Testimony of The Leukemia & Lymphoma Society and American Cancer Society Cancer Action Network

In <u>support of</u> HB 5146

March 2nd, 2021

The Leukemia & Lymphoma Society (LLS) and the American Cancer Society Cancer Action Network (ACS CAN) are grateful for the opportunity to submit the following testimony to the House Committee on Corporations in support of HB 5146, which would require all health insurance providers offering prescription drug benefits to limit a person's out-of-pocket costs to $100 per prescription for a 30-day supply.

LLS' mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients.

ACS CAN supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

We would like to thank Representative Morales and the cosponsors of this bill for bringing this legislation forward.

Patients Face High Cost-Sharing, Which is a Barrier to Care

Many plans now require an individual to meet their deductible before *any* form of cost-sharing kicks in. Not only does this place an extraordinary financial burden on patients who need access to specialty medications, but rising deductibles coupled with the increasing adoption of coinsurance (where patients pay a percentage of the total cost of a drug, rather than flat-dollar copayments) are making the problem worse every year. In practice, this means that many patients face extraordinary charges at the pharmacy counter for even a single month's supply of a medication.

As coinsurance for prescription drugs becomes more and more common, even savvy patients who do all of their homework to try to find a plan with moderate copays in order to better fit their needs or their condition may find that there are no plans available to meet that need.

It is important to remember that while premiums in the individual market are frequently offset by advance premium tax credits (APTCs), assistance with out-of-pocket costs is far more limited. 80% of exchange enrollees in Rhode Island received APTCs in 2020 (the most recent year for which complete

data is available), while less than half received assistance with cost sharing.[1] No matter what, some patients and consumers in Rhode Island are stuck with plans that expect them to pay thousands of dollars every year, on top of their premiums, before kicking in any benefit for certain prescription drugs.

That's particularly troublesome when evidence shows strongly that cost is a significant barrier to accessing care. One rigorous study showed that when patient cost-sharing exceeds reasonable amounts, prescription abandonment rates increase significantly.[2] A study by IQVIA which examined formulary claims data across a variety of drugs reached similar conclusions, finding that nearly 70% of patients abandoned newly-prescribed drugs if their cost-share was higher than $250, compared to only an 11% abandonment rate when the cost-share was lower than $30.[3] A study published just last month examining patient behavior in Medicare found not only that cost increases as low as $10 were a significant barrier for many patients, but that cost barriers caused adherence levels to drop for *all* categories of drugs – even the most critical, lifesaving medications.[4] Put simply, as cost-share rises, more and more patients are forced to risk their well-being.

With overly burdensome patient cost-sharing being increasingly utilized by insurance plan designs, there is a crucial and timely need for the protections afforded by HB 5146.

Patient Out-of-Pocket Costs Can Feasibly Be Limited

HB 5146 presents a reasonable and straightforward solution for those in Rhode Island who are unduly burdened with increasingly high cost-sharing for prescription medications, by providing clear and uniform limits on how much plans can charge consumers for their prescriptions.

This bill does not seek to eliminate cost sharing, but rather to "smooth" it – allowing patients to predictably manage their monthly prescription costs, rather than face the daunting and often impossible prospect of "maxing out" their deductible *and* annual out-of-pocket limit the first time they fill a prescription every year. It is important to remember that many consumers, in particular patients with chronic and serious conditions such as cancer, take more than one prescription. Many will still likely max out their annual out-of-pocket limit, even with this cap in place.

We recognize and are sensitive to the need to keep premiums stable and to limit premium increases. That is why we have relied on findings from analyses of out-of-pocket prescription caps conducted by the actuarial firm Milliman, Inc. Over two studies, one conducted in 2015[5] and a second in 2017,[6] Milliman's research produced the following highlights:

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[1] "Marketplace Effectuated Enrollment and Financial Assistance." Henry J Kaiser Family Foundation. Available online at: https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-financial-assistance-status-2/ (Accessed March 2 2021)

[2] 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.

[3] Devane, Katie, Katie Harris, and Kevin Kelly. "Patient Affordability Part Two: Implications for Patient Behavior & Therapy Consumption." IQVIA. (May 2018) Available online at: https://www.iqvia.com/locations/united-states/patient-affordability-part-two (Accessed February 11, 2019)

[4] Chandra, Amitabh, Flack, Evan, and Obermeyer, Ziad. "The Health Costs of Cost Sharing." National Bureau of Economic Research. (February 2021) Available online at https://www.nber.org/system/files/working_papers/w28439/w28439.pdf (Accessed March 1 2021)

[5] Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations. March 2015. A report by Milliman, Inc. commissioned by The Leukemia & Lymphoma Society. Available at: http://www.lls.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf

[6] Impact of a $150 Prescription Drug Cost Sharing Cap on Silver Tier Individual Exchange Plans. January 2017. A report by Milliman, Inc. commissioned by The Leukemia & Lymphoma Society. Available at: https://www.lls.org/sites/default/files/National/USA/Pdf/Milliman-Report-on-150-Cap-for-Silver-Exchange-Plan_20170104.pdf

- ***Premiums:*** For silver, gold, and platinum coverage levels, the 2015 study found that a *pre*-deductible limit of $100 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 if the insurer chooses to do so.

- ***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.

- ***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 out-of-pocket copay cap limits were applied, the analysis showed dramatic reductions in patients' total annual out-of-pocket 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, which demonstrates that reducing the cost-share for medications needn't trigger serious negative impacts in other areas of a plan's benefit design.

For these reasons, we urge your support for this vital legislation.

With questions, please contact:

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