



Quality is Our Bottom Line

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Insurance Committee Public Hearing

Tuesday, February 24, 2015

Connecticut Association of Health Plans

Testimony in Opposition to

SB 25 AAC Out-of-Pocket Expenses for Prescription Drugs

The Connecticut Association of Health Plans respectfully urges opposition to SB 25 AAC Out-of-Pocket Expenses for Prescription Drugs. The effort, known nationally as the "Cap the Copay" campaign, is supported by a number of advocacy groups, but it is largely funded by pharmaceutical companies which should raise some red flags for Connecticut policy makers.

Pharmacy continues to be one of the single largest drivers of health insurance costs. On average, prices increase between 15% to 20% a year.

As you know, the reasons for such increases are varied. The number of overall prescriptions issued has increased dramatically in recent years as new products have come on line faster as a result of quicker FDA approval and, as always, consumer demand continues to escalate. Aggressive marketing of various pharmaceuticals adds appreciably to the demand - one that will only increase as the baby boomer generation continues to grow older and new niche drugs like Sovaldi, which run as much as \$1000 a pill or \$85,000 for a full treatment, become more prominent.

Insurers often use formularies and/or cost-sharing mechanisms as one means by which to incent their members towards a lower cost of quality care. Some drugs are prohibitively 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. SB 25 simply removes a valuable tool that insurers can use to help keep premiums lower. If cost sharing is unduly restricted, the natural consequence will be rising premiums and consumers will have even less ability to impact the cost of their own care.

One of the most pertinent argument against the adoption of SB 25 stems from the timetable required under the ACA for the development of rates and benefit packages associated with the state's health insurance Exchange. The Exchange Board just last week approved the standard benefit designs for 2016. Health plans are right now preparing their benefit packages and rate filings for submittal to the Connecticut Department of Insurance by April 30th. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been

finalized and rates have been filed, the Exchange and the carriers will have to reopen the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. The sheer volume of mandate legislation currently under consideration by the legislature adds appreciably to the volatility of the overall process and is not conducive to an efficient, stable and predictable insurance market – all of which would derive to the benefit to Connecticut's consumers.

Thank you for your consideration.