

May 19, 2017  
The Hon. Stephen Sweeney  
President  
New Jersey Senate  
via Electronic Mail

Dear Senate President Sweeney:

**We at the Immune Deficiency Foundation respectfully request that S.814, sponsored by Senator Loretta Weinberg, be posted for a vote by the full Senate.** By limiting cost-sharing for prescription medications, this bill will make a real impact in helping patients with primary immunodeficiencies access the treatment prescribed by their doctor.

Founded in 1980, the Immune Deficiency Foundation (IDF) has been dedicated to improving the diagnosis, treatment and quality of life of persons with primary immunodeficiencies (PI) through advocacy, education and research. People with a PI are born with part or all of the body's immune system missing or functioning improperly which leads to an increased vulnerability to infections that can be recurrent, unusually severe, or won't clear up. Fortunately, for many of our patients there is a treatment that when taken for the **rest of their lives**, they can live normal, healthy and productive lives. The only viable treatment option available to many patients with PI, is the infusion of immunoglobulin (Ig), a blood plasma product that helps prevent frequent and/or severe infections. Ig replacement therapy is lifesaving and requires life-long infusions. It is also expensive, costing on average of \$7,500 to \$10,000 per month.

Health plans are structuring their pricing using a specialty tier co-insurance model that, in many cases, forces patients to pay 20 to 50 percent or more of the cost of treatment instead of a fixed co-pay. In recent years, there has been a steady increase in the use of this co-insurance cost-shifting to sick patients who require expensive specialty drugs. Making this problem even worse is the growing prevalence of high deductibles: in 2017 silver plans, the average combined deductible is more than \$3,700.<sup>i</sup> Often these plans require consumers to meet their full deductible before *any* coverage is provided.<sup>ii</sup>

**The financial burden on patients and families increases the likelihood that many patients will forego care.** In fact, according to IDF's 2014 Health Insurance Survey of patients with PI, approximately one-third (1/3) of patients reported that they had skipped treatments because they could not afford the out-of-pocket costs required by payers.<sup>iii</sup> They literally put their lives at risk because they couldn't afford the high cost of their treatment. According to several studies, prescription abandonment rates increase significantly when patient cost-sharing exceeds \$100.<sup>iv</sup> These burdensome cost-sharing designs have been very common in health plans sold on New Jersey's health insurance exchange. In fact, use of co-insurance in silver plans was more significant in New Jersey than in any other state: 59% of silver plans in New Jersey require patients to pay a co-insurance of more than 40% for drugs in 22 different classes.<sup>v</sup>

Patients who forego treatment create significantly more costs to the healthcare system than if they had received their original treatment. Non-adherence to medication regimens not only has a direct impact on health and disease progression – it contributes direct annual costs of an additional \$100 billion to the US healthcare system. Indirect costs exceed \$1.5 billion annually in lost patient earnings and \$50 billion in lost productivity. Many medicines used to treat chronic diseases are breakthrough treatments

that often prevent disability, save and improve lives, and allow patients to function and remain in the workforce. Unfortunately, certain insurer practices threaten to put medications financially out of reach for many New Jersey residents as they shift astonishing costs to consumers. These practices go against the basic premise of insurance and are causing commercially insured patients to underutilize treatments or go without their treatments entirely.

### **The Solution: S.814**

This legislation will place limits on the out-of-pocket costs that patients can be required to pay for each prescription medication:

- In health plans offering platinum, gold, and silver levels of coverage, the patient cost-share for a 30-day supply of a medication should be limited to \$100.
- In plans offering bronze coverage, this amount should be limited to \$200.

These limits apply pre-deductible—meaning, these limits should be applied to a patient's out-of-pocket costs regardless of whether the plan deductible has been reached. Otherwise, when patients fill their prescriptions each month, those with higher deductibles are unlikely to experience any improvement in the affordability of their cost-share.

### **Feasibility**

An analysis of plans available in the 2015 health insurance marketplace by Milliman, an actuarial firm, found that these policy changes would dramatically improve affordability for patients *and* could be implemented with little-to-no impact to premiums and Actuarial Value (AV) compliance.<sup>vi</sup> Here is an overview of key findings:

- **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 the above changes were applied, the analysis showed dramatic reductions in patients' total annual 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.
- **Premiums:** For the silver, gold, and platinum coverage levels, a \$100 limit 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. For bronze coverage, the analysis indicated that a \$200 limit could produce increases of up to 1.6%, but here too the analysis showed that this potential increase could be offset with simple modifications to another component of the plan design.
- **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.

IDF respectfully urges the Senate to vote on S.814 and support patients reliant on high cost medications by giving them an option for insurance that they can afford and that meets their medical needs.

Respectfully submitted,



Lynn H. Albizo  
Director of Public Policy

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<sup>i</sup> Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2016. Avalere analyzed data from the FFE Individual Landscape File released October 2016 and the California and New York state exchange websites.

<sup>ii</sup> Breakaway Policy Strategies and Robert Wood Johnson Foundation. "Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces." May 2014.

<sup>iii</sup> Immune Deficiency Foundation, (2014) National Health Insurance Survey. Unpublished data

<sup>iv</sup> 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.

<sup>v</sup> Avalere PlanScape® a proprietary analysis of exchange plan features, April 2016. Sample includes all Silver plans offered in 50 states and the District of Columbia.

<sup>vi</sup> Milliman, Inc. Pharmacy Cost Sharing Limits For Individual Exchange Benefit Plans: Actuarial Considerations. March 2015.