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CVSHealth

Testimony In Opposition To SB 25 An Act Concerning Out-Of-Pocket Expenses For Prescription Drugs

February 24, 2015

Good morning Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. My name is Theresa Talbott, Regional Director for State Government Affairs at CVS Health. I submit this testimony in opposition to SB 25, An Act Concerning Out-of-Pocket Expenses for Prescription Drugs to prevent an increase in overall healthcare costs to the residents of Connecticut.

S.B. 25 inappropriately seeks to cap monthly out-of-pocket expenditures for patients receiving drug benefits under an insurance plan. CVS Health operates 150 CVS/pharmacy stores in Connecticut which filled over 17million prescriptions in 2013 for Connecticut patients. Our CVS/caremark pharmacy benefits manager also processed over 9 million Connecticut prescriptions in 2013. CVS/caremark's clients, including public and private payers, union trusts, health plans, and the State Employee plan of Connecticut, rely on us to help to manage the cost of prescription drug benefits.

One of the tools used to control the rising cost of prescription drugs is a tiered formulary cost sharing structure. A formulary is a list of drugs covered by a health plan, which helps to identify medically appropriate and cost-effective drug products and therapies that best serve the health interests of plan members. Formularies include both brand name and generic drugs, and plans must include choices within commonly prescribed medication categories and classes. A tiered formulary divides medications into groups based primarily on cost. A plan's formulary may have multiple tiers depending on plan design and the sponsor's requirements. If a plan negotiates a lower price on a particular medication, that medication can be placed in a lower tier and any savings realized can be passed onto plan members. The tiered formulary cost sharing structure has contributed to lower growth of prescription drug spending. Senate bill 25, if enacted, would undermine this important tool used to control medication costs.

Senate bill 25 appears to be consumer-friendly because it attempts to set limits on a patient's out-of-pocket expenses for medications. Unfortunately, caps on copays, co-insurance, and deductibles do little to reduce the actual cost of the medication which is set by drug manufacturers. In reality, patient cost sharing incentivizes drug manufacturers to price their products competitively. Capping the amount that a patient contributes removes this incentive and allows drug manufacturers to keep medication prices at a higher rate because it limits the need for them to compete on price in order to receive preferred placement on a tiered formulary.

S.B. 25 also prohibits all prescription drugs in a given class being placed in the highest cost-sharing tier of a tiered drug formulary. In most plan designs, this scenario would only occur for products referred to as "specialty" drugs. These medications are generally used to treat complex or rare conditions, such as multiple sclerosis, cancer, and Hepatitis C. Specialty drugs are generally extremely expensive and are expected to account for 50% of all drug expenditures in the next 5 years. They require complex management including evaluation of appropriateness of therapy, patient education on administration and side effects, and lifestyle adjustments to help to maximize quality of life. Prohibiting placement of drugs of the same specialty class may disrupt current management programs that are necessary due to the sensitive nature of these patient populations and the high cost of the medications. The decision of where to place these

medications should remain with plan sponsors.

Thank you for your consideration of our comments. Please feel free to contact me if you have any questions.

Theresa M. Talbott, R.Ph.

Regional Director, State Government Affairs
533 Bossardsville Rd
Stroudsburg, PA 18360