Independence

Public Testimony

Senate Banking and Insurance Committee

Senate Bill 841, Printer's No.963

Cost Sharing Caps - Specialty Drugs

Senate Bill 893, Printer's No. 1056

Pharmaceutical Cost Transparency

October 25, 2016

Introduction

Independence Blue Cross (Independence) thanks Chairman White, Chairman Wiley and members and staff of the Senate Banking & Insurance Committee for the opportunity to discuss two pieces of legislation that seek to address a major issue that has for too long gone unanswered in health care - specifically the affordability of prescription drugs. Senate Bills 841 and 893 admittedly take different approaches to addressing affordability, but it is an issue that warrants our time and attention and we are pleased to be able to offer our perspective as the leading health insurance organization in southeastern Pennsylvania.

Independence has been operating for nearly 80 years in the 5-county southeastern Pennsylvania region and provides insurance coverage to nearly 2.5 million customers with the mission of enhancing the health and well-being of the people and communities we serve. Independence is on the front lines of this issue as we seek to maintain products that include comprehensive prescription drug coverage for our members – an increasing challenge in the current environment. Last year alone, overall prescription drug spending for our commercial plans rose 17 percent while pharmacy costs for our individual Affordable Care Act (ACA) plans increased by about 40 percent.

None of us would argue against the premise that the development of breakthrough or specialty drugs to treat serious, complex and chronic conditions holds great value and promise for patients. The ability to cure Hepatitis C and a 23 percent decline in cancer death rates since the 1991 peak all speak to the progress being made. There is also no disputing the significant economic contributions the pharmaceutical manufacturing and biotech industries have made and continue to make in Pennsylvania.

The overarching concern, however, is - what good are any of these developments if people cannot afford their medications? And how do we balance the value of new specialty drugs in particular with the very real issue of health care access and affordability in general?

Defining the Problem

The headlines unfortunately are all too familiar. A few examples include:

- The price of EpiPen, a medication that treats life-threatening allergic reactions, has been raised 400 percent since 2007 and is now just over $600 for a two-pack. This case has drawn national attention and has resulted in a number of Congressional hearings and inquiries. The drug's manufacturer also recently agreed (with no admission of wrongdoing) to an over $450 million settlement with the U.S. Department of Justice and other government agencies for how the drug was classified and priced which resulted in the federal Medicaid program being overcharged for the drug.

- Another example is naloxone, a drug that can block the effect of an opioid overdose. In 2008, drug overdoses passed auto fatalities as the leading cause of accidental death in the United States. Naloxone quickly became a critical drug in the fight to address this public health crisis. The one manufacturer of this drug hiked prices at that time by nearly 1,100 percent. In Pennsylvania, since late 2014 we have reversed over 1,400 deaths with the help of naloxone. While the value of reversing even one death cannot be quantified, is there any real justification

for such a dramatic price increase that in turn strains resources for law enforcement, first responders, schools and families?

- One other timely example is abuse-deterrent opioids or ADOs, prescription drugs with the same chemical makeup as opioids such as OxyContin but more difficult - but not impossible - to manipulate. While these drugs have not been scientifically proven effective in reducing addiction or abuse, they are an option covered generally by health insurance for patients who should be prescribed an ADO. As with naloxone and as the opioid/addiction crisis has worsened, prices have gone up. At Independence, for example, while we have imposed stronger prior authorization standards for high dose opioids since the fourth quarter of 2014 that has contributed to a decrease of over 40,000 inappropriate opioid prescriptions in just a 14-month period, there has been no subsequent decrease in cost. For example, Opana ER, an ADO has increased from about $600 per prescription to about $1600 per prescription in two years. Five of the top ten highest cost per prescription opioid medicines are ADOs.

The increasing cost trend is also not unique to specialty drugs. Generic drugs, including those that have been on the market for decades have seen sharp increases. The following two examples are for drugs introduced in 1967:

1. Doxycycline Hyclate, an antibiotic used to treat a variety of infections, had an average market price increase from $20 to over $1,800 - an 8,000 percent increase – in a single year from 2013-2014; and,
2. Albuterol Sulfate, a drug used to treat asthma and other lung conditions, increased from $11 to $434 in the same time period, an over 4,000 percent increase.

The rising cost of drugs is not a concern unique to consumers and insurance carriers – state governments bear these costs. At a meeting in Pittsburgh just last week, the National Academy for State Health Policy reported that states spend more than $20 billion annually on prescription drug coverage for state employees. In Pennsylvania in the last fiscal year alone, over $180 million dollars was spent on prescription drug benefits for 73,606 state employees. Also impacted are state Medicaid and Corrections programs. Pennsylvania's Medicaid program spending on Hepatitis C drugs alone went from $33.7 million to $131.8 million in two years. The Pennsylvania Department of Corrections spent $54.4 million on prescription drugs in the last year.

So the question remains - what is to be done to stem this tide, aside from Congressional hearings and lawsuits? A federal solution, at least at this time, appears elusive - so what can states do?

Discussion/Recommendations

While we can certainly appreciate the intent of Senate Bill 841 in protecting consumers by capping monthly out-of-pocket costs for specialty drugs, this legislation merely masks the true issue. Capping consumer costs at $200 per month for all specialty drugs prescribed when a single specialty drug can cost hundreds of thousands of dollars per year will do nothing to address the underlying cost issue. It is worth noting that in 2010 at Independence, less than 1,000 of our members were prescribed a drug costing more than $1,000 per month. Last year, over 4,000 members were prescribed at least one such costly drug, a 300 percent increase. Also worth noting is that of the 54 new drugs approved by the FDA

in 2015, 26 or about 48 percent were specialty drugs. This year alone, 95 specialty drugs are up for review by the FDA.

As the number and cost of specialty drugs continues to climb, capping what consumers will pay out of pocket does nothing to address actual costs. If cost sharing is capped, specialty drug costs will have to be borne elsewhere, resulting in increased cost sharing in other areas, benefit adjustments or premium increases necessary to accommodate the monetary caps on drug spending.

Conversely, Senate Bill 893 seeks to bring a level of transparency to drug pricing. As one of the most regulated industries at both the state and federal levels, health insurers can fully appreciate the fact that the private industry generally neither welcomes nor embraces government intervention and regulation. However, the provisions of Senate Bill 893 and the information being sought as part of the prescribed review process are certainly a step in the right direction in providing some level of transparency to an industry that few of us can fully understand in terms of how prices are developed.

In addition to greater transparency in drug pricing, other recommendations for consideration include:

- Encouraging consideration of cost-effectiveness in the drug approval process. Although a federal issue, state lawmakers can certainly join forces to advocate that our federal lawmakers support changes to the current approval process and require that cost-effectiveness be considered when approving new specialty drugs in particular.

- Also at the federal level, we should be encouraging competition in the drug market through the development and utilization of effective generic drugs and biosimilar medications, both of which would be helpful in the effort to provide cost effective alternatives to patients. The first step in this process is clearing the backlog of generic drug applications that currently exists and bringing this process into the newly launched 10-month approval timeframe at the FDA.

- At the state level, we should do all we can to educate and encourage the use of generic or biosimilar medications as less expensive alternatives to high cost medications for insurers and consumers.

- A growing trend among both private and public payers (such as Medicaid programs) is a form of "pay for performance." In other words, some insurance companies and Medicaid programs have entered into specific agreements for a drug they will cover based on the performance or outcomes for patients. This has been done in particular in some states in terms of Hepatitis C drugs which can prove costly to both Medicaid and Corrections programs. It may be worth exploring if the Commonwealth should be required to move more aggressively in this direction.

- Oftentimes, it is just as important to *not* make certain policy changes that may seem like reasonable solutions but will in reality only serve to mask the real issue. Capping co-pays and other cost sharing and restricting insurers from using tools such as tiering, prior authorization, and other medical management practices to maintain affordability are artificial solutions that will not bring any real or long-term relief to consumers and will continue to mask true total costs paid for these increasingly expensive drugs.

Independence again thanks Chairmen White and Wiley for this opportunity and for having the foresight to discuss what many lawmakers are concerned about, but may ultimately dismiss as a federal issue. There is a need for more informed dialogue about what may be working in the private and public payer sectors and in other states when it comes to prescription drug benefits and a more robust conversation as to how Pennsylvania consumers may be better protected in this effort.