FLORIDA HEALTH INSURANCE ADVISORY BOARD

November 14, 2018

David Altmaier, Chair
Commissioner
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399
850-413-5914
FAX: 850-488-3334
David.Altmaier@floir.com
Office of Insurance Regulation

W. Adam Clatsoff, Vice Chair
President/CEO
Adcahb Medical Coverages, Inc.
476 NW 120 Drive
Coral Springs, FL 33071
954-881-4172
FAX: 877-329-2326
adam@adcahb.com
Term Ending: 12/31/2020
Agent

Molly McKinstry
Deputy Secretary
Division of Health Quality Assurance
Florida Agency for Health Care Admin.
2727 Mahan Drive, Mailstop #2
Tallahassee, FL 32308
850-412-4334
FAX: 850-922-2897
molly.mckinstry@ahca.myflorida.com
Agency for Health Care Administration

Louisa McQueeney
Communications Director
Florida Voices for Health
9653 El Clair Ranch Road
Boynton Beach, FL 33437
FAX: 561-364-0246
MOBILE: 561-302-0345
louisa@healthyfla.org
Term Ending: 12/31/2019
Individual Policyholder

Ken Stevenson
Vice President, Employee Benefits
Earl Bacon Agency
3131 Lonnbladh Road
Tallahassee, FL 32308
850-878-2121
FAX: 850-878-2128
kens@earlbacon.com
Term Ending: 12/31/2018
Agent

Christina Lake
Executive Vice President
Datamaxx Group, Inc.
2001 Drayton Drive
Tallahassee, FL 32311
850-558-8102
Christina.lake@datamaxx.com
Term Ending: 12/31/2019
Employers or Employer Representatives

William "Bill" Herrle
Executive Director
NFIB
110 East Jefferson Street
Tallahassee, FL 32301
850-681-0416
FAX: 850-561-6759
MOBILE: 850-728-7356
Bill.Herrle@nfib.org
Term Ending: 12/31/2018
Employers or Employer Representatives

Brad Bentley
Senior Vice President,
Underwriting, Actuarial & Reg. Affairs
AvMed Health Plan
4300 NW 89th Blvd.
Gainesville, FL 32606
352-337-8760
Brad.Bentley@avmed.org
Term Ending: 12/31/2018
Carrier

Richard B. Weiss, CPA
President, Florida Market
Aetna
1340 Concord Terrace
Sunrise, FL 33323
954-858-3434
FAX: 954-858-3479
MOBILE: 954-554-1757
rbweiss@aetna.com
Term Ending: 12/31/2020
Carrier

John J. Matthews
Regional General Counsel, Southeast
UnitedHealthcare
4560 Grove Park Drive
Tallahassee, FL 32311
FAX: 866-480-7774
MOBILE: 850-443-6996
John_J_Matthews@uhc.com
Term Ending: 12/31/2018
Carrier

Mark S. McGowan
Senior Counsel, Legal Affairs Division
Florida Blue
4800 Deerwood Campus Pkwy, 100-7
Jacksonville, FL 32246-8273
904-905-6570
FAX: 904-905-9873
MOBILE: 904-923-2545
mark.mcgowan@bcbsfl.com
Term Ending: 12/31/2018
Carrier

Rick Wallace
President/CEO
FAB and FAMOS, LLC
PO Box 10437
Tallahassee, FL 32302
MOBILE: 850-879-2649
Rick@teamwallace.org
Term Ending: 12/31/2020
Employers or Employer Representatives

Robert Muszynski
Vice President – Finance
Orlando Regional Realtor Association
1330 Lee Road
Orlando, FL 32810
407-617-5261
robertm@orlandorealtors.org
Term Ending: 12/31/2020
Employers or Employer Representatives

Chris Paterson
Vice President
Centene Corporation
1560 Sawgrass Corporate Pkwy, Ste 200
Sunrise, FL 33323
954-514-1735
MOBILE: 954-235-7714
cpaterson@centene.com
Term Ending: 12/31/2019
Carrier

FLORIDA HEALTH INSURANCE ADVISORY BOARD
BOARD MEETING

December 13, 2018

Antitrust Statement

We are here to discuss and act on matters relating to the business of the Florida Health Insurance Advisory Board. We are not here to discuss or pursue the business interests of any individual companies. All of us should proceed with caution and awareness of the requirements and prohibitions of federal and state antitrust laws. We should not engage in discussions, either at this meeting or in private conversation, of our individual companies' plans or contemplated activities. We should concern ourselves only with the business of the Florida Health Insurance Advisory Board, as set forth in the agenda for this meeting and each company's business plans cannot be discussed. If you have questions, please contact the General Counsel.

DRAFT

FLORIDA HEALTH INSURANCE ADVISORY BOARD
Board of Directors Meeting Minutes
Monday, November 5, 2018, 2:00 PM
Via Teleconference
Tallahassee, Florida

Board Members Present:

David Altmaier, Chair	Ken Stevenson	Rick Wallace
W. Adam Clatsoff	Christina Lake	Robert Muszynski
Molly McKinstry	Brad Bentley	Chris Paterson
Louisa McQueeney	Richard B. Weiss	Seth Phelps *(for Mark McGowan)*

Others Present:

- Amy Hardee, Administrative Assistant II to the Deputy Commissioner – Life & Health, Office of Insurance Regulation (OIR)
- Shannon Doheny, Senior Attorney, Legal Services Office, OIR
- Craig Wright, Chief Actuary & Deputy Commissioner - Life & Health, OIR
- Chris Struk, Life & Health Policy Advisor, OIR
- Mike Yaworsky, Chief of Staff, OIR
- Erin VanSickle, Deputy Chief of Staff, OIR
- Warren Mills, Director, Life & Health Product Review, OIR
- Monica Ross, Chief Assistant General Counsel, OIR
- Caitlin Murray, Director of Government Affairs, OIR
- Jon Moore, Communications Director, OIR

I. Call to Order

Commissioner and Chair David Altmaier called the meeting to order at 2:01 PM indicating the meeting was properly noticed to the public in accordance with Florida Law.

II. Roll Call

Amy Hardee conducted a roll call, noting the presence of a quorum.

III. Antitrust Statement

Shannon Doheny was recognized to review the antitrust statement.

IV. Chair's Opening Remarks

The Chair thanked the Board members for being members of this Board and for the invaluable insights into their respective areas of the health insurance market in Florida as potential legislative proposals are discussed.

V. Approval of Minutes – October 4, 2018

The Chair presented the minutes from the October 4, 2018, meeting for adoption, noting that members had been provided with advance copies. Adam Clatsoff moved to adopt the minutes as written, with a second by Robert Muszynski, and the minutes were adopted without objection.

VI. Legislative Proposals for 2019

The Chair noted that the purpose of today's call was to discuss legislative proposals for 2019 and reminded the Board that only proposals receiving unanimous consent of the Board, and not opposed by any Board member, will be forwarded to the Florida Legislature. However, Board members are certainly welcome to pursue legislative proposals on their own, whether or not they are accepted by the Board.

The Chair noted that eight legislative proposals were received, all from Louisa McQueeney. To allow each proposal to receive full consideration, the Chair asked Ms. McQueeney to review each of her recommendations one at a time with time for discussion and questions between each one, noting that the proposals will be voted on during our next meeting.

Recommendation #1: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.

Ms. McQueeney noted that her first recommendation is a little bit different than the one she recommended last year. It's an employee/dependent option coverage in the small group plans. Under most employer-sponsored group health plans, employers subsidize the employee's premium to a great extent, but usually not the spouse/dependent coverage, making it very expensive for the company to get health insurance. Covering a spouse is not mandated by federal law and in the Affordable Care Act (ACA) environment, it would be advantageous to have the option to not offer spousal coverage, so that the spouse could qualify for Premium Tax Credits (PTCs). In Florida, this is not an option.

Mr. Clatsoff stated that he loves this recommendation and it is exactly right on.

Brad Bentley asked for clarification on what was different between last's year recommendation and this year's recommendation. The difference is that last year's recommendation was for spousal dependents and dependent children; whereas, this year's recommendation is only for dependent children. This will allow the spouse to go out into the open market and get tax credits if they qualify for that.

Recommendation #2: Allow consumers a Deductible Health Credit Transfer to the new policy equal to the deductible paid by the consumer.

Ms. McQueeney noted that she had made this recommendation before and it remains a problem. When an employer changes healthcare plan midstream and employees have already paid their deductible, they have to start all over again with a new deductible. For 2019, these deductibles could be as high as $7,900 for an individual and $15,800 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all and this creates a hardship.

Seth Phelps asked for clarification as to when this is happening because there is a requirement under state law (*section 627.666(2), Florida Statutes*) for when an employer changes insurance companies. Ms. McQueeney noted that her recommendation is not just for when an employer changes health insurance plans but also when an individual changes insurance plans (i.e., they move from one county to another). Mr. Phelps noted that the statute he was referring to only applies to group insurance. Ms. McQueeney asked if it could be expanded to individual insurance.

Recommendation #3: Provide consumer with one free copy of their medical record, to be provided to consumer by mail or electronic mail, at the time of payment request for services provided.

Ms. McQueeney noted that patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). The same law allows providers to charge fees for providing the requested copies. Many requests for records are not honored in a timely fashion if honored at all and some at great expense to the consumer. Obtaining one's own medical records is especially important when disputes arise with insurance companies, resulting in denial of claims, leaving patients in precarious financial positions. She has seen this issue become more prevalent with the rise of short time medical policies and pre-existing conditions. This will also allow consumers to see exactly what services were provided and what's being billed for.

Mr. Clatsoff agreed that this is an important problem. However, he suggested that a better solution would be to require that these records be provided at a cost to be dictated by the Board. He asked if a time limit (30 days or 60 days) on obtaining these records could be put into law. He is reluctant to ask hospitals, etc. to provide these records for free as they have bills to pay also. Molly McKinstry asked to clarify that this would be a requirement of the provider (hospital, etc.) rather than the insurer and Ms. McQueeney confirmed that is correct. Ms. McQueeney asked if insurers could work with providers to get consumers these records in a timely fashion since they negotiate with the providers. Ms. McKinstry noted that there are regulations in law already for different types of health care facilities with regard to the timeframe for releasing records and the cost (i.e., for hospitals, the charge for non-paper records cannot exceed $2 total or $1/page). She suggested that maybe it would be beneficial to have the deadlines for releasing records and the cost for these records be the same for all providers as opposed to the way it is now with each type having its own rules. She also mentioned the possibility of a patient portal to get the information so that it would not cost either party money.

When Ms. McQueeney asked to clarify that a patient portal would provide the records free of charge, Ms. McKinstry noted that she believes establishing a patient portal would get closer to reducing the cost to the provider but she would have to touch base with some of the provider groups to confirm this. She also noted that some providers already have patient portals while others would have to establish them which would incur additional cost. Ms. McQueeney expressed her opinion that consumers are already paying the provider for a service and feels that the medical record should just be part of that transaction. Mr. Clatsoff asked why Ms. McQueeney doesn't feel it's appropriate to pay for medical records and she noted that consumers received itemized receipts for other services they pay for so why not with medical services. Ms. McKinstry noted that whether providers are paid a rate that would cover the cost of providing records would be questions that would need to be answered by individual providers. However, she did agree that ensuring these records are provided timely and efficiently makes a lot of sense. Ms. McQueeney asked if insurers pay for medical records when they are doing a medical review. Rich Weiss responded that yes, sometimes insurers do pay for medical records; however, it's at a negotiated rate. Ms. McQueeney also noted that sometimes consumers do not receive any kind of confirmation that they have requested their records which results in getting the runaround. Ken Stevenson noted that he has run into this issue as well with medical records being up to 400-500 pages and the provider charging $1/page and this can create a hardship if the consumer is just trying to work through an appeal.

<u>Recommendation #4</u>: Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier from expanding the formulary and lowering prices throughout the policy year.

Ms. McQueeney noted that this recommendation is a repeat from last year. Consumers often pick a health insurance plan based on the prescription drugs covered and the cost tiers they are classified in. Insurers routinely reclassify drugs to more access restrictive drug tiers, increase the consumer's co-payment, co-insurance or deductible, and reclassify drugs to higher cost sharing tiers. Consumers enter into a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period.

Mr. Clatsoff asked if this would just apply to the insured or everyone in the block of business and Ms. McQueeney said everyone. Mr. Clatsoff asked if this could just be applied to people in the block who are using the specific drug being changed. Ms. McQueeney stated that she thought it should apply to everyone. Mr. Weiss stated that doing this could inadvertently cause the price of insurance to go up. Pharmaceutical companies tend to change their prices on a quarterly basis so insurance companies would have to build in some type of cost increase to allow for changes throughout the year. Mr. Clatsoff agreed that this is a problem for consumers taking a specific drug that gets a price increase or goes away complete. Mr. Weiss noted that usually there is a similar drug that can be substituted in these cases. Mr. Muszynski has encountered these while working in a university pharmacy which caused the drug to be too expensive to carry. Mr. Weiss said he understood the concern; however, it's usually done from a cost protection standpoint. It was noted that maybe the recommendation needs to be that pharmaceutical companies cannot change drug prices midstream.

Ms. McKinstry said she believes the Medicaid Program would need to be exempted from this requirement as they are single-formulary with changes made quarterly through a very prescribed process. Ms. McQueeney asked for this information and Ms. McKinstry said she would share it.

Recommendation #5: In inadequate narrow networks, treat out-of-network care as in-network care and/or, at a minimum, apply the cost of the care to the accumulators, such as the deductible. Improve network adequacy.

Ms. McQueeney noted that this recommendation is to direct the OIR to develop better and more inclusive standards of network adequacy for all group and individual health plans. There is not reasonable access for certain consumers, especially in rural areas, where they cannot find providers. The "reasonable access" standard identified by CMS is insufficient at ensuring timely access to consumers as well as culturally and linguistically appropriate competency among providers. These standards are even more insufficient for consumers who are members of vulnerable populations with health disparities for instance in rural areas, where travel distances are an additional problem. When provider networks are inadequate, consumers may have no choice but to seek care outside their health plan's network. In those cases, insurers often require enrollees to pay a greater share of the cost for out- of-network care, and the insurer is not required to count those costs toward annual out-of-pocket maximums under the ACA.

Ms. McKinstry noted that the Agency for Health Care Administration (AHCA) regulates the network adequacy requirements for commercial non-Exchange plans, excluding Medicaid because it has its own separate process. AHCA has a mechanism to accept any type of complaints or concerns about insufficient networks and asked that these types of concerns be shared with them to see if it can be resolved within the existing regulations. There have been single-case agreements put in place to treat certain individuals with unique needs when the particular specialty they require is not within reasonable access.

Recommendation #6: Apply the balance billing rules under HB221, signed into law by Governor Scott in April 2016, to include emergency transportation.

Ms. McQueeney noted that this recommendation is to prohibit balance billing for emergency medical transportation. In June 2018, the Florida Insurance Consumer Advocate's Office issued an "Emergency Medical Transportation Costs in Florida" White Paper as a result of the its Emergency Medical Transportation Working Group's work to address this problem. Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road, water or air to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but some coverage gaps can leave consumers with surprise high medical bills for the service. This is an interesting problem because usually market forces will drive prices down, but in this particular case, the price actually goes up because the more vehicles you have, the more staff you need to be available.

Mr. Phelps noted that the state is not able to do anything about costs for air transportation because that is pre-empted by federal law. There are some laws regarding this issue which have been introduced at the federal level but nobody knows if any changes will result from them.

The Chair noted that this recommendation was approved by the Board last year and submitted to the Florida Legislature.

Recommendation #7: Establish a process for creating a standardized prior authorization form to be used by providers and insurance plans in the state. Allow for electronic submissions of prior authorization forms.

Ms. McQueeney noted that this recommendation is to standardize the Prior Authorization process. Prior authorization (PA) requirements are used by health plans to eliminate or minimize treatments that are potentially ineffective, wasteful, or even harmful. However, navigating the process can be very challenging for both healthcare providers and patients, because often payers require different forms for different plans, which may be specific to the type of drug, and their requirements for authorization may also vary. For people with chronic illnesses like Multiple sclerosis (MS), barriers related to prior authorization requirements can have a negative impact on their lives and their health outcomes. It can cause a delay in receiving an MRI or accessing a prescribed medication for weeks or even months until their insurer's prior authorization forms are submitted, reviewed, and approved. On the healthcare provider side, frustration and confusion surrounding the process are common.

Mr. Clatsoff asked what the process would be and who would be in charge of it. Ms. McQueeney suggested the OIR or the Board. Mr. Clatsoff stated that this could become very controversial quickly because each entity would want their PA Forms to look a specific way. Ms. McKinstry asked if there was any current effort for the Office to develop a standardized PA form. Chris Struk noted that in 2017, SB502 was passed which required to OIR to develop a standard PA form; however, it is only required to be used by health insurers which do not provide an electronic PA process and his understanding is that very few insurers do not use an electronic process. Mr. Weiss confirmed that each carrier has their own portal so they probably do not look the same.

Recommendation #8: Establish clear, meaningful, and accessible procedures for prescribers to override the process by requesting an exemption and prohibit insurers from requiring insured patients to fail a drug more than once.

Ms. McQueeney noted that this recommendation is to establish Step Therapy Protocols. Step therapy or "fail first" policies allow health plans to control the order in which patients take certain therapies. Step therapy protocols require that patients must try one or more medications selected by their insurer before the plan will grant coverage for the drug originally prescribed by the healthcare provider. Patients and healthcare providers have voiced concern regarding the potential adverse effects of step therapy, when it is not paired with protections for patients. When patients are required to cycle through and document a "step"—or in some cases, more than one step or medication—the process may result in substantial delays in treatment deemed appropriate by their healthcare provider. The use of ineffective treatment has been associated with higher costs due to additional office visits, increased drug costs, and even the increased likelihood of needing additional treatment or hospitalization. The risk profile of the medication as well as side effects and the ability for an individual to adhere to the medication must also be taken into account.

The Chair thanked Ms. McQueeney for bringing these recommendations before the Board and encouraged each member to discuss these recommendations with their colleagues within their organizations so they can be prepared to vote on them at the next meeting, which is scheduled for December 13 via teleconference.

VII. Other Business

The Chair asked if there was any other business to be brought before the Board. There being none, the Commissioner moved to the next agenda item.

VIII. Public Comment

The Chair asked if there were any members of the public who would like to comment. There being none, the Commissioner moved to the next agenda item.

IX. Adjourn

The Commissioner thanked everyone for participating. Having no further business, the meeting was adjourned at 2:44 PM.

_____ _____

David Altmaier, Chair Date

FHIAB 2019 LEGISLATIVE PROPOSALS RECEIVED FROM BOARD MEMBERS

Louisa McQueeney, Florida Voices for Health
Individual Policy Holder Representative

1. Employee/Dependent Option Coverage in Small Group Plans

In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium but spouse/dependent coverage are offered under the plan completely at the employee's expense, with no employer contribution.

Covering a spouse is not mandated by federal law and in the ACA environment, it would be advantageous to have the option to not offer spousal coverage, so that the spouse could qualify for Premium Tax Credits (PTCs). However, in the group market, carriers do not give small groups the option of not offering spousal coverage.

Recommendation: Provide a clear legislative directive whereby small group employers be specifically allowed the option to offer "employee/dependent(s)" coverage in the open market, where dependent(s) are dependent children only.

2. Deductible Health Credit Transfer.

With the continual rise in annual health insurance deductibles to consumers, having to start a new deductible in the middle of the year creates financial hardship. The deductibles for 2019 could end up being as high as $7,900 for an individual and $15,800 for a family. Some policies require the insured to pay the entire deductible before the insurance company pays anything at all.

When consumers change health insurance plans outside of the Open Enrollment period, as a result of an employer changing plans outside of annual renewal, or as a result of a change of employer, or a change in geographic area, annual deductibles start all over again even if a consumer has met part or all of the accumulators out of their own pocket.

Recommendation: Allow consumers a Deductible Health Credit Transfer to the new policy equal to the deductible paid by the consumer.

3. Provide health care consumers with one free copy of their own medical records.

Patients have a right to their medical records under the Health Insurance Portability and Accountability Act (HIPAA). The same law allows providers to charge fees for providing the requested copies. Many requests for records are not honored in a timely fashion if honored at all and some at great expense to the consumer. Obtaining one's own medical records is especially important when disputes arise with insurance companies, resulting in denial of claims, leaving patients in precarious financial positions.

Recommendation: Provide consumer with one free copy of their medical record, to be provided to consumer by mail or electronic mail, at the time of payment request for services provided.

4. Protect Consumers from prescription drug formulary changes during a policy year.

Consumers often pick a health insurance plan based on the prescription drugs covered and the cost tiers they are classified in. Consumers enter into a contract with the health insurance plan for a twelve-month period and pay an agreed upon amount per month for this period.

In recent years, insurance carriers have been making changes to their drug formularies during the policy period. Insurers routinely reclassify drugs to more access restrictive drug tiers, increase the consumer's co-payment, co-insurance or deductible, and reclassify drugs to higher cost sharing tiers. There are also instances of certain drugs being dropped from coverage altogether. Consumers are then informed by mail that they will be financially responsible for the entire cost drug in the middle of the policy year.

Recommendation: Prohibit insurance carriers from amending or removing a covered prescription drug during the policy year. This will not preclude the insurance carrier form expanding the formulary and lowering prices throughout the policy year.

5. Direct the Florida Office of Insurance Regulation to develop better and more inclusive standards of network adequacy for all group and individual health plans.

Network adequacy standards are required to ensure that health plans provide access to the services for which subscribers pay. Insurers have created narrow networks to control costs. However, every network should be minimally adequate to enable access to a multiplicity of necessary health services including, but not limited to primary care, pediatric care, hospital care, mental health care, oncology care, obstetric and newborn care, and dental care where applicable. The "reasonable access" standard identified by CMS is insufficient at ensuring timely access to consumers as well as culturally and linguistically appropriate competency among providers. These standards are even more insufficient for consumers who are members of vulnerable populations with health disparities for instance in rural areas, where travel distances are an additional problem.

When provider networks are inadequate, consumers may have no choice but to seek care outside their health plan's network. In those cases, insurers often require enrollees to pay a greater share of the cost for out- of-network care, and the insurer is not required to count those costs toward annual out-of-pocket maximums under the ACA.

Recommendation: In inadequate narrow networks treat out-of-network care as in-net-work care and/or at a minimum apply the cost of the care to the accumulators, such as the deductible. Improve network adequacy.

6. Prohibit balance billing for emergency medical transportation

Consumers in a life-threatening accident or major medical emergency in need of emergency transportation by road, water or air to receive immediate health care attention at a nearby facility, are not able to make an informed decision or negotiate at arms-length about the cost of the transport. Health insurance companies provide coverage for this event, but some coverage gaps can leave consumers with surprise high medical bills for the service.

Recommendation: Apply the balance bill rules under HB221, signed into law by Governor Scott, to include emergency transportation.

7. Standardize the Prior Authorization Process

Prior authorization (PA) requirements are used by health plans to eliminate or minimize treatments that are potentially ineffective, wasteful, or even harmful. However, navigating the process can be challenging for both healthcare providers and patients, because often payers require different forms for different plans, which may be specific to the type of drug, and their requirements for authorization may also vary.

For people with chronic illnesses like MS, barriers related to prior authorization requirements can have a negative impact on their lives and their health outcomes. It can cause a delay in receiving an MRI or accessing a prescribed medication, for weeks or even months until their insurer's prior authorization forms are submitted, reviewed, and approved.

On the healthcare provider side, frustration and confusion surrounding the process are common. A study published in *Health Affairs* (as cited by the American Medical Association) reported that processing these requests used around 20 hours each week of physician, nurse, and clerical staff time.

Recommendation: Establish a process for creating a standardized prior authorization form to be used by providers and insurance plans in the state. Allow for electronic submissions of prior authorization forms.

8. Establish Step Therapy Protocols

Step therapy or "fail first" policies allow health plans to control the order in which patients take certain therapies. Step therapy protocols require that patients must try one or more medications selected by their insurer before the plan will grant coverage for the drug originally prescribed by the healthcare provider. Patients and healthcare providers have voiced concern regarding the potential adverse effects of step therapy, when it is not paired with protections for patients.

When patients are required to cycle through and document a "step"—or in some cases, more than one step or medication—the process may result in substantial delays in treatment deemed appropriate by their healthcare provider. The use of ineffective treatment has been associated with higher costs due to additional office visits, increased drug costs, and even the increased likelihood of needing additional treatment or hospitalization. The risk profile of the medication as well as side effects and the ability for an individual to adhere to the medication must also be taken into account.

Recommendation: Establish clear, meaningful, and accessible procedures for prescribers to override the process by requesting an exemption. Prohibit insurers from requiring insured patients to fail a drug more than once.