Medical Society of the District of Columbia

Testimony Before

The Committee on Business, Consumer, and Regulatory Affairs

On The

Specialty Drug Copayment Limitation Act of 2015

Bill 21- 0032

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Member, MSDC Board of Directors

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The Specialty Drug Copayment Limitation Act of 2015

B21-0032

Chairman Orange, members of the Committee, good afternoon. My name is Dr. Angus Worthing and I am testifying today as a member of the Board of Directors of the Medical Society of the District of Columbia and on behalf of our 2,800 members. I am a resident of Ward 3 and have practiced medicine in the District of Columbia since 2003. In addition to my rheumatology practice in downtown DC, I am a Clinical Assistant Professor of Medicine at Georgetown University Medical School. On behalf of the entire medical community and the thousands of patients whom District physicians treat each day, I thank you for holding today's hearing and for considering the remarks that follow.

The Medical Society strongly supports the Specialty Drug Copayment Limitation Act of 2015 and commends Councilmembers Cheh and Bonds for its introduction. When the Medical Society looks at proposed legislation, we always ask one question first, "Is it good for patients?" In this case, the answer is most certainly "yes"!

We are here today to address a very serious, and increasingly widespread, barrier to care- one that did not exist a few years ago. We all understand that the purpose of insurance is to insure- to spread risk, and health insurance has been designed to do exactly that, and for the most part it does a reasonable job. Unfortunately though, for patients who have health conditions that are best or solely treated by high-cost prescription drugs, they are frequently poorly served by their insurance.

Until a few years ago, health insurance provided coverage for prescription drugs, with patients being responsible for their copays. Those copays frequently vary from zero to $50. Insurers generally distinguish between generic, branded, and off-formulary drugs. For most patients, these costs have been manageable and not created barriers to care.

However, in recent years, break-through drugs have come to market, and while they are often quite expensive, the relief or cure they provide to patients is priceless. Health insurers have responded to these developments by creating one or more new tiers of coverage that use coinsurance rather than fixed copays to cover prescription drug costs. The monthly coinsurance that the patient may be required to pay can be in the hundreds or thousands of dollars. Steering patients to lower cost drugs that are equally or comparably efficacious is one thing; creating high-cost financial barriers to deprive patients of needed treatment is another. It is not what individuals or employers believe they are purchasing when they pay insurance premiums. The legislation before the Committee will address this by eliminating coinsurance for prescription drugs and capping the amount of copays to a reasonable, and in most cases, affordable amount. The result will be that patients will have access to needed therapeutic drugs across all diseases.

As a physician, I cannot begin to tell you how frustrating it is to see a patient with a painful autoimmune disease like rheumatoid arthritis, or HIV/AIDS or cancer, be unable to treat their disease as a result of high-cost coinsurance. One in six people with rheumatoid arthritis reduce their medication due to cost. Also, when patients with rheumatoid arthritis stop

taking a specialty medicine and then restart it, their immune systems can react to the medication and neutralize it or cause an allergic reaction – the same way that a person's first bee sting may be harmless, but a subsequent one can cause an allergic reaction. For this and other reasons, in the long run, there is science that supports the belief that patients in compliance with their drug therapy are in fact less expensive to treat over time, than patients who are unable to continue their drug regimen.

The entire country is grappling with the high cost of health care, but we cannot throw our patients under the bus in the name of "cost containment". The pendulum has swung too far in putting the burden on insureds. The neighboring jurisdictions of Maryland, Delaware and Virginia have all recognized this problem. Maryland and Delaware have passed legislation to limit patient responsibility for prescription drug costs, and the Virginia General Assembly is currently addressing this issue with the anticipation that copay limits will pass in the 2016 session. We may be three separate jurisdictions, but we are one insurance market, and this legislation seeks nothing more than to expand those protections to District residents. Just last Friday, I saw a rheumatoid arthritis patient who resides in Maryland and feared she would owe hundreds of dollars per month for her new specialty medication. When I told her about Maryland's law, her face changed from fear and frustration to a smile of relief.

We all share the goal of *doing right by patients* - no one more so than the 10,000 physicians licensed in the District of Columbia. The best way we can show that is passage of the Specialty Drug Copayment Limitation Act of 2015. As a physician it is a privilege to be here today and be able to

advocate on behalf of my patients and the thousands of individuals likewise situated. I look forward to your questions. Thank you.