To: Chairman Greenlick and members of the House Committee on Health Care

Re: Support of HB 2951

The Leukemia & Lymphoma Society greatly appreciates the opportunity to comment on this critical issue facing patients with life-threatening and chronic diseases.

The Challenge

Thanks to innovative new treatments, diseases that were once fatal are now being treated as chronic conditions. But these breakthrough treatments will be out of reach for many patients.

Insurers have used tiered cost-sharing in their drug coverage as a way to encourage patients to try lower-cost medications before turning to more expensive ones. Costlier options would appear on the second or third tier of a health plan's formulary – the list of medications covered by the plan – where the patient cost-share would be a flat co-pay that increased moderately with each tier.

Today, however, it is common for formularies to include a fourth, fifth, or even higher tier, where the cost-share is often a percentage of the actual cost of the medicine, rather than a flat co-pay. Known as coinsurance, this type of cost-sharing can require a patient to pay as much as 50% of a medication's cost.

These higher tiers have come to include a significant number and range of medications, including drugs that have *no* generic or cheaper equivalent. Another emerging trend is for the highest-cost tier to contain *all* the medications available for a certain condition; for patients needing one of these treatments, even a generic option will involve a high cost-share.[1] Making this problem even worse is the growing prevalence of high deductibles. This year, in health plans sold through the state marketplaces, the average combined deductible in bronze plans is $5,249 and, in silver plans, $2,658.[2] Commonly these plans require consumers to meet their full deductible before *any* coverage is provided.[3]

The Patient Impact

- The combined result of these benefit designs: patients must pay high upfront costs in order to access the treatment that offers the greatest potential medical benefit.
- These benefit designs are commonly applied to medications used to treat cancer, HIV/AIDS, arthritis, multiple sclerosis and other debilitating and life-threatening diseases. This creates a financial strain for patients who are already among the most vulnerable.
- For example: imatinib is a medication used to treat chronic myeloid leukemia (CML). Many CML patients must take this medication daily, for the rest of their lives. Given the price for an average monthly supply[4] of imatinib, a cost-share of even just 20% generates an out-of-pocket expense of at least $1,200 per month.

- When cost becomes a barrier to access, patients do not use their medications appropriately, skipping doses in order to save money or abandoning a treatment all together. According to several studies, prescription abandonment rates increase significantly when patient cost-sharing exceeds $100.[5]

The Solution : HB 2951

- Limits should be placed on the out-of-pocket costs that patients can be required to pay for each prescription medication. HB 2951 proposes:
  - In health plans offering platinum, gold, and silver levels of coverage, the patient cost-share for a 30-day supply of a medication should be limited to $100.
- These limits should apply pre-deductible—meaning, these limits should be applied to a patient's out-of-pocket costs regardless of whether the plan deductible has been reached. Otherwise, when patients fill their prescriptions each month, those with higher deductibles are unlikely to experience any improvement in the affordability of their cost-share.
- In addition, based on evidence cited below, we are proposing to amend the bill to include:
  - In plans offering bronze coverage, patient cost-share for a 30-day supply of a medication should be limited to $200.
  - For enrollees that are enrolled in HSA-qualified High Deductible Health Plans, the limit shall take effect only after the minimum deductible is met, as set forth in IRS regulations. For 2015, IRS regulations set the minimum deductible at $1,300 for an individual and $2,600 for a family. Even if a plan has a deductible higher than $1,300/$2,600, the caps still take effect after the minimum deductible is met.

Is This Feasible?

The Leukemia & Lymphoma Society commissioned an analysis of how these proposed changes would impact patient cost-sharing, premiums, and actuarial value[6] (AV) compliance. Using plans available in the 2015 health insurance marketplace, an actuarial firm, Milliman, found that these policy changes would dramatically improve affordability for patients *and* could be implemented with little-to-no impact to premiums and AV compliance. Here is an overview of key findings (the full report has been attached as an additional exhibit):

- **Patient cost-sharing:** Milliman studied claims data for patients taking one of six specialty medications typically used to treat either cancer, HIV/AIDS, or rheumatoid arthritis. Once the above changes were applied, the analysis showed dramatic reductions in patients' total annual costs, ranging from as high as 32% for blood cancer, 42% for rheumatoid arthritis and 55% for HIV/AIDS. These reductions include savings on medicines as well as savings on other benefits and services.

- **Premiums:** For the silver, gold, and platinum coverage levels, a $100 limit would trigger minor increases in premium, ranging from 0.2% to 0.8% only, which could be offset with minor changes in another component of the plan design. For bronze coverage, the analysis indicated that a $200 limit could produce increases of up to 1.6%, but here too the analysis showed that this potential increase could be offset with simple modifications to another component of the plan design.

- **Actuarial value (AV) compliance:** Because these policy changes will have little impact on actuarial value, plans can implement these changes and remain compliant with the AV requirements in the Affordable Care Act.

We urge you to join LLS and other patient advocacy groups to support this critical issue for patients with life-threatening and chronic diseases. Thank you again for your time and consideration of this important issue.

LLS is the world's largest voluntary health agency dedicated to the needs of blood cancer patients. Each year, over 140,000 Americans are newly diagnosed with blood cancers, accounting for nearly 10 percent of all newly diagnosed cancers in the United States. The mission of LLS is to find cures for leukemia, lymphoma, and multiple myeloma and to ensure that blood cancer patients have sustainable access to quality, affordable, coordinated healthcare. LLS funds lifesaving blood cancer research, provides free information and support services, and advocates for public policies that address the needs of patients with blood cancer. Since our founding 65 years ago, LLS has invested nearly $1 billon into research for cures and LLS-funded research has been part of nearly all of the FDA-approved therapies for blood cancer.

Sincerely,

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Attachments: *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations.* Milliman. (2015)

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[1] Jacobs, D.B. and Sommers, B.D. "Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace." *New England Journal of Medicine*. January 2015. 372: P399-P402. Available online at: http://www.nejm.org/doi/full/10.1056/NEJMp1411376

[2] Avalere PlanScape® for 2015, a proprietary analysis of exchange plan features, December 2014. Avalere analyzed data from the FFM Individual Landscape File released November 2014 and the California and New York state exchange websites.

[3] Breakaway Policy Strategies and Robert Wood Johnson Foundation. "Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces." May 2014. Available online at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/05/eight-million-and-counting.html

[4] Imatinib carries a retail price in the $6,000 to $7,500 range for an average monthly supply.

[5] Streeter, S.B., Schwartzberg, L., Husain, N., Johnsrud, M. "Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions." *American Journal of Managed Care*. 2011. 175 (5 Spec No.): SP38-SP44.

[6] Actuarial value of a health plan is an approximate measurement of the portion of total average costs for covered benefits that a plan will cover.