Chairman Lips, Vice Chair Stewart, Ranking Member Liston, and members of the House Committee on Public Health Policy: Thank you for the opportunity to present testimony to you today and for your interest in prescription drug prices and benefit design.

My name is Ben Link, and I am a pharmacist who works at 3 Axis Advisors, a consultancy that uses private prescription claims data in order to educate our clients on the workings of drug pricing within the drug supply chain as well as president of the non-profit, 46Brooklyn Research, which uses publicly available data to educate on the role of drug prices within programs like Medicare and Medicaid. My work in both organizations is nationally recognized, having been referenced in esteemed bodies such as the US House of Representatives Oversight and Accountability Committee and nationally recognized publications such as the JAMA Network, Bloomberg, the Wall Street Journal, and others.

I am here today to in my role as a drug supply chain expert to provide clarification into terms used within the drug supply chain that are often unknown or get confused by people who have not dedicated significant time to learn the industry jargon that dominates healthcare. I believe my testimony will be of worth to your considerations on Public Health Policy both today, and into the future.

To begin, we should recognize that there are many sources of prescription drug coverage. The principal way that people obtain prescription medications is through the use of prescription drug insurance. In order to obtain prescription medications via our insurance our plan sponsor, that is the organization responsible for helping to pay the bills, must have developed and offered to me a prescription drug benefit. The principal way that prescription drug benefits are offered to the majority of individuals in the United States is through their employer, in what is known as employer sponsored healthcare (or health plans). However, large numbers of individuals access prescription drug benefits through public programs like Medicare, a program generally targeted for individuals over the age of 65, as well as Medicaid, a program that generally supports the impoverished, such as those who are unemployed. Regardless of the manner in which you obtain prescription drug coverage through whichever insurance mechanism is available to you, one of the key documents provided to individuals, whether they recognize it or not, is known as the Summary of Benefits. Insurance companies and job-based health plans must provide you with[1]:

- A short, plain-language Summary of Benefits and Coverage (SBC)
- A Uniform Glossary of terms used in health coverage and medical care

The requirement for these documents was enacted under the Affordable Care Act (ACA) and have been the law of the land for years. However, for the benefit of this Committee, and for the removal of doubt, allow me to explain what is generally contained within the Summary of Benefits and Coverage more specifically.

First, the document will outline the manner in which your prescription drug coverage will operate. There are numerous different ways to insure prescription drug costs including, but not limited to, exclusive provider organizations (EPOs), health maintenance organizations (HMOs), and preferred provider organizations (PPOS). In general, the structure is normally based upon a constraint on what providers, doctors, pharmacies, hospitals, clinics, etc., are available for members to use and under what circumstances. For example, in EPOs, the insured generally agrees to have one provider take point in

[1] https://www.healthcare.gov/health-care-law-protections/summary-of-benefits-and-coverage/

their care and need to use them to get referrals to any other potential providers they may need, such as specialist. In this way, we have what are known as network constraints. The network is the group of facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. In general, the SBC will explain that members will incur different costs depending upon whether they utilize services from an in-network, or otherwise preferred provider, or an out-of-network, or otherwise non-preferred provider. As the name implies, high costs will be passed onto patients for use of non-preferred, out-of-network providers.

As my explanation makes plain, contained within the Summary of Benefits and Coverage is the information regarding member cost sharing. Cost sharing is the hare of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Unpacking this definition, let us begin with the manner in which prescription drug coverage is paid for. Insurance coverage is paid through the use of premiums, which is the amount you pay for your health insurance every month, regardless of whether you utilize any healthcare services. This is akin to premiums paid on car insurance, you pay those regardless of whether or not you've had an accident and need car insurance to help you cover costs. With employer sponsor health plans, generally premium costs are split between the employer and employee and the amount the individual is paying is deducted and viewable on their pay stub. If you use healthcare services, your cost experience will depend upon whether or not you have a deductible. Plans with a deductible require members to pay for covered health care services **before your insurance plan starts to pay (or share in the cost)**. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, the Summary of Benefits and Coverage will delineate expected cost sharing in terms of copayment or coinsurance. Copayments are a fixed amount ($20, for example) you pay for a covered health care service after you've paid your deductible. Coinsurance is costs incurred as a percentage of costs of a covered health care service you pay (20%, for example) after you've paid your deductible. Note that the Summary of Benefits and Coverage may have a lot of different approaches to the manner of cost sharing, such as requiring copayments when using in-network providers and services and coinsurance when using out-of-network providers and services. Specific to prescription drugs, the Summary of Benefits and Coverage will identify the drug list your benefit covers. The drug list is a list of prescription drugs covered by a prescription drug plan offering prescription drug benefits. It is also called a formulary, or a preferred drug list (PDL). Much like doctors and pharmacies preferred and non-preferred status, the drug list will identify products that are preferred and non-preferred. Again, these products will almost certainly be associated with different cost sharing requirements to plan members based upon their preferred and non-preferred status. As an example, a preferred medication to treat diabetes may have a small, flat copay charge of $5 to the member, whereas a non-preferred medication on the drug list may have a coinsurance charge of 20% of the $1,000 list price of the medication. The most that a member can be expected to pay for healthcare services is also identified within the SBC and is defined as the out-of-pocket maximum or limit. After you spend this amount on deductibles, copayments, and coinsurance for in-network care and services, your health plan pays 100% of the costs of covered benefits.

With this background information provided, we can begin to better appreciate the role of manufacturer assistance programs, also known as patient assistance programs, that have been developed to help address drug costs. Manufacturer assistance programs related to prescription drugs take many forms

including coupons used at the point-of-sale to lower costs as well as organizations which help individuals purchase and obtain drugs. In general, there is a recognized issue with prescription drug affordability. Patients consistently rank drug affordability challenges as one of the key topics that Congress should seek to address. The origin of this issue is multifaceted including, but not limited to, insurance benefit design, list price of medications, and retrospective, non-transparent price concession within the drug supply chain. Regardless of the origin, manufacturer assistance programs are designed to lower patient drug costs to increase utilization of their products. Manufacturers only make money when their products are sold (i.e., utilized). If patients are unable to afford their medications, they will not be taken and therefore there will be no sales. While couponing and other efforts are generally understood within the broader marketplace of commerce, what has happened in regard to prescription drug insurance has been changes in benefit design which seek to capture the value of these manufacturer assistance programs. The most common of these programs are copay accumulators and copay maximizer programs which may be implemented by sponsors of prescription drug benefits, in coordination with third-party vendors such as pharmacy benefit managers (PBMs).

A copay accumulator program is a feature within an insurance plan whereby a manufacturer's payments (via assistance programs or coupons) do not count toward the patient's deductible and out-of-pocket maximum. The manufacturer assistance funds prescriptions until the maximum value on the program is reached. After that, the patient's out of pocket costs begin counting toward their annual deductible and out-of-pocket maximum.

A copay maximizer is another program within an insurance plan whereby a manufacturer's payments do not count toward the patient's deductible and out-of-pocket maximum. However, unlike the accumulator program, the maximum value of the manufacturer's assistance is applied evenly throughout the benefit year.

At the end of the day, both programs are designed to shift the value of the manufacturer assistance from the patient and to the plan sponsor. Underwriting health insurance policies is a complicated task and made potentially more difficult when programs are operated that seek to circumvent the designed drug list and cost share structure. I appreciate that it is not easy to wrap one's head completely around the dysfunctional nature of prescription drug insurance and the complicated lexicon used that generally uses three equivalent or near equivalent terms to describe the same action or function. However, I hope my testimony aids your thoughtful process of legislating Ohio's Public Health Policy and I am happy to answer any questions you may have of me.