June 30, 2015

TO: Members, Senate Health Committee

FROM: Mira Morton, Policy Advocate

SUBJECT: **AB 339 (GORDON) HEALTH CARE COVERAGE: OUTPATIENT PRESCRIPTION DRUGS**
HEARING SCHEDULED - JULY 7, 2015
OPPOSE - AS AMENDED JUNE 24, 2015

The below-signed organizations **OPPOSE AB 339 (Gordon)**, which severely restricts the ability of health care issuers and pharmacy benefit managers (PBMs) to control health care costs on behalf of purchasers through their prescription drug benefit designs, and places strict caps on prescription drug copayments. While we share the author's concerns about the ability of patients to afford necessary and potentially life-saving medications, capping out-of-pocket costs for expensive medications without addressing the underlying cost of those drugs will jeopardize the affordability of health care coverage for millions of California enrollees and purchasers.

AB 339 shifts costs instead of controlling them.
AB 339 does nothing to lower the actual cost of prescription drugs. Instead, it caps what an enrollee can be asked to pay out-of-pocket for a month's supply at $260. This means that health care issuers would have to pay a larger share of the purchase price for affected prescription drugs and spread that additional cost out to all enrollees and purchasers in the form of higher premiums. According to the analysis done by the California Health Benefits Review Program (CHBRP), this one provision of **AB 339** is apt to increase premiums by approximately $378 million in 2016.

AB 339 will increase what issuers have to pay for prescription drugs and drive up health care spending.
Significantly, **AB 339** doesn't just ignore the high cost of some prescription drugs – it would also encourage inefficient utilization of the most expensive medications *and* increase what health care issuers and PBMs must pay for them. CHBRP's analysis predicted that **AB 339** will *"increase the use of existing a newly developed high-cost prescription drugs, and lead to an increase in overall expenditures,"* in large part because co-payment caps shield patients and their doctors from the cost of treatment, preventing them from taking cost into consideration when deciding which prescription drug is the right one to take or prescribe. Patients who might otherwise be treated effectively by a less expensive drug, even another top-tier drug, would have no incentive to ask about the comparative cost of their other treatment options, nor will their doctors.

AB 339 will also drive up spending because it requires health care issuers and PBMs to cover all medically necessary prescription drugs that have no therapeutic equivalent, meaning there are no generic formulations available for that medication. For example, Sovaldi, Viekiera Pak, and Harvoni are all brand name drugs used to treat, and often cure, hepatitis C, but they do so in different ways and have no generic alternatives. As such, **AB 339** would require issuers and PBMs to include all three drugs in their formularies, eliminating their leverage to negotiate lower pricing with the drugs' manufacturers in exchange for access to their enrollees. In late 2014 Express Scripts, one of the larger PBMs, was able to negotiate a multi-year deal with AbbVie, the manufacturer of the Viekira Pak, to make the cure exclusively available to all eligible enrollees of Express Scripts' clients, regardless of their disease progression, in exchange for a great purchase price. The deal saved Express Scripts' clients more than $1 billion, but it would not have been possible if **AB 339** had been law at the time.

In addition, **AB 339** imposes restrictions on how drugs may be placed in a plan's formulary, further limiting how much of a drug's cost can be recovered from enrollees, and further undermining the ability of issuers and PBMs to negotiate lower prices with drug manufacturers. For example, **AB 339** prohibits prescription drugs from being placed on the top tier of a formulary based solely on their cost. Federal guidance released this past February and regulations adopted by Covered California in May, on the other hand, explicitly allow issuers to place prescription drugs on the highest formulary tier based solely on their cost unless there are enough versions on the market to

allow issuers and PBMs to negotiate the price down. The strict rule imposed only by **AB 339** gives drug manufacturers leverage to demand a higher price without having to worry that their drugs will be placed on the most expensive tier of an issuer's or PBM's formulary, and as such, it will increase the purchase price of many of the most expensive prescription drugs.

This impact on premiums is apt to increase rapidly with the introduction of new drug therapies.
The introduction of the new hepatitis C medications mentioned above had a huge impact on overall health care spending in 2014 due to their high price-tags - Medicare alone spent $4.5 billion on them. However, while these medications can cost as much as $1,000 per pill, there are only 3 million people in the United States with hepatitis C, and after a course of treatment, most individuals are cured of the disease and do not require additional treatment. This June, though, the federal Food and Drug Administration advisory committee recommended approval of two new cholesterol medications that are expected to cost between $7,000 and $12,000 per patient, per year. Even though these new medications will cost much less than those used to treat hepatitis C, they could still significantly impact overall health care spending and premiums due to the sheer number of people who suffer from high cholesterol. To put it in perspective, if all 3 million individuals with hepatitis C were treated at once for $84,000 each, the total cost would be a whopping $252 billion, but if all 120 million Americans with high cholesterol were treated for $12,000 per person, it would cost over $1.4 trillion each year with these new medications! With drug costs rising generally, and new, more expensive drugs entering the market all the time to treat common, chronic conditions, health care costs and premiums are bound to rise no matter what, but **AB 339** eliminates the incentive for patients and doctors to be cost-conscious, and takes away many of the tools health care issuers and PBMs use to curb inefficient and unnecessary spending on prescription drugs. As such, it's apt to cause prescription drug spending to rise much faster than it otherwise would, and not necessarily to the benefit of enrollees.

Drug cost-sharing caps will affect affordability more outside of Covered California.
Finally, unlike the cost-sharing caps imposed by Covered California, which can be modified each year when the agency develops its benefit offerings for the coming year, **AB 339** would put these changes into law, making them harder to adjust later on. In addition, over 88% of individuals enrolled in Covered California's plans receive a premium subsidy, which buffers them somewhat from increases to their premium rates, but **AB 339** will impact premiums for millions of Californians who do not qualify for these subsidies, and their employers. It is important to keep in mind that health care costs have consistently grown faster than inflation and the economy, and even without **AB 339**, affordability is a growing issue for purchasers. The least expensive plan available through Covered California for a family of four making $98,000, for example, just over the eligibility threshold for a premium subsidy, costs $781/month and has a $4,500 individual deductible and a $9,000 family deductible. At 9.3% of that family's gross income, it's hardly affordable, but **AB 339** would make it still less so.

To be sure, the problems associated with rising drug costs are real and growing, and they impact individuals, employers, and employees, not to mention state and local governments. Unfortunately, though, **AB 339** avoids the fundamental problem, the underlying cost of prescription drugs, and instead seeks to impose a complex regulatory scheme to shield enrollees from drug costs and reasonable utilization management. In the long run, this will increase health care costs for everyone, further limiting access to preventative care and life-saving treatments.

For these reasons and more, we **OPPOSE AB 339 (Gordon)** and urge you to vote **NO** when it comes before you in committee.

Sincerely,

California Chamber of Commerce
California Association of Health Underwriters
California Farm Bureau Federation
CVS Health
Pharmaceutical Care Management Association

cc: Donna Campbell, Office of the Governor
The Honorable Richard Gordon
Teri Boughton, Senate Health Committee
Joe Parra, Senate Republican Caucus
Senate Office of Floor Analyses
District Office, Members, Senate Health Committee