PENNSYLVANIA
SENATE BANKING AND INSURANCE COMMITTEE
PUBLIC HEARING
OCTOBER 25, 2016

TESTIMONY
ON
SENATE BILL 841—"CAP-THE-COPAY"
SENATE BILL 893—PHARMACEUTICAL PRICING TRANSPARENCY

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Chairman White, Chairman Wiley and members of the Senate Banking and Insurance Committee, thank you for the opportunity to provide comments on two pharmacy related bills referred to the committee: Senate Bill 841, which would place limitations on health insurers' ability to design pharmacy benefits, and Senate Bill 893, which would establish a process for the Commonwealth to better understand the pricing of pharmaceutical products.

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 Senators Mensch and White, the respective prime sponsors of Senate Bill 841 and Senate Bill 893. Both bills appear to have similar intent—address the rising cost of health care services, specifically pharmacy benefits. Prior to discussing the bills, Highmark would like to provide some background data on its pharmacy benefits.

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. From minor conditions such as an ear or sinus infection to 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 some specialty medications cost over $100,000 annually, threatening the financial sustainability of providing health care coverage.

Senate Bill 841—"Cap the Co-pay"

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

Prior to addressing the specifics of Senate Bill 841, explaining how health insurance customers pay for coverage will help inform the discussion. 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 $6850 for individuals and $13,700 for a family plan (2016 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 paying out-of-pocket for services while others prefer to have higher cost sharing in exchange for lower premiums.

Senate Bill 841 would restrict insurance benefit designs by limiting the copayment or coinsurance amount 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. Highmark understands that the "sticker shock" experienced by some consumers motivates proposal such as Senate Bill 841. 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:

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[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

[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.

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. Our customers will not experience savings or reduced health care costs because of Senate Bill 841; they will simply see their costs shift from one bucket to another.

The intent behind Senate Bill 841 is understandable—protect consumers from large health care costs, specifically specialty drug costs. Senate Bill 841, however, does not address the root cause behind this phenomenon. Health insurer's 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.

It will be helpful for the committee to understand that Highmark members pay, on average, $100 per month in out-of-pocket for drugs that may cost $5,000 to $6,000 per month. This suggests that exposure to high out-of-pocket pharmacy costs for Highmark members is limited.

Highmark also reminds the committee of the limitations of state mandates, including benefit design mandates such as Senate Bill 841. Health plans governed by the Employee Retirement Income Security Act (ERISA), a federal law establishing standards and requirements for certain group health plans (generally the self-insured market), cannot be subject to state mandates. A majority of Highmark's customers are under a self-insured plan meaning less than half of the insurance market would be impacted by Senate Bill 841.

Senate Bill 893—Pharmaceutical Transparency
The timing of this public hearing coincides with an emerging trend across many states—the introduction of legislation requiring greater transparency of prescription drug prices. In June of this year (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] It is clear that public policy makers are recognizing a need to address unsustainable rising pharmaceutical prices.

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 2016 and the

[5] https://www.statnews.com/2016/02/04/shkreli-hearing-drug-prices/

Insurance Department quickly posted the information on http://www.insurance.pa.gov/Consumers/HealthInsuranceFilings/Pages/default.aspx 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 profits to 20 cents / 15 cents of every premium dollar.

Highmark draws this parallel as the principles expressed in Senate Bill 893—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 if they are still employed in the workforce. Highmark believes Senate Bill 893 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.