STATEMENT OF THE NATIONAL HISPANIC MEDICAL ASSOCIATION

Before the

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM

Hearing Entitled:

"The Patient Perspective:
The Devastating Impacts of Skyrocketing Drug Prices on American Families"

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The National Hispanic Medical Association (NHMA) is a non-profit association representing over 50,000 Hispanic physicians with the mission to improve the health of Hispanics and other undersesrved. NHMA thanks the Committee for its attention to the impact of the rising out-of-pocket cost of medications and appreciates the opportunity to provide input on how this issue affects the patients we serve.

Hispanics are now 17 percent of the population and projected to be one out of four Americans by the year 2042. Hispanics are still the largest ethnic group in the country who are uninsured and live in medically underserved areas and face poverty, lack of education and literacy as well as cultural values such as fatalism when faced with chronic disease. Even the growing middle class Hispanic families face competing basic life decisions when it comes to purchasing – often going without physician, dental or mental health visits due to the high costs of care. In addition, the health care system lacks the Hispanic physician and other health professional workforce in parity with the growing population and the system.

The issue of drug pricing is multi-faceted, and any solutions must address systemic issues across the health care supply chain – pharmaceutical companies, insurance companies, and government subsidies.

Pharmaceutical Companies and Lowering Costs of Medications

We do recognize that pharmaceutical companies have patient assistance programs and drugs can be bought by health care companies or government programs (clinics) to offer their patients cheaper drugs. However, these efforts are small compared to the demand. Pharmaceutical companies should focus on policies that provide more affordable medications – such as insulin and diabetes medications so that the Latino community can live with less stress and patients can have better quality of life, living with less burden from complications for a longer period of time. Of course, when it comes to innovation and higher cost medications and therapies, there is a need for other policies to create affordability to the average American.

High Deductible Health Plans

There has been a changing insurance market that impacts care and medication utilization, and for Hispanics, there is a lack of education about health care insurance and benefits. According to the National Center for Health Statistics, the percentage of adults with employer-based coverage enrolled in high deductible health plans (HDHPs) without a health savings account (HSA) increased from 10.6% in 2007 to

24.5% in 2017.[1] That number continues to grow: in 2018, it was estimated that the percentage of people under age 65 with private coverage enrolled in a high deductible plan (with or without an HSA) increased to 47% in the first three months of 2018.[2] Similarly, plans in the exchange market often carry a high deductible: an Avalere study found that, on average, deductibles neared $4,000 for silver plans in 2018.[3]

The rise in HDHPs means we may also need to revisit coverage limitations under the deductible threshold. Earlier this month, the Internal Revenue Service (IRS) released guidance[4] expanding the list of preventive care benefits that health savings account (HSA) insurance products may provide with first dollar coverage – meaning, these benefits can now be covered under the deductible. Previously, the IRS' position was that preventive care generally does not include any service or benefit intended to treat an illness. This guidance will enable patients with chronic disease to access needed treatments without having to pay fully out-of-pocket until their deductible is met. This policy will especially help patients with chronic illness who have no access to any other options except a HDHP.

Rebates

With regard to drug costs specifically, the issue is more extensive than pricing. Again, benefit design must be a key part of the solution. Most insurers place drugs on tiers within a formulary, with differing cost-sharing requirements for each tier. The most expensive specialty products are placed on a "specialty tier," which requires the patient to jump through various utilization management hoops for the privilege of paying up to 50% coinsurance once the insurer approves the physician's prescription. In Medicare Part D, for example, virtually all plans have a specialty tier, with drugs on such a tier subject to as high as a 33% coinsurance based on the list price. Besides the patient access challenges inherent in these extremely high coinsurances, the topic of "list price versus net price" deserves further discussion as well.

Pharmacy benefit managers (PBMs) determine what products are placed on which formulary tiers, with little thought given to clinical value or affordability for the patient. Rather, formulary design is based on the size of the rebate paid by the drug company to the PBM. As noted above, the patient's cost-sharing is often based on the list price of the drug, which does not reflect any rebates paid to the PBM. In a simplified example, a patient may pay a 33% coinsurance on a product with a $500 list price, for which the PBM received a net price of $250. This means the patient pays $165 for a product that cost the PBM $250. And of course, if the patient is in his or her deductible phase, they would pay the full $500 – again, on a product that cost the PBM $250. This must end.

Another implication of this bizarre system is that drug companies currently compete with one another based on the size of the rebate they pay to the PBM, instead of the price of their product for the patient. In fact, there is data indicating that PBMs sometimes prefer the product with the higher list price for this reason: it maximizes the potential rebate to the PBM. Drug companies will provide assistance for patients outside of federal programs in the form of copay assistance (such assistance is prohibited in federal programs) and, while these programs are critical, rebate reform would directly lower prices for patients and reduce the need for this assistance.

We hope that this makes clear that the rebate system, inside and outside of Medicare, is in desperate need of reform. Any drug pricing policy proposals must untangle the perverse incentives inherent in the current rebate system.

Generics

Generics make up 90% of all retail prescriptions filled in our country: this is an extraordinary success, as these products offer identical treatment options at a much lower cost for patients. Data shows

[1] https://www.cdc.gov/nchs/data/databriefs/db317.pdf
[2] https://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201808.pdf
[3] https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market
[4] https://www.irs.gov/pub/irs-drop/n-19-45.pdf

that these products especially benefit patients with lower incomes: a 2018 study in the Journal of Managed Care and Specialty Pharmacy found that patients with incomes under 200% of the federal poverty level were more likely to use generics than those with higher incomes.[5] No such correlation existed between generic uptake and any other sociodemographic characteristic. The study did note, however, that there are still negative perceptions about generics, especially among older adults and minority groups. This indicates we have more educational work to do about the fact that brands and generics are pharmaceutically equivalent.

We would be remiss not to mention copay assistance in the context of generic drugs as well. There is data indicating that copay assistance provided by brand drug manufacturers reduces generic drug uptake. Thus, insurers attempt to limit the availability of such assistance through various mechanisms, such as copay accumulators. And, as noted above, copay assistance is already prohibited in federal health programs. However, generics (or biosimilars) do not exist for all drugs. Thus, banning copay assistance across the board prevents patients from receiving any help with paying for drugs for which there is no generic available. In those cases, the copay card will not prevent the patient from choosing the generic, since there isn't one. Rather, access to copay assistance in these cases can make the difference between the patient getting treatment, or not. This nuance is often lost in the debate about copay assistance.

We hope our input has been useful to the Committee as you consider the problem of rising out-of-pocket costs for patients. Please do not hesitate to contact us for additional information.

[5] https://www.jmcp.org/doi/full/10.18553/jmcp.2018.24.3.252