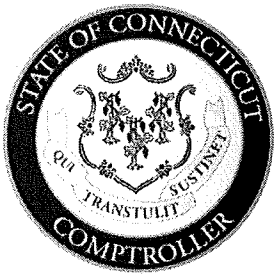
KEVIN LEMBO
STATE COMPTROLLER

MARTHA CARLSON
DEPUTY COMPTROLLER



STATE OF CONNECTICUT
OFFICE *of the* STATE COMPTROLLER
55 Elm Street
Hartford, CT 06106

Written Testimony
Comptroller Kevin Lembo
March 7, 2017

Concerning
S.B. 925 AAC Increases in the Cost of Prescription Drugs and Promoting Value-Based Insurance Designs

Good morning Senator Larson, Representative Scanlon, Senator Kelly, Representative Sampson, and Members of the Insurance Committee:

Thank you for raising this legislation and for the opportunity to talk about the necessity of these measures to stop the unsustainable rising cost of prescription drugs.

This five-point legislative plan emphasizes data-driven decision making, transparency, accountability and common-sense health care policy that puts quality and wellness for everyone above skyrocketing profits and wealth for a select few.

This plan was not created in a vacuum. It was developed after research into what other state health plans are doing, and after consulting with representatives across all sectors of the health care industry. In forums, roundtables and direct meetings over the past few years I have met with various types of providers, pharmaceutical companies, pharmacy benefit managers, insurance carriers, labor, patients and patient advocates.

Whomever the stakeholder, we can all agree on one thing: Pharmaceutical costs continue to skyrocket at unsustainable rates, breaking budgets at the federal level, the state level, for large and small employers, nonprofits, towns and cities and just about every household.

Just as drug costs are surging, consumers are increasingly bearing a greater share of those costs. Some families face financial burdens – having to scrape together thousands of dollars for a single drug to keep a loved one alive – and then there are those families who have to go entirely without potentially lifesaving drugs.

As state comptroller, I administer the state health plan, including pharmacy benefits, for about 200,000 state and municipal employees, retirees and their dependents. Even as overall drug utilization was down about 1.3 percent in Fiscal Year 16, and the overall medical cost trend was

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maintained at single-digit growth, the state pharmacy plan experienced a 15-percent increase in costs over the prior year.

When you drill deeper down into those pharmacy costs, you'll find even greater spikes for certain classes of drugs – for example, 52-percent growth in the cost of antidiabetic drugs.

This legislation attempts to address unsustainable prescription drug costs at every angle by requiring justifications for sharp price increases, reviewing oversight options for unreasonable drug prices and price increases, ensuring that consumers benefit from rebate savings, promoting insurance plans that emphasize affordable co-pays and preventive care, and rationalizing the reimbursements for physician-administered drugs.

Components of the plan include:

1. Require pharmaceutical manufacturers to justify launch prices and price increases over a certain threshold.

To address rising drug prices that may appear to be arbitrary and unjustifiable, I propose a requirement that when drug manufacturers increase prices beyond certain annual thresholds (10% for brands and 25% for generics) or establish a launch price that exceeds certain annualized thresholds ($35,000 for brands and $3,000 for generics) they must provide the state with information about each factor involved in the manufacturer's calculation of the launch price and price increase to the Insurance commissioner. In addition manufacturers must provide a description of all efforts made to reduce the cost of the drug to consumers and any other information the commissioner may require. Finally, the bill requires all manufacturers to submit to the commissioner a report disclosing the value of all price concessions the manufacturer provides to each pharmacy benefit manager for each of the drugs it manufactures.

The commissioner is required to evaluate the information submitted by the manufacturers and report findings to the legislature on an annual basis.

The information revealed should shine a light on the drivers of rising pharmaceutical costs, allowing policy makers to target problem areas with specific interventions.

2. Establish a task force to recommend possible legislative or regulatory remedies for unreasonable drug prices or price increases.

The task force is charged with recommending a process for determining if prescription drug prices or price increases are reasonable and recommend possible state actions to take when increases are deemed unreasonable. These recommendations, before implementation, must come before the legislature for approval.

3. Promote the adoption of value-based insurance design.

Requires health insurance policies sold in Connecticut to incorporate value-based insurance design options. Value-based insurance design reduces barriers to high value care by lowering patient cost shares. By reducing barriers to high value care, the frequency of such services increases, improving patient health and lowering long-term costs. An example of value-based insurance design is lowering co-pays for prescription drugs that assist in managing chronic diseases. Lower co-pays have been shown to improve medication adherence for chronic disease medication resulting in better disease management and reduced in-patient hospital stays and emergency room visits.

The state employee plan has seen significant increases in medication adherence since adopting a lower co-pay structure for maintenance drugs through the state Health Enhancement Plan (HEP), as members have little financial impediments to filling their scripts. Our most recent data shows significant increases in adherence over the levels experienced prior to HEP implementation and the state continues to outperform other government plans on this measure. Improved medication adherence has been shown to improve patient health and avoid in-patient hospital stays and ER visits. For diabetic members, adherent members have more than $4,000 less in claims costs per year than non-adherent members.

4. Allow consumers to benefit from negotiated drug rebates.

Require health plans to base co-insurance and deductible payments on the net price of the drug, after rebates, rather than the list price, allowing the consumer to share in rebate savings negotiated by their pharmacy benefit manager or plan administrator. For certain highly rebated drugs the list price can be as much as three times more than the final price paid by a health plan after manufacturer rebates.

5. Rationalize reimbursements for physician-administered drugs.

In 2004, Medicare began to reimburse physicians 6 percent of the acquisition cost of drugs for "handling and overhead". Commercial payers, which often base their reimbursement policies on Medicare, quickly followed suit. As a result, many physician-administered drugs have seen massive price increases since 2004, with many oncology drugs now well in excess of $100,000

per regimen. The bill requires state-regulated insurance plans to completely delink the reimbursement for the administration or handling and overhead costs of physician-administered drugs from the underlying cost of the drug by barring such reimbursement from being based on a percentage of the drug cost and allowing market pressures to guide the negotiations of these costs.

The state of the pharmaceutical market has reached a near crisis level. Rising costs touch every business, every sector and every family in one way or another. Access to the data – above all else – is essential in order to make informed policy decisions to curb future costs and bring relief to all those effected.

For all of these reasons, I urge your support.

Thank you for your time.