

# Support B21-0032: Specialty Copay Limitation Act of 2015

## Protect Access to Medications

Leading patient advocates support this issue:



**B21-0032 will increase access to prescription medication by ensuring that the required copayment or coinsurance applicable to prescription medication does not exceed \$150 per month for a 30 day supply.**

### High Out-of-Pocket Costs are a Problem for DC Patients

Insurers are increasingly shifting cost-sharing for prescription medications onto patients, by requiring patients to pay a percentage of the total cost of their drugs, rather than manageable and fixed copays. This can result in hundreds or even thousands of dollars per month in additional out-of-pocket costs for even a single medication and can be discriminatory to patients living with chronic or life-threatening conditions.

- Although any DC patient might be affected by high co-insurance, those patients most affected will likely include those living with chronic illnesses such as rheumatoid arthritis, hemophilia, multiple sclerosis and those with life-threatening conditions such as HIV, breast cancer, colorectal cancer and leukemia.
- Drugs for these conditions are typically new and not available as less expensive generic prescription drugs, so patients often have no choice but to take the brand name medication prescribed to them.
- The high cost of co-insurance required for many medications may be difficult for a family to absorb, often leaving no option but to cut back on a prescription's use or stop taking it altogether. Non-adherence to medication regimens not only have a direct impact on health and disease progression - it contributes direct annual costs of \$100 billion to the US health care system. Indirect costs exceed \$1.5 billion annually in lost patient earnings and \$50 billion in lost productivity.<sup>1</sup>

### The ACA Doesn't Fix the Issue

- Despite the protections in the ACA, consumers are still exposed to significant cost-sharing. **While the ACA establishes a maximum annual limit on out-of-pocket spending, spending for individual services and drugs is not capped.** This means that at the point of sale or service, consumers can be faced with substantial out-of-pocket expenses in the form of deductibles, co-pays, and co-insurance.
- Additionally, not all utilization applies towards the annual out-of-pocket maximum. Out-of-network providers, services and drugs that are not covered, and non-essential health benefit services do not need to count towards the annual out-of-pocket maximum.

### Neighboring States Have Taken Action

- **Maryland, Delaware and Louisiana** have passed a \$150 per month cap on prescription medications in a specialty-tier.
- **Virginia** has passed legislation requiring an insurance company to provide a patient with 30-days notice if their prescription medication is being moved to a higher cost tier. Legislation has also been introduced in **Virginia** limiting out-of-pocket costs for prescription medications to \$100 per month.

### The Solution

**Support B21-0032 and ensure that DC Patients have access to the medication they need.**  
**For more info, contact: Kelly Fitzgerald; [kfitzgerald@unneedpsi.org](mailto:kfitzgerald@unneedpsi.org) or visit <http://www.msdc.org/copay>**

<sup>1</sup> Goldman D.P., et al. (2004). Pharmacy benefits and the use of drugs by the chronically ill. JAMA., 291(19): 2344-2350

# The Washington Post

## Protect Access to Medications

By Dr. Angus Worthing  
June 5, 2015

This spring, a patient with rheumatoid arthritis called me in tears because she could no longer afford her medication. The drug was an expensive specialty medication, and her insurance co-payment had risen to \$2,000 per month. Her joints had felt fine for several years while taking the drug, and she rightly worried that her arthritis would return if the drug were stopped. "I don't want to become disabled!" she pleaded.

Every doctor in the District has been in a situation like this. Even in the high-rent areas of Chevy Chase and K Street, where my offices are located, patients struggle. As a rheumatologist, I treat autoimmune diseases and regularly prescribe specialty medicines that can help people recover from debilitating joint pain so they can return to work, care for their families, avoid disability and live longer.

Watching my patients regain health is extremely gratifying; however, every day, patients tell me they cannot afford their medicines. The most frustrating part of this is the increasingly common way patients are forced to share the high cost of a specialty prescription with their health insurance company — \$10 or \$20 co-pays for a drug have morphed into co-insurance with the patient paying a percentage of the cost of each prescription. That's intended to turn people toward generic and other less-expensive medicines. But sometimes a specialty drug is the only one that works.

A person with rheumatoid arthritis may be required to pay 20 percent to 50 percent of the total cost of medication.

This can range from hundreds to thousands of dollars per month. The patient I mentioned had to consider cheaper alternatives that aren't as effective.

After years of gnashing my teeth at this situation, I was able to offer my patients hope: D.C. Council members Mary Cheh (D-Ward 3) and Anita Bonds (D-At Large) have introduced a bill to limit specialty drug co-payments in the District. Similar bills have passed in Maryland and Delaware and are under review in Virginia and at the federal level. These bills limit what insurance companies are allowed to charge patients for specialty medicines. This strategy enjoys popular support among doctors and patients.

A recent national study of the co-payment problem showed that if insurance companies were to distribute specialty drug costs more fairly, individual premiums would increase only \$3 per year. This distribution of financial risk is the purpose of insurance. I understand that health-care economists suggest that co-payments can be helpful to offset the so-called "moral hazard" of free care. From this perspective, health insurance beneficiaries might pursue too much treatment if the care is free, thereby increasing costs for everyone. However, it is clear to me, as an employer who purchases health insurance and as a physician, that the system has gone too far. While insurance companies and the pharmaceutical industry debate costs, the burden should not be foisted onto people suffering from painful chronic conditions such as arthritis.

That is why capping co-payments is needed.

Unfortunately, introducing the bill appears to be the easy part. The Specialty Drug Co-payment Limitation Act of 2015 awaits a hearing in committee.

Our neighbors in Maryland and Delaware recently gained legal protection from high specialty drug co-payments. D.C. residents urgently require the same. Members of the D.C. Council's Committee on Business, Consumer and Regulatory Affairs can help make the District a place where people can obtain the life-changing medications they need.

*The writer, a rheumatologist, is chair of the Public Policy Education Committee of the Rheumatism Society of the District of Columbia.*

[http://www.washingtonpost.com/opinions/protect-access-to-medications/2015/06/05/29925502-fd9f-11e4-833c-a2de05b6b2a4\\_story.html](http://www.washingtonpost.com/opinions/protect-access-to-medications/2015/06/05/29925502-fd9f-11e4-833c-a2de05b6b2a4_story.html)