Independence

Public Testimony

House Insurance Committee

House Bill 161, Printer's No.125

Pharmaceutical Cost Transparency

February 8, 2017

Introduction

Independence Blue Cross (Independence) thanks Chair Pickett, Chairman DeLuca, and members and staff of the House Insurance Committee for the opportunity to discuss Chairman DeLuca's House Bill 161, legislation intended to bring a level of transparency to prescription drug pricing. Although widely discussed in the media and in numerous Congressional hearings, policymakers at the state and federal levels continue to struggle with how to address prescription drug affordability. As the leading health insurance organization in southeastern Pennsylvania, Independence is pleased to come before the Committee to offer our perspective on the proposed legislation as well as the larger affordability issue.

Independence has been operating for almost 80 years in the five-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 the prescription drug pricing issue as we strive to continue offering health plans that include comprehensive prescription drug coverage for our members — an increasing challenge in the current environment. The following statistics illustrate the challenge:

- In 2015, overall prescription drug spending for Independence commercial plans rose 17 percent.
- Also in 2015, Independence pharmacy costs for our individual Affordable Care Act (ACA) plans increased by about 40 percent.
- Historically, 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.

None of us would argue against the premise that the development of breakthrough drugs and the continued use of effective drugs available in the market to treat serious, complex, and chronic conditions hold great value and promise for patients. 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 and goal of the Committee's hearing, however, is — what good are any of these developments if people cannot afford their medications? And, how do we enact public policy that will balance the value of prescription drugs with the very real issues of health care access and affordability in general?

Defining the Problem

Unfortunately, the headlines are all too familiar. For example:

- Spinraza, approved by the FDA in December 2016 as the first drug for children and adults to treat the rare and debilitating disorder of spinal muscular atrophy, is priced at the cost of $750,000 per patient, putting this medication at the top of the list for most expensive prescription drugs.

- 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, resulting in the federal Medicaid program being overcharged.

- Another example is naloxone, a drug that can block the effect of an opioid overdose. In 2008, drug overdoses surpassed auto fatalities as the leading cause of accidental death in the United States, and naloxone quickly became a critical drug in the fight to address this public health crisis. The one manufacturer of this drug at the time hiked prices by nearly 1,100 percent. At last count, over 2,300 Pennsylvanians had been saved 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 strains resources for law enforcement, first responders, schools, and families?

- One other example is abuse-deterrent opioids or ADOs. These prescription drugs have the same chemical makeup as opioids such as OxyContin, but are more difficult — albeit not impossible — to snort, smoke, inject or otherwise manipulate. Though an option generally covered by health insurance for patients who should be prescribed an ADO, these prescription drugs have not proven scientifically effective in reducing addiction or abuse, and have in fact been identified as a contributing factor in increased heroin use. And, as with naloxone and as the opioid/addiction crisis has worsened, prices have gone up. For example, Opana ER has increased from about $600 per prescription to about $1,600 per prescription in two years. Five of the top ten highest cost prescription opioid medicines are ADOs. At Independence, we are continuing to look at opportunities to curb the use of potentially addictive opioids. One such example is the stronger prior authorization standards for high dose opioids that we have imposed since the fourth quarter of 2014. These new standards contributed to a decrease of over 40,000 inappropriate opioid prescriptions in just a 14-month period. However, there has been no subsequent decrease in cost.

- Generic drugs, including those that have been on the market for decades, have seen sharp price increases. This includes two drugs originally introduced in 1967. 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 (2013-2014), and 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 Impact Nationally and in Pennsylvania

A recent report from the U.S. Department of Health and Human Services (HHS) found that retail prescription drug spending experienced a nine percent rate of growth in 2015 — the highest rate of growth when compared to all other health care sectors. This means prescription drug costs are increasing at a rate higher than hospital, doctor, home health, or any other cost component within the health care system. The rise in overall trend is attributable to across-the-board increases not only in new medications, but also existing brands available on the market and prices of generic and historically "cheaper" alternatives.

Although the rising cost of drugs is a very real problem impacting both the consumers' ability to afford and adhere to medications and insurers' ability to offer affordable premiums, this is not a concern unique to these segments – state governments also bear these costs. 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 2015.

So the question remains — what can be done to stem this tide, aside from Congressional hearings and lawsuits? It is encouraging that there appears to be a more robust federal discussion on the horizon, but in the meantime, what can states do?

Discussion/Recommendations

As the Commonwealth has just begun the budget process for 2018 with a deficit of at least $2 billion according to the Independent Fiscal Office, we ask the Committee to seriously consider proposals like House Bill 161 which will begin to address rising drug costs for your constituents and for the state. House Bill 161 seeks to bring a level of transparency to drug pricing by requiring a drug manufacturer to report on key pricing elements if a given medication exceeds dollar or percentage increases as established by the legislation. If companies fail to report, insurance coverage of such medications is not assured.

As one of the most regulated industries at both the state and federal levels, health insurers can fully appreciate that private industry — in general — neither welcomes nor embraces government intervention and regulation. However, the provisions of House Bill 161 and the information being sought as part of the prescribed reporting 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:

Federal Recommendations

1. **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. Specialty drug prices grew by almost 19 percent in 2016, a year when over 95 specialty drugs were up for review by the FDA. This price increase is expected to be matched in 2017.
2. 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.** This can be done by 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, and will be helpful in providing cost effective alternatives to patients.

State Recommendations

1. 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.**
2. **Pennsylvania should consider entering into specific contracts for covered drugs based on the performance or outcome for patients in order to more aggressively manage high cost drugs that are also widely prescribed.** This has been done in some states for Hepatitis C drugs, which can prove costly to both Medicaid and corrections programs.
3. **It is just as important to first *"do no harm"* and not entertain certain policy changes that may seem like reasonable solutions but will 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 Blue Cross again thanks Chair Pickett and Chairman DeLuca for this opportunity and for shining a light on an issue that has a financial impact on your constituents, our members, and the Commonwealth.