STATEMENT

In Opposition to Connecticut SB 442

March 3, 2017

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) respectfully opposes SB 442, an Act Prohibiting the Predatory Pricing of Pharmaceuticals to control the costs of prescription drugs. Efforts to mitigate costs must take a holistic approach to the entire health care continuum and recognize the value of medicines and the substantial rebates, discounts, and fees that branded manufacturers pay to PBMs, insurers, and the federal and state governments. Price controls and arbitrary caps on drug prices will not help patients and could threaten access to needed prescription medications and the innovation of future treatments.

Discussions about the cost and affordability of medicines are important. No patient should have to worry about whether they can afford the health care they need. However, the notion that spending on medicines is the primary driver of health care cost growth is false, and this misconception ignores the cost savings that medicines provide to the health care system overall. Medicines lead to fewer physician visits, hospitalizations, surgeries and other preventable procedures – all of which translate to lower health care costs. New medicines are making crucial contributions to medical advances and changing the direction of health care as we know it. This bill likely could skew discussions of policy issues in ways that are systematically biased against innovation.

Despite the fact that the best available data on health care spending shows that in nearly all years other categories of services account for far larger increases in premiums and heath costs, the bill focuses only on medicines. While this legislation singles out the biopharmaceutical industry, there are a variety of stakeholders involved in determining what consumers ultimately pay for a medicine, including insurers, pharmacy benefit managers, wholesalers, and government agencies like Medicaid. The important role that these entities play in setting drug prices and in drug coverage is overlooked by the requirements of this legislation. For example, pharmacy benefit managers (PBMs) and payers—which dictate the terms of coverage for medicines—use their control over which medicines patients can access as leverage to negotiate substantial rebates and discounts. Also, the statutory rebates, discounts, and fees biopharmaceutical companies are required to provide to government programs have increased in recent years due to an increase in the Medicaid rebate, closing of the Medicare Part D "donut hole" and a massive expansion of the 340B program. In fact, brand manufacturers provided more than $556 million in Medicaid rebates to Connecticut in 2015—retail spending on brand prescription medicines is less than 5% of Connecticut's total Medicaid spending.

Specifically, a January 2017 Berkley Research Group study shines a light on the entities that benefit from drug pricing and that dictate drug coverage and reports that in 2015, brand biopharmaceutical companies realized just 39% of total gross drug spending, which is based off the list prices of medicines before rebates, discounts and fees are calculated. This is down from 41% in 2013 due to increases in the rebates and discounts paid to PBMs and payers. Increased rebates and discounts have largely offset increases in list prices and reflect the competitive market for brand medicines.

Further, **CVS Health, one of the largest PBMs in the country, reports that prescription drug spending grew by 3.6% in the first half of 2016.**[1] CVS Health, which manages pharmacy benefits for health plans and employers, reports that drug spending for its clients grew by 3.6% in the first half of 2016 (after taking rebates into account). This is considerably lower than growth rates reported by CVS Health for 2014 (11.8%) and 2015 (5.0%). According to CVS Health, the majority of its employer and health plan clients saw their rate of prescription drug spending growth decline between 2015 and mid-year 2016 and more than a third of clients had a negative trend, meaning they experienced a reduction in their total prescription drug spending.

The legislation does not account for the value provided by innovative therapies nor the burden that the evolution of insurance design has placed on patients.

It is important to remember that advances in medicine help control health care spending. Greater patient access to prescription medicines means fewer doctor visits and hospital stays and a decrease in costly medical procedures, all of which translate into lower health care costs overall. For example, in 2014, a new drug came to the market that provided a cure for more than 90% of patients with hepatitis-C, eliminating a lifetime of hospitalizations, debilitating symptoms, and treatments with harsh side effects and replacing it with a complete cure in just 12 weeks. Often, patients with hepatitis-C needed liver transplants, which could cost almost $500,000. Since 2014, several new treatments have come to the market, further driving down the price of the medicine. Clearly, innovation and progress in the pharmaceutical industry means better outcomes and quality of life for patients and their families as well as reduced health care costs to patients and the system.

Furthermore, medicines are the *only* part of the health care system where costs decrease over time. When brand name medicines face brand competition, or when they lose their patent protection and generic drugs become available, prices drop, often significantly. Today, nearly 90% of all medicines dispensed in the United States are generic and cost pennies on the dollar.

However, health insurance and plan administration costs are rising at more than twice the rate of drug spending. Recent data shows that insurers are increasingly requiring patients to pay exorbitant out-of-pocket costs to access the medicines they need, far more than other health care services covered by an enrollee's health plan. This is contrary to the purpose of insurance—to spread the costs of health care utilization so that patients can access affordable needed care, including medicines.

A recent IMS report found the number of plans with a deductible for medicines doubled from 2012 to 2015. That means a patient who previously could go to the pharmacy on January 1 and pay copay for a medicine, instead is forced to meet a deductible before insurance covers the medicine. In 2013, Americans spent more than $200 billion to support administrative costs of insurance including sales commissions, dividends, and other health plan costs.[1] Today, a patient pays only about 5% for out-of-pocket hospital costs but 20% or more for their medicines. Additionally, insurers are increasing utilization management techniques to aggressively restrict a patient's use of medicine.

Efforts to institute price controls are subject to federal preemption and can discourage innovation.

Any effort to implement a price control or to cap a drugs price would be vulnerable to a federal preemption challenge. Federal courts have stricken price controls before due to the impact on individual patent rights (see *PhRMA and BIO v. District of Columbia* (Fed Cir. 1997) which demonstrated that a price control undercut a company's ability to achieve the objectives of the federal patent law).

Innovative drug manufacturers are rewarded with a patent for the substantial risks taken to bring a new drug to market. A recent Tufts study notes that it costs more than $2.6 billion to bring a new drug to market. Efforts to jeopardize the reward process for taking the risk in researching and developing new medicines will discourage investors for investing in innovative companies and could jeopardize patient access to new medicines and cures.

In summary, the biopharmaceutical industry is committed to working with Connecticut's lawmakers and stakeholders to pursue policies that promote innovation and help ensure consumers have access to needed medicines. However, SB 442 is not the way to accomplish this important goal and, therefore, PhRMA respectfully urges lawmakers to oppose this bill.

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[1] PhRMA analysis of CMS data, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip

[i] CVS Health. 2016 Midyear Gross Trend Declines to 3.6%: More than a Third of Clients Had Negative Trend. *Insights*, Issue 17, September 20, 2016. http://insights.cvshealth.com/2016-midyear-gross-trend-declines