

Dear Madame Chair & Committee Members,

My name is Kyle Leggott and I am a practicing Family Physician in Aurora and Lone Tree. I help take care of patients in the clinic and the hospital. I am writing in support of House Bill 1370 to help my patients and all Coloradans be able to live healthier, fuller lives, by improving access to affordable health insurance and prescription medications.

As a physician, I know how critical it is for patients to have regular check-ups for preventive care, which helps keep serious health issues at bay. Affordable access to Primary Care allows for identifying medical conditions early before they become crises and ultimately preventing hospitalizations which saves money for individuals and the system as a whole. Often, these preventative visits illuminate the need for patients to seek further testing through labs, imaging, referrals to a specialist, etc. Physicians know how critical these diagnostic tests are, yet patients are often concerned about the additional costs they could incur from these needed next steps. Some patients may delay or even skip them altogether, allowing treatable conditions to worsen.

Thankfully, we have an opportunity to help ensure patients in Colorado have transparent costs, can make informed choices, and have better access to these needed services. By passing House Bill 1370, you can help Coloradans know exactly what they'll be expected to pay for health care services when they sign up for insurance. Requiring 25% of plans to have set dollar copays, rather than less predictable percentage-based payments, will ensure patients know what services will cost and better plan to use them.

Often patients require prescription medications to treat their medical conditions, and picking up these medications can also cause financial concerns. As a physician, it is heartbreaking to see patients forgo life-saving prescriptions because of cost or because of red tape in the system. Physicians should be able to determine what medications are best for our patients, not insurance carriers. Patients shouldn't have to spend hours on the phone arguing to get the prescriptions their physicians have advised them to take.

House Bill 1370 will help patients get the medications they need by ensuring medications can't be dropped from coverage and that out-of-pocket payments for them can't increase during the year of their insurance contract. By allowing exemptions for health care providers to help get patients the medicine they need — when they need it, not just when it's approved by insurance — patients can feel better and become healthier. Finally, by passing on the rebates currently lining the pockets of insurance carriers, House Bill 1370 can help Coloradans protect their financial security along with their health.

House Bill 1370 will help physicians care for patients, and will help patients better prevent and treat health conditions. I thank the bill sponsors for introducing it and encourage a Yes vote today. Doing so will save countless lives and help all our communities thrive.

Sincerely,  
Kyle Leggott, MD

Dear Committee Members,

Thank you for the opportunity to share my testimony with you. My name is Dr. Micahel Belmonte. I'm an OBGYN in the Denver Metro area.

Not long ago, I saw a patient who delayed care for what would have been a treatable condition.

The patient had an abnormal pap smear, which can be managed with fairly routine, straightforward interventions.

Unfortunately, the patient was concerned that they would not be able to afford the copays and most worrisome to her, any unknown additional costs that insurance companies refuse to cover.

Because this patient delayed care out of concern that seeking health care would ruin them financially, their condition got worse, resulting in vaginal bleeding, which was found to be caused by cervical cancer.

These stories of people who get sicker because of high, unaffordable health care costs are too common in health care today.

Just the unknown and the expectation of hidden extra costs discouraged this patient – and many like them – to throw their hands up in defeat and skip health care to avoid huge bills.

One in five Coloradans skip health care because they're worried about costs.

One in five Coloradans say they get stuck with bills that contain extra costs their insurance companies should have covered, but didn't.

As physicians, we cannot and must not accept this broken status quo.

As Coloradans, we cannot and must not allow insurance companies to break their promises to the families they're supposed to cover.

My patients are rightfully fearful that their insurance companies are nickel-and-diming them with hidden costs and add-ons, except that the nickels and dimes add up into the thousands, tens of thousands and sometimes hundreds of thousands of dollars.

I've had patients come in to see medical professionals for help beating a heart disease or an infection, and ended up losing their homes or filing for personal bankruptcy.

Nobody should have to worry about losing their life savings because they want to beat cancer and live.

Insurance company and drugmaker profits must not come before our families' lives.

And HB22-1370 can help us address this unfair condition, help us hold insurance and drug corporations accountable, and put Coloradans first.

Thank you for your time. I hope you vote for HB-1370.

Michael A. Belmonte, MD

## Members of the Colorado General Assembly House Health & Insurance Committee

Dear Committee Members:

I'm Joni Inman, the Executive Director of the Colorado Women's Alliance, one of the largest non-profit, non-partisan organizations in the state representing the interests and concerns of women of all ages and geographic regions of Colorado.

Formed in 2010, The Colorado Women's Alliance supports research, education and advocacy in areas of concern to female voters. We seek to discover and understand women voters' values and priorities throughout the state, then take those findings and advocate for women's concerns by meeting with elected officials, candidates and other influencers. That's why I'm here today.

Consistent in our research, year after year, women identify the rising cost of healthcare as a top issue that they specifically *want* the State Legislature to address. Over the past decade it has always been amongst the top five most important policy issues to women – above homelessness, racism, public safety, roads and transportation, and other critical issues.

And so, I commend you for your continued struggle and attempts to address the rising cost of healthcare for families.

I am providing testimony today in the spirit of these concerns regarding House Bill 22-1370. While providing for reform, or rollback, of several anti-consumer practices used by insurance companies and drug middlemen (pharmacy benefit managers), HB22-1370 misses the mark on major reform of the prescription drug supply chain that could save Colorado consumers thousands of dollars every year on their prescription costs.

The missing piece in this bill is the lack of any meaningful change to—or reform of—the current pay-to-play system known as drug rebates in which insurance companies and pharmacy benefit managers compel drug manufacturers to pay a 'rebate' to them in order to have drugs listed on the approved coverage list. These rebates never reach the pocketbooks of families.

I saw some recent estimates that put the annual amount of rebates paid in Colorado at around \$1.2 billion dollars. \$1.2 *billion* dollars. Can you imagine? I know the argument that these rebate dollars are ostensibly to be applied by insurers to lower the overall cost of medical insurance coverage. However virtually no transparency or enforcement exists, at least that I've been able to find, to ensure these dollars don't end up simply increasing the profits of the corporations that collect them.

For several years, the Colorado Women's Alliance and others have been speaking out on and advocating for action by the legislature to address the problems with drug rebates. It is our understanding that during this legislative session, serious discussions were held with various stakeholders of HB22-1370 directing that all drug rebates be passed through to consumers at the point of sale – a proposal that would save Colorado patients and their families thousands of dollars per year, especially for those who are dependent on expensive life-saving medications.

Unfortunately, as introduced, HB22-1370 does not include this rebate pass-through provision, leaving patients stranded with artificially inflated out-of-pocket costs for medications while insurers and pharmacy benefit managers retain \$2 billion in rebate revenue.

This intentional blind-eye to the drug rebate system creates damaging impacts for Colorado families. With women making up the majority of voters in the state we are certain that we are being impacted disproportionately by the high cost of prescription drugs and shouldering burdens that could be substantially relieved by implementing a direct-to-consumer rebates. But instead of empowering Colorado women, who must either care for their families or who rely on life-saving medicines themselves, HB22-1370 strips them further of their consumer rights.

We support the underlying principles of HB22-1370 to rectify some of the inequities present in our healthcare system, especially when it comes to prescription drugs. But this bill can should do much more. Healthcare issues are complicated but providing for a direct-to-consumer savings takes a step at detangling a complex web. Colorado families could see fast and tangible results.

We strongly urge the Colorado legislature to amend HB22-1370 to restore the drug rebate pass-through to consumers. In so doing, you would be, at least partially, answering the call of the women and families that we represent.

Thank you.



Colorado Senate  
200 E Colfax Avenue  
Denver, CO 80203

April 20, 2022

**Re: Support HB22-1370 Coverage Requirements For Health-care Products**

Dear House Health and Insurance Committee:

Good Business Colorado (GBC) is a statewide grassroots organization of over 420 business owner members in 31 counties across the state. Our values-driven members work together to advocate for a prosperous economy, equitable communities, and a sustainable environment. On behalf of our membership, I urge you to please vote yes on **HB22-1370** to promote affordable, dependable healthcare in our state.

The unpredictable and unaffordable nature of health care costs is an increasing problem. Employers and their employees depend on their health insurance to cover their care, whether for unexpected expenses, or chronic conditions. They do not expect confusing or unfair denial of treatment and most are unprepared for excessive out-of-pocket costs.

HB22-1370 provides greater predictability with set dollar co-pays, and a guarantee that medication cannot be dropped mid-year. It provides affordability by ensuring third party assistance with bills count toward a patient's out-of-pocket costs and ensuring that rebates go to patients, not carriers. And it halts the dangerous practice of forcing already fragile patients to go through a step therapy protocol, even when their doctor knows what they need from the get-go.

Healthcare affordability and accessibility remains a top issue for our membership and it is a particular challenge for small business entrepreneurs and solopreneurs. They simply do not have the buying power and larger risk pools that larger companies use to access more affordable premiums and better coverage. Prescription drugs play an outsized role in healthcare costs overall and significant health disparity between White communities and Black, Latinx/Hispanic, and Indigenous communities remain a problem. **We urge you to vote yes on HB22-1370 to immediately reduce health care costs for Coloradans.**

Best Regards,

*Debra Brown*, Executive Director  
*Angelique Espinoza*, Policy Director

Good Business Colorado  
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Colorado House Committee on Health & Insurance  
200 E Colfax Avenue  
Denver, CO 80203

April 18, 2022

Chair Lontine and Vice Chair Ortiz, members of the committee:

On behalf of the Chronic Disease Coalition, thank you for the opportunity to provide support for HB 1370, which will enact essential protections for Coloradans living with chronic disease.

The Chronic Disease Coalition is a nationwide nonprofit organization dedicated to protecting the rights of chronic disease patients against discriminatory policies and practices. The coalition was founded in 2015 and has since worked to advocate for people living with long-term or lifelong health conditions such as diabetes, kidney disease, multiple sclerosis, psoriasis, cancer, and other chronic diseases.

This legislation has several important components that are critical to improving Coloradans' access to affordable, lifesaving health care.

The bill will ensure that at least 25% of insurance plans offered on individual and small group market are copay only, helping Coloradans on fixed and low incomes. The bill will also enact necessary rebate reform to ensure that lower costs for insurers translate to lower costs for patients.

Additionally, the bill will prohibit an insurer from increasing the price of a medication or dropping coverage midyear, an unfortunate practice that disproportionately impacts Coloradans with chronic disease who rely on consistent coverage.

Finally, this bill will help improve patient outcomes across the state by establishing clinical review criteria for step therapy protocols and expanding existing exemption protections to all patients. Step therapy is a harmful practice that leads to higher costs and treatment delays for Coloradans.

As health care leaders in Colorado, we urge you to join the Chronic Disease Coalition in supporting this legislation. This is an important step that will lead to better patient outcomes across the state. Thank you for your consideration.

Sincerely,

Nathaniel Brown  
Director of Advocacy

House Health & Insurance

04/20/2022 01:30 PM

HB22-1370 Coverage Requirements For Health-care Products

Typed Text of Testimony Submitted

Name, Position, Representing	Typed Text of Testimony
Virginia Gebhart For Self	<p>Please vote to pass this bill, as it attempts to address some of the most unethical and immoral business practices of PBMs. Wendell Potter, former Cigna executive turned whistle blower, tells us that the Big Three of the Big Six health insurance corporations in the U.S. make more money “managing” Americans’ prescription medications than by administering our health insurance plans. Aetna supersized itself when it merged with CVS, which operates the country’s largest pharmacy benefit management company, Caremark, in 2017. Cigna bulked up the next year when it merged with Express Scripts, the second largest PBM. And United’s fastest growing and most profitable division is Optum, which encompasses the country’s third largest PBM. Together, CVS, Cigna, and United control nearly 80% of the national PBM market. At all three companies, the PBMs now generate more profits than their health plan businesses.</p> <p>Wouldn't it be great if we had simple, guaranteed health care for all for life, including regulation of prescription drug prices? There would be no more vertical monopolies of Big Pharma, PBMs and insurance corporations profiteering on the backs of sick people. The CO Assembly would not have to pass dozens of bills every session, year after year, to fix our messed up health care finance system.</p> <p>The complexity and high cost of corporate-run health insurance are killing us. We need your help. We're dying out here.</p>
James Potter For Colorado Foundation for Universal Health Care	<p>Dear Members of the House Health &amp; Insurance Committee:</p> <p>The Colorado Foundation for Universal Health Care is a non-profit, non-partisan 501(c)(3) organization dedicated to improving health care for all Coloradans. We believe that health care is a human right which requires that access be without financial and other barriers. We support legislation that makes health care more just and more accessible, while also realizing that the entire health care system needs fundamental reform to make it truly universal.</p> <p>We support this bill because it attempts to correct a market failure in our health care system. It requires health insurers to offer coverage where they current do not, thus allowing health care consumers more choices, and it addresses the problem of Pharmacy Benefit Managers who have undue market power as a result of consolidation and oligopoly power</p>

	<p>over drug prices. With respect to the latter point the three leading PBMs—CVS Caremark, Express Scripts, and OptumRX—now control 85 percent of the market. As a result, instead of lowering prices by aggregating health plan customers to form large networks that allow them to negotiate discounts, PBM’s now use their market power to fatten their bottom line without passing those savings on to health care consumers. They do so in a number of ways including demanding rebates from manufacturers without passing along those rebates to lower drug costs for consumers, imposing prior authorization requirements on consumers, and by billing health plans at higher amounts than they reimburse pharmacies. All of these practices result in higher prices for those who desperately need these medications.</p> <p>We urge you to vote for this bill because it will help to correct this growing problem.</p> <p>Yours truly, James R. Potter</p>
<p>Matthew Porter For National Multiple Sclerosis Society</p>	<p>Hello Chair Lontine and members of the House Health and Insurance Committee. Thank you for the opportunity to speak to you today on House bill 1370, which would reform step therapy protocols and how it would impact Coloradans living with multiple sclerosis (MS). MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.</p> <p>Step therapy or “fail first” policies are used by 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.</p> <p>Patients (including people with MS) and healthcare providers have voiced concern regarding the potential adverse effects of step therapy, when it is not paired with protections for patients.</p> <p>Step therapy protocols transition medical decisions from a shared decision-making approach, between the provider and the patient, towards more standardized policies that focus on cost-effective care. These policies may not take into account detailed conversations between healthcare providers and patients, as they discuss the right medication for each person. In the case of MS, effectiveness of the drug should not be the only factor considered. 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.</p>

	<p>According to “The Use of Disease-Modifying Therapies in Multiple Sclerosis: Principles and Current Evidence,” a consensus paper by the Multiple Sclerosis Coalition, evidence supports the initiation of treatment with an FDA-approved disease-modifying therapy (DMT) as soon as possible following a diagnosis of relapsing MS.</p> <p>I urge this committee – and the larger legislative body – to pass House bill 1370 this session. Allowing individuals, especially those with chronic diseases such as MS, access to step therapy protocol exceptions will improve their quality of life.</p>
<p>Jon Franko For National Multiple Sclerosis Society</p>	<p>Hello Chair Lontine and members of the House Health and Insurance Committee. Thank you for the opportunity to speak about Senate Bill 959, which would reform step therapy protocols and how it would impact Coloradans living with multiple sclerosis.</p> <p>It can take years following an MS diagnosis to find the most effective course of treatment and when a patient does, they should remain on that drug uninterrupted. Considering the cost of MS medications, patients cannot afford to take drugs out of step order and without coverage. In 2013, the average price of MS DMTs was around \$60,000; in 2018 the median price of brand DMTs increased to \$80,000 and just three years later in 2021, the brand median price is \$93,672. Five MS DMTs are priced at more than \$100,000 per year.</p> <p>Although insurers utilize step therapy as a means to control cost, research has demonstrated that step therapy can in fact lead to higher spending over time. 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. Additionally, in the case of MS, effectiveness of the drug should not be the only factor considered. 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.</p> <p>HB22-1370 would ensure the protocols given to patients are dictated by clinical review criteria. Patients would be given prescription drugs that have supportive evidence of their efficiency, while not being forced to take medication that they previously “failed”.</p> <p>These common-sense protections would make it easier for Coloradans with MS and other chronic diseases to access the treatments they need, when they need them.</p> <p>On behalf of Coloradans living with MS, I urge this committee – and the larger legislative body – to pass HB22-1370 this session. Protect the residents of Coloradans and ensure that they receive the best care possible.</p>
<p>Lisbet Finseth For National Multiple Sclerosis Society</p>	<p>Multiple sclerosis (MS) is an incredibly diverse and prevalent disease, and it is the leading disabling neurological condition of young adults. As of yet, this disease cannot be predicted and there is no cure. If not treated appropriately with the right prescriptions in a timely manner, MS can lead to severe life-long disability.</p> <p>Mid-year formulary changes, often referred to as “non-medical switching”, are changes that health insurers make to prescription drug</p>

	<p>benefits during the plan year. Insurers can currently make several types of changes to their drug formulary during the plan year, such as moving a prescription to a higher cost-sharing tier, adding utilization review requirements or removing a prescription from a drug formulary. Changing access to prescriptions during a policy term can create either unmanageable expenses or worsening symptoms for individuals living with MS. A poll by the Alliance for Patient Access found that two-thirds of respondents saw an impact in their ability to work. Nearly 60% reported suffering at least one complication from the switch. Allowing health insurers to remove coverage of a prescription drug or reclassify it to a higher cost-sharing tier during a policy term conflicts with treatment recommendations.</p> <p>Copay reform and rebates, such as described in this bill, would help patients navigate the high financial costs of necessary prescription drugs by ensuring that 25% of small and individual plans use copays instead of coinsurance so that patients know the exact amount they owe, that not all prescription drugs for a disease are on the highest drug tier, and that patients are able to pay their out-of-pocket maximum throughout the entire year rather than thousands of dollars in a single month. These modifications will help those living with MS manage the financial burden of necessary MS drugs.</p> <p>Allowing individuals, especially those with chronic diseases such as MS, access to step therapy protocol exceptions will improve their quality of life by providing the right treatment in a timely manner. Stopping non-medical switching will guarantee that the contracts patients sign with health benefit plans are protected for the entirety of the contract.</p> <p>Enacting copay reforms will help lessen the financial burden of high prescription costs. Protect the residents of Colorado and ensure that they receive the best care possible.</p>
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## **Members of the Colorado General Assembly House Health & Insurance Committee**

Dear Committee Members:

As the mother and primary caregiver of a child with genetic disease, I am fiercely focused on finding the best solutions for accessing the drugs my daughter needs to live a healthy life. She depends on affordable, accessible prescription medicines, which as we all know by now continues to be a daily struggle.

To the members of the committee, and to all of our elected and health care officials in Colorado, I urge you to please consider strengthening the consumer protections in House Bill 1370.

While there are several proposals in the bill that can improve access, care and treatment for Colorado families, the bill simply does not go far enough to reform the prescription drug supply chain in ways that could save Colorado consumers as much as \$1,000 every year on their prescription costs.

What's sorely needed in HB1370 is a proposal to meaningfully reform the current practice of drug rebates in which insurance companies and middlemen (called pharmacy benefit managers or PBMs) force drug manufacturers to pay a 'rebate' in order to have drugs listed on the approved coverage list or formulary.

I have read reports that put the annual number of rebates paid in Colorado at close to \$1.2 billion dollars. These rebate monies are ostensibly to be applied by insurers and PBMs to lowering the overall cost of prescription drug insurance coverage. However virtually no transparency or enforcement exists to ensure these funds don't end up simply increasing the profits of the corporations that collect them.

Colorado caregivers and moms like me have been actively involved for years pleading with our elected officials to find meaningful and immediate ways to lower the cost of drugs. Despite supposed major initiatives we have seen little in the way of a direct impact on the cost of prescriptions. Instead, our out-of-pocket costs continue to go up.

That is why we are very disappointed that that the state legislature is missing the opportunity to lower the cost of drugs by not including a pass through of rebates directly to us, the consumer, where we buy our drugs. It is our understanding that during this legislative session, serious discussions were held with various stakeholders of HB22-1370 directing to include the pass-through, which could save Colorado families as much as \$1,000 a year on their prescriptions – real savings that would bring real relief to my family and I'm guessing thousands of others.

Rather than create more transparency and greater power for us, the prescription drug consumer, the proposed bill turns a blind eye to Colorado families.

We support the underlying principles of HB22-1370 to rectify some of the inequities present in our healthcare system, especially when it comes to prescription drugs. But this bill can and should do much more.

**We strongly urge the Colorado legislature to amend HB1370 to include the prescription rebate pass-through and put the economic power back in the hands of Colorado consumers.**

Thank you.

Shawna Grieger



## Stacey Gilbert Testimony in Support of HB22 1370:

Ladies and Gentlemen, Health Insurance Committee Chair:

**I fully support this bill.** As an employee benefits consultant, I see the cost everyday. PBM's are costing employers, employees, individual policyholders AND taxpayers (Medicare and Medicaid) **over 20% of the medical premiums we pay with all the games going on in the background with PBM's and pharmaceutical companies.**

**My opinion is based on over 25 years of Employee Benefits expertise:**

- 1. PBM copays need to be defined to a maximum in the legislation.** Otherwise you will see some of these insurance companies create \$1000 or more copays. We already have some plans that are at \$500 copay for Tier 4 Specialty. This is as outrageous as the % copay. I know the bill is intended to get rid of the % payment on some insurance companies for Tier 4 Rx. In reality, most of these insureds are paying their out of pocket max if they are on a Tier 4 Rx due to the Rx cost, frequency they have to buy and take it and other health care costs related to their condition
2. Legislators voting on this bill must understand that once we put this bill in place, even with the PBM controls, the insurance companies will **still raise premiums to pay for expensive Rx in a health plan** even with the PBM controls in place, because these pharmacy companies keep increasing the prices and the cost billed to the insurance company is 5-10 times more than the insureds copay. In fact, I expect the insurance companies to raise premiums higher as they have to absorb the difference in cost due to loss of PBM kick backs!
- 3. 10-16-122.4:** Brokers and agents receive a formulary list and a list of "no longer covered Rx" once or twice a year from each insurance company.....They are constantly not covering an RX or they have "**mandatory" or forced generic RX and no coverage of the brand name.**

I would like to share that I have clients complaining that their diabetes meter (the one that is the best for them) is not being covered, and/or supplies are covered under durable equipment (deductible and coinsurance-when some of these items should be a copay). I think that the legislation should include **diabetes meters (not pumps) and these meters should be considered to be added to a formulary as Tier 3 or 4 copay.** I also have a client currently on Aetna LFP, they tell him they only cover generic albuterol and he can only take Pro Air without a reaction

4. I also feel that the legislation should also require insurance companies to have **lower copays, or forced lower Tiers to be applied for many higher cost generics in the legislation. Let me give you an example: Fluticasone** <https://www.goodrx.com/fluticasone-salmeterol> The copay on most health plans is \$50-\$80 for a monthly supply of 2 doses a day. That's almost \$1000 a year an insured is paying out of pocket for generic Advair.

Also, I want the committee to take a look at the cost on [Good Rx](#) on all Rx. The right side is the cash price that in some cases is lower than the insurance copay. Look at **the left column, this is what is billed to the insurance company and is driving up the cost of both fully insured and level funded and self funded health plans**

5. The language in the bill seems to only cover fully insured plans. **I want to make sure this legislation specifies the same for all health plans including level funded and self funded health plans** that have plan designs filed in the state. (Trustmark, Allstate, Aetna, Cigna, Humana, Anthem). I don't know how we can apply the law to employer based level funded or self funded plans put together by a TPA with stoploss, or a captive that does not file their plans with Colorado.

- 6 The legislation should add: "**The DOI shall create a simple DORA form, that the MD fills out with the name of the patient, address, the insurance information and the prescribed Brand Name Rx with the MD's analysis why the patient is not able to take the generic or other Rx on the formulary". The patient can then submit the signed form to the insurance company.....** and the legislation should make it **mandatory that the insurance company approve the payment of the brand name Rx within 72 hours (not including weekends) of receipt of the forms".** That way you don't have the patient fighting appeals for Tier 2-Tier 5 Rx that are constantly forcing people who are allergic or otherwise cannot take a generic form of a drug

**7. Payment for deductibles and copays are not the business of the medical provider, insurance company or TPA and the legislation shall indicate that payment should be accepted by ANY party to pay what is owed on behalf of the patient.**

Insurance companies put out the Summary of Benefits and Coverage (the blue and white documents) and the Summary Plan Description as part of their “contract” with an individual or employer. The insured is responsible for the deductible, coinsurance and copays which all go into one big bucket we call the “out of pocket maximum”. **There is nothing in the insurance contract language the excludes payment from another party on the patient’s behalf.**

That payment can come from family, friends, co-workers, a private loan, their credit card. Insureds who live paycheck to paycheck are put on monthly payment plans (credit programs at the doctor's office or surgery center if they don't have what they will owe in advance)

When a surgery is scheduled, everything is coordinated in advance with the pre-certification process and most medical providers will find out the insured's out of pocket max that is left for the year. Once that is determined, the provider will invoice them that difference as the insurance company will pay the rest.

**The legislation should add: “A medical provider shall NOT deny payment or partial payment of the invoice because the payment was a paid by a party other than the insured, on behalf of the insured.**

To prevent fraud, legislation should require the following options for payment by another party:

1. DORA form called “Medical Payment By Another Party Form”: Name and Address of Patient, Date of Service, Paying Party Name and Address, the amount owed on the provider invoice, paying party bank, check number and amount paid with attached invoice, Both the insured and payor sign the form and submit to the invoicing party for the medical provider. Medical provider invoicing company must provide receipt of payment.
2. All medical providers shall set up credit card and ACH payment on their website with SSL security that ask the following before it goes to the payment screen with payment options.:  
Paying Party: \_\_\_Patient \_\_\_Other (if “other answered” who is paying, name address, phone, number, then payment screen.

Regards,

Stacey Gilbert  
DenverTechInsurance.com  
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**Next Gen Employee Benefits: Group Health Insurance | Alternate Funding with Refund Potential | Cost Containment | 1099 Coverage| Business Insurance | Workers Compensation | Professional Liability/Tech E&O | Cyber**

CBGH did a presentation on PBM's <https://cbghealth.org/wp-content/uploads/2018/10/PDF-Merging-Result-Website-2.pdf>