OAG HEAU_FAV_SB0621.pdf
Uploaded by: Patricia O'Connor
Position: FAV

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OFFICE OF THE ATTORNEY GENERAL
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March 2, 2022

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: The Office of the Attorney General's Health Education and Advocacy Unit

Re: Senate Bill 621 (Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 621 which would prohibit changes to coverage, benefits, or drug formularies under a health insurance policy or contract during the term of the policy or contract. The bill expressly provides that the coverage of services or benefits provided under a health insurance policy or contract may be changed on renewal of the policy or contract. The bill further provides that, during the term of a policy or contract, a drug or device may not be removed from a formulary or moved to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance amount for the drug or device, but that such removals or tier changes may happen on renewal as long as an affected member and her provider are given at least 30 days written notice and are told how to seek an exemption.

The HEAU has assisted consumers who have been adversely affected by changes to coverage, benefits and drug formularies during the terms of health insurance policies and contracts. Remedial relief can be hard to obtain under current law. We support this bill because we believe consumers are entitled to the benefit of the bargain they entered into at the beginning of a policy or contract term, plain and simple.

We ask the committee for a favorable report.

cc: Sponsor

22_SB621SponsorTestimony.pdf
Uploaded by: Paul Corderman
Position: FAV

PAUL D. CORDERMAN
Legislative District 2
Washington County

Budget and Taxation Committee
Subcommittees
Education, Business and Administration
Pensions

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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District Address
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Hagerstown, MD 21742
240-313-3929

March 2, 2022

Testimony in Support of SB 621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies - Timing

Chair Kelley and Members of the Senate Finance Committee:

Thank you for hearing *SB621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies - Timing*. Under current law, patients may only be given 30 days advance notice for removal of a drug from the formulary. Additionally, there is no guarantee that the services they rely on will continue to be offered by the end of their contract.

This legislation would protect Marylanders by prohibiting insurers and service plans from changing or removing benefits and drug formularies during the term of the health insurance policy. Insurance companies would also not be permitted to raise a device or prescription drug to a tier requiring the client to pay a higher deductible during their coverage.

This legislation will ensure no citizens of Maryland are left medically unprotected because of changes in their ongoing health insurance policies.

Thank you for your consideration as I respectfully ask for a Favorable report on SB 621.

Sincerely,

Senator Paul D. Corderman
District 2 – Washington County

2022 ACNM SB 621 Senate Side.docx.pdf
Uploaded by: Robyn Elliott
Position: FAV

AFFILIATE OF
AMERICAN COLLEGE of NURSE-MIDWIVES
With women, for a lifetime®

Committee:	**Senate Finance Committee**
Bill:	**Senate Bill 621 - Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing**
Hearing Date:	**March 2, 2022**
Position:	**Support**

The American College of Nurse Midwives supports *Senate Bill 621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing.* Under the bill, insurance plans would not be able to change coverage or remove drugs from their formulary during the plan year. As providers, we work closely with our patients on selecting medications that work best for them clinically and are affordable under their insurance plan. If the insurance plan changes its formulary mid-year, this change can disrupt treatment as we work to find new medications that are both covered and effective for the patient.

We ask for a favorable report on this legislation. If we can provide additional information, please contact Robyn Elliott at relliott@policypartners.net.

2022 MCHS SB 621 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **Senate Bill 621 - Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing**

Hearing Date: **March 2, 2022**

Position: **Support**

Maryland Community Health System supports *Senate Bill 621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing.* The bill prohibits state-regulated private plans from removing or making changes to coverage for prescription drug benefits during the plan year.

Maryland Community Health System is a network of federally qualified health centers focused on providing somatic, behavioral health, and dental services to underserved communities. We support this legislation because it promotes continuity of care for our patients. If carriers remove a drug or make changes to cost-sharing requirement during the plan year, our patients may be forced to pay more out-of-pocket. Many of our patients have limited resources and unexpected out-of-pocket expenses can be challenging. Patients may have selected the plan specifically because it provided coverage for their medication regimen, and it is unfair to change that coverage before the end of the plan year.

We ask for a favorable report. If we can be helpful in any way, please let us know by contacting Robyn Elliott at relliott@policypartners.net.

2022 MNA SB 621 Senate Side.pdf
Uploaded by: Robyn Elliott
Position: FAV

Committee:	**Senate Budget and Taxation Committee**
Bill:	**Senate Bill 621 - Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing**
Hearing Date:	**March 2, 2022**
Position:	**Support**

The Maryland Nurses Association (MNA) supports *Senate Bill 621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing.* The bill would prohibit private insurers from removing a drug or changing copayment requirements during the plan year. Consumers, particularly those with complex medical needs, often pick their insurance plans based on drug coverage. If there are changes mid-year, consumers may not be able to afford the resulting unexpected out-of-pocket costs for their medications. This means that they will have to return to their providers to identify which medications are covered under their plan, and this process can be time-consuming, add to medical costs, and disrupt continuity of care.

We ask for a favorable report on this legislation. If we can provide additional information, please contact Robyn Elliott at relliott@policypartners.net.

9 - SB 621 - X - FIN - Health & Wellness Council -

Uploaded by: State of Maryland (MD)
Position: FAV

MARYLAND STATE ADVISORY COUNCIL ON HEALTH AND WELLNESS

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, MD, 21401

RE: SB 621 Health Insurance - Changes to Coverage, Benefits, and Drug Formularies - Timing

Dear Chair Kelley and Committee Members:

The Maryland State Advisory Council on Health and Wellness (the Council) is submitting this letter of support for Senate Bill 621 (SB 621), titled "Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing."

The purpose of SB 621 is to prohibit health insurance providers from changing coverage for services or benefits during the term of a health insurance policy or contract. SB 621 also prohibits health insurance providers that cover prescription drugs from removing drugs from their formulary or moving drugs to a benefit tier with higher out-of-pocket costs during the term of the insurance policy or contract.

The Council supports SB 621 as it seeks to promote good health and chronic disease management by limiting disruptions to medical care and prescription regimens. More than one-third of Maryland adults live with chronic diseases such as cardiovascular disease, diabetes, and chronic lower respiratory disease, which are among the leading causes of death in the state.[1, 2] People living with common chronic diseases often rely on consistent medical care and medication to properly manage their health.

Disruptions to medical services, benefits, or prescriptions can be devastating to individuals' health and costly for the health system. Changes in health insurance coverage are associated with less access to routine medical care, delays in seeking care, and increases in unmet health needs.[3,4] The cost of medication and complexity of treatment are two of the most common reasons why people with chronic conditions do

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[1] Maryland BRFSS 2019. Prevalence of Chronic Disease Risk Factors and Outcomes. https://health.maryland.gov/phpa/ccdpc/Reports/Documents/2019%20MD%20BRFSS%20-%20Chronic%20Disease%20Risk%20Behaviors%20and%20Outcomes.pdf

[2] Centers for Disease Control and Prevention: National Center for Health Statistics. Stats of the State of Maryland 2017. https://www.cdc.gov/nchs/pressroom/states/maryland/maryland.htm#:~:text=MD%20Leading%20Causes%20of%20Death%2C%202017%20%20,%20%2049.4%20%206%20more%20rows%20. Retrieved 4 February, 2022.

[3] Burstin, H.R., Swartz, K, O'Neil, A.C., Orav, E.J., and Brennan, T.A. (1999). The Effect of Change of Health Insurance on Access to Care. Inquiry 35(4), 389-397. https://www.jstor.org/stable/29772784.

[4] Frederico, S.G. et al. (2007). Disruptions in Insurance Coverage: Patterns and Relationship to Healthcare Access, Unmet Need, and Utilization Before Enrollment in the State Children's Health Insurance Program. Pediatric 120(4), e1009-e1016. https://www.publications.aap.org/pediatrics/article-abstract/120/4/e1009/71289/Disruptions-in-Insurance-Coverage-Patterns-and?redirectedFrom=fulltext

not follow their prescribed treatment regimen.[5,6] People with chronic illnesses who are not able to adhere to their medication regimens are nearly 70 percent more likely to be hospitalized than those who are adherent.[7] Lack of medication adherence is estimated to cost the healthcare system between $100 billion and $290 billion every year.[8]

SB 621 provides basic consumer protection for health insurance customers by preventing insurance providers from changing coverage during a policy term. Many insured individuals may not be aware that insurance companies are currently allowed to change coverage during the policy term, and they may only find out when coverage for care they need is no longer available.

The Council respectfully asks this Committee to approve SB 621 as an important public health measure to protect the health of people living with chronic conditions and ensure that Maryland health insurance customers have consistent access to the services, benefits, and medications they need.

Sincerely,

Jessica Kiel, M.S., R.D., Chair, State Advisory Council on Health and Wellness

[5]Banerjee, A. et al. (2016). Health system barriers and facilitators to medication adherence for the secondary prevention of cardiovascular disease: a systematic review. *Open Heart* (3), e438. https://openheart.bmj.com/content/3/2/e000438.

[6] Yap, A.F., Thirumoorthy, T., Kwan, Y.H. (2015). Systematic review of the barriers affecting medication adherence in older adults. Geriatrics and Gerontology International 16: 1093-1101. https://onlinelibrary.wiley.com/doi/abs/10.1111/ggi.12616

[7] Centers for Disease Control and Prevention: Public Health Grand Rounds (2017). Overcoming Barriers to Medication Adherence for Chronic Diseases. https://www.cdc.gov/grand-rounds/pp/2017/20170221-medication-adherence.html.

[8] Rosenbaum, L. and Shrank, W.H. (2013) Taking Our Medicine — Improving Adherence in the Accountability Era. New England Journal of Medicine 369: 694-695. https://www.nejm.org/doi/pdf/10.1056/NEJMp1307084.

SB0621_FWA_MedChi_HI - Changes to Coverage, Benefi
Uploaded by: Danna Kauffman
Position: FWA

MedChi

The Maryland State Medical Society

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www.medchi.org

TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Paul D. Corderman

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone

DATE: March 2, 2022

RE: **SUPPORT WITH AMENDMENT** – Senate Bill 621 – *Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports with amendment** Senate Bill 621. Senate Bill 621 states that a carrier may not change the coverage of services or benefits provided under a health insurance policy or contract during the term of the policy or contract. The bill also prohibits a carrier from removing a drug from its formulary or move a prescription drug or device to a benefit tier that requires a member to pay a higher deductible, copayment, or coinsurance amount for the prescription drug or device during the term of a health insurance policy or contract. The bill allows these changes to occur on renewal but if the carrier is removing a drug or moving it to a higher tier, it must provide a member who is on that prescription drug notice at least 30 days before the change.

Currently Maryland law does require each carrier to establish a process by which a member may either receive a drug not on the carriers' formulary or receive a drug that has been removed from the formulary. The process must also address when the member may continue the same cost sharing requirements if the carrier has moved the prescription drug or device to a higher deductible, copayment, or coinsurance. Under either circumstance, the carrier must provide notice to the patient or prescriber 30 days before making the change.

Health care costs continue to increase, with individuals paying more out-of-pocket in the form of both premiums and cost sharing. As such, consumers must be better "shoppers of health care," an initiative promoted by the State. For example, the Maryland Health Care Commission operates https://www.wearthecost.org/ to better inform consumers of how costs for the same procedure may differ between hospitals. Consumers should feel confident that the health plan they purchase in the beginning of the plan year will remain consistent through the plan year, especially given the fact that individuals

can only switch health plans during open enrollment. This is especially true for individuals with chronic or serious conditions. Many often choose their health plan based on whether their medication is covered and that it is covered under an affordable cost tier. Requiring an individual to change medication without consideration of the medical repercussions or the reasoning behind the physician's decision to initiate a medication places the patient's health at risk, potentially causing adverse side effects and decreased effectiveness of the medication.

While MedChi ultimately supports prohibiting mid-year plan changes, MedChi does support the amendment put forth by the bill's sponsor, which changes the notice provision from 30 days to 60 days and amends the current exemption process to specifically address the issues that occur when a patient is currently on a medication. Changing the notice provision from 30 days to 60 days would allow additional time for patients and prescribers to readjust medications, if necessary. Regarding the exemption process, the amendment specifically addresses those individuals who are currently on a medication that is effectively treating their condition at the time of the mid-year formulary change. It allows them to remain on the drug based on the judgment of the prescriber. The current exemption process appears to require a switch to an equivalent prescription drug or device unless that drug has been ineffective in treating the disease or condition or has caused or is likely to cause an adverse reaction or harm – a standard that implies that the member has to try it or has tried it in the past to qualify for an exemption.

Therefore, Senate Bill 621 is about fairness. Fairness in purchasing a health plan and being confident that it will remain the right health plan for you throughout the year. For the reasons stated above, we request a favorable vote on Senate Bill 621 with the requested amendments.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Christine K. Krone
410-244-7000

SB 621_Frozen Formularies_Oppose.pdf
Uploaded by: Allison Taylor
Position: UNF

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

March 2, 2022

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 621 – Oppose

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente regretfully opposes SB 621, Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 800,000 members. In Maryland, we deliver care to over 460,000 members.

SB 621 prohibits a carrier from changing the covered services or benefits provided under a health insurance policy during the term of the policy. A carrier frequently needs to make changes to a formulary mid-year to reflect market changes, such as to provide coverage for the COVID-19 vaccines or to implement a new mandate, such as to cover COVID testing. Occasionally, we must remove drugs from the formulary if safety issues have been identified for a particular drug (e.g., FDA drug recall), and this bill would not permit us to do so. For these reasons, we request an unfavorable report for SB 621.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

SB 621 - Oppose.pdf
Uploaded by: Deborah Rivkin
Position: UNF

Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
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SB 621 – Health Insurance – Changes to Coverage, Benefits, and Drug Formularies – Timing

Position: Oppose

Thank you for the opportunity to provide written comments on Senate Bill 621. 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.