Recommendations for Ensuring Access to Prescription Medications

The emergence of innovative new treatments has changed the landscape of illness. Many once-fatal or disabling diseases are now manageable chronic conditions, while others have greatly increased life-expectancy and quality of life. But today, under many health insurance plans, patients living with chronic and life-threatening diseases must pay thousands of dollars in out-of-pocket costs to access the treatments prescribed to them. This is true for medications used to treat cancer, HIV/AIDS, arthritis, multiple sclerosis and other debilitating and life-threatening diseases. This access barrier is made only worse by a lack of clear and accessible information made available to patients when they are purchasing and/or utilizing their health insurance coverage.

In short, when plan transparency and cost-sharing become barriers to access, patients find themselves facing difficult decisions about whether to take medically-necessary treatments or to risk the family's financial stability.

As members of the patient advocacy community throughout the state, we strongly support efforts to increase access to medication for Oregonians. We urge the Oregon Prescription Pricing and Cost Workgroup to take steps to:

1. Address insurmountable deductibles

It's not uncommon for high deductibles to prevent patients from accessing medications, especially in the early months of the plan year. This could be mitigated in a number ways:

- Requiring first-dollar coverage for medications;
- Limiting combined medical/pharmacy deductibles; and/or
- Limiting the size of the pharmacy deductible.

Ideally, an insurer would be obligated to meet these criteria in at least **25% of the plans** it offers within each metal tier.

2. Address the coinsurance barrier

According to several studies, prescription abandonment rates increase when patient cost-sharing exceeds $100 for a 30-day supply of a prescription medication. [1] Yet coinsurances for specialty tier medications can reach into the thousands of dollars for a 30-day supply. This barrier can be addressed by requiring insurers to:

- Offer at least some plans that apply an all-copayment structure to medications—that is, formularies that do not apply coinsurance to any medication, including for off-formulary drugs that are accessed through an exceptions request, and
- Limit the maximum copay for any single medication to a moderate amount such that patients are able to adhere to prescribed treatment regimens.

Ideally, an insurer would be obligated to abide by the above requirements in at least **25% of the plans** it offers within each metal tier.

3. Address adverse tiering

Higher drug tiers sometimes include a significant number and range of medications, including drugs that have no generic or cheaper equivalent. Referred to as "adverse tiering", this trend in formulary design can create serious barriers to care, which policymakers could address by expressly prohibiting health plans from clustering all

[1] 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

drugs to treat a single disease on the highest cost-sharing tier of a formulary. At a minimum, steps should be made to identify potentially discriminatory benefit design elements when certifying plans, as required by current federal rules.

4. Address plan transparency

To be able to make informed decisions when purchasing and using their health insurance coverage, consumers must have access to clear and comprehensive plan information, including the following as it relates to drug formularies:

- Estimates of real out-of-pocket costs for prescription drugs, including those that involve coinsurance,
- Information about how to request coverage for a drug that is either off-formulary or removed from the formulary mid-year, and
- Annual notification to current enrollees (prior to open enrollment) if their treatments are no longer on-formulary and doctors are no longer in-network.

We, the undersigned organizations, urge you to consider the above recommendations as you evaluate policy concepts that are proposed to the Oregon Prescription Pricing and Cost Workgroup.

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