PENNSYLVANIA
SENATE BANKING AND INSURANCE COMMITTEE
PUBLIC HEARING
OTOCBER 24, 2017

TESTIMONY
ON
PHARMACEUTICAL PRICING TRANSPARENCY
SENATE BILL 637

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Chairman White, Chairman Street and members of the Senate Banking and Insurance Committee, thank you for the opportunity to provide comments on pharmaceutical benefits, specifically the cost and cost drivers of pharmaceuticals.

Highmark Inc. (Highmark) is the insurance arm of Highmark Health, an integrated delivery and financing system providing commercial health insurance products in Pennsylvania, West Virginia, and Delaware; delivering an array of other products through various diversified business entities, including Medicaid products through Gateway Health Plan; and providing direct health care services through the Allegheny Health Network. The comments and recommendations presented to the committee today represent the view of Highmark which provides health insurance coverage to over four million lives in Pennsylvania.

Highmark would like to acknowledge the work of the Senate Banking and Insurance Committee. The legislation in front of the committee, Senate Bill 637 and the proposed amendment, seeks to address the rising cost of health care services, specifically pharmacy benefits. The Committee began this journey many years ago when investigating health insurance benefit designs for certain specific pharmaceuticals. The Committee sought to provide certain protections for health insurance consumers from disproportionate out of pocket costs. The Committee's work revealed that health insurance (both private and public) benefit designs ultimately have limited impact on the driving cost of pharmaceuticals—i.e. their price. In fact, the more benefit designs hide the cost of prescription drugs, the larger the cost to the overall health care system. The rising cost of health care is undeniable and public policy makers continue to struggle with mechanisms to stabilize costs with the goal of making health care costs sustainable. Highmark believes this committee's efforts during the past several years, leading to the drafting of Senate Bill 637 and the amendment represents a thoughtful, reasonable step in the right direction.

Prior to discussing the bills, Highmark would like to provide some background data on its pharmacy benefits and national policy trends.

Background

Prescription drug benefits are an integral and crucial component of a person's overall health coverage. Both acute and chronic conditions often can be treated with a prescription medication. Minor conditions such as an ear or sinus infection or more complex ailments such as high blood pressure or high cholesterol can, in many cases, be treated or at least managed with a prescription drug. The emergence of specialty drugs is providing groundbreaking treatment options for individuals living with Hepatitis C, cancer, HIV, arthritis and many other ailments.

Providing prescription drug benefit coverage contributes to the rising premium and out-of-pocket costs our customers can experience. From 2013-2015, Highmark (PA only) prescription drug claims increased over 20 percent, from $1.4 billion to $1.7 billion. During this same time period, the specialty drug claims increased nearly 50 percent, $335 million to $495 million. Worth noting is the specialty drug trend—during these

three years, the specialty drug spend has increased from 24% to 30% of the overall pharmacy spend.[1] The cost of specialty drugs underscores the significance of this trend as specialty medications are approaching the $500,000 threshold. Two recently approved CAR-T drugs—one for the treatment of leukemia and one to treat a form of non-Hodgkins lymphoma—will cost $475,000 and $383,000. There also are promising gene therapy drugs in the pipeline with similar cost implications. Treatment breakthroughs that hold the promise to improve health outcomes but at a costs that threatens the financial sustainability of providing health care coverage.

Out of pocket costs

Understanding the aforementioned costs describes the financial enormity of pharmaceutical costs. It is also important to explain how health insurance customers pay for health insurance coverage. Broadly, consumers' health insurance costs are a combination of the health insurance premium and cost sharing.

- Premium—generally speaking, the monthly amount a customer pays for health insurance benefits;
- Cost sharing—three different tools generally describe cost sharing as it relates to health insurance costs. They are:
    - Deductible—Generally, an amount that a covered individual must pay prior to the health insurance policy providing financial coverage for health care services.
    - Copayment—Generally, a flat fee which a customer pays to share in the cost of the health care service. For example, in the case of a pharmacy benefit, a policy could have a copayment structure of $8/$40/$60/$100[2] for three different tiers plus a specialty tier of prescription drugs
    - Coinsurance—Generally, a percentage fee which the customer pays for a health care service. For a pharmacy benefit, such coinsurance structure could be 20 percent with a minimum of $10 and maximum of $100.Some designs will have a different percentage and some may not have any minimums or maximums.[3]

The cost sharing in a benefit design is the out-of-pocket costs that consumers pay. Federal law provides a cap on all out-of-pocket expenses at $7,150 for individuals and $14,300 for a family plan (2017 plans) increasing to $7,350 and $14,700, respectively, for 2018 plans. Many group customers choose lower out-of-pockets maximums based on their individual needs.

Premiums and cost sharing primarily comprise the costs our customers pay for health insurance coverage. Generally speaking, higher cost sharing responsibility allows for lower premiums. Highmark uses a combination of premium, deductible, copayments and coinsurance to design a variety of plans to meet the demands of our customers. Some customers prefer to pay higher costs in premium to avoid the experience of

[1] This reflects Highmark's risk and non-risk business—stated differently, it includes fully insured and self-insured customers.

[2] This cost sharing structure is for illustrative purposes only. It is not meant to describe any one cost sharing design in the Highmark family of products.

[3] IBID

paying out-of-pocket for services while others prefer to have higher cost sharing in exchange for lower premiums.

This discussion is particularly important as it relates to prescription drug coverage, costs, and legislative mandates. A growing trend in legislative health insurance mandates sees proposals restricting insurance benefit designs. For example, Highmark has seen variations of proposal that would limit the copayment or coinsurance amount for prescription drugs to $100 for a 30-day supply of a specialty tier drug and would further limit the aggregate copayment or coinsurance amount to $200 per month. We also have seen proposals that seek to limit out of pocket costs for drugs treating specific diseases.

Driving these policy options is the growing cost of health care services—germane to today's discussion, prescription drug costs. Highmark understands that the "sticker shock" experienced by some consumers motivates such proposals. For example, a customer with a 20% coinsurance who fills a prescription for Sovaldi could be exposed to $5,300 in cost sharing when she or he fills the prescription.[4] Highmark cautions that the answer to limiting such a large cost share by restricting the manner in which insurers design plans will likely result in one of two unintended outcomes:

1) Customers will see decreased choice in the marketplace as cost sharing limits will prohibit a variety of plan designs. The effect of this will be larger premium costs for customers.
2) The cost sharing will be shifted to other medical and behavioral health benefits.

The common theme to these outcomes is cost shifting and nothing addresses the root cause behind this phenomenon—the actual cost of the health care service. Health insurers use a variety of plan designs to address our customers' costs needs. Stated another way, plan designs with high cost sharing exist because the cost of care, in this case, pharmaceuticals, can be extremely high. The fundamental public policy question at hand is the high cost of pharmacy care.

National Policy Trends

This public hearing coincides with another emerging trend across many states—the introduction (and passage) of legislation requiring greater transparency of prescription drug prices.

In June of 2016, Vermont became the first state to pass legislation requiring justification for pharmaceutical price increases—this includes providing information to the Vermont Attorney General's Office describing the factors contributing to increases in the wholesale acquisition cost. Congress also has taken an interest in this issue by holding Congressional hearings after Turing Pharmaceuticals raised the price of Daraprim, a decades old drug, by more than 5,000 percent.[5] Following this trend, other states have recently enacted slightly different versions of this public policy:

[4] See www.goodrx.com/sovaldi. $5,800 cost share is based on a $29,000 price for a 28 day supply of Sovaldi 400mg.
[5] https://www.statnews.com/2016/02/04/shkreli-hearing-drug-prices/

- *Nevada*: In 2017, Nevada passed legislation (Senate Bill 539) into law. This law requires pharmaceutical companies to disclose diabetes drug prices, manufacturing costs, and research investments as well as justify price increases[6]. This law recently (October 17, 2017) withstood a challenge by the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Biotechnology Innovation Organization when a federal judge denied these organizations' request to block implementation of the law.
- *California*: On October 9, 2017, the Governor of California signed Senate Bill 17 into. The law provides transparency around pharmaceutical pricing methods, including a requirement for manufacturers to provide a 60 day notices if prices increase more than 16 percent over a two year period.[7]
- *Maryland*: In late May 2017, the Maryland Governor allowed a bill to become law, which aims to curb generic drug price increases by allowing the state's Medicaid program to alert the Attorney General if manufacturers raise the price of a drug by 50% or more in a year with the potential for a fine.[8]

Furthermore, the National Conference of State Legislatures reports that at least 176 pharmaceutical pricing bills have been introduced in 36 states during 2017.[9] It is clear that public policy makers are recognizing a need to address unsustainable rising pharmaceutical prices.

Senate Bill 637—Pharmaceutical Transparency

Highmark does not recommend adopting public policy "simply because" other states have or are doing it as well. Pennsylvania needs to develop policy to the benefit of Pennsylvanians, both individuals and employers. The trend to require greater transparency in pharmaceutical pricing is not being done "simply because." In fact, it is an evolution of what currently exists in other sectors of the health care system.

Health insurance, the payment side of the health care equation, has long been the subject of public policy transparency initiatives. Stated another way, it is time for the cost side of the equation to catch up to the rest of the marketplace.

By way of comparison, Highmark encourages the committee members to review the information Highmark makes available for its pricing. Per federal and state requirements, Highmark submitted our ACA rate filings in the spring 2017 and the Insurance Department quickly posted the information on http://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/default.aspx

[6] Bekker, Jessi, Las Vegas Review-Jounrnal. October 17, 2017 (https://www.reviewjournal.com/news/politics-and-government/nevada/federal-judge-refuses-to-halt-diabetes-drug-transparency-law/)
[7] Reuters. October 9, 2017. (https://www.reuters.com/article/us-usa-healthcare-drugpricing/california-governor-signs-drug-pricing-transparency-law-idUSKBN1CE28W)
[8] Ramsey, Lydia. Business Insider. June 4, 2017. (http://www.businessinsider.com/states-with-drug-pricing-transparency-bills-2017-6/#maryland-is-tackling-generic-drug-price-hikes-1)
[9] Reuters, October 9, 2017

inviting consumers and the general public to submit comments to the PID. The filings contain voluminous data and other information providing justification for rate filings. Worth noting is that these rate filings are not arbitrarily decided by Highmark, they are reviewed and must be approved by regulators based on federal and state requirements, adding an additional level of oversight. The pricing of health insurance policies also are regulated on the "back end" as federal requirements effectively dictate the amount of profit from such policies. Individual market policies are restricted to an 80 percent medical loss ratio (MLR) whereas group policies are limited to an 85 percent MLR. Stated differently, the government requires that 80 cents / 85 cents of every premium dollars invested by a customer be spent on medical expenses. This limits any administrative costs, marketing and margin to 20 cents / 15 cents of every premium dollar.

Not only are transparency measures currently in place for the payment side of health care, the measures continually evolve. By way of example, the House Insurance Committee recently approved House Bill 1848, which will increase corporate governance disclosure requirements (i.e. filings) on insurers. This is yet another legislative/public policy initiative to increase transparency in health insurance. This will not be the last transparency initiative as the National Association of Insurance Commissioner continually reviews and evaluates existing standards in order to recommend improvements, which generally results in additional legislative mandates.

Highmark draws this parallel as the principles expressed in Senate Bill 637—namely transparency and pricing justification—are applied to the payer side of the health care delivery system. This suggests a public policy trend in revealing data driven pricing decisions to the public and policy makers in an attempt to address rising health care costs. These efforts take on additional importance when we consider public health care budgets such as Medicaid, Corrections, PACE, CHIP, etc. The cost drivers in the health care system, pharmaceuticals in the context of this discussion, should be more closely examined in order to develop effective solutions to unsustainable health care costs.

Highmark appreciates the committee's focus on health care costs. Both private and public payers are struggling with cost controls. Highmark's customers continue to demand more value for their health care premium. As taxpayers, these customers are being asked to shoulder such medical costs twice as their tax dollars support the public health care programs in addition to their private health insurance costs. Highmark believes Senate Bill 637 extends existing public policy standards to a significant driver of these costs—pharmaceuticals. We look forward to further discussions with the committee, our regulators, and other stakeholders to further this initiative.