SENATE RESOLUTION

WHEREAS, Patients, especially those with serious or chronic conditions, should be able to continue the course of therapy recommended by their physician; and

WHEREAS, Health plans and pharmacy benefit managers (PBMs) have implemented policies called "non-medical switching" that require patients to switch to cheaper, insurer-preferred drugs; these policies include making formulary changes that limit or restrict access to certain treatments and increasing out-of-pocket costs; and

WHEREAS, A stable patient should not be required to switch treatments simply due to payer cost controls; and

WHEREAS, Studies have shown that patients with chronic conditions, who have been stabilized on drug therapy and then switched to another drug, face negative consequences, such as allergic reaction or lack of response; and

WHEREAS, Nearly all health plans and PBMs in the United States switch patients between drugs as part of a utilization management program offered to employers and other customers, including states; and

WHEREAS, Switching a stable patient for non-medical reasons may be dangerous, is usually unnecessary, and rarely generates overall cost savings; and

WHEREAS, Out-of-pocket costs for patients can exceed 30% of the costs of primary care, specialist visits, and some medications, while average deductibles have increased by 150% over the past 5 years; and

WHEREAS, Despite protections in the Patient Protection and Affordable Care Act (ACA), consumers are still exposed to the whims of health plans and pharmacy benefit managers (PBMs) when it comes to health services being changed or denied; and

WHEREAS, States may have statutory or regulatory protections for patients to continue health care if a health care provider is no longer with a health plan; very few states protect a patient when a health plan changes service or pharmaceutical coverage in the middle of the plan year; and

WHEREAS, The 2016 Letter to Issuers from the Centers for Medicare & Medicaid Services does require some health plans to increase transparency about what is covered; the federal government encourages but does not require health plans to temporarily cover non-formulary drugs as if they were on formulary and without imposing additional cost sharing when

either a person changes plans or the plan makes a change in the middle of a plan year; therefore, be it

RESOLVED, BY THE SENATE OF THE NINETY-NINTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that it is critical to promote, support, and encourage continuity of care for patients; and be it further

RESOLVED, That health benefits should be designed to support treatment decisions that are based on clinical judgment and patient or physician decision-making, not by costs to the payer, to promote long-term health; and be it further

RESOLVED, That the possibility of legislation should be examined to safeguard affordable and continuous patient access to health care services and treatments; and be it further

RESOLVED, That suitable copies of this resolution be delivered to the Governor, the Director of the Illinois Department of Insurance, the Director of the Illinois Department of Health and Family Services, and the Director of the Illinois Department of Public Health.