# Legislative History for Connecticut Act

**PA 16-214**

SB371

| | | |
|---|---|---|
| Senate | 2423-2427, 2441-2442 | 7 |
| Insurance & Real Estate | 990, 993-995, 996-997, 1049, 1050-1052, 1059, 1060-1061, 1121-1122, 1156-1160, 1163, 1164-1165 | 23 |
| House Transcripts have not been received. They are available on CGA website, but are not the Official copy. Contact House Clerk for assistance (860) 240-0400 | | **30** |

**Transcripts from the Joint Standing Committee Public Hearing(s) and/or Senate and House of Representatives Proceedings**

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**S - 698**

# CONNECTICUT
# GENERAL ASSEMBLY
# SENATE

## PROCEEDINGS
## 2016

**VOL. 59**
**PART 8**
**2400 – 2750**

On Calendar Page 42, Calendar 275, Senate bill 19, I'd like to mark that PT.

On Calendar page 27, Calendar 534, House Bill 5621, I'd like to mark that PT.

On Calendar page 9, Calendar 399, Senate Bill 18, I'd like to mark that PT.

On Calendar page 38, Calendar 125, Senate Bill 21, I'd like to mark that item on our Consent Calendar, please. Place that item on our Consent Calendar please.

THE CHAIR:

No objections, so ordered sir.

SENATOR DUFF (25TH):

Thank you, Madam President.

THE CHAIR:

Mr. Clerk.

On page 41, it is Calendar 269, Substitute for Senate Bill Number 371, AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS.

THE CHAIR:

Senator Crisco. Good morning, sir.

SENATOR CRISCO (17TH):

Good morning, Madam President. Madam President, I move for acceptance of the Joint Committee's favorable report and passage of the bill.

THE CHAIR:

The motion is on acceptance and passage. Will you remark, sir?

SENATOR CRISCO (17TH):

Yes, Madam President. Madam President, the Clerk has an amendment, LCO 5155. I ask that it called and I be given permission to summarize.

THE CHAIR:

Mr. Clerk, 5755.

THE CLERK:

LCO Number 5155, Senate A, offered by Senator Crisco.

THE CHAIR:

Senator Crisco.

SENATOR CRISCO (17TH):

Thank you, Madam President. I move its adoption.

THE CHAIR:

The motion is on adoption. Will you remark, sir?

SENATOR CRISCO (17TH):

Yes, Madam President. This amendment enhances the clarification of the language in the bill to point out that this is the practice of medicine and not the clinical trials.

THE CHAIR:

Will you remark further on Senate A? Will you remark further on Senate A? If not, I will try your minds. All those in favor please say Aye.

SENATORS:

Aye.

THE CHAIR:

Those opposed? Senate A passes. Senator Crisco.

SENATOR CRISCO (17TH):

Thank you, Madam President. Remarking on the bill, I think the best way to quickly summarize this, but I will go into additional facts of the bill, is the testimony of President Looney at the public hearing. He stated that this would offer hope, H, O, P, E, to terminally ill patients who suffer from diseases for which there is no effective, approved treatment. This is extraordinary, Madam President, in regards to giving people a chance on life. The bill allows for certain terminally ill patients on their specified conditions to access medications and devices not approved for general use by the Federal Food and Drug Administration. The bill applies to investigational drugs, biological products and devices that have completed phase one of an FDA-

approved clinical trial and are still part of the trial. To qualify for the program, patients must meet certain eligibility criteria and complete a detailed informed consent document.

Madam President, I could go on and on and on, but as Senator Looney stated, this provides hope that did not exist for some terminally ill people.

THE CHAIR:

Will you remark further on the bill? Will you remark further on the bill? Senator Kelly, good morning sir.

SENATOR KELLY (21ST):

Good morning, Madam President. I rise also in support of the bill, which did pass insurance unanimously and concur with Senator Crisco's comments regarding what the bill does with regards to offering terminally patients hope and the ability for drugs to help with their treatment. So I fully support the bill.

THE CHAIR:

Thank you, will you remark further? Will you remark further? If not, Senator Crisco.

SENATOR CRISCO (17TH):

Thank you, Madam President. If there is no objection, I request that it be placed on the Consent Calendar.

THE CHAIR:

Seeing no objection, so ordered, sir. Mr. Clerk.

THE CLERK:

On page 12, Calendar 426, Substitute for Senate Bill Number 453, AN ACT CONCERNING REMITTANCE OF REVENUE FORM CERTAIN TRAFFIC FINES TO MUNICIPALITIES.

THE CHAIR:

Good morning, Senator Fonfara.

SENATOR FONFARA (1ST):

We've made it all the way to the morning, Madam President.

THE CHAIR:

We sure have. Let's not try for the afternoon, sir.

SENATOR FONFARA (1ST):

I will do my best.

THE CHAIR:

I bet you will. I know that.

SENATOR FONFARA (1ST):

Madam President, I move for acceptance of the Joint Committee's favorable report and passage of the bill.

THE CHAIR:

If the Clerk can now call the items on the Consent Calendar and then followed by a vote, please.

THE CHAIR:

Mr. Clerk.

THE CLERK:

On page 10, 10 409, Senate Bill 458; page 12, Calendar 426, Senate Bill 453; page 23, Calendar 508, Senate Bill 461; page 38, Calendar 125, Senate Bill 21; on page 41, Calendar 269, Senate Bill 371.

THE CHAIR:

Mr. Clerk, will you please call for a roll call vote, and the machine will be open.

THE CLERK:

Immediate roll call has been ordered in the Senate. Immediate roll call on today's Consent Calendar has been ordered in the Senate.

THE CHAIR:

All members have voted? All members have voted? The machine will be closed. Mr. Clerk, will you please call the tally.

THE CLERK:

On today's Consent Calendar,

Total Number Voting 36

| | |
|---|---|
| Those voting Yea | 36 |
| Those voting Nay | 0 |
| Absent and not voting | 0 |

THE CHAIR:

The Consent Calendar passes. Senator Duff.

SENATOR DUFF (25TH):

Thank you, Madam President. I move that all items that need action by the House be immediately transmitted.

THE CHAIR:

So ordered, sir.

SENATOR DUFF (25TH):

Thank you, Madam President. Is Senate Agenda Number 2 on the Clerk's desk?

THE CHAIR:

Mr. Clerk.

THE CLERK:

The Clerk is in possession of Senate Agenda Number 2. It's dated Monday, May 2, 2016.

THE CHAIR:

Senator Duff.

SENATOR DUFF (25TH):

# JOINT
# STANDING
# COMMITTEE
# HEARINGS

## INSURANCE AND
## REAL ESTATE
## PART 3
## 963 – 1385

**2016**

REP. ORANGE (48TH): That's a good question, but I don't have the answer to that.

REP. SCOTT (40TH): Sorry to put you on the spot. That's all I've got for now.

SENATOR CRISCO (17TH): If you get the answers to Representative Scott, we would appreciate it.

REP. ORANGE (48TH): Will do.

SENATOR CRISCO (17TH): Any other questions? Thank you very much.

REP. ORANGE (48TH): Thank you, sir.

SENATOR CRISCO (17TH): Proceeding now with Senator Looney.

HB 5270
SB 134

SENATOR LOONEY (11TH): Good afternoon, Senator Crisco and distinguished members of the Insurance and Real Estate Committee. I'm Martin Looney, State Senator for the 11th district, representing Hamden, New Haven and North Haven. I'm here to testify in support of House bill 5517, AN ACT CONCERNING COST-SHARING FOR PRESCRIPTION DRUGS; Senate bill 371, AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS; and Senate bill 367, AN ACT CONCERNING SEVERE MENTAL AND EMOTIONAL IMPAIRMENT AND WORKERS' COMPENSATION COVERAGE.

First of all, the price of prescription drugs is creating an unsustainable burden on many Connecticut citizens, and House bill 5517 would cap these costs at $100 per drug per month. The average annual cost of the specialty pharmaceutical drug is higher than

in the exchange at the metal levels that are already designed.

For example, earlier today, when we were debating the bill, I was showing how a $20 co-pay that we were mandating become zero could make a plan become $100 more a month because it would stop being a silver plan and become a gold plan. Do you have any information in your research on how this bill might impact the metal levels of the plan designs we have in just the exchange, alone?

SENATOR LOONEY (11TH): No, I don't. I don't know exactly what levels it might – how it might impact those cost factors – but I think, clearly, that is something to be factored into in deliberations on it. But, since other states are taking action in this area, I think we should we examine what they have been able to do because, obviously, those other states are operating with exchanges, as well.

REP. SCOTT (40TH): So, I'm just concerned. We've got a lot of mandates as it is in the state, and I do have some reservations about, as we keep mandating more stuff, how we just keep making things more expensive for a small group marketplace. That's all I have for now. Thank you.

SENATOR CRISCO (17TH): Thank you, sir. Thank you, Senator Looney. Do you want to proceed?

HB5270

SENATOR LOONEY (11TH): Yes, thank you. Thank you, Mr. Chairman, and good afternoon, Representative Megna, my colleague from New Haven. Senate bill 371 would offer help to terminally ill patients who suffer from diseases for which there is no effective

approved treatment. This legislation is similar to House bill 5270, which was heard in the Public Health Committee recently. Unfortunately, recent federal court decisions have held that terminally ill patients do not have the right to try experimental treatment. As a result of these decisions, a number of states have passed so-called right to try laws to give these patients access to potentially life-saving therapy.

The legislation before you would allow drug and device manufactures to make investigational drugs and devices available to certain terminally ill patients, and this would allow qualifying patients to experimental treatments. Qualifying patients must have considered all other treatment options currently approved by the FDA, been unable to participate in the clinical trial for the terminal illness within 100 miles of home, have received a recommendation from the treating physician for the experimental treatment and have given written informed consent. The legislation would also prohibit any cause of action against the pharmaceutical company for harm done by a drug given in this particular situation.

While some argue that access to experimental treatments pose a significant risk of harm to the patient, it would seem that this danger is far less than that posed by certain death due to the underlying illness in cases where other treatments have been tried and failed. This bill strikes a reasonable balance and contains numerous safeguards and allows access to these treatments only for terminally ill patients.

It does not require that insurance companies cover these treatments and it allows, but does not require, the manufacturer to make the products available. I urge the committee to pass this legislation, which would offer hope to patients afflicted with terminal illness.

The last bill on which I wanted to comment, Senate bill 367, would ameliorate some of the unfortunate changes made to the workers' compensation law back in 1993. Specifically, it would expand workers' compensation coverage to certain individuals, notably police officers suffering from mental or emotional impairment as a direct result of witnessing the death or maiming of another human being whose death or maiming was caused by an act of a person. I'm pleased that this bill does not limit the coverage to an intentional act. It would see that a person's mental impairment would not depend on whether or not the act he or she witnessed was intentional. Ideally, the legislation would be expanded to include other first responders, in addition to police officers, which would be similar to the language in Senate bill 134, which has also been proposed on this subject.

In recent years, medical science has made it increasingly clear that mental health impairment can be as disabling as physical impairment, and it really is arbitrary to have our current requirement that compensation for a psychological or mental injury has to be accompanied by a physical component. Otherwise, its reality will not be recognized. Unfortunately, our current statutes do not reflect this new understanding. The bill would require that the worker be diagnosed by a

psychiatrist or psychologist who must determine that the impairment originated from witnessing the death or maiming or the immediate aftermath of the death or maiming, and the immediate aftermath would be limited to six hours after the scene is secured by law enforcement. The visual witnessing must also be causally connected to the employee's employment.

Passage of this bill would allow workers who are suffering from specific work-related mental trauma to benefit from workers' compensation. This would be a positive change and would bring our statues in line with a moderate understanding of mental health and do away with the arbitrary barrier of refusing to recognize the mental injuries that do not have a physical component.

Again, I want to thank the committee for hearing bills on these crucial issues and for the very important work that this committee does and the critical issues that you grapple with year in and year out. Thank you, Mr. Chairman.

SENATOR CRISCO (17TH): Thank you, Mr. President. Are there any questions on the latter two bills?

Yes, Representative Scott.

REP. SCOTT (40TH): Thank you, sir. Along the same realm of a comment I made or a question I had a minute ago – on 371, with the use of experimental drugs, the legislation doesn't appear to identify how the insurance companies can create the costs associated with those drugs. Are they allowed to charge a deductible, throw it in the prescription

drug tier, or is it supposed to be paid for at 100 percent?

SENATOR LOONEY (11TH): I think the legislation doesn't mandate that. The insurance companies just offer the option for the drug to be provided in these circumstances if the manufacturer is willing to.

REP. SCOTT (40TH): Okay. There's got to be a cost to it somewhere. So, I'm just wondering how it's supposed to be paid for – whether the insurance company has to eat the entire cost or if it's through cost sharing. And again, instead of paying –

SENATOR LOONEY (11TH): Right. I imagine there would have to be cost sharing here, if there is any coverage at all. I don't believe it mandates insurance coverage but just basically provides the incentive, I think, for the insurance company to participate, exempting them from liability should they provide the drugs and, obviously, if it turns out to be beneficial, they may find out that it may accelerate their [indiscernible 0:31:58.2] of that drug in the marketplace.

REP. SCOTT (40TH): Okay. Thank you, Mr. Chairman.

REP. MEGNA (97TH): Thank you, sir. Are there any further questions? Thank you very much, Senator. Good to see you.

Representative Conroy.

REP. MEGNA (97TH): Susan Halpin. We have a one-two punch going on here.

SUSAN HALPIN: Good afternoon, Senator Crisco, Representative Megna and members of the committee. For the record, my name is Susan Halpin, and I'm here today on behalf of the Connecticut Association of Health Plans. I apologize for not being in the room when the earlier bill was heard. I had a conflict, but I am here today to offer testimony in opposition to H.B. No. 5517 and Senate bill 373, in particular, as well as our concerns about 371 and 374.

All of these bills seek, in some manner, to limit the ability of health insurers to manage drug costs at the same time that those same health insurers are being asked to hold down premiums. We believe that it's really time to change this conversation – to change the conversation from what's covered under health care with respect to pharmaceuticals to why the pharmaceutical prices are what they are. We share the frustration of our members around the costs that are being levied and the excessive marketing of products that are increasing the demand, but it is in the interest of keeping premiums affordable that the insurers are using tools like tiered formularies, step therapy and cost sharing to, not only control cost, but to also ensure clinical safety and appropriateness.

I put this in here that it wasn't too long ago that I was in the unenviable position of lobbying against the Pain Management legislation that went before the Legislature. Hindsight for all of us is always 20/20, but fast forward 10 years, and it's clear

that the overprescribing of pain meds is one of the major contributing factors to today's opioid addiction crisis.

If you look at 373, in particular, which would prohibit health plans from removing a particular drug from a formulary during a policy term, just consider the headlines last summer when you had the overnight increase from $13.50 a pill to $750 a pill for – I believe I'm going to pronounce it right – Daraprim. You know, that's an AIDS and a cancer drug and also used to treat life-threatening parasitic infections. When you eliminate the ability of a health plan to remove a drug from their formulary, you limit their ability – any negotiating ability that they have with those companies – and we really think it would be a huge mistake to move in that direction.

These prices are not just causing harm in the commercial sector, they're crippling the sustainability of public programs like Medicaid and Medicare. Think about the enormous costs of the hep C drug, Sovaldi – I know Brian mentioned it earlier, I wasn't in the room – which went above $100,000 a course of treatment, to $84,000 a course of a treatment and I think, most recently, I saw $48,000 a course of treatment. When you have other competing drugs come on the market, I think that you have to allow the health insurers to look at those things as a way to manage those costs.

I'll just summarize quickly because I know the buzzer went off. We do appreciate the desperation that's behind Senate bill 371 and 374, and the experimental treatment legislation, and we

appreciate that 371 does not mandate coverage for drugs, but we are really concerned about 374. If we're interpreting it correctly – because I think the language is a little tough to follow – we do believe that it's heading in the direction of mandating coverage for experimental treatment. As the health insurers, again, we understand and appreciate those situations. That's why we worked for several years with folks on the clinical trials legislation whereby the health insurers cover the routine costs associated with clinical trials because we recognize the importance of that.

So, I would just leave you with the couple thoughts that we've put in all of our testimony this year, which is that this is going to apply to the fully insured market, which is probably only 40% of the market now. It's not going to imply to self-insured market. It's going to have a real impact on the health insurance exchange policies, as you've heard. So, it will really undermine what's happening already at the exchange level, and we would really caution you against moving in that direction, and we hope that instead of moving toward coverage restrictions like those that are under your consideration, that you look to a broader conversation on drug pricing, overall. We included a couple charts about some of the recent experience and increases in drug pricing, and we hope you'll take a look at those as you deliberate these bills. Thank you.

REP. MEGNA (97TH): Thank you, Susan. Susan, the formulary process – the tiering process for Medicaid and Medicare – is it identical or very similar to what is used in the private market?

SUSAN HALPIN: It's very different. Actually, I can't really speak to Medicare as well as I can speak to Medicaid. With Medicaid – I'm dating myself a little bit and my experience has not kept up with where things are – but they develop a preferred drug list whereby the State negotiates discounts with the pharmaceutical companies and put those on a PDL. It's somewhat similar to a formulary but not exactly similar to how it works in a commercial sector. Somebody else could probably explain that better than I could. But, the costs are still the costs, which is the fundamental argument that I'm making. You know, whether you're talking about negotiating on a PDL or you're talking about Express Scripts negotiating for the health plan – we're all still talking about the same unit costs, and everyone is trying to bring their market share to bear in negotiating for those prices, but if you're starting at such a high place, you're trying to get down, but you're only going to get down so far unless you are able to have competing products.

REP. MEGNA (97TH): Okay, thank you very much. I get that part of it.

Representative Zoni.

REP. ZONI (81ST): Thank you, Chairman Megna. Nice to see you, Susan.

SUSAN HALPIN: Always a pleasure.

REP. ZONI (81ST): Um, 374 – I'm trying to understand this language, and it appears that it's

feels is appropriate. I'm certain that if we dug into the details, I could find examples specific to this. I don't have one right at my fingertips.

REP. MEGNA (97TH): That would be helpful. I appreciate your testimony. Were there any other questions? No? Thank you very much.

DAWN HOLCOMBE: Thank you.

REP. MEGNA (97TH): Paul Pescatello.

PAUL PESCATELLO: Good afternoon. I'm Paul Pescatello, here for the New England Biotech Association. I'm president and CEO of the Association. I'm here to speak in support of Senate bill 374. I'd also like to make some comments on Senate bill 371, if I could.

Senate bill 374 is about protecting our most vulnerable patients and providing those patients with peace of mind. Senate bill 374 is common sense legislation that ensures coverage for medical treatment when such treatment is consistent with the best practices, is prescribed as medically appropriate by a patient's health care provider or supported by peer review literature. This legislation is proactive. It establishes protection against potential future efforts to deny or restrict care based on a diagnosis that a disease's progression is likely terminal. It recognizes, more importantly, that what constitutes a terminal condition is for the patient and his or her doctor to assess – something not to be left to the legal parsing of an insurance contract.

Senate bill 374 is, as well, hopeful and reasonably so. The biopharma industry is making great strides in treating formerly incurable and formerly untreatable conditions. Many once terminal conditions are now curable or, if not curable, often able to be rendered a chronic condition, successfully treatable long term with powerfully effective medicines. Today, I'll give you two examples – HIV/AIDS and melanoma were once terminal illnesses with few treatment options. Biopharma research and development resulted in new medicines that literally transformed patients from terminal to having normal or near-normal life spans. It would be tragic were seemingly terminal patients denied access to existing, if short-term, life-extending treatments that turn out to be bridges to cures for long-term survival. Senate bill 374 gives patients confidence that they have the right to a full spectrum of reasonable treatment options. I hope you'll support it.

If I could, I'd like to make some comments on 371. For 371, I'm here for the New England Biotech Association and also the Bioscience Growth Counsel of the CBIA. I'm here to oppose Senate bill 371. Rigorously designed, administered and executed clinical trials are critical to an effective process for approving new medicines and for patients in the public to have confidence that newly approved medicines are safe and effective. Legislations aimed at giving patients the "right-to-try" experimental medicines, while very understandably well meaning, will hurt – not help – the clinical trial process. Right-to-try experimental medicines legislation would reduce the incentive for patients to participate in clinical trials. Right-to-try

experimental medicines legislation could negatively affect the supply of investigational drugs, generally in very tight supply, with barely enough medicine often to be made available to meet the requirements of clinical trial protocols.

The Federal FDA has responded to the understandable desire of patients to try investigational drugs with a much improved, streamlined, compassionate use process. Expedited FDA compassionate use is working. There is little evidence that patients with legitimate requests to try early-stage non-FDA-approved drugs are unable to obtain them. I would note, too, that there is no evidence of any patients receiving experimental drugs because of right-to-try legislation that has been passed to other states.

We built a robust biopharma sector in Connecticut. Biopharma companies and research institutions and universities depend on a clear regulatory framework for clinical trials. Right-to-try experimental medicines would complicate and confuse a successful regulatory process, ultimately undermining our collective goal of bringing new and better treatments and cures to patients as speedily as possible. I would be happy to take any questions. Thank you for letting me speak on both.

REP. MEGNA (97TH): Thank you, Doctor. Are there any questions? Thank you very much for your testimony.

PAUL PESCATELLO: Thank you.

REP. MEGNA (97TH): Senate bill 368. Mary Boudreau.

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**Testimony Presented to the**
**Insurance and Real Estate Committee of the Connecticut General Assembly**

**Thursday, March 10, 2016**

**Paul R. Pescatello, JD, PhD**

## S.B. 371
## An Act Concerning the Use of Experimental Drugs

Good afternoon Senator Crisco, Representative Megna, Senator Hartley, Representative Zoni, Senator Kelly, Representative Sampson, members of the Insurance and Real Estate Committee.

I'm Paul Pescatello, Senior Counsel and Executive Director of the Connecticut Bioscience Growth Council.

I am also President/CEO of the New England Biotechnology Association and Chair of We Work for Health Connecticut.

The Connecticut Bioscience Growth Council is a committee of the Connecticut Business and Industry Association's biotech and biopharma members.

The Bioscience Growth Council was formed as a means to foster collaboration both among Connecticut biotech and biopharma companies themselves and, just as importantly, *with* our state. As you know, Connecticut – *this* General Assembly – has chosen wisely to invest in the life sciences as a foundation for Connecticut's 21st century economy and as a means to create a broad spectrum of jobs.

Last week's ribbon cutting for Alexion Pharmaceutical's world headquarters in New Haven – with labs and offices for over 1,000 employees – the strides we have made in regenerative medicine and stem cell research, and the research and economic development already being accomplished by Jackson Labs, name only a few of the dividends generated by this Connecticut investment.

Rigorously designed, administered and executed clinical trials are critical to an effective process for approving new medicines, and for patients and the public to have confidence that newly approved medicines are safe and effective.

Legislation aimed at giving patients the "right to try" experimental medicines, while understandably well meaning, will hurt, not help, the clinical trial process.

Right to try experimental medicines legislation would reduce the incentive for patients to participate in clinical trials:

Right to try experimental medicines legislation could negatively affect the supply of investigational drugs, generally in very tight supply, with barely enough medicine made to meet the requirements of clinical trial protocols.

The FDA has responded to the understandable desire of patients to try investigational drugs with a much improved, streamlined "compassionate use" process.

Expedited FDA compassionate use is working. There is little evidence that patients with legitimate requests to try early stage, non-FDA approved drugs are unable to obtain them.

I would note too that there is no evidence of any patients receiving experimental drugs because of "right to try" legislation in other states.

We have built a robust biopharma sector in Connecticut. Biopharma companies and research institutions and universities depend on a clear regulatory framework for clinical trials. Right to try experimental medicines would complicate and confuse a successful regulatory process, ultimately undermining our collective goal of bringing new and better treatments and cures to patients as speedily as possible.

I would be happy to answer any questions you may have or expand upon any points made in my testimony.

Thank you.

Line 8

*Quality is Our Bottom Line*

**Insurance Committee Public Hearing**

SB 34
SB 36

**Thursday, March 10, 2016**

**Connecticut Association of Health Plans**

**Testimony in Opposition to**

**HB 5517 AN ACT CONCERNING COST-SHARING FOR PRESCRIPTION DRUGS.**

**SB 373 AN ACT LIMITING CHANGES TO HEALTH INSURERS' PRESCRIPTION DRUG FORMULARIES.**

**SB 371 AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS.**

**SB 374 AN ACT PROHIBITING HEALTH INSURERS FROM RESTRICTING OR REDUCING COVERED BENEFITS FOR INSUREDS DIAGNOSED WITH A TERMINAL CONDITION.**

The Connecticut Association of Health Plans strongly opposes the adoption of HB 5517, SB 373, SB 371 and SB 374 which all seek, in some manner, to limit the ability of health carriers to manage drug costs at the same time the carriers are under enormous pressure to control escalating premiums. It's time to change the conversation from health insurance coverage to health care costs and look instead at why pharmaceutical prices are what they are.

Insurers share the frustration of their members around the exorbitant drug prices being levied and the excessive marketing of products that increase demand. It's in the interest of keeping premiums affordable, that insurers use tools like tiered formularies, step-therapy and cost-sharing to not only control costs, but to also ensure clinical safety and appropriateness. It was not too long ago, that the health carriers were in the unenviable position of lobbying against pain management legislation cautioning against the over prescribing of known controlled substances. Hindsight is always 20/20 of course. But, fast forward ten years and it's clear that over-prescribing of pain meds is a major contributing factor in today's opioid addiction crisis.

SB 373 would prohibit health plans from removing a particular drug from a formulary during a policy term. Consider the headlines last summer when the 32 year-old CEO of Turing Pharmaceuticals jacked up the prices of a 62 year old drug called Daraprim from $13.50 a pill to $750 overnight. Daraprim is used by some AIDS and cancer patients and to treat life-threatening parasitic infections. Eliminating a health plans ability to

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manage their formulary leaves a carrier with no means by which to apply any pressure on Turing to reduce their prices.

Pharmaceutical costs aren't just an issue in the commercial sector, they are crippling the sustainability of public programs like Medicare and Medicaid across the country. Think about the $84,000 cost of the Hepatitis C drug - Sovaldi. No one disputes that these drugs are critically important, but without some other check and balance on the price, formularies , tiering and even cost sharing (which would be limited under HB 5517 to no more than $100 per 30 day supply) are critically important tools that are needed to counter against such high pricing which is why the pharmaceutical industry lobbies so strongly against these insurance measures. We need to keep these tools in place.

The Association appreciates the desperation of terminally ill patients to access experimental drugs as contemplated under SB 371 and SB 374 which is why the industry worked so hard on legislation over several years to provide for coverage for various clinical trial costs which prior to passage of those acts would have been covered by the pharmaceutical companies in large part. We appreciate that SB 371 doesn't mandate coverage for such drugs, but we are very concerned about the intent of SB 374 which, if we're interpreting it correctly, does seem intended to mandate coverage for experimental treatment.

The bills noted above are just a few of the drug bills of concern under consideration this session. The Insurance Committee already JF'd out SB 34, requiring drug coverage while a decision is under appeal and SB 36, requiring coverage for oral medications if similar IV medications are covered.

As more and more companies and government entities move toward self-insured status, the fewer the number of people there are actually subject to this type of legislation if passed. The one's that are subject to it are those that can least afford it like small employers. CT is now nearing the ratio of 60% self-insured to 40% fully-insured. As the ACA recognized, the system cannot continue to absorb the additional costs of new mandates.

As CTAHP has noted on a number of bills this session, the ACA requires strict adherence to a particular timeline that would be undermined by these proposals under consideration today. Connecticut's Exchange is ***right now*** preparing their standard benefit designs and carriers are ***right now*** preparing their non-standard plan designs. Health carriers must then file the associated rates with the Department of Insurance. If any new mandates or other cost sharing provisions are adopted after the standard benefit design has been finalized and rates have been filed, the Exchange and the carriers will have to ***reopen*** the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. The sheer volume of mandates and the other insurance provisions under consideration by the Committee add appreciable volatility to the overall process that is not conducive to an efficient, stable and predictable insurance market.

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All of the arguments above point to the need for a broader conversation on drug pricing. We hope you will take these concerns, as well as the cost dynamics summarized on the attached sheets, under consideration and "hold" HB 5517, SB 373, SB 371 and SB 374.

Thank you for the opportunity to comment.

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.crahp.com

# Then and Now: The cost of prescription drugs

**Despite the introduction of new, and in many cases more innovative medical treatments,** prescription drugs that have been around for years continue to get more and more expensive. **And what about** claims of innovation **when the price of one drug can rise by an astounding 9,145 percent in only six months? 9,145 percent, really? This is just one example that we have highlighted below that shows while the drugs may have stayed the same** -- their price tags skyrocketed

Doxycycline in 2013
$20 per bottle

9,145% increase

Doxycycline in 2014
$1,849 per bottle

H.P. Acthar Gel in 2007
$700 per vial

4,471% increase

H.P. Acthar Gel in 2014
$32,000 per vial

U-500 in 2007
$220 per bottle

445% increase

U-500 in 2014
$1,200 per bottle

EpiPen in 2007
$56.64 per pen

222% increase

EpiPen in 2014
$184.35 per pen

Benicar in 2007
$2.25 per pill

164% increase

Benicar in 2014
$5.95 per pill

Gleevec in 2007
$118 per pill

158% increase

Gleevec in 2014
$306 per pill

Copaxone in 2008
$2,358.60
per 30 syringes

157% increase

Copaxone in 2014
$6,072.40
per 30 syringes

RUNAWAY Rx
AFFORDABLE PRICES FOR REAL CURES

# MYTHBUSTER: Rx PRICING EDITION

It's time to set the record straight on prescription drug prices and the scanty justifications for why they are so high. While the industry continues to minimize, shrug off, and ignore the problem, taxpayers, lawmakers, employers, doctors, and payers will keep asking questions. But the truth is we will never get to the bottom of this pricing problem as long as the industry remains shrouded in darkness with no transparency on how they set prices.

## The Pharmaceutical Industry Wants You to Believe...

## But the Fact is...

### Prescription Drugs Represent Just 10% of the Health Care Dollar

✓ This misleading statistic ignores prescription drugs administered in a health care setting.


**Rx spending actually represents 19% of employers' and Medicare health spending.**

### Research & Development (R&D) Costs Drive High Drug Prices

✓ R&D costs do not explain massive **price hikes** on brand name and generic drugs that have been around for **decades**.

✓ **Nearly half** of all R&D funding comes from the government, academic institutions, research hospitals, and charitable organizations.

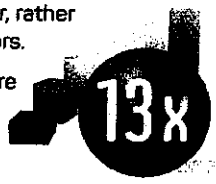
✓ Drug companies spend **19 times more** on marketing and advertising than they do on R&D.


**9,000% increase on Doxycycline, from $20 per bottle in October 2013 to $1,850 by April 2014.**
(GENERIC ANTIBIOTIC)

### Competition Leads to Lower Prices

✓ Six-figure price tags are setting the floor, rather than the ceiling, for follow-on competitors.

✓ In 2012, all but one new cancer drugs were priced at $100k per year or more. By 2014, all but one were priced at $150k.

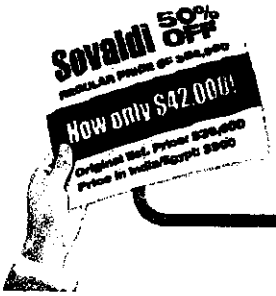



**The top two insulin makers raised their prices in lockstep 13 times over 5 years.**

### Discounts and Rebates Make Drugs Affordable

✓ Even with discounts and rebates, Americans pay significantly **higher prices** than other advanced countries.

✓ Sovaldi was on the market for **14 months** at the full price tag before any discounts were offered.




**Even at a 50% discount, Sovaldi's price is still higher than its original developer had estimated.**

**For more information, please go to www.calhealthplans.org or www.runawayrx.org.**

California Association of Health Plans

January 2016

Testimony

NATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
*New Haven, Hamden & North Haven*

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

March 10, 2016

HB 5270
SB 134

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee. I am here to testify in support of HB 5517, AN ACT CONCERNING COST-SHARING FOR PRESCRIPTION DRUGS, SB 371, AN ACT CONCERNING THE USE OF EXPERIMENTAL DRUGS, and SB 367, AN ACT CONCERNING SEVERE MENTAL AND EMOTIONAL IMPAIRMENT AND WORKERS' COMPENSATION COVERAGE.

The price of prescription drugs is creating an unsustainable burden on many Connecticut citizens and HB 5517 would cap these costs to $100 per drug per month. The average annual cost of a specialty pharmaceutical drug is higher than the national annual median income[1]. It is unfortunate that states cannot actually affect the prices of these drugs, but they can offer some financial relief for patients. This bill would certainly provide a meaningful incentive for insurers to do a better job negotiating with the pharmaceutical companies.

I would urge you to add to this legislation the transparency provisions that some other states are considering. The pharmaceutical companies claim that these astronomical prices are justified because they spend large sums on research and

[1] https://www.washingtonpost.com/news/wonk/wp/2015/11/20/specialty-drugs-now-cost-more-than-most-household-incomes/

development. If the prices are in fact justifiable, these corporations should not object to this transparency. The pharmaceutical companies should be willing to disclose manufacturing, production, research and development costs as well as profits and the costs to them of patient assistance programs. I will provide the committee with a chart created by the Senate Democrats' policy department regarding other states' actions on these issues[2]. Even more recently, the governor of New York has included in his budget a proposal to cap the prices and require disclosure. The Attorney General of Massachusetts is investigating the possibility of bringing an unfair trade practice suit against Gilead Sciences (the maker of the Hepatitis C drug Solvadi). California will have a ballot measure that would, among other things, cap the price that the state would pay for prescription drugs at the rate that the VA pays. The VA, unlike Medicare, is permitted by law to negotiate drug prices with the pharmaceutical industry. I am including a chart that shows the difference between the VA price and the Medicare price on certain prescription drugs.[3] While federal action on drug prices would be most desirable, that does not appear likely. I believe it is time for our state to act; HB 5517 would provide significant relief for many Connecticut citizens and I urge the Insurance and Real Estate Committee to pass this legislation.

SB 371 would offer hope to terminally ill patients who suffer from diseases for which there is no effective approved treatment. This legislation is similar to HB 5270 which was heard in the Public Health Committee. Unfortunately, recent federal court decisions have held that terminally ill patients do not have a right to try experimental

[2] Also this article is a summary http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/02/states-limiting-patient-costs-for-high-priced-drugs
[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4451044/

treatment[4]. As a response to these decisions, a number of states have passed "right to try" laws to give these patients access to potentially life-saving therapy. The legislation before you would allow drug and device manufacturers to make investigational drugs and devices available to certain terminally ill patients. This would allow qualifying patients access to experimental treatments. Qualifying patients must have considered all other treatment options currently approved by the FDA, been unable to participate in a clinical trial for the terminal illness within 100 miles of home , received a recommendation from the treating physician for the experimental treatment, and have given written, informed consent. The legislation also prohibits any cause of action against the pharmaceutical company for harm done by a drug given in this situation.

While some argue that access to experimental treatments poses a significant risk of harm to the patient, it would seem that this danger is far less than that posed by the certain death due to the underlying illness. This bill strikes a reasonable balance; it contains numerous safeguards and allows access to these treatments only to terminally ill patients. It does not require that insurance companies cover these treatments, and it allows but does not require the manufacturer to make the products available. I urge the Insurance Committee to pass this legislation which would offer hope to patients afflicted with terminal illness.

SB 367 would ameliorate some of the unfortunate changes made to the workers' compensation law in 1993. Specifically, it would expand workers' compensation coverage to certain individuals (police officer) suffering from a mental or emotional impairment as a direct result of witnessing the death or maiming of another human being whose death or maiming was

SB134

[4] Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach, 495 F.3d 695, 696 (D.C. Cir. 2007) (en banc), *cert. denied*, 128 S. Ct. 1069 (2008).