODSHALL: Okay. That was one question that has come up, you know, and that I wanted to have some clarity on.

Thank you for your testimony. There are no other questions at this point.

REPRESENTATIVE OBERLANDER: Thank you. Thank you, Mr. Chairman.

MAJORITY CHAIRMAN GODSHALL: Good hearing from you.

REPRESENTATIVE OBERLANDER: I appreciate that.

MAJORITY CHAIRMAN GODSHALL: We have a full agenda this morning, and I would ask all the presenters to respect the 10-minute time limit on their presentations. And everyone will be allowed that time limit, and we will have time for questions, hopefully, at the end -- or after each presenter, actually.

PANEL I:

COALITION

MAJORITY CHAIRMAN GODSHALL: And at this time, the first is representatives for Pennsylvanians for Fair Health Coverage: Katie Kugler, the President of the Pennsylvania Society of Physician Assistants; Gretchen Knaub, Regional Director, Epilepsy Foundation of

Western/Central Pennsylvania; Suzanna Masartis, Executive Director of the Community Liver Alliance; and Sarita Battish, a medical doctor, the National Patient Advocate Foundation.

Anybody can start wherever you want to. Identify yourself before your presentation, please. Thank you, and we're ready to get started.

MS. MASARTIS: Okay.

Good morning, Chairman and Members. Thank you so much for having us here today and giving us this opportunity to speak on behalf of House Bill 2113.

MAJORITY CHAIRMAN GODSHALL: You didn't give us your name.

MS. MASARTIS: I'm Suzanna Masartis. I am the Executive Director of the Community Liver Alliance, which is leading the Pennsylvanians for Fair Health Coverage coalition.

We are a group of patients and providers who are protecting patients. Our goal is to pass this bill to allow and ensure that the contract is adhered to for that contract year.

I have a brief story about a patient, and I would like to have my other colleagues up here, who also have very brief remarks about their experiences, just to illustrate to all of you what this means to patients in

Pennsylvania.

We have a patient friend who her family, her son, has ADHD. He has been diagnosed and been treated for many years by a professional, a doctor who has had more than 30 years of experience treating patients with ADHD.

Well, he has been stable on his medication, three pills a day for many years, and then one day they got a letter saying that the insurance company would only pay for one of those pills, even though he has been stable on it.

Not only does it affect the patient's health, who has chronic illnesses, but it also puts the family into a bad financial situation when they are not able to afford those other two pills. So this is just one illustration of what has happened to a patient and a colleague of mine.

And I would like to introduce---

DR. BATTISH: Good morning, Chairman Godshall and Honorable Thomas Caltagirone and Members of the Consumer Affairs Committee.

I'm Dr. Sarita Battish. I'm a physician, a patient, and an advocate speaking in favor of House Bill 2113 on behalf of the National Patient Advocate Foundation.

I'm going to share a brief story myself.

I had seen a patient walk into the pharmacy, and they were waiting to get their regular blood pressure medication. And the pharmacist hands them another

medication and tells them, your other medication is no longer covered.

So with medications, with blood pressure medications especially, having the right mix is very important. Even though it's a non-generic medication, just mixing one of them will have detrimental consequences, maybe not today but maybe a week down the line.

Thank you for the opportunity to speak.

MS. MASARTIS: I would also like to introduce my colleague, Gretchen Knaub, with the Epilepsy Foundation.

MS. KNAUB: Good morning, Chairman and Members of the Committee.

My name is Gretchen Knaub, and I am the Regional Director for the Epilepsy Foundation Western/Central Pennsylvania.

I'm here because House Bill 2113 is critical for Pennsylvanians living with epilepsy, the people whom I serve. I'm just going to share a real brief example.

We have a family that we have worked with for many years. The daughter of the parent, she has had epilepsy since she was 12 -- or I'm sorry, 2; she is now 17 -- and she has been seizure free for many years. But one day she began to experience involuntary tics, which was indicative of seizure activity for that patient.

So concerned, her mother, she checked and found

that the pills had been switched. So it had been ordered by her family's health insurer in the middle of the policy year. Unfortunately, they did not tell the parent or her doctor.

So after a long appeals process, she was able to get the company to give her daughter that medication. However, they were charging her four times the amount that they had previously. So it has been detrimental to them.

Thank you very much for your time.

MS. MASARTIS: I would also like to introduce my colleague, Katie Kugler, who has also got important information to share.

MS. KUGLER: Good morning.

As she said, I'm Katie Kugler. I'm the President of the Pennsylvania Society of Physician Assistants, and I do appreciate the time to speak before you this morning.

This is a very important issue for providers as well as patients, and I just wanted to share a story that was shared with me about a patient here in Pennsylvania.

An older woman who had emphysema was stable on inhalers, and midyear, her plan changed and her inhalers had to be adjusted. Over a 2-week course, she had a worsening of her condition; ended up admitted to the hospital. She spent 3 days in the intensive-care unit, intubated, because of difficulty breathing; spent 10 days

total in the hospital, then additional days in an inpatient rehabilitation facility prior to being able to go home.

When she went home, she was on four new medications due to complications from this health event that she had, and this happened midyear because of inhalers that were changed.

I do appreciate your time. Thank you.

MAJORITY CHAIRMAN GODSHALL: We'll open it up to questions.

MS. MASARTIS: We're ready for questions. Thank you.

MAJORITY CHAIRMAN GODSHALL: Okay. Any questions from the Members?

Representative Nelson.

REPRESENTATIVE NELSON: Thank you, Mr. Chairman, and thank you for your testimony, ladies.

My question is just very basic. You know, I'm jumping to the conclusion that oftentimes these changes are for cost-saving measures and, in each of the cases, there wasn't an alternate medicine that would have been offered or, you know, a different type of treatment technology.

So in each of your scenarios, when you explained that the medicine was withheld, were there any alternate options that those family members chose not to participate

in, or was it, we're just not going to pay for this anymore and you'll have to out-of-pocket the difference?

MS. MASARTIS: I'll go first.

For my patient, it was that they just were simply not going to pay for the additional two pills, which amounted to $600 apiece.

DR. BATTISH: In my case, the treatment should have been discussed with the patient and the physician, between the patient and the physician. So if the change is necessary, the symptoms or the side effects can be managed more effectively, more cost-effectively.

MS. KNAUB: With the patient that I worked with, with folks with epilepsy, the treatment is very individualized. So what medication works for one person is not going to work for another person. So it would have been very important for the doctor to know this so that he could have discussed different options possibly with the family.

MS. KUGLER: And in my scenario, the physician was aware of the change and made a change using a now approved inhaler. But unfortunately, it wasn't as effective, which is why she worsened over those 2 weeks. So there was a switch to one that was then approved.

REPRESENTATIVE NELSON: Thank you.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN GODSHALL: Representative Kampf.

REPRESENTATIVE KAMPF: Thank you, Mr. Chairman.

Just, maybe I don't fully grasp the impact of the legislation, but, I mean, I assume the premise is that a mid-policy or a midterm change by the carrier is the issue. Correct me if I'm wrong.

And then I guess secondly, do you have some sense of how widespread that is, how often it occurs in a policy year?

I mean, I appreciate your anecdotes. I don't doubt that they occurred in any way and that there are more of them, but I guess my question is, how often?

MS. MASARTIS: So you are correct. The essence of this bill is to just honor the contract, to honor the contract for that contract year.

And we have many members of our Coalition who have these kinds of stories and experiences, so it's widespread across our State.

I don't know how to quantify it with numbers. I can't say there is 25 or 250, but it's many/much/often.

MAJORITY CHAIRMAN GODSHALL: Chairman Caltagirone.

MINORITY CHAIRMAN CALTAGIRONE: Thank you.

I'm just curious, was there any kind of

notification prior to?

MS. MASARTIS: With my particular patient, they did receive a letter saying that the medication would no longer be available.

DR. BATTISH: In my scenario, no.

MS. KNAUB: And neither -- mine did not receive any notification.

MS. KUGLER: There was also no notification in my case.

MINORITY CHAIRMAN CALTAGIRONE: Thank you.

MAJORITY CHAIRMAN GODSHALL: Representative Metzgar.

REPRESENTATIVE METZGAR: As a follow-up to what Representative Kampf asked regarding how widespread is this issue, would it be fair to say that it would be almost impossible to know how widespread it could be because you only run into it whenever someone has an issue? They could be changing them with regard to someone's medication or treatment at any time, and if you don't need that, you wouldn't know it. Is that fair to say or not?

MS. MASARTIS: That is a fair statement, and patients oftentimes aren't really good self-advocates or know where to turn or what to do, particularly older patients, people who don't have caregivers that are savvy. And so these practices can happen, and they wouldn't know

it or know what to do about it.

Thank you.

MAJORITY CHAIRMAN GODSHALL: Are there any additional questions?

Seeing none, I just want to say I know one person that was taken off XARELTO, a blood thinner, and went on baby aspirin, and that didn't work real well, needless to say.

But thank you for your testimony, and we're going to have the second panel come up.

MS. MASARTIS: Thank you to the Chairs and to the Committee for your time.

PANEL II:

INSURANCE INDUSTRY

MAJORITY CHAIRMAN GODSHALL: The second panel consists of Arielle Phillips, Government Affairs Director, Independence Blue Cross; Douglas Furness, Senior Director of Government and Regulatory Affairs, Capital BlueCross; Mike Yantis, Vice President of State Government Affairs, Highmark; and Sam Marshall, President and CEO of the Insurance Federation of Pennsylvania.

And (inaudible) and have had some rough times here lately.

MR. MARSHALL: That's true enough, Mr. Chairman, but today we'll focus on this one.

You know, just before I turn it over to my Blues colleagues, you have our testimony. I'm always struck in these, you know, we do these things by panels, and it strikes me that we would almost be better off having a roundtable type of a discussion. That's something that would be more effective. We heard the people beforehand speak on it, and I have questions on what exactly happened in those situations.

You know, as insurers, we're not in the business of undercutting our patients, our policyholders. You know, I mean, the examples that we heard, I don't know exactly why that was done in any of those situations. You know, our interest is in getting our policyholders good care, better care.

The challenge I see in this, you know, first, I mean, the bill goes broader than just prescription drug coverage. I'm not aware of any changes made in benefits generally. Sometimes that does happen. It's usually for the patient's betterment.

But talking just about the drugs, you know, drugs evolve, and therefore, our coverage of them evolves in real-time. It's not a calendar-year basis. You learn about good effects, bad effects, other alternatives, other

means of coverage, during the course of a year.

Your coverage of those drugs should evolve with that. It's not something static: Here on January 1, we know this, and anything we learn over the next 12 months, we don't apply until the next January 1. That doesn't make sense. You should evolve.

The balance that I see is you don't want an insured, a patient, to face a switch in coverage that is going to interrupt the quality of that care, you know. So I'm concerned when I hear that patients are being switched medications without either the patient or the patient's doctor knowing about it. I don't know exactly how that happens. We want to learn more.

But that seems to me to be the balance rather than to say there are no changes, even as the science evolves, during the course of a policy period. That's different than saying, you know, that you should have changes that are well documented, well known, and well explained to both the patient and the patient's provider.

And in that sense, again, I mean, we haven't been introduced to the panel that came beforehand, but it strikes me, I mean, we're happy to sit down and talk with them and go over that. That might lead to a better crafted solution.

You know, we don't have that many health insurers

in Pennsylvania anymore. I think we're dealing with a finite group. And I know speaking on our behalf, you know, we're happy to do that.

And I'll turn it over.

MS. PHILLIPS: Good morning.

I am Arielle Phillips. I represent Independence Blue Cross. We are the Blue plan in the five counties in the southeast Pennsylvania region. We have been around for about 80 years, serve about 2.5 million members, so a lot of experience in administering both the medical and the prescription drug benefit.

We are very interested to kind of hear what we just heard from the patients prior to this, because as Sam had mentioned, we don't receive a ton of complaints. This is not -- we don't have a widespread pattern of complaints here, so this was something that was a little bit new to us when we heard about the issue.

Real briefly so my colleagues can have a chance to address you as well, our concerns would just be the broad prohibitions in the bill. We think it focuses mostly on prescription drugs, but it goes well beyond that into the medical services, procedures, treatment services, and of course prescription drugs. So when you talk about those things fully, that's quite expansive.

There are some exemptions in the bill, but they

may not go far enough or they may not allow us the flexibility -- again to your point, Sam -- to keep up with changing medicine and changing science. It's ever evolving, and that's how we manage our benefits.

So while there are exemptions, it may not allow us to do what we need to do to meet the members' needs.

What we do now, real briefly, we do file with the Pennsylvania Insurance Department each year and with the Federal Government with CMS. As part of that filing, they take a look at our cost-sharing, so our rates, our premiums, those don't change during the year.

And then also, they take a look at our formularies, so they make sure that we have an adequate number of medications in each class and each category; that our practices, the way we tier things, how our formulary lists are established, are not discriminatory in any way and that we don't have an unusually high number of medications subject to prior authorization or step therapy.

So there are some checks and balances there. We're not kind of making it up as we go. There is quite a bit of oversight in that area.

And maybe I should have started with this, but the member is at the center of all that we do, so we understand that integrated medical benefits and prescription drug benefits is to our benefit -- not to

overuse that word -- but it's to our benefit and it's to the member's benefit. We don't want to do anything, make any sudden, abrupt changes that might be detrimental to the health of the member. So we do take great caution in our approach to formulary management.

And we heard a little bit about notices. We do provide notices whenever there are changes. We look keenly at those members with clinically sensitive conditions, some of the patients that you heard from earlier, the patient advocacy organizations you heard from earlier. And those changes are also approved by a Pharmacy and Therapeutics Committee within our health plans that are absolutely independent of the people that we employ. So they are folks on a committee not employed by the health plan.

So I wanted to just kind of do a little bit of level setting in the fact that we haven't heard of this being a big problem before, but the bill, we think, goes far beyond maybe what the solution is that's needed.

And I'll just pass it along to Doug then.

MR. FURNESS: Good morning.

Doug Furness, Senior Director of Government and Regulatory Affairs at the Capital BlueCross.

Capital BlueCross is a BlueCross plan that serves 21 counties in south-central Pennsylvania and the Lehigh Valley. We have been around also for about 80 years.

A couple -- I'll just add a couple of things, because I agree with both Sam and Arielle, but some things that I think the Committee should be aware of.

Number one: When we make changes -- and I'm going to specifically address the pharmaceutical piece of this, which I believe is the driving force.

The changes we make to a formulary are really in three areas: one, for the safety of the policyholder; two, the effectiveness of the drug in question is in fact questioned by medical science; and three, we have found lower-cost alternatives that are equally effective.

So it's important to understand that we keep the policyholder foremost in our thoughts when we're dealing with that.

Two: We do notify our policyholders when a change is made, upwards to 6 months in advance before a change is actually made. We will let the policyholder know, and they have then an appeal process with our companies. The first step is an internal appeal process. If they do not like the result there, there is an outside appeal process.

And just to -- and I know Representative Kampf just left, and I think this is important.

Along those lines -- and I'll speak for Capital. In 2017, Capital BlueCross filled 4.8 million prescriptions

for our policyholders. We received 1,585 complaints -- of 4.8 million prescriptions, 1,500 complaints. Of those 1,500 complaints, 946 were overturned on behalf of the policyholder.

Now, I'm going to echo Arielle. We just don't see this as a problem. One, if it does happen, the policyholder is given the opportunity to appeal that decision. They are notified of it. They can appeal the decision. And in most circumstances, the appeals are found in their favor, at least from our perspective.

So it's hard to get our hands around just the scope of this problem. I would like to echo Sam Marshall's comments that we look forward to working with the Committee and the prime sponsor of the bill and the advocacy groups to try to find out where this problem exists.

I will give a possible suggestion. Anywhere from 50 to 75 percent of the health insurance market in this State is found in the self-insured market. This bill would not apply to them. They are -- it's overseen by the ERISA plan, the ERISA program at the Federal level, and this bill would not have any impact on it.

So if those complaints that you heard expressed by the first panel are coming from self-insured plans, maybe that's a discussion that we need to have outside of the legislative process, which would be more effective.

So I'll turn this over to Mike.

MR. YANTIS: Thank you, Doug.

Good morning. Mike Yantis with Highmark.

Highmark provides commercial health insurance coverage in Pennsylvania to 62 of the 67 counties. We also provide coverage in Delaware and West Virginia. And Highmark is part of the Highmark Health enterprise, and as an enterprise, we also have a provider arm, so we are coming at this from the perspective of both an insurer as well as a health-care provider.

I'll summarize with three key points, the first of which, I think in general and in principle, I think we agree with just about everything that has been said here in terms of the principles.

When someone is issued a health insurance policy, that policy should be honored and it should be enforced. We cannot change those policies during a year.

What can change is the clinical and scientific evidence that governs and manages how certain care is provided. And I believe Mr. Marshall alluded to this; that needs to be able to change, because clinical and scientific evidence doesn't function at a point in time. It evolves continuously throughout the year. So there needs to be the ability to adapt the coverage policies to reflect what is in the patient's best interests, and that is what drives

everything that we do.

Secondly, contracts are currently enforced, and I'm particularly intrigued by the examples that were provided. They really give me concern, because many of those should not happen.

If physicians and patients are not receiving notice, that's a problem, because as our colleagues had noted, if there are changes made to a formulary, notice is provided. For Highmark, our Pharmacy and Therapeutics Committee meets quarterly. So at most, four times a year there could be a change to a formulary.

If there is a change, both the physician and the patient receives a 60-day notice, at a minimum. It could be longer. At a minimum, they will receive a 60-day notice. That provides them time to evaluate the clinical options that are available. And as Doug appropriately noted, that can be appealed. Even if a drug is taken off of a formulary, that can be appealed and it can still be provided to the individual, because care is individual and it will depend on the individual.

So the way the system works is it allows for those changes. Those contracts are enforced.

Third, just from a broad perspective, we are concerned that the legislation may not exactly address the problem. We think the solution may be too broad for the

problem.

And an example that gives us pause is, Highmark recently, in March, made a change to our formulary in terms of opioid coverage. We reduced the availability of opioids to a 5-day prescription.

The way the legislation is currently written, we would not be able to do that. And I don't believe that's the intent of the legislation, and I'm sure there's a way to fix it and correct for that, but we need to be careful that we clearly identify and understand the problem that is out there and that we can marry the solution to it. And again, we believe that the solution exists in the current system, because it is flexible and allows for change and allows for appeal.

So those are the three, I think, key points. You have our testimony, and I think we'll gladly take any questions.

MAJORITY CHAIRMAN GODSHALL: I guess I'm not quite clear on what you said.

If I'm a patient and my doctor changes a drug I have been on for a couple of years, and all of a sudden (inaudible).

MR. YANTIS: (Inaudible.) What would change is the way that prescription lies on the formulary. So the coverage of that prescription may change. And the doctor,

as well as the patient, is informed of that in advance, and then if there are concerns, there are discussions that should occur between the physician and physicians within our company.

I imagine, and I don't mean to speak for everybody; it might be slightly different. But no, it's not, I guess, an arbitrary decision. It is based upon the clinical evidence, and then if there is a need for the patient to continue on the drug that has been changed or moved off the formulary, those discussions can occur and should occur.

Does that answer the question?

MAJORITY CHAIRMAN GODSHALL: As you well know, medication for the same disease can affect people differently. You know, it's not universal, correct?

MS. PHILLIPS: We also at Independence Blue Cross -- I'll just speak for us -- we take a look at the condition itself. So we don't make -- we never like to think we make arbitrary changes, but we look at clinically sensitive populations. So some of the folks that are represented here today -- HIV, hemophilia, med psych, transplant patients -- we would certainly look at the person and their condition.

And a lot of those changes, when they happen, if they happen, are on a go-forward basis so they don't impact

the entire patient population. Those that are taking the medication would be grandfathered, and the changes might just impact those going forward.

MR. FURNESS: I think it's important to keep in mind, before a company makes a change like this, there is going to have to be evidence to support it, either the drug is unsafe. Regardless of what the FDA may say, we find out that drugs are unsafe before the FDA makes a determination. Two, the drug just doesn't work as it's intended -- okay? -- for a person suffering from that particular illness. Or three, that there are lower-cost alternatives that are equally as effective.

So that's what we're going to make the decision on. Then you're notified and your doctor, and then as Mike says, it's a dialogue, all right? If you can show proof that this is what you need, a company is going to listen to that information. But if the drug is not safe or if the clinical studies that are out there show that it doesn't work as it was intended, we're going to make those suggested changes.

Now, as I pointed out, if the policyholder disagrees, they do have an appeal process. And in the case of my company, which I am quite sure you're going to find it very similar in all the companies represented here, the number of prescriptions we do in a year, we just don't see

the complaints, and the complains that we do get, a large portion of those are in fact overturned on behalf of the policyholder. So that's where we are on this.

MR. MARSHALL: Mr. Chairman, there's a perception that the changes are made -- we don't make the changes to hurt our policyholders. We don't make the changes to hurt the quality of care. In fact, the changes are made to improve the quality of care.

Doug mentioned, you know, with one company, 4.8 million prescriptions. You know, it is evolving. There may be some instances where there is some confusion, and if there's a way to better make sure that that doesn't happen, so be it. But understand, we can and should make changes the minute we feel that to do so is to improve the quality of care that goes to our policyholders. That, particularly in the world of prescription drugs, is the driving force.

And it was mentioned, I mean, as one of the panel beforehand mentioned on the inhalers, without knowing all the specifics of that, obviously that patient underwent a much more difficult and, from a purely, you know, dollars-and-cents perspective, a much more expensive process. That's not the outcome that anybody wants. We don't want it to be more expensive; we want it to be more efficient and better care. That's the motivating goal in

changing it, and I don't think you want us to wait a year to do that.

MAJORITY CHAIRMAN GODSHALL: Representative Metzger.

REPRESENTATIVE METZGAR: Thank you, Mr. Chairman.

Mr. Yantis, you said something I really like. You said, technology changes, so we have to be adaptive and embrace that technology so that we can, you know, move ahead.

I guess, you know, I'm a solution-driven guy here, and I'm trying to get us to, you know, an agreement. And obviously this panel is not in agreement with the first panel and there's some work to do, but maybe we can shortcut it.

I think it was Mr. Furness that said that there's three reasons why -- if the product is unsafe, if it doesn't work according to, I guess, your people, or the clinical trial or something -- but not the doctor that is treating, the physician, right?

MR. FURNESS: Generally speaking, those studies are ongoing on these drugs, and they are not internal to my company. They are external peer-reviewed clinical studies of the effectiveness of these drugs.

REPRESENTATIVE METZGAR: But the question is, the determination of whether a drug works or doesn't work is

not made by the physician treating the patient; it's made by someone else, correct?

MS. PHILLIPS: I'll add a little bit of color to that.

The bill does allow for the FDA, allows for a notice from the FDA as part of one of the exemptions. Our folks were concerned about that, because the FDA doesn't come out with blanket statements on issues unless it's prominent and it's widespread.

What they did say is we follow specific guidelines for a specific condition. Cancer -- we have cancer guidelines we follow. We follow cardiac guidelines. There are certain guidelines that come out that we follow that are condition specific, and a drug may be out and it may not impact the majority of patients, but there might be sensitivities for older adults. There might be sensitivities for pregnant women. There might be sensitivities for pediatrics.

So it's very hard for us to wait for the FDA to come out and make a blanket statement. Even though, yes, they are the authority on the approvals, it's very hard for us to wait for that.

So we look to those guidelines, and then we'll work with the patient's doctor if that drug that we make the change to, after the notice is provided and with the

appeals notification or the ability to appeal the decision, we'll work with that patient's provider.

REPRESENTATIVE METZGAR: And then the last thing, of course, is the lowest-cost alternative that you mentioned.

But if we can get to a spot where you can't change an existing treatment program unless it's unsafe, will you agree to allow us to pass that law?

MS. PHILLIPS: If we---?

REPRESENTATIVE METZGAR: I mean, not that you have to allow us.

MS. PHILLIPS: Yeah; that's true.

REPRESENTATIVE METZGAR: But, I guess, would you get on board with that?

Yeah; that's the cool part about where we work. You know, you don't have to go along with it.

But I guess my question is, won't you get on board if we simply say, all right, unless it's unsafe, and it's in that contract period, because, I mean, that's the gist of this, that, you know, our patients, our constituents, can't get out of the contract. They're in it. They're stuck to you. They're married. And you say about an appeal process, but in the meantime, the patient is holding the bag because they're not getting the treatment.

So my question is, can't we get ourselves to a spot where, unless this medicine is unsafe, they keep getting it during this contract period. Isn't that fair?

MR. YANTIS: I think, I think the best approach to that is kind of where Mr. Marshall started this conversation. It would be helpful to have a roundtable to talk about that.

And I understand where you're coming from, and it makes sense, but in some cases, it does go beyond just the safety. It speaks to the clinical effectiveness and the value proposition of the treatment for the patient.

Something could be---

REPRESENTATIVE METZGAR: But doesn't the doctor decide that?

MR. YANTIS: And the doctor does decide that.

And in the case of pharmaceuticals, since that seems to be the heart of the discussion, the doctor does do that. The doctor makes the prescription.

If there is a change in the insurer's formulary, the doctor and the patient are informed in advance. And then if there is a clinical need for patient X to continue on a particular drug, those discussions need to happen.

But it's not just always because there has been a safety issue. It's a clinical effectiveness issue. Does that make sense, the way I said it?

REPRESENTATIVE METZGAR: It makes perfect sense. I guess I just believe, you know, I somewhat disagree with you and think that the doctor is in the position to make that clinical decision much more readily on a patient-to-patient basis than for you to categorize and deal with them categorically. That's probably not the best way to practice medicine.

So I'm just hoping -- I understand you want to have a roundtable. I think that's great, but there is some degree of urgency here, because obviously I think we have people that are trying to get treatment and aren't getting it. So I would encourage you to come to the table as quickly as possible with that.

MR. MARSHALL: Yep.

One of the things, Representative, you know, "unsafe" in and of itself, I mean, is fine, but sometimes you make a change because it makes it better. It's not just that drug A is all of a sudden found to be unsafe; it is that the change that you are implementing is for a better scope, you know, for a better coverage, for a better drug. And I think you don't want to lose that focus of improving the coverage that you provide.

So, I mean, there may be a little bit of, you know, just wordsmithing here. I think the key is that there be prior notice. And I think we all agree that if

there is prior notice, that gives the individual doctor the chance to learn why the change is made. And sometimes the individual doctor doesn't know everything that's going on in that area of prescription, in that area of drugs. It's the chance to have that dialogue.

And I think that, you know, the instances that all of the panel beforehand raised all seem to be prior notice questions, and that's why a roundtable -- I'm not sure why there wasn't prior notice. That's something we really need to learn.

REPRESENTATIVE METZGAR: I guess, just as a follow-up, what good is prior notice if they just simply can't get the medicine?

MR. MARSHALL: Because as I think all of us have said, when there's prior notice, every insurer has an appeal process and a review process.

REPRESENTATIVE METZGAR: Right. To the insurance company, though.

MR. MARSHALL: Well, actually, ultimately to the State.

REPRESENTATIVE METZGAR: Right.

MR. MARSHALL: That's the way we're -- I mean, you know, the appeals ultimately go to the Department of Health.

MR. FURNESS: I think that even some of the

testimony we heard from the previous group indicated that the appeal process actually works. I mean, it works for my company. I would hazard a guess it works for all of us in that, one, we don't see the complaints that seem to be the genesis here, the volume of complaints; and two, that we all have internal processes that work, okay? And we have external appeals processes that work, too.

And our customers are getting the drugs they need, and I think that's the important thing, the important point to keep in mind for the Committee, is our customers are getting what they need, okay? And they have a voice in what they're getting, as does their doctor, and that's, I think, an important point to be made.

MAJORITY CHAIRMAN GODSHALL: Chairman Caltagirone.

MINORITY CHAIRMAN CALTAGIRONE: Thank you.

This appeal process, do all of you practice this appeal process, and is it part of your contracts with whomever or whatever?

MR. MARSHALL: It's part of the law.

MINORITY CHAIRMAN CALTAGIRONE: But do you practice it? I'll give you some examples.

I'm a doctor. Do I get notified? She's the pharmacist. Does she get notified so that they could tell the patient or client, you have the right to appeal? Do

they know this? Do they practice this?

MS. PHILLIPS: The provider and the member would get that notification in advance, and it would articulate the appeals process.

MINORITY CHAIRMAN CALTAGIRONE: The doctor that's treating you, does he get the notification?

MS. PHILLIPS: Yes.

MINORITY CHAIRMAN CALTAGIRONE: You're saying he does?

MS. PHILLIPS: Yes, he does.

If we identify a population, and maybe we're looking to make a change in that population, the members and their providers would receive that notification.

MINORITY CHAIRMAN CALTAGIRONE: And you're saying it is required by law, for a contract? Yes?

MR. FURNESS: Yes.

MINORITY CHAIRMAN CALTAGIRONE: All of you?

MR. MARSHALL: The appeal process. But, Chairman Caltagirone---

MINORITY CHAIRMAN CALTAGIRONE: Go ahead.

MR. MARSHALL: What I think you're going at is our changes in the formulary.

MINORITY CHAIRMAN CALTAGIRONE: Well, are they doing the changes because, go to a generic because it's cheaper, it's more cost-effective, when they're switching

these meds?

MR. MARSHALL: Maybe they can switch to a generic, you know, as was mentioned, and I think Representative Oberlander, I'm not sure if the bill does exempt that. But I think, you know, the intent is, if you're going to a generic, that's okay.

But sometimes you make a change in the formulary because you learn more about a given drug.

MINORITY CHAIRMAN CALTAGIRONE: But do you give prior notice?

MR. MARSHALL: And the answer is---

MINORITY CHAIRMAN CALTAGIRONE: Everybody gives prior notice---

MR. MARSHALL: And the answer is yes.

MR. YANTIS: Yes.

MINORITY CHAIRMAN CALTAGIRON: ---to the patient, the client? Does the doctor get notified to that effect?

MR. YANTIS: Yes; yes. If a change is made to the form---

MINORITY CHAIRMAN CALTAGIRONE: How about the pharmacists?

MR. YANTIS: I don't know if the pharmacist receives notification through this route.

In other words, if you are on a medication as a

patient and your insurer makes a change to the formulary that impacts that medication, we know who's on that medication and we know the physician. So you and the physician will receive the notification. What I don't know is, I don't know if the pharmacist receives that same type of notification.

The pharmacy will receive notification about a formulary change, but I don't think it's patient-specific as it is to the patient and doctor for this case. But I will check on that.

MINORITY CHAIRMAN CALTAGIRONE: All right.

One of the last things that I think, and it has been mentioned here several times, and Sam, you even pointed it out. They're still here. You're still here. When this hearing ends, if you want to use this room here or if you want to come over to my office or the Chairman's office, I'm sure we'll make it available so that you can sit down and have a conversation with them so they can be specific about the situations that they testified to here this morning.

I think it's a wonderful idea, Sam, and I think while you all are here, if you have a few minutes afterwards, I think you ought to talk about this to see, where's the problem and how can it be resolved, with or without the legislation or some changes that have been

mentioned, that, you know, could maybe be a compromise between both groups. It's up to you all.

MR. MARSHALL: Yeah.

MR. FURNESS: Yeah.

MS. PHILLIPS: Yeah. Thank you.

MR. YANTIS: Thank you.

MINORITY CHAIRMAN CALTAGIRONE: Okay.

MAJORITY CHAIRMAN GODSHALL: Representative Nelson.

REPRESENTATIVE NELSON: Thank you, Mr. Chairman.

Thank you for your testimony.

The last paragraph of this bill talks about how it does not prohibit additional medication. So if technology advanced or if there was a new treatment available, that would still be able to occur. So I don't necessarily know that this bill would impede that at all.

And the prior testimony did talk about the appeals process, but I'm not familiar with how that process goes. So the example of the liver patient that would be looking at a 1,200-dollar-a-month increase in copay for the $600, you know, two of those pills were no longer covered, during the appeals process, does the individual have to pay out of pocket until that process is resolved?

And it seems to me that this bill wouldn't prohibit technology or upgrades; it would just protect that

if a prescription was covered at the beginning of the period, that in the middle of it, they would not be able to withdraw that, and almost it seems to be the prescription aspect of it to force that individual to then now pay out of pocket for something that maybe for the first 3 months was provided. That was the first part of that question.

MR. YANTIS: I'll take a shot here. I'll piece it into two parts, I think.

The first, in terms of the out-of-pocket responsibility during the appeals process, the goal is for that to be resolved before the change would actually take effect. That's why we provide at a minimum 60 days' notice.

So in other words, the goal is that if that patient should still continue to be receiving that medication, that should be resolved in that 60 days. That's why sufficient notice is provided.

Now, there are circumstances where it may bleed beyond -- bad choice of words. It may extend beyond the 60-day period, and in those situations, I don't know how that works. There might be an extension, whatnot, as the appeal process continues. I'll have to do some digging into that. But the goal is to get that resolved and out of the way before the change actually takes effect.

And then the subset to that is that the potential change for an out-of-pocket exposure to a patient, a lot of times that change takes place not because there's a change on the formulary but because there's a change in the cost of the medication.

A patient wouldn't experience that if it's a copayment, but there are plans that have co-insurance and deductibles as part of it. Both of those cost-sharing mechanisms are dependent on the actual cost of the service.

So a drug can change its price from month to month. That is out of our control. So if that price goes up and the patient has a co-insurance, say 10 percent, that 10 percent doesn't change but the dollar value changes because maybe the price of the drug goes up. That could explain why there are changes in the cost-sharing experience of a consumer.

And then the other aspect about medicines still being allowed to come on; in other words, we can add benefits? That certainly is appreciated and that should take place. But there also needs to be the ability if, using Sam's example, if there is something that comes onto the market that provides a better clinical outcome than the existing treatment, then that existing treatment we should be able to put off to the side and be replaced by the newer

technology.

That might be an oversimplification of it, but that's our concern with the way it's written. Does that help?

REPRESENTATIVE NELSON: Yes. Yeah; that was very helpful.

The second part of my question, in your testimony you had mentioned that this does not include self-insured plans, and a large portion of Pennsylvanians fall into that self-insured. Can you expand on that a little bit more and why this would not impact them?

MR. MARSHALL: Well, under Pennsylvania law, I mean, it's not like it doesn't include self-insured plans, and in the private market, that's about half of the Commonwealth. You know, that's because the State doesn't regulate self-insured plans. That's regulated at the Federal level. It also doesn't include government programs, which are Medicare and Medicaid.

So, you know, in truth, when we're talking about the population that is covered by all of us, it's roughly a quarter of all Pennsylvanians. So, I mean, obviously to us, that's important. You know, that's the population we serve, and those are the people we care about.

But any bill that you pass isn't going to affect 70 to 75 percent of all Pennsylvanians.

MAJORITY CHAIRMAN GODSHALL: Representative Charlton.

REPRESENTATIVE CHARLTON: Thank you, Mr. Chairman.

What ability does insurance companies have to negotiate prices on prescriptions? We talk about those fluctuations going up and down month by month. I mean, ultimately, insurance companies are the largest end buyer of the prescriptions. You'll not be using it, but you're paying for it. So do you have the ability to negotiate to keep those prices on a flatter plain or is that something that's just ultimately out of your control?

MR. YANTIS: How long do we have the room for?

It's a great question, and I don't mean to minimize it by being slightly humorous.

That's a complicated process, and quite honestly, somebody else at the table may be able to answer it a little bit better. But there are multiple players that negotiate the end price of the prescriptions in terms of who pays.

But at the end of the day, even when those negotiations occur and there are coverage parameters set in place among an insurer, a PBM and a manufacturer, and the pharmacist, the prices of the drugs will still fluctuate during those contract years. That transcends the

parameters of those contracts. So a drug could go up in price $100, $200, during a contract year, and that would be reflected in the cost-sharing.

That's a way oversimplification of it, but that's generally---

REPRESENTATIVE CHARLTON: So maybe the drug manufacturers should be a part of this roundtable that we're discussing. I mean, ultimately, this is the problem, the cost of the medicine, not necessarily -- you know, it seems to me the reason why you would be shifting from maybe, you know, paying for one pill and three pills or back the other way is ultimately dependent on the price of it. If it's cost prohibitive, that certainly becomes an issue for everybody.

MS. PHILLIPS: I have some---

MR. FURNESS: And each one -- oh; excuse me.

But each one of us is going to negotiate a different deal with those pharmaceutical companies because based on the number of covered lives we have and economies of scale and things like that. So it is very complicated and almost unique to each one of us, too, so.

MS. PHILLIPS: Representative, I just wanted to add a few comments on that, specific price increases and that. And we didn't really get into this, but I just always carry them around in a folder with me, so.

Since January 2017 -- this was a pharmacy benefits consultant analysis in Axio not too long ago, so I guess within the last 14 or 15 months.

Twenty of the drugs that they looked at had a price increase of 200 percent or more. About 40 had a price increase of 100 percent. And some of their top three selling drugs, or top three grossing drugs in the world -- Humira, Enbrel, and one other, Revlimid -- increased by over 20 percent, on average 20 percent.

So when we talk about cost sharing and benefits and taking away benefits from people, it's not that we want to take away benefits from people. A lot of times we're trying to manage the costs that are driven by price increases from the drug manufacturers.

So if that results in us up-tiering a drug, unfortunately, sometimes someone might have to pay, they go from a $25 copay to a $50 copay, or to Mike's example, co-insurance, the co-insurance would go up. But the reason we do that is to -- and never to take away something and not replace it with something else, but we want to replace it with something that's a little bit more affordable for the member.

So a lot of that is driven from the pricing of the manufacturers.

REPRESENTATIVE CHARLTON: Thank you.

MS. PHILLIPS: Yeah.

MAJORITY CHAIRMAN GODSHALL: Chairman Caltagirone.

MINORITY CHAIRMAN CALTAGIRONE: I don't blame you all, but I have been after these pharmaceuticals, first of all, for creating the opioid epidemic, which I think their fingerprints are all over it.

And secondly, it's something none of you can control, and I think some of the prices on the medication are so outrageous that somebody, either at the Federal or State level, they're going to have to look into this, because how much profit do they want? What's the bottom line?

Don't give me the nonsense that medications that they developed 20, 30 years ago -- they're still producing a very sufficient profit margin for these pharmaceuticals.

I don't blame you. I'm not throwing it at you. I'm just saying, certain controls have got to be implemented, I think at the Federal Government, to stop this price gouging of the consumers and patients in this whole nation, not just Pennsylvania, because it's passed on to you all. You have got to do something financially to cover the costs.

The patients, they end up getting whacked, and I'm thinking to myself, come on, don't give me R&D nonsense

about millions and millions of dollars on something that has been already, you know, done years ago and all of a sudden now they keep hammering away at this, oh, well, we've got to have another 25-percent increase; oh, we've got to have a 50-percent increase.

It just blows my mind that it's medications that people are on that keep them alive, and they keep playing games with us as consumers to jump up, jump up, jump up. How much copays? How much to the insurance companies?

And the patients, either they are breaking their pills in half. We have heard so many stories about that, life-threatening situations. And I look at this and I think to myself, look, I agree they should make a fair profit, especially on their investments with new medications, but then you have got to say to yourself, how much is enough? When do you draw the line in the sand and say, stop it, you're gouging. And you're forcing the insurance companies to make tough decisions, which is passed on to the patients and the clients, and I just shake my head in amazement and I think, when are we going to stop this merry-go-round? Everybody is caught in it, and it's like, is anybody listening out there?

I just had to say that, because in some of these situations, I know it's not your fault. It's thrown into your lap and you have got to deal with it. And then the

clients and patients, they have got to deal with it, too.

It's just sheer frustration. I'm sorry. I just---

MR. MARSHALL: And, Mr. Chairman, we as insurance companies are heavily regulated in the rates that we can charge. We have medical loss ratios. We have prior approval.

But going to your point and the difficulty in negotiating and getting good prices on pharmaceuticals, you know, I would encourage you -- and, you know, your colleagues, Chairman Deluca and Chairman Pickett, have a jointly sponsored bill over in the House Insurance Committee that deals with prescription drug transparency, which would at least give a better chance for those of us, you know, the insurance companies, the State, et cetera, you know, all the people that purchase drugs, to do a better job of understanding and getting a good price.

So maybe if you go to the Floor today, you may want to mention to the two of them that you would like to help push that bill along.

Thank you.

MINORITY CHAIRMAN CALTAGIRONE: Thank you.

MAJORITY CHAIRMAN GODSHALL: Looking at remarks, I have the following submitted written comments for inclusion in the record from the Pennsylvania Insurance

Department, the National MS Society, the U.S. Pain Foundation, the Arthritis Foundation, and (inaudible).

And I would like to thank all the presenters for their testimony, and if there are no further questions, the meeting is adjourned. And hopefully these microphones will be taken care of.

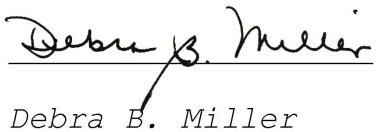
I want to say one thing in conclusion that I wanted to touch on. You know, I know we talked about safety, but there's another thing when you are taking medications that has an effect, and that is how each individual can handle that new medication.

And I know well, you know, those situations. Just a little bit of a change in the medication to an individual that has an ailment, you know, they may not be able to tolerate it. So that's something that wasn't brought up and should be brought up.

The meeting is adjourned. Thank you.

(At 11:36 a.m., the public hearing adjourned.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.



Debra B. Miller

Transcriptionist

dbmreporting@msn.com