CO-INSURANCE & PRESCRIPTION MEDICATION

Virginia Alliance for Medication Access & Affordability

Joint Commission on Health Care
November 2013

The Virginia Alliance for Medication Access and Affordability

- ***"We advocate for an affordable solution that increases access to the medications used to treat people living with genetic disorders, rare diseases and chronic illnesses in order to improve quality of life."***

- Members Include:
  - American Cancer Society - Cancer Action Network
  - Arthritis Foundation Mid Atlantic Region
  - Epilepsy Foundation
  - HealthHIV
  - Hemophilia Association of the Capital Area
  - Lupus Foundation DC/MD/VA Chapter
  - National Multiple Sclerosis Society
  - Medical Society of Virginia
  - National Patient Advocate Foundation
  - Patient Services, Inc.
  - Virginia Hemophilia Foundation
  - Virginia Organizations Responding to AIDS

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What are "specialty-tier" medications?

- "Specialty drugs" are innovative, unique, and typically high-cost drugs that in many cases have no generic or lower-cost alternative.
- Typical cost-sharing tiers for drug formularies:
  - ♦ Tier 1: Generic
  - ♦ Tier 2: Preferred Brand
  - ♦ Tier 3: Non-Preferred Brand
  - ♦ Tier 4: Specialty Drugs
- "Specialty-tiers" utilize potentially unaffordable co-insurance methods.
  - Patients pay a percentage of cost of medication as opposed to fixed co-pay.

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The Issue

- Specialty-tiers need to be addressed because they unfairly discriminate against patients with expensive, chronic conditions.
  - Research indicates that many people stop taking high-cost medications when that cost reaches a certain impact on their personal budget. At that point, they choose not to purchase and then lose the drug's life-saving benefits.
  - "Nearly half of all personal bankruptcies are due in part to medical expense. And research suggests that patients faced with higher cost sharing cut back on both needed and discretionary care.*
  - Action is required on the state level because the ACA did not address the issue of specialty-tiers and the limit on out–of-pocket spending was delayed until 2015.

*Center for Studying Health System Change, "Patient Cost Sharing: How Much is Too Much?" Issue Brief No. 72, December 2003, Sally Trude.

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Patient's Story

- Ms. Becca Rudolph

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VAMAA Virginia Survey Results

- Surveyed Virginians Statewide
  - 279 respondents
    - 71% female, 29% male
    - 94% currently have some type of health insurance
- Income Level of Respondents

Income	Number of Respondents	Percent of Respondents
$0-$24,999	43	16.04
$25,000-$49,999	52	19.40
$50,000-$74,999	44	16.42
$75,000-$99,999	31	11.57
$100,000-$124,999	39	14.55
$125,000-$149,999	20	7.46
$150,000-$174,999	14	5.22
$175,000-$199,999	6	2.24
$200,000 and up	19	7.09

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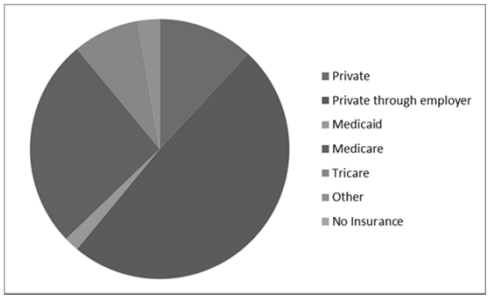
VAMAA Virginia Survey Results

- Type of Health Insurance Held by Respondents



- Paying for Medication
  - 72% have prescription that costs more than $600/month
  - 35% pay a co-insurance
  - 48% currently receive help paying for their specialty tier medication
    - 65% of respondents with income less than $75,000/year receive help paying for medication

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VAMAA Virginia Survey Results

- 31 percent of respondents report that they take two or more specialty-tier medications.
- 35 percent of respondents indicated that they had difficulty paying for their specialty tier medication(s) in the past 12 months.
- The average co-insurance that respondents pay per specialty-tier medication is 29% of the cost of the drug.
  - The highest co-insurance was identified for people with private non-employer based coverage at an average of 38% of the cost of drug.

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VAMAA Virginia Survey Results

- Respondents were asked, "Have you ever done any of the following to save money on your specialty tier medication(s)?"

Skipped pills, injections, or dosages	23.0%
Split pills, injections, or dosages	8.5%
Delayed filling your prescription	25.0%
Delayed starting a new medication	14.0%
Chose to not take a particular brand because it was too expensive, even though you or your doctor felt it was the best medication for your condition	15.0%

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VAMAA Virginia Survey Results

- Respondents were asked, "Have you had difficulty with any of the following due to the cost of your specialty tier medication(s)?

Making mortgage or rent payment on time	12.0%
Purchasing food/groceries	22.5%
Making a car payment	8.0%
Buying clothes or other needed items for self or family	22.5%

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Virginia Survey Results

Access and Notification

- 31% of respondents indicated that they have had to wait to pick up their medication as a result of required prior authorization, pre-certification, or step-therapy.
- Approximately 72 people (36%) indicated that the cost of their medication had been increased by their health insurance company.
  - Of these respondents, 69% reported that they received notice of this change to their formulary less than 59 days before the change went into effect.
    - 39.7% reported that they received notification less than 30 days before the change was made.

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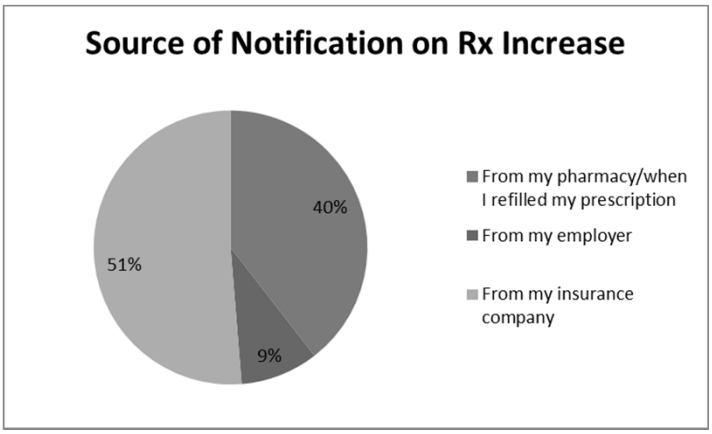
Virginia Survey Results



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Legislation Across the Country

State	Legislation	Year
Arkansas	Requires 60 day notice before changes to enrollee "financial responsibility" as a result of modification of drug formulary.	2013
Delaware	Limits monthly cost sharing for specialty tier drugs to $150/prescription	2013
New Mexico	Limits changes to Rx drug coverage for Rx drugs to every 120 days with 60 day notice; requires plans provide plain language explanation of drug formularies.	2013
Oklahoma	Requires 60 day notice before removing drug from formulary.	2013
Maine	Health plan covering prescription drugs may not require cost sharing, deductibles or coinsurance obligations for prescription drugs that exceed the dollar amount for nonpreferred brand drugs or for brand drugs if there is no nonpreferred brand drug category; $3500 out-of-pocket limit for prescription medication.	2012
Vermont	Establishes an annual out-of-pocket limit for prescription drugs at $2,000/individual and $4,000/family for employer sponsored health plans.	2012
Louisiana	Requires plans to provide enrollees with plain language explanations of drug formularies; permits enrollees to continue using a medication until contract ends if it is removed from formulary; prohibits plans from making modifications during plan year.	2011
New York	Prohibits use of high co-insurance tier for specialty drugs.	2010
Texas	Requires plans to provide enrollees with plain language explanations of drug formularies; permits enrollees to continue using a medication until contract ends if it is removed from formulary. Extended to large employers and individuals in 2011.	1999

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Previous Legislation

- HJ 579 in 2009
  - Introduced by Delegate O'Bannon
  - Michele Chesser's JCHC presentation in September 2012
- SB 947 in 2013
  - Introduced by Senator Puller
  - Incorporated into SB 945
- SB 945 / HB 2030 in 2013
  - Introduced by Senator Puller and Delegate Peace
  - Passed Senate; tabled in house
  - Led to further study by JCHC and stakeholders

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Policy Options

- Policy Option 1: Introduce legislation to require that health insurance plans can only move a drug to a higher tier at the beginning of the plan year.
- Policy Option 2: Introduce legislation to require health insurance Plans to provide a 60-day notice to the insured when a drug is moved from one tier to another.
- Policy Option 3: Introduce legislation to require health insurance plans to cap the out-of-pocket co-pay for each specialty tier drug to no more than $150 per prescription.

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