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HB 675 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing

Position: Oppose

Thank you for the opportunity to provide written comments on House Bill 675. This bill prohibits carriers from making changes to coverage, benefits, or drug formularies during the term of the health insurance policy or contract.

As part of its mission, CareFirst is committed to driving transformation of the healthcare experience with and for our members and communities. Ensuring equitable access to quality, affordable services across the healthcare continuum is essential to advancing holistic care and improving health outcomes. Fundamental to holistic care is an informed strategy to address the prescription drug and other therapeutic needs of our members and the communities we are honored to serve.

The Bill Will Cause Consumer Harm

There are several safety, efficacy, and consumer-friendly cost avoidance reasons a drug may be shifted into a higher cost-share tier or removed from the formulary during the benefit year, which this proposed law would prohibit. To deny carriers the ability to appropriately modify their formulary mid-year to reflect changes rooted in safety or the evolving nature of drug approvals would therefore not protect consumers as the proposed law intends, but instead would likely result in consumer harm.

- If safety concerns are raised regarding a drug mid-year, insurers currently can remove the drug from their formulary to prevent consumer harm. As written, however, the proposed law would require insurers to leave drugs on their formulary even when safety concerns have been raised. This is clearly not in the best interest of consumers, particularly if an equally effective drug with a more favorable safety profile is available.
- If there is a new FDA-approved indication for a drug or published evidence in available literature that makes a more effective drug available at a lower price than an existing higher price drug, moving the higher price drug to a higher cost-share tier will encourage consumer utilization of the lower price, more effective drug. This will result in lower premiums for members with greater treatment efficacy. As written, however, the proposed law would require insurers to maintain drugs on their existing tier, which will only result in consumers paying more for a drug when a cheaper, equally effective one is available.
- Similarly, if there is a new FDA drug approval that makes a more effective drug available at a lower price than an existing higher price drug, moving the higher price drug to a higher cost-share tier will promote consumer utilization of the lower price, more effective drug. This will also result in lower premiums for members with greater treatment efficacy. Again, however, the proposed law would not allow this even though it is in the best interest of consumers.
- If the cost of a drug is substantially increased mid-year by a manufacturer, insurers currently can exclude that drug from the formulary, move it to a higher cost-share tier, or require the member to take an equally effective drug first. The proposed legislation, however, would require insurers to wait until a new plan year to make that change, resulting in higher costs for businesses and consumers and, potentially, premium increases. This could also lead to unfavorable pricing/contracting strategies by pharmaceutical manufacturers, who could wait until January 2nd

annually to increase prices knowing that insurers are prohibited from responding to such price increases for most plans in that market. This would in turn lead to unnecessary and avoidable increases in healthcare costs and consumer premiums.

The Underlying Policy Concern Is Already Addressed by Insurer Processes, as well as Federal and State Law

CareFirst has a tier exception and a non-formulary exception request process in place to address situations where drugs used by our members are adjusted in our formulary during the contract year. For the tier exception, if a member has a medically necessary indication from their healthcare provider for the drug in a higher tier (i.e., other drugs have not been effective) then the cost may be altered to reflect the lower tier's cost sharing requirements. Similarly, if a drug is excluded from our formulary, the member can get access to the drug through the exceptions process.

Moreover, there are already consumer protections afforded under state and federal law and regulation to address concerns with mid-year benefit or coverage changes. The Patient Protection and Affordable Care Act (ACA) and its implementing regulations prohibit carriers from making certain changes to the coverage of services or benefits during the term of the policy or contract (see 45 CFR § 148.122 and 45 CFR § 146.152), with a limited exception specific to drug formularies for the reasons referenced above. Maryland also has protections in existing state law (see Md. Insurance Code Ann §§ 15-1212 and 15-1309) that provide reasonable protections against changes to coverage, benefits, and drug formularies during an existing policy or contract term.

The Bill Will Create Confusion for Health Care Providers and Consumers

This bill would also create confusion among physicians, pharmacies, and our members in the employer-sponsored insurance market, which represents nearly half of Marylanders. Employer-sponsored health insurance plans do not uniformly begin or renew their plan year on January 1st like individual market coverage. Plan years in the employer-sponsored market may begin or renew any month during the year. Locking in the formulary for the entirety of the policy or contract year has the unintended consequence of requiring 12 separate, additional formularies due to employers having different renewal dates throughout the year.

We urge you to reconsider this legislation as it undermines our shared goal of ensuring access to affordable coverage for consumers. CareFirst stands ready to partner with legislators, the Maryland Insurance Administration, providers, pharmacies, and other stakeholders to employ targeted strategies to improve the health and wellbeing of our members, provider partners, employees, and communities.

We urge an unfavorable report.

About CareFirst BlueCross BlueShield

In its 84th year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and employers in Maryland, the District of Columbia, and Northern Virginia. In 2019, CareFirst invested $43 million to improve overall health, and increase the accessibility, affordability, safety, and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn or Instagram.