State of Connecticut

SENATOR LEONARD A. FASANO
SENATE REPUBLICAN PRESIDENT PRO TEMPORE
34TH DISTRICT

LEGISLATIVE OFFICE BUILDING
300 CAPITOL AVENUE, SUITE 3400
HARTFORD, CONNECTICUT 06106-1591
www.SenatorFasano.com

HARTFORD: (860) 240-8800
TOLL FREE: (800) 842-1421
FAX: (860) 240-8306
Len.Fasano@cga.ct.gov

Testimony
Sen. Len Fasano
Public Health Committee
March 7, 2017
SB 442 An Act Prohibiting Predatory Pricing of Pharmaceuticals
SB 445 An Act Concerning Pharmaceutical Price Transparency and Disclosure.

Senator Gerratana, Senator Somers, Representative Steinberg, Representative Srinivasan and members of the Public Health Committee, thank you for the opportunity to submit testimony in favor of ***SB 442 An Act Prohibiting Predatory Pricing of Pharmaceuticals*** and ***SB 445 An Act Concerning Pharmaceutical Price Transparency and Disclosure.***

Over the last several years we have worked together on a bipartisan basis to address our changing health care delivery system by improving its transparency and efficiency. Together we passed legislation requiring the disclosure of provider prices, notice of facility fees, protections against surprise medical bills, and other measures designed to provide consumers with the information they need to make value based decisions about their health care, or, when lacking that information, protect them from unreasonable health care fees and bills.

We knew at the time that there was a major area we were not addressing. Pharmaceutical costs account for 10% of total health care spending, or about $1,000 a year per person. More concerning, spending on prescription drugs increased 20 percent between 2013 and 2015.

While some people may go all year without requiring a single prescription medicine, others need daily life saving medication costing thousands of dollars a month or more. Prescription medications save lives and often save money in the long run. However, recent examples of previously affordable lifesaving medications skyrocketing in price for no apparent reason have consumers anxious and frustrated.

These recent examples include:

- The cost of EpiPens rose from $57 in 2007 to over $500.
- Daraprim, a drug used to treat some cancer and AIDS patients, rose from $13.50 to $750 in one year.
- Insulin prices increased by 160 percent in less than five years.
- Albuterol, one of the oldest asthma medicines available, cost $50 to $100 per inhaler in 2013, but was less than $15 a decade ago.[1]

---

[1] Notably, the vast majority of these cases do not involve major long standing legitimate pharmaceutical manufacturers, such as Pfizer or Boehringer Ingelheim or the other companies that contribute so much to Connecticut's economy and workforce.

Consumers' frustration is compounded by a complex opaque pharmaceutical market where federal regulation, middle men and multiple layers of contracting make even knowing the true price of a particular drug, never mind understanding its justification, nearly impossible. The pharmaceutical market operates on a system of exclusive patents and subsidies that are intended to support research, innovation and the development of drugs to treat rare and deadly diseases, drugs that without this support might not see the light of day. However, this system has the potential to artificially stifle competition and foster monopolies and is vulnerable to manipulation.

That is why robust anti-trust laws are essential to remedy market abuses. Anti-trust enforcement is important, not only to protect consumers who are directly harmed by anticompetitive market behavior, but also those legitimate pharmaceutical manufacturers who are put at a competitive disadvantage by such behavior.

I want to recognize the hard work of our own State Attorney General, George Jepsen, and his staff who, despite the complexity and the incredible amount of resources it takes to bring an anti-trust case, are leading the way in this area. His office is spearheading a major multi-state anti-trust enforcement action against numerous generic drug manufacturers accused of price fixing. According to reports, price fixing contributed to an average 448% increase in the price of certain generic drugs in just one year.

In talking to the Attorney General's Office about SB 442 it became clear that, while implementing a state drug price gouging law may be premature and have unintended consequences, there is something fairly simple we can do to strengthen our existing legal framework. We can join the majority of states that have amended their anti-trust laws to clarify that states and consumers, as indirect purchasers, can bring anti-trust actions against manufacturers who engage in price fixing and other anti-competitive behavior. This clarification is essential in a market, such as the pharmaceutical market, where consumers are almost never "direct purchasers" but instead purchase through pharmacies, pharmacy benefit managers or other middle men. When price fixing or other illegal schemes inflate the price of drugs, that cost is passed on to the consumer. The consumer, and the state as a purchaser, is harmed, not the middle man. If only "direct purchasers" are allowed to bring a cause of action, that harm will not be remedied, and there will be no disincentive for this illegal conduct.

Therefore, I join the Attorney General and Senator Looney in advocating that SB 442 be drafted to allow consumers and the state to enforce our existing anti-trust laws when they are harmed by anti-competitive behavior. I understand the Attorney General has submitted language for your review.

SB 445 seeks to promote price transparency in the pharmaceutical market. Competitive markets cannot operate efficiently and consumers and payers cannot make smart value based decisions unless they are armed with accurate price information. Unfortunately, because of the multiple layers of payers, wholesalers and pharmacy benefit managers, consumers have no way of knowing the actual cost of a drug, yet many, due to copays and high deductible plans, are paying for those drugs out of pocket. (See "Pipeline To Profits: How Drug Middlemen Make Their Money")

While a comprehensive price transparency framework will require thoughtful collaboration among payers, pharmaceutical manufacturers, the state, policy makers and others, again there are some simple things we can do now to improve the market for consumers.

I attached a Bloomberg news report that ran recently in the Hartford Courant about pharmacists being forced to remain silent as they watch their customers pay more than necessary for medication. In some cases, consumers are paying more out of pocket than the total cost of the drug. Yet, gag clauses in some pharmacy benefit manager contracts prevent pharmacists from informing consumers of the true cost of the drug, or advising them about more affordable options.

A number of states have adopted or are considering statutes prohibiting these gag clauses or otherwise clarifying that nothing can interfere with a pharmacist's right and professional obligation to advise his or her patients regarding the cost and efficacy of various medications.

A related issue involves pharmacy benefit manager "claw back" provisions. Under these provisions, a consumer may pay a $20 copay for a $3 drug. The pharmacy may keep a $2 prescription fulfillment fee, and the balance goes to the PBM. In this scenario, the consumer has paid four times the actual cost of the medication with the PBM reaping the benefit. In effect, the PBM is being paid twice for the same drug.

Again, a number of states have adopted anti-claw back provisions to ensure that consumers do not pay more out of pocket than the actual cost of the drug. Particularly with the increase in high co-pay and high deductible plans, it is imperative that we protect consumers from these obvious abuses.

I have attached sample language for both the anti-gag and anti-claw back provisions that could be drafted in SB 445 and encourage the committee to support these provisions.

I would also ask that the committee consider adding disclosure and transparency requirements for pharmacy benefit managers generally, particularly with regard to the disclosure of rebates or incentives that the PBM receives that may conflict with the PBM's contractual or fiduciary duty to the payer or result in higher cost drugs being prescribed to consumers and higher out of pocket costs. Again, other states such as Vermont, Maryland and Arkansas have adopted similar provisions. I would be happy to provide copies of examples of these provisions if you are interested.

I also want to recognize the work that our state Comptroller is doing on pharmaceutical issues. As a major purchaser and payer, the state has a vested interest in promoting transparency and accountability for pharmaceutical prices. Controller Lembo has worked with the National Association of State Health Policy (NASHP) on model state legislation. Some of these provisions have been drafted in SB 925 in the Insurance Committee. While I believe some of the provisions of SB 925 will require further collaboration and deliberation, I look forward to working with him and all of you on these issues as they progress through the legislature.

Thank you for your time and attention.

Len Fasano
Senate Republican President Pro Tempore

LOGIN
Search

Article Archives

- June 2016
- July 2016
- All Current Articles

Article Categories

- All Current Articles

Zurik Reports

- Part 1
- Part 2
- Part 3
- Part 4
- Part 5
- Part 6
- Part 7

In the News

Filling a prescription? You might be better off paying cash

Posted: 06/24/2016 12:00 am | **Category:** Newsletter Articles

Kaiser Health News via CNN

- Benefit management firms sometimes take back a portion of patient payments from a pharmacy
- Experts say that shopping around and doing legwork will help consumers avoid paying too much

Some consumers who use health insurance copays to buy prescription drugs are paying far more than they should be and would be better off paying with cash, especially for generics.

The added cost runs as high as $30 or more per prescription, say pharmacists, and the money is largely being pocketed by middlemen who collect the added profit from local pharmacies.

Cash prices started to dip below copays a decade ago when several big box stores started offering dozens of generics for as little as $4 per prescription. But as copays have risen and high-deductible insurance plans become more common, more consumers are now affected.

The phenomenon illustrates the complexity of how drugs are priced in the U.S. and has led to finger-pointing about who is benefiting or who's to blame.

Pharmacists say large pharmacy benefit management (PBM) firms that handle benefit clams for millions of Americans are pocketing the difference, while those firms say pharmacists themselves are being greedy.

"In some cases, consumers are blaming high drug prices on manufacturers, but really the cause of their costs may be the insurance company or the pharmacy or the pharmacy benefit manager," said Adam J. Fein, who follows the drug industry for management advisory firm Pembroke Consulting in Philadelphia. "It's very hard to figure this information out."

A Bewildering Array Of Factors

How much consumers pay at the pharmacy counter depends on a bewildering array of factors, including health insurance policies that set copayments and deductibles, the pharmacies they choose, and which behind-the-scenes PBM their employer or insurer hires to manage claims and negotiate prices with pharmacies and drug makers.

The back-and-forth between pharmacists and PBMs is part of a long-running feud between the two groups. Not every PBM negotiates prices that allow for these overpayments, the pharmacists say, and not all drugs are affected.

Still, here's how pharmacists say consumers are getting squeezed. At the pharmacy counter, patients pay their share of the cost -- the copay -- as set by their PBM and insurance plan.

Days or weeks later, the PBM firm takes back a portion of that patient payment from the pharmacy after the PBM determines what it will actually pay for the drug -- a practice sometimes called a "clawback." That money does not go to the consumer, but is generally kept by the PBM.

"It's a fraudulent misrepresentation to the patient of what is the cost of the drug," said Susan Hayes, principal with Pharmacy Outcomes Specialists, which audits pharmacy programs on behalf of insurers.

In a survey by the National Community Pharmacists Association taken in early June, members provided examples. None of the pharmacists would talk on the record for fear of being kicked out of the PBM networks, so their responses could not be independently verified.

One told surveyors that a major PBM required the pharmacy to collect a $35 copay for a generic allergy spray, then took $30 back from the pharmacy. Another said a PBM charged a $15 copay for insomnia drug Zolpidem, then took back $13.05. Patients were charged $30 above the cash price for a generic cholesterol medication at another pharmacy.

In effect, the customer has paid more for the drug than the PBM ultimately pays even though "they assume what they are paying is the cost of the drug," said Susan Pilch, vice president for policy and regulatory affairs with the pharmacists' group.

In response, the CEO of the benefit managers' trade association blames pharmacists, whom he says should simply offer customers the cash price of the drugs -- if cheaper -- bypassing their insurance plans altogether.

"Not everything has to go through the plan," said Mark Merritt, president and CEO of Pharmaceutical Care Management Association. "The only reason [for pharmacies] to process the claim is to keep the copay for themselves."

While agreeing that in some cases consumers could get their drugs for less if they paid cash, Pilch said pharmacists are specifically barred from discussing the cash price under terms set by contracts between them and the PBMs. Its June survey of 650 pharmacists found that more than 38 percent said they were unable to tell patients about cheaper cash prices 10 to 50 times in the previous month.

"We are required to run it through insurance and we do not have the option of advising the patient regarding matters of the terms of their plan or their options, or we run the risk of being cut from the network," she said.

For their part, PBMs say patients pay the amounts specified by their insurance plan benefit design. And the amounts they take back, they say, can help hold down cost and slow future premium increases to the insurers and employers who hire them.

Still, Louisiana lawmakers this month passed legislation to rein in the practice by directing pharmacists to tell patients about all their options -- including less expensive alternatives.

Arkansas lawmakers last year passed a law that bars PBMs and pharmacies from collecting more from customers for medications than the pharmacy will ultimately be paid.

The laws "should eliminate these consumer clawbacks, which I believe are rare, but are an example of bad behavior by a PBM making a drug more expensive than it should be, said Pembroke's Fein.

Marketplace Practices

Optum RX, a PBM that is part of UnitedHealth Group, was cited as a firm engaged in such efforts by the national pharmacy association and its affiliates in Arkansas and Louisiana.

UnitedHealth spokesman Matt Wiggin said only a small portion of claims were affected, although he could not give a specific percentage. The firm, he said, is moving to change its contracts to avoid the situation in the future.

At Cigna, another firm called out by the pharmacists, spokeswoman Karen Eldred would not say if it takes back a portion of the customer's payments from pharmacists. But she said customers "would not pay more than the retail price (cash price) reported to Cigna by the pharmacy."

A spokesman for Express Scripts, one of the nation's largest PBMs, said the firm does not engage in the practices which "are not in the best interest of patients or the country," said spokesman David Whitrap.

Market experts agree that shopping around and doing some leg work are tactics that will help consumers avoid paying too much because of the clawback.

Cigna, Express Scripts and other insurers also have apps and websites where members can check drug prices at multiple pharmacies and decide for themselves how best to proceed. But if a health plan or PBM doesn't offer an app, consumers can check the cash price for prescriptions through one of the online websites like GoodRX or Blink health before heading to the pharmacy.

In some cases, it might be less expensive to pay cash. But experts caution that such cash payments don't always count toward annual drug deductibles. Consumers who expect a lot of drug costs might want to think twice about paying cash. But others may still find it saves them money, even if they never hit their deductible.

"The safest thing to do is always know what the pricing is in the marketplace," said Mike Miele, an area president who advises employers on benefits for consulting firm Arthur J.Gallagher. "There are literally thousands of generics that are below $10."

Sworn To Secrecy, Drugstores Stay Silent As Customers Overpay

JARED S. HOPKINS Bloomberg

Eric Pusey has to bite his tongue when customers at his pharmacy cough up co-payments far higher than the cost of their low-cost generic drugs, thinking *their insurance is getting them a good deal.*

Pusey's contracts with drug-benefit managers at his Medicap Pharmacy in Olyphant, Pennsylvania, bar him from volunteering the fact that for many cheap, generic medicines, co-pays sometimes are more expensive than if patients simply pay out of pocket and bypass insurance. The extra money – what the industry calls a clawback – ends up with the benefit companies. Pusey tells customers only if they ask.

From Our Partners: Drugstore Basics For Your Beauty Routine

"Some of them get fired up," he said. "Some of them get angry at the whole system. Some of them don't even believe that what we're telling them is accurate."

Clawbacks, which can be as little as $2 a prescription or as much as $30, may boost profits by hundreds of millions for benefit managers and have prompted at least 16 lawsuits since October. The legal cases as well dozens of receipts obtained by Bloomberg and interviews with more than a dozen pharmacists and industry consultants show the growing importance of the clawbacks.

"It's like crack cocaine," said Susan Hayes, a consultant with Pharmacy Outcomes Specialists in Lake Zurich, Illinois. "They just can't get enough."

The cases arrive at a critical juncture in the quarter-century debate over how to make health care more affordable in America. President Donald Trump is promising to lower drug costs, saying the government should get better prices and the pharmaceutical industry is "getting away with murder."

The Pharmaceutical Care Management Association, a benefits-manager trade group, says it expects greater scrutiny over its role in the price of medicine and wants to make its case "vocally and effectively."

Suits have been filed against insurers UnitedHealth Group Inc., which owns manager OptumRx; Cigna Corp., which contracts with that manager; and Humana Inc., which runs its own. Among the accusations are defrauding patients through racketeering, breach of contract and violating insurance laws.

"Pharmacies should always charge our members the lowest amount outlined under their plan when filling prescriptions," UnitedHealthcare spokesman Matthew Wiggin said in a statement. "We believe these lawsuits are without merit and will vigorously defend ourselves."

Mark Mathis, a Humana spokesman, declined to comment. Matt Asensio, a Cigna spokesman, said the company doesn't comment on litigation.

"Patients should not have to pay more than a network drugstore's submitted charges to the health plan," Charles Cote, a spokesman for the Pharmaceutical Care Management Association, said in a statement.

Benefit managers are obscure but influential middlemen. They process prescriptions for insurers and large employers that back their own plans, determine which drugs are covered and negotiate with manufacturers on one end and pharmacies on the other. They have said their work keeps prices low, in part by pitting rival drugmakers against one other to get better deals.

The clawbacks work like this: A patient goes to a pharmacy and pays a co-pay amount – perhaps $10 – agreed to by the pharmacy benefits manager, or PBM, and the insurers who hire it. The pharmacist gets reimbursed for the price of the drug, say $2, and possibly a small profit. Then the benefits manager "claws back" the remainder. Most patients never realize there's a cheaper cash price.

"There's this whole industry that most people don't know about," said Connecticut lawyer Craig Raabe, who represents people accusing the companies of defrauding them. "The customers see that they go in, they are paying a $10 co-pay for amoxicillin, having no idea that the PBM and the pharmacy have agreed that the actual cost is less than a dollar, and they're still paying the $10 co-pay."

On Feb. 10, a customer at an Ohio pharmacy paid a $15 co-pay for 15 milligrams of generic stomach medicine pantoprazole that the pharmacist bought for $2.05, according to receipts obtained by Bloomberg. The pharmacist was repaid $7.22, giving him a profit of $5.17. The remaining $7.78 went back to the benefits manager.

Clawbacks are possible because benefit managers take advantage of an opaque market, said Hayes, the Illinois consultant. Only they know who pays what.

In interviews, some pharmacists estimate clawbacks happen in 10 percent of their transactions. A survey by the more than 22,000-member National Community Pharmacists Association found 83 percent of 640 independent pharmacists had at least 10 a month.

"I've got three drugstores, so I see a lot of it," David Spence, a Houston pharmacist, said in an interview. "We look at it as theft – another way for the PBMs to steal."

Lawsuits began in October in multiple states, and some have since been consolidated. Most cite an investigation by New Orleans television station Fox 8, which featured interviews with Louisiana pharmacists whose faces and voices were obscured.

Many plans require pharmacies to collect payment when prescriptions are filled and prohibit them from waiving or reducing the amount. They can't even tell their customers about the clawbacks, according to the suits. Contracts obtained by Bloomberg prohibit pharmacists from publicly criticizing benefit managers or suggesting customers obtain the medication cheaper by paying out of pocket.

Pharmacists who contract with OptumRx in 2017 could be terminated for "actions detrimental to the provider network," doing anything that "disparages" it or trying to "steer" customers to other coverage or discounted plans, according to an agreement obtained by Bloomberg.

"They're usually take-it-or-leave-it contracts," said Mel Brodsky, who just retired as chief executive officer of Pennsylvania's Keystone Pharmacy Purchasing Alliance, which buys drugs on behalf of independent pharmacies.

OptumRx is among the three largest benefit managers that combine to process 80 percent of the prescriptions in the U.S. The other two, Express Scripts Holding Co. and CVS Caremark, haven't been

accused of clawbacks. CVS doesn't use them, it said in a statement. Express Scripts is so opposed that it explains the practice on its website and promises customers will pay the lowest price available.

Pharmacies fear getting removed from reimbursement networks, a potential death blow in smaller communities. But some pharmacists jump at opportunities to inform customers who question their co-pay amounts.

"Most don't understand," said Spence, who owns two pharmacies in Houston. "If their co-pay is high, then they care."

States are responding. Last year, Louisiana began allowing pharmacists to tell customers how to get the cheapest price for drugs, trumping contract gag clauses. In 2015, Arkansas prohibited benefit managers and pharmacies from charging customers more than the pharmacy will be paid.

"The consumers don't know what's going on," said Steve Nelson, a pharmacist in Okeechobee, Florida. "We try to educate them with regards to what goes into a prescription, OK? You've got to kind of tip-toe around things."

PIPELINE TO PROFITS: HOW DRUG MIDDLEMEN MAKE THEIR MONEY

The path of prescription drugs from the factory to the patient is complicated. Here, Julie Appleby of Kaiser Health News explains how money flows through the system and contributes to the cost of a 30-day supply of a hypothetical brand-name medicine.