HB 218

<TARGET><BILL>HB 218</BILL><SUBJECT>HB 218</SUBJECT><COMM>SHSS27</COMM></TARGET>

ALASKA STATE LEGISLATURE

State Capitol Building
Juneau, Alaska 99801-1182

Sponsor Statement House Bill 218

"An Act prohibiting an insurer from using a drug formulary system of specialty tiers under certain circumstances."

Specialty medications used to treat complex chronic diseases continue to be the fastest growing segments of overall drug spend. While traditional drug spend slowed to an increase of only 1.5% in 2008, specialty drug spend continued its steady climb, increasing 15.4%*

House Bill 218 protects patients with critical illnesses from sudden changes in their drug treatment and therapy protocols which may un-expectantly deprive the patient from critical therapies due to the inability to pay for the drug or sufficient time to plan alternative financial or therapeutic strategies.

Currently, insurance companies can change their reimbursement policies with only a 30 day notice, often forcing the patient to absorb thousands of dollars of unexpected costs for expensive specialty drug therapy. By extending the notification period the savings for the patient will be absorbed by rest of the policy holders on the plan.* This may give the patient additional time to explore other options which may allow for a transition to a more affordable plan with similar therapeutic results.

Without these specialty drugs quality of life deteriorates and long term health care costs may increase. Additionally, cost savings may be achieved by exploring options like management through specialty pharmacies that use drug-utilization monitoring specifically designed for hard to manage conditions.

*2008 Specialty Drug Trend Report, Cura Script Specialty Pharmacy

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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Juneau, Alaska 99801-1182
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MEMORANDUM February 21, 2012

SUBJECT: Drug formulary tiers (HB 218, Work Order No. 27-LS0728\B)

TO: Representative Wes Keller
Attn: Janet Ogan

FROM: Dennis C. Bailey
Legislative Counsel

You have requested a sectional summary of the above-described bill. As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. States legislative findings relating to the need for prescription drugs, the categories and specialty tiers for certain drugs, the cost of drugs, excessively high payments for drugs, the need to inform patients about the cost of drugs that exceed insurance coverage; and the disparity in insurance payments for unique categories or tiers for patients whose life and health depend on certain drugs.

Section 2. States the legislative intent is to provide information to patients about the cost of drugs for certain diseases and conditions.

Section 3. Allows a health care insurer that provides coverage for drugs in unique categories or specialty tiers to impose cost sharing, deductibles, or copayment terms that exceed the cost sharing, deductibles, or copayments of nonpreferred brand drugs or the drug's equivalent if the insurer notifies the insured of the cost sharing, deductibles, or copayment terms at least 90 days before the terms apply.

Section 4. Provides that the notice requirements in sec. 3 apply to health insurance plans offered, issued for delivery, delivered or renewed on or after the effective date.

If I may be of further assistance, please advise.

DCB:plm
12-120.plm

FISCAL NOTE

STATE OF ALASKA
2012 LEGISLATIVE SESSION

Bill Version: **HB 218**
Fiscal Note Number:
() Publish Date:

Identifier (file name): HB218-DCCED-INS-02-23-12
Title: Prescription Drug Specialty Tiers
Sponsor: House Health & Social Services
Requester: House Health & Social Services

Dept. Affected: DCCED
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	FY13 Appropriation Requested	Included in Governor's FY13 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY13**	**FY13**	**FY14**	**FY15**	**FY16**	**FY17**	**FY18**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants, Benefits							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE		(Thousands of Dollars)						
1002	Federal Receipts							
1003	GF Match							
1004	GF							
1005	GF/Prgm (DGF)							
1037	GF/MH (UGF)							
1178	temp code (UGF)							
TOTAL		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS							
Full-time							
Part-time							
Temporary							

CHANGE IN REVENUES							

Estimated SUPPLEMENTAL (FY12) operating costs _____ *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY13) costs _____ *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by: Linda Hall, Director — Phone: 907-465-2560
Division: Insurance — Date/Time: 2/23/12 5:00 PM
Approved by: JoEllen Hanrahan, Director Administrative Services — Date: 2/24/2012
Commerce, Community and Economic Development

(Revised 1/17/2012 OMB)

STATE OF ALASKA
2012 LEGISLATIVE SESSION

BILL NO. HB 218

Analysis

Section 1 lists legislative findings including the cost sharing obligations for certain drugs are becoming prohibitively expensive, that some health plans have established specialty tiers for drugs and are requiring patients to pay a higher percentage of the costs of these drugs, seeking to ensure patients are well informed about cost sharing requirements and recognizing the disparities caused by these cost burdens.

Section 2 lists legislative intent of providing patients with timely information relating to the cost of prescription drugs essential for treatment of certain diseases.

Section 3 amends AS 21.42 to only allow cost sharing for specialty tiers of drugs that exceed the cost sharing for a non-preferred brand drug, only if the insurer notifies the insured of the cost sharing at least 90 days before the terms apply.

These provisions have no anticipated fiscal impact on the Division of Insurance.

LEGISLATIVE RESEARCH SERVICES

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Memorandum

TO: Representative Beth Kerttula
FROM: Chuck Burnham, Legislative Analyst
DATE: March 9, 2012
RE: Prescription Drug Formulary "Tiers" in Health Insurance Plans and the Impacts of HB 218
LRS Report 12.228

You asked a number of questions about prescription drug formulary tiers in health insurance plans and the impacts of HB 218. Specifically, you wanted to know the following:

- ***The definition of "drug formulary" and "value-based drug formulary;"***
- ***Whether insurers in Alaska use tiered formularies and a list of drugs included in tiers 4 or higher;***
- ***The states that have prohibited coinsurance on "specialty tiers" in prescription drug formularies for high cost pharmaceuticals and the costs and benefits to those states of doing so;***
- ***The impacts on health insurance premiums for Alaskans should HB 218 be enacted, thereby requiring insurers to provide policyholders with notice at least 90 days prior to increasing premiums, co-pays, or coinsurance for prescription drugs.***

Brief Summary

Alaska's major private health insurers employ 4-tier prescription drug formularies in a number of their various plans. New York is the only state thus far to prohibit such plans; however, Vermont has placed a one-year moratorium on the practice, and numerous other states are variously studying the issue and considering measures to curb or eliminate specialty drug tiers.

Because HB 218 primarily seeks to increase notification timeframes for a relatively small percentage of the state's population, it is unlikely that its passage will have a significant impact on health premiums in Alaska.

Formulary Basics

Health insurance plans that offer prescription drug coverage for pharmaceuticals and other patient-administered treatments often categorize those medications under a formulary, which lists drugs approved for coverage by the insurer for specific medical conditions. For many years, insurers often divided these drugs into three tiers according to their costs, and required differing levels of co-pay—typically a flat rate paid by the policyholder—for each tier. So, for example, an insurer may charge a $10 co-pay for less expensive, "tier 1" substances, and respective co-pays of $20 and $50 for higher cost drugs in tiers 2 and 3. This flat-rate co-pay model serves both to reduce costs to the insurer, thereby allowing for lower premium rates system wide, and to provide predictable and relatively low-cost medications to the insured.

Enter Tier 4

Two events in recent years combined to challenge the traditional 3-tiered system. First, in recent decades pharmaceutical companies have increasingly developed highly effective "specialty drugs" to treat complex chronic diseases like rheumatoid arthritis, multiple sclerosis, and certain cancers. These drugs are very expensive to develop and produce and extremely costly to purchase. Further, because these substances are used to treat chronic diseases, the costs are not only very high per dose but potentially recurring monthly throughout a lifetime of disease. Second, the 2006 enactment of the Medicare "Part D" prescription drug plan allowed insurers participating in the program to place specialty drugs in a separate tier and charge more for them. Private insurers rapidly adopted the model, creating tiers 4 and higher, and switched their policyholders' portion of costs from *co-pay* to *coinsurance*, which charges a *percentage* of the price of the prescription rather than a flat rate.

As a result, policyholders who had been paying $10, $20, or $50 per month for their medications were met with pharmacy bills many times those amount—upwards of $2,000 per month in some cases.[1]

To be fair, the advent of specialty drugs has placed insurers in a difficult situation. Annual inflation rates on such medications have increased much faster than for other healthcare services, which, in turn, have been climbing at a rate multiple times that of overall inflation in the U.S. economy. The Kaiser Family Foundation reports 17 percent inflation for specialty drugs in 2010, and that spending on these medications often accounted for 15 percent to 25 percent of an employer's total pharmacy benefit costs.[2] Insurers, employers and benefit plan designers have stemmed, somewhat, the rate of growth of specialty tier plans over the past two years through various methods, including steering clients to "value-based formularies," which offer access to generic drugs and pharmacies through which discount prices have been negotiated. Nonetheless, the proportion of plans that use specialty tiers doubled from 2008 to 2011, comprising 14 percent of all prescription drug benefit plans by the end of that period.[3]

Specialty Tiers in Alaska

In fiscal year 2011, the private health insurance market in Alaska—that which would be impacted by HB 218 (we provide information on plans not covered under the bill below)—was dominated by two insurers: Premera Blue Cross Blue Shield and Aetna. The companies respectively hold 56.69 percent and 10.19 percent of the total market, and their collective market share of over two-thirds dwarfs the next largest private health insurer, United Healthcare Insurance, and its 3.97 percent of the customer base.[4]

According to plan documents, Premera's standard tier 4 coinsurance rate is 30 percent, although this rate may differ under the variables of specific plans.[5] Aetna publishes multiple rates for its various small group prescription drug plans, ranging from 30 percent to 50 percent.[6] These rates compare to typical co-pays for tiers 1-3 of $10-$100.[7]

States Respond

We found just one state—New York—that has prohibited insurance companies from creating specialty tiers with coinsurance models. (Vermont put in place a one-year moratorium on specialty tiers effective May 6, 2011.) California Assembly Bill (AB) 310, which is currently under consideration, proposes to ban specialty tiers and limit co-pays to $150 per monthly prescription. Other states, such as Louisiana and Texas, have set mandatory 60-day notification schedules that must be met before changes to prescription drug costs can be made. At least seven other states have undertaken studies of the impacts of specialty tiers on costs, access to drugs, and outcomes, among other measures, as a first step toward regulating the issue. Various measures prohibiting, limiting, or otherwise regulating the use of specialty tiers are currently under consideration across the country.[8]

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[1] Julie Appleby, "Workers Squeezed as Employers Pass Along High Costs of Specialty Drugs: Some Employers Make Patients Pay a Percentage of Cost Instead of a Co-Pay," Kaiser Health News, August 22, 2011, *http://www.kaiserhealthnews.org/Stories/2011/August/22/Workers-Squeezed-As-Employers-Pass-Along-High-Costs-Of-Specialty-Drugs.aspx*.

[2] Richard Farris, Vice President and National Practice Leader, Rare and Specialty Therapeutics, Medco Health Solutions, Inc., as quoted by Julie Appleby.

[3] "Employer Health Benefits 2011 Annual Survey," Exhibit 9.1, Kaiser Family Foundation, *http://ehbs.kff.org/Default.aspx?page=abstract&id=2*.

[4] "Division of Insurance 73rd Annual Report," Alaska Department of Commerce, Community, and Economic Development, *http://commerce.alaska.gov/insurance/Insurance/programs/Consumers/pubs/annual%20reports/annual_report_73.pdf#page=86*.

[5] "How Drug Benefits Work," Premera Blue Cross Blue Shield, *https://www.premera.com/stellent/groups/public/documents/xcpproject/pharm_tier_drug_benefits.asp*.

[6] "Alaska Plan Guide," Aetna, *http://www.aetna.com/employer-plans/document-library/states/ak_plan_guide.pdf*.

[7] Aetna appears to offer low-cost plans that charge a co-pay for certain tier 2 and tier 3 drugs.

[8] "Specialty Tiers/Coinsurance," The Alliance for Biotherapeutics, June 2011, *http://www.bioalliance.org/Downloads/Policy-CoinsuranceAndSpecialtyTiers.pdf*.

Impacts on Premium Costs

You were particularly interested to know if prohibiting specialty tiers increased health insurance premium rates in New York, which enacted its prohibition October 31, 2010. Our research located no study of the law's impact on premiums, and we expect that insufficient time has elapsed to allow a complete understanding of the law's impact on costs.

California's Health Benefits Review Program—comprised of a research team from several of the state's prestigious universities—conducted a study of the medical, financial, and public health impacts of AB 310, the bill currently under consideration. The group projected that the prohibition on specialty drug tiers would increase per month, per member premiums by an average of between zero and $3.69, depending on the market in question (group, individual, Health Management Organizations [HMO], etc.). Total net premium expenditures were projected to increase by roughly $31.7 million (0.0332 percent) as aggregate premium increases caused by the bill would be largely offset by reduced overall co-pays across the pool of 20.9 million policyholders impacted by the bill.[9]

Projected Impact of HB 218 on Premiums

As you know, HB 218 does not contemplate an outright prohibition on specialty tiers per se. Rather, the bill prohibits the use of the 4-tier model for the purpose of establishing deductibles, co-pays, or coinsurance unless the insurer provides policyholders notice of at least 90 days prior to changing the cost terms of their prescription drug coverage. Nonetheless, in a letter to House Health, Education, and Social Service Committee Chair Representative Wes Keller, Premera Blue Cross Blue Shield of Alaska Senior Vice President Jack C. McRae states that the notification timeframe in HB 218 will "inflate costs for specialty drugs and will increase overall healthcare premiums for Alaskans."[10]

Although not required by Alaska law, Premera's current policy, as stated by Mr. McRae, is to provide its policyholders notice 30 days prior to changes on costs associated with prescription drugs. Therefore, assuming that the insurer would comply with the increased notification timeline in HB 218 rather than discontinue its tier for specialty drugs, the impact of the legislation would be to increase by 60 days the amount of notice required prior to changing costs associated with medications. Further limiting the impact of the bill is the proportion of Alaskans to which it would apply if enacted. According to Insurance Division Director Linda Hall, the bill does not apply to public plans (state and federal employees, Medicare, Medicaid, Indian Health Service) or self-insured plans that are merely administered by insurers, which are most commonly funded by large organization like the State of Alaska and companies with a large pool of employees.[11, 12] Individuals covered by public and self-insured health plans, combined with the approximately 16 percent of uninsured Alaskans, total 85 percent of the state's population. The provisions of HB 218 would, therefore, apply to the remaining 15 percent of residents covered by state-regulated, "fully-insured" health plans in the private market.

The change to which Mr. McRae refers in his letter of opposition to HB 218 is, then, an additional 60 days of notice provided to 15 percent of the Alaska population. Presumably, the cost associated with the bill would be two months of the difference in cost between the proposed increase in price to drugs for which Premera is, by definition, already funding at a lower rate (that is, if the drug in question were not already being funded, notification of price change would not be in question). Although we are aware of no study on the impact of the changes described above, assuming the cost projections in the study of California AB 310—which, again, would *completely prohibit* specialty tiers—are remotely accurate, the cost of a 60-day delay in implementing increased costs for specialty drugs would, presumably, be a small fraction of the maximum per month premium increases projected by that study. We asked Director Hall for her views on the likely impact of HB 218 on premiums. She stated that the bill was unlikely to bring significant increases.

We hope this is helpful. If you have questions or need additional information, please let us know.

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[9] "Analysis of Assembly Bill 310," California Health Benefits Review Program Report to the 2011-2012 California Legislature, April 14, 2011, p. 11, *http://www.chbrp.org/docs/index.php?action=read&bill_id=120&doc_type=3.*

[10] Documents associated with HB 218 are available online at *http://www.legis.state.ak.us/basis/get_documents.asp?session=27&bill=HB218.*

[11] Ms. Hall can be reached at (907) 269-7900.

[12] Self-insured and public plans are exempted from state regulation under the federal Employee Retirement and Security Income Act of 1974 (ERISA), as amended (P.L. 93-406, 29 USCS § 1002). More information on ERISA and its treatment of different types of plans is available at *http://www.allhealth.org/briefingmaterials/erisaregulationofhealthplans-114.pdf.*

Fact Sheet
AB 310 – Assemblywoman Fiona Ma
Fair Specialty Drug Payments

Summary: AB 310 would prohibit health plans and insurers from using "co-insurance" and cap out-of-pocket co-pay costs for patients.

Background & Problem:
When patients pay for drug medications, many health care plans include a pricing structure. The tiers are often labeled 'generic,' 'preferred,' and 'non-preferred' and each have a set cost-sharing amount. For example, $10 for generic, $30 for preferred and $60 for non-preferred.

In 2006, Medicare Part D plans (PDPs) started introducing a fourth level known as a "specialty tier," which provides the plan with the ability to use a co-insurance to share the costs of the most expensive medications with the patient

Many private healthcare and drug plans have copied this model for the most expensive medications, but instead of a fixed amount like in Medicare, plans may now require enrollees to pay co-insurance, which is a percentage of the cost of medications. These plans have been charging patients, on average, 25 to 33 percent, which can end up costing the patient thousands of dollars a month out of pocket. These extortionate co-insurance charges can be as high as over $8,000 per month.

The Kaiser Family Foundation Employer Health Benefits 2010 survey reports a dramatic increase in specialty tiers, using the co-insurance method of payment. Nationwide, in 2004, only 3% of workers were in a plan with four or more tiers of coverage. However, in 2010 that number increased to 13%, covering more than 20 million Americans. Data also indicates that in 2006, 50% of Medicare drug plans used specialty tiers. In 2008, specialty tiers were represented in 81% of Medicare plans.

In addition, Prime Therapeutics released a study in 2009 that measured multiple sclerosis medication OOP expense association with decline to fill rate. It showed that when MS medication OOP expenses were greater than $200 the decline to fill rate compared was six times greater than if the co-payment was less than $100.

Many of the drugs on specialty tiers are used to treat conditions such as: cancer, autoimmune conditions like Crohn's disease, lupus, multiple sclerosis, myasthenia gravis, myositis, psoriasis, scleroderma, rheumatoid arthritis, hemophilia and other bleeding disorders, hepatitis, primary and secondary immune deficiencies, neuropathy, and transplant patients.

Drugs found on specialty tiers have been in the marketplace for over twenty years and have been covered by insurance plans without charging co-insurance. Many of these therapies have remained at the same price, with the exception of new generations of these drugs. These drugs have no generic alternatives, are used to treat rare diseases, genetic disorders, and chronic conditions that without treatment will lead to disability and death.

Solution:
Beginning January 1, 2012 AB 310 prevents health plans and insurers from using the co-insurance method of payment. The bill also places $150 dollar out-of-pocket cap for a one month supply of medication, or its equivalent for prescriptions for longer periods, as adjusted for inflation.

In addition, AB 310 makes sure that if a health care service plan provides for a limit on patients' annual out-of-pocket expenses, the patients' out-of-pocket costs of covered prescription drugs shall be included in that limit.

Support:
The National Multiple Sclerosis Society (Sponsor)
The Alliance for Plasma Therapies (Sponsor)

Contact:
Nick Hardeman, 916.319.2012
Kasey O'Connor, 916.319.2012

Brenda Robertson
22500 Columbia Glacier Loop
Anchorage, AK 99577-9572

July 13, 2011

The Honorable Wes Keller
Alaska House of Representatives
State Capitol
Juneau, AK 99801-1182

Dear Representative Keller:

The new specialty drug tiers have caused us to have to consider stopping my husband's MS medication. Our Co-Pay went from $30/mo to nearly $1200/mo. No financial assistance applies to us although it is a major financial burden. Other states have laws banning tier 4 drug pricing (New York, etc). Does it make sense to have people stopping their meds & making more hospital trips? Please direct me how to get this on someone's radar so this can be dealt with. I am sure there are many others suffering as well. ALL MS medications are now tier 4. I would appreciate anything you can do. It looks like the HB 218 only requires 90 days notice. The problem is the same, in 90 days people will just have to stop their medication. We have always paid our own way, not on welfare, don't take govt assistance...but $1200 a month? Plus our massive insurance premiums we pay each month?? We need help - please let me know if there is anything you can do.

Sincerely,

Brenda Robertson
907-350-0502

Alaska State Legislature

Please enter into the record my testimony to the (H) HSS
committee name

committee on HB No. 218 dated 2/28/12
bill/subject

- I strongly support HB 218 and encourage this committee to pass this Bill for my daughter + other Alaskans who take "specialty" drugs.
- My daughter was diagnosed with "juvenile idiopathic arthritis" when she was about 11. For about 5 years, she was only able to attend school part-time; she was hospitalized about 2, and up to 4 times per year for "joint injections"; she could not participate in sports because of the inflamation + instabilities in her joints.
- Then, she started taking a "biologic" - a specialty drug! She began improving in 3 months and went back to school full-time.
- She is now in her 1st year at UAA - attending full-time. She was accepted into the UAA Honors College, has declared a chemistry major, + wants to study medicine!
- This specialty drug has been amazing for my daughter + our family. The cost is pretty amazing too - $400/week or $1600/month
- Because of the cost, I strongly support HB 218 because it gives us notice to make the right decisions.
- Please support this Bill to make sure my daughter, and other Alaskans like her, are able to continue on the path to be productive citizens of our communities + our State.

Signed: Barbara A. Jones Barbara A. Jones
Testifier

myself
Representing (Optional)

PO Box 90041, Anchorage AK 99509
Address

907-248-0427
Phone No.

2/28 Legislative Information Office

Advocates for Responsible Care

We will be their voice until their voices are heard.

Specialty Tier Story Submission

Today health insurance companies are creating a fourth and fifth tier of drugs, called *Specialty Tier* drugs. *Specialty Tier* medications include drugs that are injected, infused, taken orally, inhaled, or that require special dosing and handling, close supervision, or monitoring. Specifically these include medications for Rheumatoid Arthritis, Systemic Lupus, Cancer, MS, plasma therapies and other life-threatening and chronic diseases. Unlike the co-payments for the other tiers, health insurance companies are charging an extraordinarily high co-insurance (higher cost for the drug) for *Specialty Tier* medicines. This co-payment/co-insurance is 20-35% of the cost of the drug. Many individuals cannot afford this out-of-pocket expense for their *Specialty Tier* medications. This practice is restricting access to much-needed medications for patients with serious chronic diseases.

Advocates for Responsible Care (ARxC) are leading an initiative to stop the high co-insurance/co-payments for *Specialty Tier* medications in Georgia. We are asking persons who are dependent upon these medications to share with us their stories. We want to know how an increase in the cost of these specialty drugs will affect their illness and their access to these vital medications. We will use these stories to help mobilize a Georgia-wide effort to end the rise in out-of-pocket costs for *Specialty Tier* medications.

If you are dependent upon a *specialty tier* medication please share your story at http://advocatesforresponsiblecare.org/Story_Submission.html.

If you would like to learn more the issue, how you may be affected, and how you can get involved in the movement to stop health insurance providers from increasing the costs for *Specialty Tier* medications please visit our website at http://advocatesforresponsiblecare.org/Specialty_Tiers.html. You can also follow ARxC on Facebook at Advocates for Responsible Care or on twitter @ARxCAdvocates.

The Advocates for Responsible Care empower individuals to achieve their maximum wellness with a strong voice as health care advocates, effectively reducing cultural incompetency and health care delivery disparity.

National Multiple Sclerosis Society

Eliminate Tier IV or Specialty Tiering in Prescription Drug Coverage

Position

Multiple sclerosis (MS) is an often disabling, autoimmune disease affecting the central nervous system. Although there is no cure for MS, appropriate medication can slow the disease progression, reduce the frequency and intensity of flare-ups, and allow people with MS to live active and productive lives.

People with MS depend on access to affordable disease modifying therapies for improving and maintain quality of life. The annual cost of these drugs ranges from $16,500 to more than $30,000. Many are forced to stop their prescribed therapy because they cannot afford the cost-sharing associated with these high prices.

As drug prices climb, health insurance companies, including those administering Medicare Part D plans, address these increasing costs by creating a new cost sharing mechanism within their drug plans. This mechanism, called "specialty tiers," introduces a fourth tier to the traditional three tiered drug formulary structure. The fourth tier is reserved for the most expensive medications such as MS therapies. Instead of companies charging a fixed co-pay for tier IV drugs, patients are responsible for a co-insurance or a percentage (20 to 35 percent or more) of the cost of the tier IV drug. Co-insurance can amount to thousands of dollars in out-of-pocket costs to patients for drugs critical to the treatment of their disease.

Request

The National Multiple Sclerosis Society supports efforts to prohibit the practice of specialty tiering or implementing a tier IV by health insurance companies, including Medicare Part D plans. Such a practice creates a barrier to access of medically necessary medication to improve the quality of life of people with MS and will raise overall health care costs.

Supporting Rationale

National Multiple Sclerosis Society

- Health insurance companies, including those administering Medicare Part D plans, are adopting a new pricing system for expensive drugs. This new system adds a tier IV or a "specialty tier" to the company's traditional three tiered drug plan.

- Rather than charging a fixed co-pay ($10 for generic, $25 for preferred, $50 for non-preferred), companies charge patients a co-insurance or a percentage (20 to 35 percent or more) of the cost of the high-priced drug. Co-insurance can amount to thousands of dollars in out-of-pocket costs to patients for drugs critical to the treatment of their disease.

- The extraordinary disparity in cost-sharing and co-insurance resulting from specialty tiering imposes a significant burden on patients whose health depends on expensive drugs and constitutes an undue and unjust discrimination based on their disease, disability, or condition.

- People with MS depend on disease modifying therapies that range in cost from $16,500 to more than $30,000 annually. With no generic alternative available, a patient's choice is limited to paying significant out-of-pocket costs or not taking their prescribed medication.

- The below chart estimates the monthly cost of four common MS therapies and shows the estimated monthly cost for those who are subject to a tier IV co-insurance.

MS Therapy	Monthly Cost	25% Co-Pay	33% Co-Pay
Avonex	$2,270	$567	$749
Betaseron	2,198	549	725
Copaxone	2,110	527	696
Rebif	2,347	586	775

- If subject to a 25 to 33 percent co-insurance, the medication to treat MS would cost between $525 and $775 out-of-pocket each month. People with MS rely on access to these vital drugs in order to live active and productive lives. These co-insurance rates place a significant barrier to access of these medically necessary drugs.

March 16, 2012

Representative Kurt Olson
State Capitol Room 24
Juneau, Alaska 99801

Vice-Chair Craig Johnson
State Capitol Room 216
Juneau, Alaska 99801

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

Re: HB 218, Specialty Pharmacy Tiers

Dear Chair Olson, Vice-Chair Johnson, and Members of the Committee,

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our opposition to HB 218, pertaining to specialty pharmacy tiers, in its current form.

HB 218 requires member notification related to cost sharing, deductibles or copayments of pharmaceuticals in certain tiers at least 90 days before the terms apply. This bill imposes a new notification requirement that is duplicative of existing notifications already provided to our members about their coverage and changes to benefits. In addition, this notification requirement is duplicative of a new federal healthcare reform requirement. This additional notification requirement will increase costs and premiums for consumers. It can also create confusion for our members who will receive several notices already provided by Premera, as well as notices required by the healthcare reform requirement.

Regarding notice to members, Premera provides timely information to members and groups about our benefit plans, including pharmacy benefits and cost sharing. Currently, we notify members with this information upon initial plan enrollment and renewal. We also notify members if and when a pharmaceutical tier is added to their current pharmacy benefit plan. If there is a change to the prescription drug formulary that would impact member cost sharing, Premera notifies impacted members by mail 30 days before such changes occur. We also provide a notice 45 days in advance of a premium change.

As part of federal healthcare reform, beginning September 23, 2012, insurers will be required to provide a ***Summary of Benefits and Coverage*** document, inclusive of a specific section on prescription drugs and related cost sharing. This document must be provided during application for individuals and groups, upon renewal, and upon request by the member. A change at mid-year, or more specifically, a change that impacts the information provided in the summary document, triggers a notification requirement to members at least 60-days prior to the effective date of the change. This requirement and mid-year notice will impact all plans: grandfathered and non-grandfathered individual and group coverage as well as self-funded plans.

Because of existing notification requirements and processes and the imminent federal healthcare reform requirement to provide ***Summary of Benefits and Coverage*** information to members and group health plans, we oppose HB 218.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

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Jack C. McRae
Senior Vice President

February 14, 2012

Representative Wes Keller
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 218, Specialty Pharmacy Tiers

Dear Representative Keller,

On behalf of Premera Blue Cross Blue Shield of Alaska, I am writing to you to express our concerns with HB 218, pertaining to specialty pharmacy tiers.

Premera currently provides notification regarding our policy on cost sharing, deductibles or copayment terms applicable to specialty pharmacy to our members 30 days before the terms apply. To date, we've received no complaints about this approach from members: the 30-day advance notice allows members time to meet with their providers to discuss specialty drug prescription options. Members may face cost sharing changes during the year for different reasons, including a formulary change when a generic drug becomes available. Premera notifies impacted members by mail 30 days before such changes that would impact cost sharing. HB 218 includes a shift to a 90-day notification timeframe. This change will inflate costs for specialty drugs and will increase overall healthcare premiums for Alaskans. If implemented, this change could also impact and raise state employee insurance rates.

Premera Blue Cross Blue Shield of Alaska covers over 70,000 members and provides comprehensive coverage to our members, with the majority of our plans including prescription drug coverage. We currently offer a four-tier pharmacy benefit for our members. Drugs are classified into tiers by an independent committee of experts, including doctors, pharmacists, health economists, a bioethicist and a member representative. This committee continuously reviews new and existing drugs, evaluates how well drugs work, and how their cost and effectiveness compare to similar drugs used for the same condition, then compares how much additional benefit a drug provides to the extra cost in comparison to a standard treatment for the same medical condition.

It is important to note the following for specialty pharmacy:

- The Centers for Medicare and Medicaid Services (CMS) classifies specialty pharmacy as pharmaceuticals often used to treat complex, chronic medical conditions. The drugs have fewer generic alternatives and may require increased physician involvement and special storage and handling.

- The average price of specialty drugs can cost $2,000 - $2,500 for 30-day supply.

- Expenses for drugs are the fastest growing segment of healthcare, with **expenses for specialty drugs growing at the fastest rate in the drug category (15%-20% per year).**

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- Specialty drugs comprise **more than 16% of total pharmaceutical spending** in the U.S. today. If current trends continue, by 2030, specialty pharmacy costs will exceed $1 trillion/ year and account for as much as 44% of a health plan's total drug expenditures.[1]

- Less than 3% of private health plan members use specialty pharmaceuticals; however, these members account for **25-30% of total private payer medical costs.**

- Medicare first created a specialty drug tier or 4th tier to help manage rising drug costs.

- An insurer's use of drug formulary tiering is an effective cost management tool, for the insurer and for its members and allows insurers to continue to provide access to these critical drugs.

We would oppose any prohibition on specialty drug tiering, including a prohibition on imposing higher cost sharing for specialty drugs.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

[1] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2706163/

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Jack C. McRae
Senior Vice President

March 13, 2012

Representative Wes Keller
State Capitol Room 432
Juneau, Alaska 99801

Re: HB 218, Specialty Pharmacy Tiers

Dear Representative Keller,

We at Premera Blue Cross Blue Shield of Alaska continue to have concerns with HB 218, pertaining to pharmacy tiers and wanted to make you aware of a requirement in the Affordable Care Act (ACA) that will require specific information about coverage and benefits, including pharmacy benefits, to be provided to members at certain times.

The language of this bill imposes mandatory notification processes on insurers that are duplicative to current processes and new federal reform requirements and further, would add costs and confusion for our members. Specifically, HB 218 requires member notification related to cost sharing, deductibles or copayments of pharmaceuticals in certain tiers at least 90 days in advance of term applicability.

Premera provides timely information to members and groups about our benefit plans, including pharmacy benefits and cost sharing for tiers. Currently, we notify members about this information on an annual basis, upon initial plan enrollment or upon plan renewal. We also notify members if and when a pharmaceutical tier has been added to their current pharmacy benefit plan. Premera notifies impacted members by mail 30 days before such changes that would impact cost sharing.

In addition, as part of healthcare reform under the Affordable Care Act beginning September 23, 2012, insurers will be required to provide a summary of benefits and coverage document, inclusive of a specific section on drugs and cost sharing. This document must be provided during open enrollment periods for individuals and groups. A change at mid-year, or more specifically, a change that impacts the information provided in the summary document, triggers a 60-day notification requirement to members. This requirement will impact all plans: grandfathered and non-grandfathered individual and group coverage as well as self-funded plans.

We wanted you to be aware of this imminent ACA requirement as part of the discussion on HB 218.

Thank you for your consideration. I would be happy to answer any questions that you may have.

Sincerely,

Jack C. McRae

Jack C. McRae
Senior Vice President

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March 15, 2012

Representative Wes Keller, Chair
House Health & Social Services Committee
Alaska State Capitol
Juneau, AK, 99801

Re: House Bill 218: Oppose

Dear Representative Keller:

Medco Health Solutions regrets that it must respectfully oppose House Bill 218 requiring plans to provide 90-day notice of changes in copays/coinsurance for specialty prescription drugs. Medco is the parent company of Accredo Health Group, one of the nation's leading specialty pharmacies. Our clients including public and private payers, union trusts and health plans, rely on us to help manage their specialty drug costs.

According to the Utilization Review Accreditation Committee (URAC), "Specialty drugs or pharmaceuticals usually require special handling, administration, unique inventory management, a high level of patient monitoring and more intense support than conventional therapies. They could include all routes of administration."

Specialty drugs are very expensive, sometimes as much as $10,000/month or more. If a plan changes from a fixed copay for a specialty drug to a percent copay, it is possible that patients will see an increase in their monthly cost. It would be highly unusual for a plan to make this change in the middle of a benefit year. However, as our clients attempt to manage their costs, they may make a change at the start of the benefit year. Plan members are notified in advance of changes in the benefit cost structure. In our experience, usually a plan that goes from a fixed copay to a percentage copay will place a cap on the copay - say $250 per prescription. So, circumstances wherein the cost, for example increases from $100 to $1,000 is extraordinarily rare.

The average cost for a generic Rx at retail is $25.00 and the average copay is about $8.00 or a 34% member cost share. The average cost for a brand at retail is about $150 and the average brand copay is $30.00 or about a 20% member cost share. The average cost for a specialty Rx at retail is between $1,500 & $2,000. Plans generally seek to maintain a 20-25% member cost share in order to help them control costs. If we look into the future we find that by 2013, 80% of prescriptions will be generics and this will represent about 25% of plan costs, 19% of

prescriptions will be for non-specialty brands which will represent about 55% of plan costs, and specialty brands will be about 1% of prescriptions and 20% of plan costs.

Plan sponsors typically provide members with a 30 day notice prior to implementing a benefit change. HB 218 requires plans to provide 90-day notice of changes in the cost sharing requirements for drugs in a specialty tier. In late September, the federal Affordable Care Act will require plans to provide 60 day notice. HB 218 creates a conflicting standard that will create unnecessary duplication and confusion in the marketplace as plans are required to send 90-day and then 60 day notices to patients regarding the same benefit change.

For these reasons, we respectfully must oppose HB 259. Please feel free to contact me with questions.

Sincerely,

CYNTHIA M. LAUBACHER
Senior Director, State Government Affairs

LEGAL SERVICES

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MEMORANDUM April 9, 2012

SUBJECT: Single subject (Amendment to CSHB 218(L&C), Work Order No. 27-LS0728\D.2)

TO: Representative Wes Keller
Attn: Janet Ogan

FROM: Dennis C. Bailey
Legislative Counsel

You have asked whether amendment 27-LS0728\D.2, which relates to establishing a reinsurance program for residents who are high risk, could be added to CSHB 218(L&C), which relates to insurance for certain specialty drugs, without violating the single subject requirements of art. II, sec. 13 of the Alaska Constitution.

The single subject requirement

Under art. II, sec. 13, Constitution of the State of Alaska, "[e]very bill shall be confined to one subject unless it is an appropriation bill or one codifying, revising, or rearranging existing laws." This provision of the Alaska Constitution is frequently referred to as the "single subject requirement." Each bill may only contain provisions related to the bill's single subject.

The standard adopted by the Alaska Supreme Court in regard to the single subject requirement states that an "act should embrace some one general subject; and by this is meant, merely, that all matters treated of should fall under some one general idea, be so connected with or related to each other, either logically or in popular understanding, as to be part of, or germane to, one general subject." *Gellert v. State*, 522 P.2d 1120, 1123 (Alaska 1974). The Alaska Supreme Court has held that the purpose of this constitutional provision is to guard against legislative log-rolling, "the practice of 'deliberately inserting in one bill several dissimilar or incongruous subjects in order to secure the necessary support for passage of the measure.'" *Evans v. State*, 56 P.3d 1046, 1069 (Alaska 2002), quoting from *Gellert*, *supra* at 1122.

Alaska's single subject rule has been interpreted by the Alaska Supreme Court to permit very broad subject matter in a bill without violating the single subject requirement. In construing the single subject rule, the Court will "resolve doubts in favor of validity" and "in order to warrant the setting aside of enactments for failure to comply, the violation must be substantial and plain." *Suber v. Alaska State Bond Committee*, 414 P.2d 546, 557 (Alaska 1966); see also *Evans* and *Gellert*, *supra*, and *Short v. State*, 600 P.2d 20

(Alaska 1970). Specifically, the Court has held that bills relating to such broad themes as "civil actions," "taxation," "transportation," and "land" are acceptable. *Evans*, 56 P.3d at 1070; *North Slope Borough v. Sohio Petroleum*, 585 P.2d 534, 545 (Alaska 1978); *Yute Air Alaska, Inc. v. McAlpine*, 698 P.2d 1173, 1181 (Alaska 1985); *State v. First National Bank of Anchorage*, 660 P.2d 406 (Alaska 1982).

The single subject rule has been so broadly construed by the Court that the Court itself has expressed misgivings about the construction possibly rendering the rule meaningless. *See Yute Air Alaska, Inc.*, *supra* at 1180 - 1183, and *First National Bank of Anchorage*, *supra* at 414 - 415. However, without this broad construction, "statutes might be restricted unduly in scope and permissible subject matter, thereby multiplying and complicating the number of necessary enactments and their interrelationships." *Gellert*, *supra* at 1122, and quoted by *Galbraith v. State*, 693 P.2d 880, 886 (Alaska App. 1985). The Court appears reluctant to impose a stricter standard. *See Yute Air Alaska, Inc.*, *supra* at 1180 - 1181. But, the single subject rule is still of concern at least in obvious cases. *See Croft v. Parnell*, 236 P.3d 369 (Alaska 2010) (initiative proposing new oil production tax and new "clean elections" program violated the single-subject rule).

Conclusion

Under the Alaska Supreme Court's liberal interpretation of the rule, in my opinion, a court would find that the subject of the amendment, which relates to reinsurance for high risk residents, and CSHB 218(L&C), which relates to insurance for specialty tiers of prescription drugs, both address the single subject of "insurance."

Please be aware that because the house bill is now in the senate and the amendment requires a title change, a concurrent resolution suspending the rules must be approved in order to amend the bill.

If I may be of further assistance, please advise.

DCB:ljw
12-266.ljw

AMENDMENT

OFFERED IN THE SENATE

TO: CSHB 218(L&C)

Page 1, line 2, following "**circumstances;**":

Insert "**relating to a reinsurance program reinsuring residents who are high risks;**"

Page 1, line 6, following "FINDINGS":

Insert "FOR SECTION 3"

Page 2, line 14:

Delete "This"

Insert "Section 3 of this"

Page 2, following line 29:

Insert new bill sections to read:

"* **Sec. 4.** AS 21.55.220(c) is amended to read:

(c) Each member of the association shall share the losses due to claims expenses of the state plans issued or approved for issuance by the association**; each member of the association shall share the losses of a reinsurance program established by regulations adopted under AS 21.55.400 reinsuring residents who are high risks;** [,] and **each member of the association** shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments allocated to the payment of benefits shall be the liability of the members. Each member shall share in the claims expense of the state plans**, the**

[AND] operating and administrative expenses of the association**, and the losses of a reinsurance program established by regulations adopted under AS 21.55.400 reinsuring residents who are high risks,** in an amount equal to the ratio of the member's total major medical premiums, received from or on behalf of state residents, as divided by the total major medical premiums received by all members from or on behalf of state residents, as determined by the director.

*** Sec. 5.** AS 21.55.400 is amended to read:

Sec. 21.55.400. Duties of director. The director may

(1) approve the selection of the plan administrator by the association and approve the association's contract with the plan administrator, including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake, directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) formulate general policy and adopt regulations**, including regulations establishing a reinsurance program reinsuring residents who are high risks,** that are reasonably necessary to administer this chapter."

Renumber the following bill sections accordingly.

ACHIA
ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

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April 8, 2012

Senator Bettye Davis
State Capitol Room 30
Juneau, Alaska 99801

RE: Support for Children's Reinsurance Program

Dear Senator Davis,

On behalf of the Alaska Comprehensive Health Insurance Association (ACHIA), we are asking for your support for the establishment of children's reinsurance program which would provide access to health insurance coverage for children under the age of 19.

The ACHIA Board and the Division of Insurance have been wrestling with the fact that there are no child-only health insurance policies available in Alaska's insurance market today. Other states are facing the same issue. This problem has arisen, in part, as a result of the federal healthcare reform law. We have developed a solution to this problem and would like the opportunity to present it to the Senate Health and Social Services Committee. The solution would take the form of an amendment that we hope the Committee would consider with favorable action. We have identified a "vehicle" which is currently in the Committee that could serve as a "carrier" of this amendment. We have obtained the permission of the sponsor of the "vehicle" to attach our amendment to the bill, and all we need is an opportunity to present this amendment to the Committee. Finally, the Division of Insurance supports the amendment.

Given that there are no child-only health insurance policies available for purchase in the state, the ACHIA Board believes this situation needs to be changed. Allowing ACHIA to take on the reinsurance function is a simple, proven solution.

A children's reinsurance program would allow insurers to offer individual policies to children throughout the year by spreading the risk of enrolling high cost children across the entire commercial market. The proposed approach also provides premium stability for individuals and families in Alaska. If this amendment is passed, insurance companies in Alaska will be able to immediately start selling child-only policies.

The ACHIA Board sees an unmet need with respect to children being able to obtain coverage in the individual marketplace, but current Alaska statutes which govern ACHIA do not allow ACHIA to help remedy the problem. The proposal before you would allow ACHIA to fulfill this role, under the direction of the Division of Insurance. On behalf of the ACHIA Board, we are committed to working with the Legislature, state agencies, and insurers in Alaska to establish this program to benefit the youngest residents.

Thank you for your consideration of this proposal which will provide immediate and year-round access to health coverage for children in Alaska.

Sincerely,

Cecil D. Bykerk, FSA, MAAA
Executive Director
Alaska Comprehensive Health Insurance Association (ACHIA)

Marilyn W. Kasmar, RNC, MBA
Alaska Primary Care Association
Board member of ACHIA

cc: Director Linda Hall
Board of Directors