WRITTEN TESTIMONY OF
MARK GUIMOND, DIRECTOR OF STATE LEGISLATIVE AFFAIRS
THE ARTHRITIS FOUNDATION
BEFORE THE SENATE BANKING AND INSURANCE COMMITTEE
ON PENNSYLVANIA SENATE BILL 841

OCTOBER 25, 2016

Mr. Chairman – I am Mark Guimond, Director of State Legislative Affairs for the Arthritis Foundation. I am pleased to be here today on behalf of the 2.75 million people and 11,500 children in Pennsylvania living with doctor-diagnosed arthritis.

The Arthritis Foundation helps conquer everyday battles through life-changing information and resources, access to optimal care, advancements in science and community connections. Our goal is to chart a winning course, guiding families in developing personalized plans for living a full life – and making each day another stride towards a cure.

As you may know, arthritis is a life-long, complex chronic disease that can be difficult to treat, and people who suffer from the disease require regular, on-going care. As a patient advocacy organization, we value our role in helping policymakers, clinicians and health system leaders understand the nuanced nature of arthritis patients, their treatment and the needs of people who suffer from this disease. Our testimony reflects the real life health care experiences of our constituents and the safeguards that are most important in helping them maintain access to the treatments they need to live a full life.

We appreciate the efforts of Senator Mensch in his introduction and the consideration of Senate Bill 841 to provide for a health benefit plan that provides coverage for prescription drugs to ensure that any required copayment or coinsurance applicable to a specialty tier prescription drug does not exceed $100 per month for a 30-day supply of the specialty tier drug. Further, the bill would provide that the aggregate cost of all specialty tier prescription drugs required by an insured may not exceed $200 per month.

Health insurers have historically charged fixed co-payment for medications, in which an insured pays a specific dollar amount for medications on different “tiers”. As an example the out of pocket co-payments, costs might be set at $10/$20/$50 for the first three tiers. The first tier is usually the lowest costing drugs of which most are generics. The second tier contains higher cost drugs which may be an assortment of generic and brand name medications. The third tier is even higher cost medications which are predominantly brand name medications.

At the point where there is a fourth tier (or even higher tier(s)), the medications are high-cost, brand name specialty drugs – principally biologics. These "specialty tiers" often require in insured to pay coinsurance, as a percentage of their drug cost – often 25% to 50%, rather than a fixed dollar amount co-payment.

Our testimony today will focus specifically on higher tier specialty drugs that, according to the Legislative Budget and Finance Committee (LB&FC), are "often used to treat chronic or life-threatening conditions" and "because such drugs are manufactured in living organisms with high sensitivity to change in the manufacturing process, exact replication is almost impossible, and they have no generic equivalents."

The LB&FC further noted that these specialty tier medications "often require the [insured] to pay a percentage of the drug's cost (i.e., coinsurance), rather than a fixed dollar amount (i.e., copayment)" with a "typical out-of-pocket" cost in the "range of $1,500 to $3,000 per prescription…"

Senate Bill 841 is extremely important to the vulnerable population of people with arthritis and other chronic diseases because recent advances in innovative medicines have brought about a new class of medications called "biologics" which, unlike chemical compound drugs, are based on living cells. These medications, not even a generation old, have positively and dramatically changed the lives of people with arthritis and other devastating diseases. Biologics can mean the difference between a child being in a wheelchair (see Appendix 1) or running with friends or an adult being bedridden or leading a productive fruitful life.

These biologic medications, while life changing and life-saving, are extremely complex drugs that are incredibly difficult and expensive to bring to market, are not typically stored at retail pharmacies, require difficult and unusual delivery, handling, storage and inventory processes to the patient and require enhanced patient education, management or support beyond those required for traditional dispensing. It is significant to note that biologics are not simply pills that you can pick-up from a corner pharmacy – these medications can only be administered through subcutaneous or intravenous injection.

<u>The "January Effect"</u>

Biologics change lives, but one of the most significant barriers for access to these important medications is the high cost to the patient in the form of out of pocket costs (OOP) for deductibles and coinsurance. Under most health insurance policies, an insured begins a plan year with a fixed amount that must be paid out of pocket before the insurer will begin payment for medications or treatments. According to the United States Department of Health and Human Services (HHS), "With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance..."

In what is commonly termed the "January Effect", an insured begins their plan year with the entire deductible to extinguish before coverage begins. For a person on a biologic, with the LB&FC's noted monthly personal cost "of $1,500 to $3,000 per prescription", this means that the full out of pocket deductible expense can occur in the first month of the plan year – for most people that is in January.

According to the United States Census Bureau, the per capita income in Pennsylvania is $28,912, the median household income is $53,115, the state's median gross rent is $832 and the median mortgage is $1,443. For a individual with a $2,000 deductible, the amount that a person has to have just to receive their medications is equivalent to nearly two and one-half month's rent or one and one-half month's mortgage.

It cannot be emphasized enough that if a patient does not have this money in-hand, they do not receive their medications. The cost of the deductible, in and of itself, is a direct barrier to access to medications.

The out of pocket cost problem, however, doesn't just stop at deductibles because insurers also impose additional cost obligations in the form of "coinsurance". This "coinsurance" is a percentage of the cost of a medication that the insured must still pay even after the deductible is satisfied. Information from the Connecticut Health Exchange reports, "coinsurance payments for specialty drugs range nationally from 28 to 50 percent of the price of a drug" and HHS reports that the average coinsurance for specialty mediations specific to rheumatoid arthritis (RA) is "29.6%".

So, in reality, a patient may face the financial weight of a full $2,000 deductible and then the high percentage of cost for a drug through coinsurance. For a specialty medication for RA with a cost of $3,000 per month, the recurring out of pocket cost obligation would be another $888 - monthly.

While this example is illustrative for an individual at $2,000, the number quickly grows even more unmanagable when the larger deductible is taken into a consideration for an entire family. As the Kaiser Family Foundation found, the average deductible burden on a family is "$4,332". The Foundation also noted, "Even more troubling, deductibles—the set amount employees must pay with their own money before insurance kicks in—have increased 67% over the past five years".

The Patient Protection and Affordable Care Act (generally known as the "ACA") provides that the combined deductible and cost sharing amounts have an annual limit on the total out of pocket costs for both individuals and families. Once a person or family has reached these total limits, they do not have to go out of pocket anymore for that plan year (but the deductibles, coinsurance and the ACA out of pocket maximums start again at at the beginning of the next plan year, thus starting the cycle all over again).

The ACA limits are:

Year	Maximum Individual OOP	Maximum Family OOP
2016	$6,850	$13,700
2017	$7,150	$14,300

LB&FC Report on Specialty Tiers

In 2013, the General Assembly’s Legislative Budget and Finance Committee was directed to study speciality tiers “to determine their impact on access and patient care”. On September 24, 2014 the Committee released its report and recommended that the legislature “may wish to consider ‘stop gap’ measures as certain other states have done” relative to out of pocket costs for medications. The LB&FC recommended:

> “…Pennsylvania should consider requirements for annual out-of-pocket limits that include prescriptions drugs in plans that do not already include such limits. As an alternative, it should also consider per prescription out-of-pockct cost sharing limits for certain life sustaining specialty drugs for plans that do not already limit such out-of-pocket costs and require consumers to pay a percentage of the drug’s cost for drug on specialty tiers.”

National Legislative Trend

Currently, about one-quarter of the entire popluation of the United States is already provided some form of limitation on out of pockets costs for needed medications. To this point, the following states provide the following protections to their citizens:

- California – Maximum OOP of $250 with $500 for “bronze” plans.
- Delaware – Maximum OOP of $100 per month per drug with a $200 monthly OOP aggregate for multiple specialty tier medications.
- Louisiana – Maximum OOP of $150 per month per specialty tier medication.
- Maine – Maximum annual OOP of $3,500 for plans that have a separate OOP maximum for prescription drugs.
- Maryland – Maximum OOP of $150 per month per specialty tier medication.

- New York - Specialty drug cost sharing no greater than non-preferred brand tier.

- Vermont - Maximum annual OOP of $1,250 for individuals and $2,500 for families.

Conclusion

Mr. Chairman, again thank you for the opportunity for the Arthritis Foundation to share our comments with the Senate Banking and Insurance Committee as you consider Senate Bill 841. We hope that you and the other members of the Committee will move to pass a bill that is vital to provide access to life-altering innovative medications that are critical to people with arthritis and other chronic diseases.

Appendix 1

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