



Quality is Our Bottom Line

Insurance Committee Public Hearing

Thursday, March 10, 2016

Connecticut Association of Health Plans

Testimony in Opposition to

HB 5517 AN ACT CONCERNING COST-SHARING FOR PRESCRIPTION DRUGS.

SB 373 AN ACT LIMITING CHANGES TO HEALTH INSURERS' PRESCRIPTION DRUG FORMULARIES.

SB 371 AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS.

SB 374 AN ACT PROHIBITING HEALTH INSURERS FROM RESTRICTING OR REDUCING COVERED BENEFITS FOR INSUREDS DIAGNOSED WITH A TERMINAL CONDITION.

The Connecticut Association of Health Plans strongly opposes the adoption of HB 5517, SB 373, SB 371 and SB 374 which all seek, in some manner, to limit the ability of health carriers to manage drug costs at the same time the carriers are under enormous pressure to control escalating premiums. It's time to change the conversation from health insurance coverage to health care costs and look instead at why pharmaceutical prices are what they are.

Insurers share the frustration of their members around the exorbitant drug prices being levied and the excessive marketing of products that increase demand. It's in the interest of keeping premiums affordable, that insurers use tools like tiered formularies, step-therapy and cost-sharing to not only control costs, but to also ensure clinical safety and appropriateness. It was not too long ago, that the health carriers were in the unenviable position of lobbying against pain management legislation cautioning against the over prescribing of known controlled substances. Hindsight is always 20/20 of course. But, fast forward ten years and it's clear that over-prescribing of pain meds is a major contributing factor in today's opioid addiction crisis.

SB 373 would prohibit health plans from removing a particular drug from a formulary during a policy term. Consider the headlines last summer when the 32 year-old CEO of Turing Pharmaceuticals jacked up the prices of a 62 year old drug called Daraprim from \$13.50 a pill to \$750 overnight. Daraprim is used by some AIDS and cancer patients and to treat life-threatening parasitic infections. Eliminating a health plans ability to



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manage their formulary leaves a carrier with no means by which to apply any pressure on Turing to reduce their prices.

Pharmaceutical costs aren't just an issue in the commercial sector, they are crippling the sustainability of public programs like Medicare and Medicaid across the country. Think about the \$84,000 cost of the Hepatitis C drug - Sovaldi. No one disputes that these drugs are critically important, but without some other check and balance on the price, formularies, tiering and even cost sharing (which would be limited under HB 5517 to no more than \$100 per 30 day supply) are critically important tools that are needed to counter against such high pricing which is why the pharmaceutical industry lobbies so strongly against these insurance measures. We need to keep these tools in place.

The Association appreciates the desperation of terminally ill patients to access experimental drugs as contemplated under SB 371 and SB 374 which is why the industry worked so hard on legislation over several years to provide for coverage for various clinical trial costs which prior to passage of those acts would have been covered by the pharmaceutical companies in large part. We appreciate that SB 371 doesn't mandate coverage for such drugs, but we are very concerned about the intent of SB 374 which, if we're interpreting it correctly, does seem intended to mandate coverage for experimental treatment.

The bills noted above are just a few of the drug bills of concern under consideration this session. The Insurance Committee already JF'd out SB 34, requiring drug coverage while a decision is under appeal and SB 36, requiring coverage for oral medications if similar IV medications are covered.

As more and more companies and government entities move toward self-insured status, the fewer the number of people there are actually subject to this type of legislation if passed. The one's that are subject to it are those that can least afford it like small employers. CT is now nearing the ratio of 60% self-insured to 40% fully-insured. As the ACA recognized, the system cannot continue to absorb the additional costs of new mandates.

As CTAHP has noted on a number of bills this session, the ACA requires strict adherence to a particular timeline that would be undermined by these proposals under consideration today. Connecticut's Exchange is ***right now*** preparing their standard benefit designs and carriers are ***right now*** preparing their non-standard plan designs. Health carriers must then file the associated rates with the Department of Insurance. 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 mandates and the other insurance provisions under consideration by the Committee add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market.



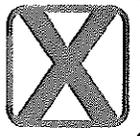
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All of the arguments above point to the need for a broader conversation on drug pricing. We hope you will take these concerns, as well as the cost dynamics summarized on the attached sheets, under consideration and “hold” HB 5517, SB 373, SB 371 and SB 374.

Thank you for the opportunity to comment.



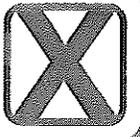
It's time to set the record straight on prescription drug prices and the scanty justifications for why they are so high. While the industry continues to minimize, shrug off, and ignore the problem, taxpayers, lawmakers, employers, doctors, and payers will keep asking questions. But the truth is we will never get to the bottom of this pricing problem as long as the industry remains shrouded in darkness with no transparency on how they set prices.



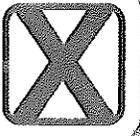
The Pharmaceutical Industry Wants You to Believe...



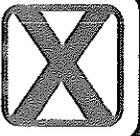
Prescription Drugs Represent Just 10% of the Health Care Dollar



Research & Development (R&D) Costs Drive High Drug Prices



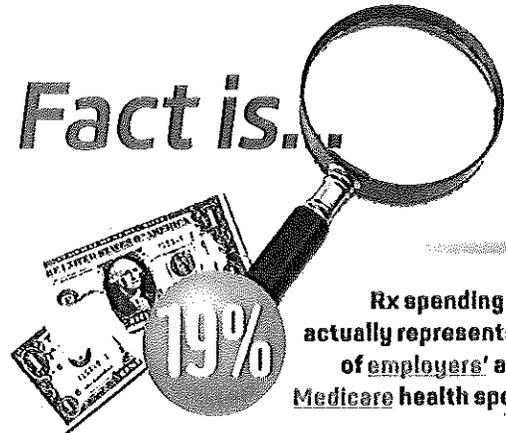
Competition Leads to Lower Prices



Discounts and Rebates Make Drugs Affordable

But the Fact is...

✓ This misleading statistic ignores prescription drugs administered in a health care setting.



Rx spending actually represents **19%** of employers' and Medicare health spending.

✓ R&D costs do not explain massive **price hikes** on brand name and generic drugs that have been around for **decades**.

✓ **Nearly half** of all R&D funding comes from the government, academic institutions, research hospitals, and charitable organizations.

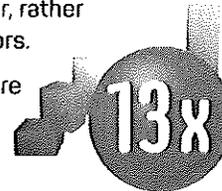
✓ Drug companies spend **19 times more** on marketing and advertising than they do on R&D.



9,000% increase on Doxycycline, from \$20 per bottle in October 2013 to \$1,850 by April 2014. (GENERIC ANTIBIOTIC)

✓ Six-figure price tags are setting the floor, rather than the ceiling, for follow-on competitors.

✓ In 2012, all but one new cancer drugs were priced at \$100k per year or more. By 2014, all but one were priced at \$150k.



The top two insulin makers raised their prices in **lockstep 13 times** over 5 years.

✓ Even with discounts and rebates, Americans pay significantly **higher prices** than other advanced countries.

✓ Sovaldi was on the market for **14 months** at the full price tag before any discounts were offered.



Even at a **50% discount**, Sovaldi's price is **still higher** than its original developer had estimated.

For more information, please go to www.calhealthplans.org or www.runawayrx.org.