

**Testimony in Support of CT HB 5251 (Orange)
Out-of-Pocket Costs for Prescription Drugs
Insurance and Real Estate Committee – March 6, 2014**

Chairmen Crisco and Megna, and Members of the Committee:

On behalf of the Leukemia & Lymphoma Society and the blood cancer patients we serve throughout the state of Connecticut, we thank you for the opportunity to submit written testimony on HB 5251. Sponsored by Representative Linda Orange, this important legislation would cap patients' out-of-pocket costs for prescription medications.

Under many private insurance plans, cancer patients face extremely high out-of-pocket costs because their prescribed medication(s) is covered under the fourth or fifth tier of their insurers' drug formularies. Insurers use these tiers – sometimes called a “specialty” tier – to impose high patient cost-sharing on expensive drugs. This often includes co-insurances that, unlike a flat co-pay, require patients to cover a percentage of the overall cost of a drug.

These higher tiers are becoming increasingly common. Between 2012 and 2013, the percentage of employer-sponsored plans using specialty tiers increased from 14% to 23%, a jump of 65% in only a single year.¹ They're widely used in exchange plans as well. In Connecticut, the Access Health CT standard benefit design requires a 4-tier formulary for every metal tier, with co-insurances imposed on the specialty tier. For bronze and silver plans, that's a co-insurance of 40%; for gold plans, 30% and, for platinum, 20%.² Consider, for example, a monthly course of Gleevec® treatment for Chronic Myelogenous Leukemia (CML). Based on the recommended monthly dosing, this medication costs as much as \$7,000/month.³ Co-insurance payments of 40% would require patients to pay \$2,800 per month. These payments are simply unaffordable for many low- and middle-income families.

It's important to note that these tiers usually contain medications taken by only 1 to 5% of the patient population⁴ – namely, patients facing cancer, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, hemophilia, and other life-threatening diseases and chronic conditions. Health insurance is supposed to spread risk in an equitable fashion across a total insured population but, with their medications clustered on these higher tiers, these patients are saddled with a disproportionate share of their drug costs.

The adverse effects of such high cost-sharing are not limited to patient finances; these costs have also been shown to discourage adherence to treatment. In one recent study, the authors estimated that, on average, every \$10 increase in co-pay yielded a 4% decrease in adherence.⁵ Unfortunately, poor adherence can lead to poor health outcomes and to an increase in non-medication costs associated with treating disease progression and/or other complications. The New England Health Institute recently estimated that medication non-adherence results in up to \$290 billion annually in increased medical costs in the U.S.⁶ Clearly, this works against the cost-containment goals that insurers cite as their rationale for building tiered formularies.

If passed, HB 5251 would help address this problem by placing both a per prescription cap and an annual cap on a patient's out-of-pocket costs for drugs. Set at \$100, the per prescription cap is critical to protecting patients against the monthly financial hardship that many of them experience at the pharmacy when filling a script for just a single higher tier drug like Gleevec®. The per prescription cap will also help ensure affordability for those patients being treated with several medications in a single month. Cancer patients, for example, are typically

prescribed supportive care therapies that manage side effects related to treatment toxicity, and these drugs too can involve high cost-sharing. Because these drugs are a necessary component of the overall treatment regimen, they require the same cost-sharing safeguards as chemotherapy pills or other drugs used as treatment therapies. The annual cap would complement the per prescription cap by limiting a patient's total annual out-of-pocket drug costs. Benchmarked to limits defined in the Affordable Care Act, that annual cap in 2014 would be \$3,175 for an individual and \$6,350 for a family. Together, these two caps would ensure that people living with a chronic disease and other serious conditions can in fact afford and comply with their treatment plans.

Fortunately, this bill is unlikely to have a significant impact on cost for the average commercial insurance plan since, again, specialty drug spending represents a small percent of total health plan spending⁷ and therefore can be effectively diluted when spread across enrollees. Vermont, for example, recently passed a law creating an annual cap on drug costs. That cap is linked to amounts specified by IRS Code, which for 2014 limits patients' drug expenditures in Vermont to \$1,250/individual and \$2,500/family. Following implementation of that bill, one insurer noted in rate-filing documents that the new cap increased premiums by less than 1/10th of 1%.⁸ Note that these caps are half the size of what's proposed under HB 5251.

We urge the committee to support this legislation, as it offers a fair and balanced solution to this issue. Insurers would retain the ability to design their pharmacy benefit as needed, while all patients – especially those living with a life-threatening disease or chronic condition – would no longer find themselves with drug coverage that offers little protection.

With questions, please contact:

Marialanna Lee
Leukemia & Lymphoma Society
Office of Public Policy
marialanna.lee@lls.org
(215) 232-2763

Jennifer McGarry
Leukemia & Lymphoma Society
Connecticut Chapter
jennifer.mcgarry@lls.org
(203) 427-2046

¹ Health Policy Briefs: Specialty Pharmaceuticals. *Health Affairs*. Nov. 25, 2013. Available at https://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=103

² Standard benefit designs available online at <http://www.ct.gov/hix/cwp/view.asp?a=4295&q=532148>

³ GoodRx, 2013. Retrieved from: <http://www.goodrx.com/gleevec>

⁴ Employer Health Benefits 2013 Annual Survey. The Kaiser Family Foundation and Health Research & Educational Trust. Aug. 20, 2013. Available at <http://kff.org/report-section/2013-summary-of-findings/>.

⁵ Eaddy et al., "How patient cost-sharing trends affect adherence and outcomes." *Pharmacy and Therapeutics*. 2012;37(1):45-55.

⁶ New England Health Institute. "Poor Medication Adherence costs \$290 billion a year." 2009. See: <http://mobihealthnews.com/3901/>

⁷ Study conducted in 2013 by Avalere Health on behalf of the Coalition for Accessible Treatments, a group of patient organizations, medical associations, and others supporting specialty tiers reforms at the federal level.

⁸ MVP 2012 Q4 rate filings. Publically available through the website for the VT Department of Financial Regulation.