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MEMORANDUM IN OPPOSITION

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Re: S.4111 (Breslin)/A.4668 (Peoples-Stokes) – An act to amend the insurance law and the public health law, in relation to prescription drug formulary changes during a contract year.

This legislation would prohibit health insurance plans from making mid-year pharmacy formulary changes, which will result in higher health insurance premiums and exacerbate the increasing cost of drugs. For these reasons, the New York Health Plan Association (HPA) opposes S.4111/A.4668.

Specifically, this legislation would prohibit health plans from making changes to their formularies except during the renewal and enrollment period leading up to the start of an employer's or individual's policy year, unless a generic drug becomes available or the Federal Drug Administration (FDA) determines that a drug should be removed from the market. Additionally, the bill would require health plans to provide advance notice of the intent to remove a drug from the formulary or alter its tier. However, S.4111/A.4668 provides an exemption for collectively bargaining agreements, creating two different standards; one that allows unions to make mid-year changes and a separate requirement for private employers and New Yorkers who buy coverage through the individual market.

Prescription drugs are one of the fastest rising components of health care costs and this legislation will do nothing to address the real reason for rising pharmaceutical costs: the high prices drug companies charge. When health plans make mid-year changes to their formularies, they do so with the intention of reducing the cost of member premiums, incentivizing use of the most efficacious drugs, and ensuring patient safety. They also help to counter unchecked and across the board increases in drug prices, so that health plans can keep prescription coverage affordable for consumers.

By limiting when health plans can make formulary changes, this legislation takes away their ability to mitigate the excessive and accelerating price hikes of prescription drugs that occur throughout the year. For example, if the price a pharmaceutical manufacturer charges for a drug goes up in the middle of the year, this legislation would leave health plans without any meaningful tools to address those increases. Rather than helping patients, S.4111/A.4668 would protect pharmaceutical companies and their exorbitant pricing practices.

Further, individuals and employers renew policies at different times over the calendar year, typically at the beginning of each month. "Locking-in" the formulary when the policy year begins would have the unintended result of creating multiple formularies each month for each new or renewing policy. The practical effect of this bill would be the creation of multiple formularies with differing coverage of medications dependent on when a policy renews, which will promote confusion among consumers, physicians and pharmacies, and significantly drive up health plan administrative costs.

This legislation would allow plans with formularies that include two or more tiers to move prescriptions during a contract year as long as patients currently receiving the drug or who have a diagnostic history

that predispose them to possibly needing this drug during the contract year are kept at the lower copay amount. This has the practical effect of requiring plans to create personalized formularies based on a member's clinical status and treatment needs. The bill also states a plan may remove a drug if the FDA determines that a drug should be removed from the market. Currently, health plans have the flexibility to proactively remove prescriptions if there are emerging safety concerns. For example, in 2020, the FDA expressed safety and utilization concerns regarding hydroxychloroquine, but did not go so far as to recall the drug. Under this bill, plans would be limited in removing drugs that have been shown to present a risk to patients, unless they have been recalled. HPA is concerned about this restriction.

Additionally, this bill is unnecessary as protections already exist for consumers. Currently, the Department of Financial Services limits how often plans may update formularies to no more than four times a year. However, health plans typically make changes less frequently and rarely remove drugs from the formularies. Further, when an individual's drug changes to higher tier, or when a drug has been removed from the formulary, there must be a therapeutic equivalent drug that is as effective as the original drug. In all cases, plans must notify affected members about the formulary changes. Moreover, New York law requires plans to have "exception" processes that enable consumers or their providers to access specific treatments, including prescription drugs. This ensures members get the most effective drugs regardless of whether the drug is on the formulary.

Decisions to update a health plan's drug formulary or to change tiers are determined by health plans' Pharmacy and Therapeutic (P&T) committees. Comprised of independent community physicians and pharmacists with expertise in the diagnosis and treatment of disease, these committees review new drugs and the latest clinical information to determine which drugs will appear on the formulary. This ensures that there is local input into a health plan's formulary and that members have access to needed medications while also helping to reduce the cost of member premiums, incentivize use of the most effective drugs, and ensure patient safety.

Formularies have existed for decades and are commonly used by hospitals, health plans, prescription benefit management companies, self-insured employers, and government programs. Formularies are designed to provide enrollees access to effective drugs in every therapeutic class to ensure efficacious treatment while managing the rising cost of medications. The formulary and review process of modification is intended to reduce the cost of member premiums, incentivize use of the most efficacious drugs, and ensure patient safety.

Increased utilization, price inflation, and higher cost drugs continue to drive up prescription drug costs. Drug companies are pushing the limits on prescription drug prices across the board. Six-figure price tags on old and new drugs have become commonplace, specialty drugs and generic drugs see similar pricing jumps, and prices for orphan drugs regularly reach above $300,000. To counter these increases and to keep prescription coverage affordable for consumers, health plans use comprehensive prescription drug formularies.

By "locking-in" the formulary of covered drugs, the legislation would prevent the continuous review, update, and change necessary to maximize premium affordability, safety, and efficiency to benefit consumers. We do not believe it is in the best interest of the health plans or the patients served to prohibit a health plan from acting to incentivize use of the most efficacious drugs and reducing the cost of member premiums by changing its formulary mid-year.

For all these reasons, HPA opposes S.4111/A.4668.