Quality is Our Bottom Line

Connecticut Association of Health Plans

Testimony Submitted in Opposition to

SB 1083 AAC Health Insurance Coverage of Prescription Drugs for Pain Management
SB 1084 AAC Out of Pocket Expenses for Nonpreferred Brand Name Drugs

Insurance Committee Public Hearing
Tuesday, March 1, 2011

The Connecticut Association of Health Plans respectfully urges the Committee's opposition to SB 1083 and SB 1084 which would seriously compromise the efforts of health plans to contain costs by using utilization review practices to help ensure cost-efficient and effective prescription drug use.

SB 1083 would prohibit carriers from requiring that members try one brand name prescription pain drug before using another brand name prescription pain drug. We know of no medical rationale for this approach. Carriers use step therapy (requiring the use and failure of one drug before another drug may be covered) because some drugs are very expensive, and yet they have no better clinical track record for outcomes than less expensive medications (brand or generic). When no clinical advantage is apparent, cost considerations often warrant moving members and providers to use the more cost-effective drug.

Any member who does not respond to treatment with the first-required drug or who cannot take that drug may then proceed to the next "step" and try the less preferred drug. This law would drive up health care costs with no improvement in clinical outcomes and frankly, it contradicts not only the goals of federal health care reform which seek to find the least costly effective treatments and encourage their use whenever possible but, also the efforts currently underway by the state itself to control escalating prescription drug costs. Without a formulary, pharmaceutical sales and marketing practices could play too large a role in prescription choices. Formularies are critical if we are serious about controlling health care costs. It's also important to note within the context of the bill, that many drugs are used for more than one purpose, and when that is the case, the pharmacist does not know if a particular drug is being prescribed for pain management or some other purpose.

SB 1084 would essentially "compress" the permissible levels of drug plan tiers so that all brand name drugs would have to be in the same tier. Members and providers can always choose and receive coverage for drugs on a higher tier, but members must pay a higher cost-share to make that choice. Tiering of benefits is something that is encouraged under federal health care reform's focus on value-based insurance design. This legislation is simply contrary to the aims of PPACA and should not be made law. Again, without tiered formularies, pharmaceutical sales and marketing practices could play too large a role in prescription choices. Tiered benefits are critical if we are serious about controlling health care costs.

While every mandate under consideration by the legislature is laudable in its intent, each must be considered in the context of the larger debate on access and affordability of health care and ***now must also be viewed in the context of federal health care reform and the applicability of the Patient Protection and Affordable Care Act of 2010 (PPACA).***

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com

Please consider recent testimony submitted by the Department of Insurance relative to another proposed mandate under consideration which urges the Committee to understand the future financial obligations that new or additional health insurance mandates may place on the State of Connecticut and taxpayers stating that:

> ***In simple terms, all mandated coverage beyond the required essential benefits (as will be determined by HHS) will be at the State's expense. Those costs may not be delegated to the individual purchaser of insurance or the insurer.***

Both the General Assembly and the Administration have pledged again this year to address the needs of the approximately 400,000 Connecticut residents who lack health insurance coverage. As we all know, the reasons people go without insurance are wide and varied, but most certainly cost is a major component. In discussing these proposals, please also keep in mind that:

- Connecticut has approximately **49 mandates, which is the 5th highest** behind Maryland (58), Virginia (53), California (51) and Texas (50). The average number of mandates per state is 34. (OLR Report 2004-R-0277 based on info provided by the Blue Cross/Blue Shield Assoc.)

- For all mandates listed, the total cost impact reported reflects a range of **6.1% minimum to 46.3% maximum.** (OLR Report 2004-R-0277 based on info provided by the Dept. of Insurance)

- State mandated benefits are not applicable to all employers. Large employers that self-insure their employee benefit plans are not subject to mandates. **Small employers bear the brunt of the costs.** (OLR Report 2004-R-0277)

- The National Center for Policy Analysis (NCPA) estimates that **25% of the uninsured are priced out of the market by state mandates.** A study commissioned by the Health Insurance Assoc. of America (HIAA) and released in January 1999, reported that "...a fifth to a quarter of the uninsured have no coverage because of state mandates, and federal mandates are likely to have larger effects. (OLR Report 2004-R-0277)

- **Mandates increased 25-fold over the period, 1970-1996, an average annual growth rate of more than 15%.** (PriceWaterhouseCoopers: The Factors Fueling rising Healthcare Costs- April 2002)

- National statistics suggest that **for every 1% increase in premiums, 300,000 people become uninsured.** (Lewin Group Letter: 1999)

- "According to a survey released in 2002 by the Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), employers faced an average **12.7% increase in health insurance premiums** that year. A survey conducted by Hewitt Associates shows that employers encountered **an additional 13% to 15% increase in 2003.** The outlook is for more double-digit increases. **If premiums continue to escalate at their current rate, employers will pare down the benefits offered, shift a greater share of the cost to their employees, or be forced to stop providing coverage.**" (OLR Report 2004-R-0277)

Thank you for your consideration.