



Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, February 18, 2016

Connecticut Association of Health Plans

Testimony in Opposition to

**SB 36 AAC HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY
ADMINISTERED MEDICATIONS**

The Connecticut Association of Health Plans respectfully requests the rejection of SB 36. While the bill may not formally qualify as ACA mandate according to last year's file copy of the same nature, it certainly does result in a fiscal note as the following excerpt from File Copy No. 9 (2015) illustrates:

The bill will result in a cost to the state employee and retiree health plan (state plan)¹ and municipalities for providing coverage for orally administered medications no less favorably than intravenously (IV) administered medications for certain diseases, which is uncertain. The cost to the state plan and municipalities will be the result of waiving or modifying co-pays or cost sharing for those individuals with certain diseases who are prescribed an orally administered medication for which there is an equivalent IV administered medication and for which a co-pay/cost sharing applies. The bill does not specify what diseases the cost parity applies to. Therefore, it is uncertain how many individuals this bill would apply to in the state plan or municipal plans and the resulting fiscal impact.

The state employee and retiree health plan covers medically necessary oral and IV medications. IV medications are traditionally administered on an inpatient basis at a hospital or at an outpatient infusion center for which there is no co-pay and the costs are billed to the medical plan. In contrast, orally administered medications are traditionally administered at a pharmacy and billed to the pharmacy benefit plan and are subject to the following co-pays and cost sharing² :

It's worth noting that **none** of the mandates under consideration by the Committee would apply to those individuals, including state employees, who are covered by self-insured plans. The burden of new mandates would fall **only** on the fully-insured market which is generally made up of the smallest employers who are least able to afford premium increases.

More and more companies and government entities that can afford to take the risk of moving to self-insured status do - meaning they set their own benefit structures, outside the scope of mandated benefits, and assume liability for the associated claims cost. The ratio of self-insured to fully-insured groups in CT is now nearing 60% to 40%. As the ACA recognizes, the system cannot continue to absorb the additional costs of new mandates.

Prescription drug prices are one of the fastest growing components of health care costs today. The Health Insurance Association of America predicts that spending on prescription drugs will increase annually an average of 10 to 13%. The reasons for such staggering increases are varied: the FDA is approving new drugs faster, the population is aging, the pharmaceutical companies are employing very aggressive marketing strategies and the new high tech sophisticated drugs are great but they're expensive.

Understandably, employers who generally pay the bulk of health insurance premiums have looked to their health insurers and pharmacy benefit managers (PBMs) for tools to help manage the escalating costs. Policies like SB 36 which dictate certain cost reimbursement structures end up restricting the ability of health plans to offer affordable benefit packages.

Please also consider that Connecticut already has a statute in place for the coverage of oral chemotherapy drugs, but this proposal is vastly more broad in scope in that it expands the mandate to apply to any and all chronic diseases.

Furthermore it's important to recognize the complexity of benefit structures. For example, intravenous medications often fall under the medical benefit portion of a policy while oral medications fall under the pharmacy benefit. Consider the state account, for instance, which has separate carriers for the medical and pharmacy benefits each with its own structure and cost sharing requirements. Tying the two benefits together adds appreciable administrative complexity.

From the quality standpoint, there are studies that suggest that compliance and safety outcomes are often better with IV treatment as opposed to oral drugs adding a critical clinical component to the argument against mandating such coverage.

We strongly urge the Committee's rejection of SB 36. Many thanks for your consideration.