HOUSE BILL REPORT
HB 2871

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to the creation of a task force on high patient out-of-pocket costs.

Brief Description: Creating a task force on high patient out-of-pocket costs.

Sponsors: Representatives Cody, Harris, Schmick, Tharinger, Kagi, Ortiz-Self and Ormsby.

Brief History:
Committee Activity:
Health Care & Wellness: 2/2/16, 2/5/16 [DPS].

Brief Summary of Substitute Bill

- Creates the task force on high patient out-of-pocket costs.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Rodne, Short, Tharinger and Van De Wege.

Staff: Ariele Landstrom (786-7190).

Background:

Generally, out-of-pocket health care costs are what a patient is responsible to pay for health care. A deductible is the amount the patient pays before the patient's health insurance begins to pay the costs associated with treatment or prescriptions. A copay is a fixed amount that a patient pays for a health care service or prescription.

Health carriers are required to provide to enrollees, upon request, a listing of covered benefits, including prescription drug benefits, if any, a copy of the current formulary, if any is used, definitions of terms such as generic versus brand name, and policies regarding

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coverage of drugs, such as how they become approved or taken off the formulary, and how consumers may be involved in decisions about benefits.

Summary of Substitute Bill:

The task force on high patient out-of-pocket costs is created. The Department of Health must convene the task force by July 1, 2016. The task force must include representatives from all participants with a role in determining prescription drug costs and out-of-pocket costs for patients, such as, but not limited to, the following:

- patient groups;
- insurance carriers operating in Washington state;
- pharmaceutical companies;
- pharmacy benefit managers;
- specialty pharmacists;
- prescribers;
- hospitals;
- the office of the insurance commissioner;
- the health care authority;
- the office of financial management;
- business interest groups;
- unions; and
- biotechnology.

The task force must evaluate factors contributing to the high out-of-pocket costs for patients, particularly in the first quarter of the year, including, but not limited to prescription drug cost trends and plan benefit design.

The task force must consider patient treatment adherence and the impacts on chronic illness and acute disease. The discussion must also consider the impact when patients cannot maintain access to their prescription drugs and the implications of adverse health impacts, including the potential need for more expensive medical interventions or hospitalizations and the impact on the workforce with the loss of productivity. The discussion must also consider the impact of the factors on affordability of health care coverage.

The task force recommendations, or a summary of the discussions, must be provided to the appropriate committees of the Legislature by December 1, 2016.

Substitute Bill Compared to Original Bill:

The substitute bill:

- specifies that insurance carriers on the task force must operate in Washington state;
- adds pharmacy benefit managers, specialty pharmacists, and business interest groups as required members of the task force;
- removes language regarding factors contributing to the out-of-pocket costs for patients to be reviewed by the task force; and

- requires the task force to consider the impact of the factors contributing to the out-of-pocket costs for patients on affordability of health care coverage.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) There is no solution for high out-of-pocket-costs currently from the patient perspective. This is something that needs to move forward. Some new medications for certain conditions are game-changers. Out-of-pocket costs have increasingly impacted access to these treatments and can be a deterrent to getting on to some of these medications, and also adherence and outcomes. There is a worry about access not only for adults, but also kids, especially for people with rare diseases that may not have assistance programs. This is not just a problem with specialty medications, but other medications as well. There has been an increase in costs to generics, which are what people use when they do not have access to biologics. Diabetes doctors have trouble getting access to modern insulin. There is broad patient support in the patient community for this.

If all of the various parties are put together, it may be uncomfortable, but positive solutions can come from that. Out-of-pocket costs can be challenging for patients and sometimes as challenging as the condition itself. For bleeding disorders, a bill for the first month of the year can range from $2,500 to $7,000. For some conditions, the out-of-pocket costs might be spread out over 2 to 3 months, but they still have to pay it. Patients know that they have to be adherent to their medications because they are life-saving. If a patient cannot obtain his or her medication, the patient's health care costs only become more expensive.

This is an important area of concern and solutions are needed. Components of a benefit design, including the benefits, copays, coinsurance, etc., are all designed to work as part of a system. There is a package of health care coverage that is actuarially balanced and as affordable as possible; costs cannot be individually pulled out without changing other parts of the coverage product and its actuarial value or the premium cost. The task force should take into consideration not only the financial impact of the copay and coinsurance on patients taking very expensive drugs, but also what the impact of any changes would have on premium affordability on other individuals and families. The price of providing some people with more affordable cost-sharing on very expensive drugs should not come at the expense of other individuals and families not being able to afford any health coverage at all.

There is recognition of the impact that the cost of drugs have on members, particularly for those with complex chronic diseases. Capping copays or coinsurance will not address drug pricing. This is placing stress on patients and overall affordability of health plan coverage. The task force will look at cost sharing and specialty tiers, which are tools that health plans

use to drive appropriate utilization across a number of services and better manage costs. Health plans use these tools because of the cost and pricing of drugs. The task force needs to evaluate the underlying cost and trends of prescription drugs and the impact that has on the overall benefit plan design. This is the root of the problem.

A business representative should be on the task force because of evaluation of impact on workforce and the loss of productivity. Given current cost trends, by 2018, pharmacy drug costs will outpace inpatient hospital costs. There are broader issues within the health care system like federal law that the task force should keep in mind.

(Opposed) None.

(Other) A pharmacist should be on the task force because the pharmacist would contribute to the conversation on patient adherence. The task force should also include a pharmacy benefit manager. Pharmacy benefit managers contract with health plans and design prescription drug benefits. When a pharmacist runs a claim, the claim goes to a pharmacy benefit manager. The pharmacy benefit manager decides whether to accept the claim, whether the drug can be switched to some other drug, and the payment directives.

Persons Testifying: (In support) Representative Cody, prime sponsor; Erin Dziedzic and Stephanie Simpson, Bleeding Disorder Foundation of Washington; Johanna Lindsay, Arthritis Foundation; Syndey Smith Zvara, Washington Healthcare Plans; Sheila Tallman, Premera Blue Cross; and Chris Bandoli, Regence Blue Shield.

(Other) Dedi Little, Washington State Pharmacy Association.

Persons Signed In To Testify But Not Testifying: None.