

January 27, 2010

The Alliance for Plasma Therapies Chair announced last Thursday, that Nebraska State Senator Abbie Cornett introduced two bills that will help to ensure that patients with life threatening and chronic health conditions receive the therapies/prescriptions that their physicians' prescribe without shifting the burden of the cost of the therapy to the patient.

LB1017 prevents insurance companies from establishing specialty tiers to cover biologics, plasma-derived therapies and their recombinants, and other expensive therapies. This practice causes patients from paying copays for therapies to coinsurance which can be from 10% to 50% of the cost of the therapy. Most patients cannot afford to pay for these costs leaving them without their lifesaving therapies. (Full text below)

LB1088 – Physician and Patient Prescription Protection Act which requires that if a physician's prescription is to be filled with a different brand, that a written communication be sent to the physician and patient notifying the change in prescription and reasons why. For many patients, who are on certain brands, substituting the product can be life-threatening and in many cases, the physician and patient are not consulted prior to the switch. This legislation will prevent the practice of switch without notification and ensure the safety of the patient. (Full text below)

Thank you, Senator Cornett for introducing these bills.

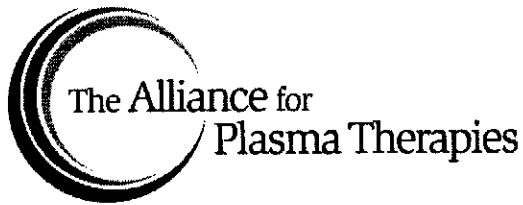
Now comes the hard work and the entire community needs to come together immediately. Senator Cornett's office has informed us that a hearing will be held within a month on both of these bills. We have the perfect opportunity to send a message to the insurance companies that the practice of specialty tiers is unacceptable and charging coinsurance for expensive lifesaving therapies for biologics, chemotherapy, IVIG, factor products, etc is illegal. It is just as important to ensure that when a physician prescribes a specific brand for a patient that it isn't switched without notification because of the potential consequences that may occur.

The following needs to occur immediately to have a successful outcome in Nebraska:

1. Need participation of as many patients/providers for a press conference in Lincoln, NE
2. Need patients who have been impacted by specialty tiers, coinsurance, and prescriptions switched without notification that caused negative outcome who would be willing to testify and/or be interviewed by the media.
3. Need providers who have patients that have stopped receiving therapies due to specialty tiers/coinsurance who would be willing to testify and/or be interviewed by the media
4. Need providers who have had their prescriptions switched without notification that caused negative outcomes for their patients who would be willing to testify and/or be interviewed by the media.

The hearing is scheduled for Tuesday, February 16th at 1:30pm. We will be holding a press conference that morning.

Please contact Michelle Vogel, Executive Director, as soon as possible of your interest in participating. You can reach her at 202-329-8643 or mvogel@plasmaalliance.org.



LB 1017: An Act to Reform Insurance Prescription Fee Practices

BACKGROUND

As medical costs escalate in Nebraska and throughout the nation, insurance companies have created a new cost-sharing mechanism known as prescription drug specialty tiers. Most plans have a three-tier structure of fixed-cost benefits to subscribers based upon whether a drug is generic (Tier 1); brand-name preferred (Tier 2); or brand-name non-preferred (Tier 3). Some insurers also have added a fourth tier for specialized drugs for serious disorders.

Health plans require subscribers to pay a specific amount out-of-pocket — a co-pay — for prescriptions in each tier, with Tier 1 being the least expensive and Tier 3 the most. In the past, co-pays were priced to encourage patients to discuss the benefits of the more specialized medicines with their physicians. In recent years, however, insurers have raised co-pays to the point that patients are forced to “play physician” and decide whether to pay the higher fees or opt for less expensive alternatives that may or may not be as effective and that may impose increased side effects or safety risks.

For subscribers with such serious conditions as cancer, hemophilia, HIV/AIDS, multiple sclerosis, myositis, neuropathy, primary immune deficiency diseases, and rheumatoid arthritis who require new or highly specialized medications, the consequences are more dire. There are no alternatives for the medications they require. Often they must pay a high percentage of drug costs, which can amount to hundreds to thousands of dollars out-of-pocket per prescription each month.

Insurance is a means by which health risk is spread across a pool of payers. Yet when a serious illness strikes, subscribers often are singled out for much higher co-pays and other out-of-pocket costs. This negates the very reason they had been paying for insurance in the first place — to be protected from financial hardship should they become ill.

FACTS

- From 2000 to 2008, average co-pays for Tier 2 medicines more than tripled, from \$15 to \$46, while average Tier 3 co-pays rose from \$29 to \$46. Moreover, in just four years — from 2004 to 2008 — the average co-pays for specialized Tier 4 drugs increased from \$59 to \$75.
- Due to high co-payments and/or coinsurance, patients pay 100 percent of the full cost of 24 percent of all prescriptions filled in Nebraska, and 75 percent of the full cost of 32 percent of all filled prescriptions in the state.
- For the top 100 prescription drugs, Nebraska ranks above the national average in the percentage of time the co-pays reach 75 percent and 100 percent of the total drug costs. For 75 percent, it's 32 percent in Nebraska versus 26 percent nationally; for 100 percent it's 24 percent versus 19 percent nationally.

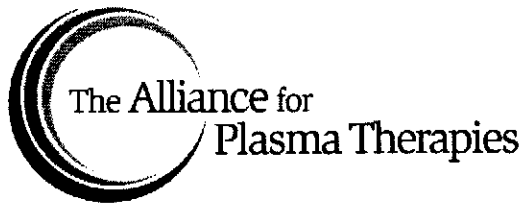
- Co-pays for prescriptions have risen at a much higher rate than the price of pharmaceuticals. Between 2000 and 2008, the drug prices went up by 3.6 percent annually, while co-pays insurers charge for preferred brand-name drugs rose by 7.1 percent. The cumulative impact to patients over this period is a 73 percent increase in co-pays—more than twice the cumulative annual CPI increase for all prescription drugs—for the preferred, branded medicines their doctors prescribed.
- Higher co-pays, co-insurance, and outright denial of prescription medications are forcing more and more people to stop filling needed prescriptions. When this occurs, the actual costs to patients and society can be far greater in terms of decreased quality of life, increased physician and hospital visits, and lost workplace productivity.
 - A recent study by Prime Therapeutics found that multiple sclerosis (MS) patients with an out-of-pocket expense greater than \$250 were seven times more likely to decline to fill their prescription than patients with an out-of-pocket cost of \$100 or less.
 - A report released in April 2009 by Wolters Kluwer Health indicates that U.S. patients overall failed to fill 6.8 percent of their branded medications in 2008, a 34 percent increase from 2006. The report found that co-pays of \$100 or more resulted in a non-fill rate of 20 percent, while co-pays of \$10 or less carried a non-fill rate of just 4 percent.
 - According to the *Wall Street Journal*, Wolters Kluwer Health reported that health plans denied nearly 11 percent of brand-name prescriptions in the fourth quarter of 2008, a 21 percent increase from the first quarter in 2007.
- Patients who depend on such lifesaving, infusible therapies as biologics, plasma-derived therapies and their recombinants, interferon, etc., face even more hurdles. These therapies are moved from their health plans major medical benefits to specialty tiers with out-of-pocket costs that can range from 10-50 percent of the cost of the therapy. On average, the plans charge 35 percent of costs under Tier 4, and Tier 5 plans threaten to cost patients on chemotherapy, factor products, immune globulin therapy, immune suppressants, interferon, and many other therapies, far more. The cost to the patient can be thousands of dollars per day—a price few can afford.

SOLUTION

LB1017 ensures that every insured Nebraskan has access to reasonable prescription drug benefits by requiring that all health plans delivered or renewed on or after Jan. 1, 2011, meet the following criteria.

- Insurers cannot create specialty tiers that require payment of a percentage of prescription costs.
- Insurers cannot charge prescription drug co-pays that exceed the cost of that prescription to the health care plan, nor can they charge a co-pay that exceeds by 500 percent the lowest prescription drug co-pay in the plan.
- If a health plan includes a limit for out-of-pocket expenses for benefits other than prescription drugs, the insurer must include a provision that would result in the lowest out-of-pocket prescription drug cost to the subscriber. Either out-of-pocket expenses for prescription drugs would be included under the plan's total limit for out-of-pocket expenses or prescription drugs could not exceed \$1,000 per individual or \$2,000 per family for the contract year.

Contact: Michelle Vogel, Executive Director, 202-329-8643, or mvogel@plasmaalliance.org.



LB 1088: Physician and Patient Prescription Protection Act

BACKGROUND

In Nebraska and throughout the nation, it has become increasingly difficult for patients to obtain the medications their physicians prescribe. From the pharmacy window to infusion centers, insurance companies impose barriers to filling doctor-intended medical orders. Many insurers have taken steps to encourage physicians and patients to switch prescriptions based solely on cost considerations. Patients are being forced to switch to drugs that are similar to, but not the therapeutic equivalent of, the prescriptions that their doctors ordered. In many cases patients and physicians are not told that the substitution has taken place, thereby placing patients' lives in jeopardy. Known as therapeutic substitution, this practice takes patients off medicines that work well for them and switches them to different medications with different active ingredients that are less expensive, but not necessarily as effective or safe.

Here's how therapeutic substitution occurs. Insurers define one or more medicines considered to be "therapeutically equivalent" to others. They then identify patients taking a specific medication and communicate to physicians, pressuring them to switch these patients to other medications. More disturbingly, they also send letters directly to patients encouraging them to reject the medicines that their doctors prescribed. Often the letters are simply a one-line statement telling them that coverage of the preferred medication has been rejected, but that another drug is available. When it comes to specialty infusible therapies such as biologics, plasma-derived therapies and their recombinants, interferon, etc., patients are often switched to different brands when being infused without any prior notification. Physicians may learn about such medicine rejections and switches when the patients arrive in their offices in medical distress or when a patient has a severe reaction during an infusion. This practice not only undermines the physician-patient relationship, it can harm patients' health by ignoring important differences between medicines, reducing adherence to treatment and leading to dose confusion. From a public health perspective, therapeutic switching is counterproductive because the drugs originally prescribed can help prevent more expensive and complicated conditions down the road.

FACTS

- Cost-driven prescription switching affects individuals and the entire health care system. The short-term savings of switching to a less expensive medication often is offset by increases in physician and emergency room visits, and long-term health consequences for patients.
- Cost-switching affects physicians as well. According to a national survey conducted by Weill Cornell Medical College and published in *Health Affairs* in May 2009, physicians on average spend the equivalent of three work weeks annually on administrative tasks required by health plans. The total cost to U.S. physicians in lost time and earnings is \$31 billion annually and accounts for nearly 7 percent of all U.S. expenditures for physician and clinical services.

- Cost-switching fails to factor in that physicians do consider less expensive options when prescribing medications. In fact, the U.S. has the largest worldwide market for generics. More than half of all prescriptions filled are generics and the generic drug share of the market has risen from 19 percent in 1984—when the Waxman-Hatch Act that promoted generic drug competition passed—to 64 percent in 2008.
- Insurers in some states use financial incentives to encourage physicians to switch patients from preferred medications to less expensive alternatives. For example, Blue Care Network of Michigan, an HMO affiliate of Blue Cross/Blue Shield, offered physicians \$100 per patient to switch patients on branded cholesterol-lowering medications to generic alternatives.
- Insurers in some states use incentives to encourage pharmacies to urge customers to switch medications. For example, Humana developed a Pay for Performance program designed to reward pharmacies to increase their generic dispense rate (GDR). Pharmacies that increased their GDR to targeted levels established by Humana received bonus payments based on the amount of medications switched.
- Numerous organizations in Nebraska and nationwide have come out against therapeutic switching. Among them are the American Medical Association, American Osteopathic Association, Academy of Neurology, Alliance for Plasma Therapies, National Alliance on Mental Illness, Mental Health America, Hemophilia Federation of America, and many others.

SOLUTION

LB1088 would ensure that insurers and pharmacy benefits managers (PBMs) send notifications of request for medication changes to patients and their physicians or other prescribing health professionals whenever the insurer or PBM recommends changing a patient's medication to a different therapeutic agent. Among other things, this notification will:

- Acknowledge that no medication change will be allowed without the authorization of the original prescribing health care professional.
- Clearly identify the originally prescribed medication and the medication to which the patient would be changed.
- Describe any financial incentives that may be provided or offered to the prescribing health care professional by the insurer or the PBM.
- Describe any financial incentives that a health insurer or PBM may receive to encourage a medicine exchange.
- Explain any cost-sharing changes for which the patient would be responsible should the medication change take place.
- State that the insured has the right to discuss the propose medication change before it occurs.

Importantly, LB1088 will return the dialogue about prescription drug benefits and risks to the patient examining room where it belongs. Physicians, rather than insurers, know best the treatments that will or won't work for their patients. Factoring in the patient's medical history and current condition, physicians can help patients make informed decisions about prescription drug costs, quality and health benefits.

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