1. **<u>Would this bill steer patients to higher-cost brand name drugs as opposed to cheaper generic equivalents?</u>**

No. In almost all cases, copay assistance is used for brand name drugs without generic equivalents. A study from IQVIA found that only **0.4% of copay assistance use in the commercial market was for brand name drugs that have a generic equivalent**.[1]

Insurers and PBMs have utilization management protocols, such as step therapy and prior authorization, which steer patients towards the insurer-preferred treatments. Copay assistance only becomes a factor for a medication once an insurance company has granted approval for the patient to utilize that medication. We also note that due to rebates and other business deals, utilization management strategies can steer patients <u>away</u> from medications with cheaper list prices as well as biosimilars and generics.

2. **<u>Is Restricting Copay Accumulators a Tool to Circumvent Plan Design?</u>**

No. If a health plan has prior authorization, step therapy or other utilization management protocols in place, a copay assistance program can't circumvent that design. This legislation does not address the type of drug approved and covered by the plan; it only addresses the payments for the drugs that are counted toward the deductible and out-of-pocket costs.

3. **<u>Does Copay Assistance Guide Patient Decision-Making?</u>**

No. Patients are not proactively choosing expensive drugs, but have been prescribed their treatment regimen by their provider. Patients often try multiple drugs before finding the treatment that works best for their individual, complex medical situation, taking into consideration co-morbidities, drug interactions, and side effects, and utilization management strategies employed by PBMs and insurers. Copay assistance only becomes a factor once an insurance company has granted approval for the patient to utilize that medication.

However, **copay accumulator adjustor programs DO guide patient decision-making**. Many people with chronic illnesses that rely on specialty medications reach their out-of-pocket (OOP) maximum each year, sometimes within the first month or two. For people who depend on copay assistance to afford their medication, copay accumulator adjustor programs mean that they have to skip doses, extend their dose inappropriately by taking less than prescribed, or seek alternative, less effective, treatments. All of these practices can have severe and/or irreversible negative consequences on patient health. Copay assistance helps patients adhere to the treatment prescribed by their doctor *and approved by their insurance plan/PBM*.

The opposition likes to describe copay assistance as "coupons" because for other products, coupons can guide consumer decision-making. However, coupons for other products do not have other stakeholders (i.e. insurers and PBMs) within the process like there is with medications. A grocery store manager does not stand in the aisle telling a consumer which kind of detergent to select. However, for medications, the insurer must 1) include the treatment on its formulary and 2) agree that it is medically necessary before copay assistance is relevant. We also note that, unlike coupons, copay assistance are real funds being transferred from one party to another.

[1] IQVIA. "Evaluation of Co-Pay Card Utilization." Available online at: https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization.

4. <u>Does copay assistance provided by manufacturers keep drug prices high by incentivizing the use of high-cost treatments instead of lower-cost generic equivalents?</u>

No. Copay accumulator adjustment policies (CAAPs) largely target specialty medications for which there are generally no generic equivalents available. In fact, data shows that for all commercial market claims only **0.4% of copay assistance use was for brand name drugs that have a generic equivalent**.[2] If copay assistance programs were intended to drive patients away from generic alternatives, then this share would be significantly higher.

Copay assistance is a critical lifeline that helps ensure that the most vulnerable patients can access their needed medications. When barriers prevent patients from accessing these medications, it ends up costing the health system more money due to complications and worsening health outcomes. Research has found that the cost of patients not receiving optimal medication therapy is over $528 billion each year in the United States.[3]

5. <u>Will banning copay accumulator adjustor programs change the actuarial value (AV) of the plan?</u>

No. The bill will not alter actuarial value (AV). Actuarial value describes how much of a person's health care expenses a plan offered on the ACA marketplaces (this aligns with the metal tiers – platinum plans cover more of a person's costs than a silver plan does). Approximately 16 million lives are covered by marketplace plans (as compared to 155 million covered lives in employer plans).[4, 5]

This bill doesn't change how much the patient owes for the deductible or prescription drug copayment. Copay assistance is a source used to pay the amount set by the health plan and/or PBM. Copay assistance was common for years before plans started implementing copay accumulator adjustment policies. The real change was HHS allowing copay accumulator adjustment policies to be used widely, which allowed plans to collect far more from enrollees for their care than suggested by the plan design. Since HHS has not included copay accumulator adjustor policies in the AV calculator, they also must not see it as affecting AV.

6. <u>Would this legislation cause patients to select more expensive plans?</u>

No. Patients who rely on copay assistance are often carefully balancing their budgets to afford their healthcare. And even "higher value" (or more expensive) plans may have unaffordably high cost-sharing requirements. For example, a gold or platinum plan may have a lower deductible, but it will also have a significantly higher monthly premium and high cost-sharing for specialty-tier drugs.

In a random selection of plans from Healthcare.gov in April 2023, a gold plan from Ambetter in Indiana has a $500 premium, $750 deductible, and 50% coinsurance for specialty tier drug. A platinum Blue Cross Blue Sheild plan from Florida has a $810.45 premium, $1,000 deductible, and 50% coinsurance for specialty drugs. A 'lower-value' plan such as a silver plan, may have a more reasonable monthly premium, but will have a higher deductible and the coinsurance will remain high. Between high premiums and coinsurance up to 50% of the list price of a drug, the average patient cannot afford these monthly charges. Copay assistance will help them cover the cost-sharing associated with specialty drugs.

Further, the number of people in High-Deductible Health Plans (HDHP) is growing. HDHPs are increasingly common in the employer market, and the dollar amount of deductibles within these plans is rising, with a more

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[2] IQVIA. "Evaluation of Co-Pay Card Utilization." Available online at: https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization.

[3] Watanabe, Jonathan H et al. "Cost of Prescription Drug-Related Morbidity and Mortality." *The Annals of pharmacotherapy* vol. 52,9 (2018): 829-837. doi:10.1177/1060028018765159

[4] https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[5] https://www.kff.org/report-section/ehbs-2021-summary-of-findings/

than $500 average increase since 2010, reaching $2,424 for individual coverage and $4,705 for family coverage in 2021. The number of people enrolled in HDHPs has risen in recent years, with 28% of covered workers in these plans in 2021. Coupled with rising premiums and co-pays, the median spending on health care was 11.6% of household income in 2021[6].

7. <u>What has been the experience in the 17 states and Puerto Rico that have enacted copay accumulator legislation?</u>

To date, 17 states, (Arkansas, Arizona, Connecticut, Delaware, Georgia, Illinois, Louisiana, Kentucky, Maine, New Mexico, New York, North Carolina, Oklahoma, Tennessee, Virginia, Washington, West Virginia) and Puerto Rico have enacted copay accumulator legislation. There have been active campaigns in more than 20 additional states.

The states that have conducted a fiscal impact analysis have concluded that passage of copay accumulator legislation would have minimal to no fiscal impact. These states include New York, Louisiana, and Ohio.[7,8,9]

In its analysis of its copay accumulator adjustor bill, Kentucky stated "Our estimated increase in premiums for health benefit plans, excluding Medicaid and state employee plans, is approximately $0.00 to $0.99 per member per month (PMPM)."[10]

The AIDS Institute examined the change in the average benchmark premium in marketplace plans in states that enacted copay accumulator adjustment bans between 2019 and 2022 as compared to states that did not enact copay accumulator adjustment bans. It found that these laws had no impact on premiums.[11]

8. <u>Would a nationwide ban on all copay accumulator adjustor programs lead to Medicare-eligible people dropping Medicare and going onto the marketplace plans to use copay assistance?</u>

No. Generally, if eligible for Medicare, a person cannot sign up for a Marketplace plan, even if they choose not to enroll in Medicare.[12] And it is illegal for someone who knows a patient has Medicare to sell them a Marketplace plan.[13] Moreover, if a Medicare-eligible individual wanted to enroll in a Marketplace plan instead, they would face stiff financial penalties that would likely make that choice unaffordable.[14]

Also, when looking at Marketplace enrollment between 2019 and 2023, people over age 65 represents less than 2% of total enrollment with no difference between states that have enacted CAAP legislation and those without laws.[15]

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[6] Trilliant Health. "2022 Trends Shaping the Health Economy." October 2022. https://www.trillianthealth.com/insights/reports/2022-health-economy-trends.

[7] https://nyassembly.gov/leg/?default_fld=&leg_video=&bn=A01741&term=2021&Summary=Y&Actions=Y&Committee%26nbspVotes=Y&Floor%26nbspVotes=Y&Memo=Y&Text=Y&LFIN=Y&Chamber%26nbspVideo%2FTranscript=Y

[8] https://legiscan.com/LA/supplement/SB94/id/202374/Louisiana-2021-SB94-Fiscal_Note_-_SB94_Enrolled.pdf

[9] https://www.legislature.ohio.gov/download?key=18734&format=pdf

[10] https://apps.legislature.ky.gov/recorddocuments/note/21RS/sb45/HCS1HM.pdf

[11] https://aidsinstitute.net/documents/Copay-Assistance-Does-Not-Increase-Premiums-Final.pdf

[12] Medicare & the Health Insurance Marketplace, https://www.medicare.gov/Pubs/pdf/11694-Medicare-and-Marketplace.pdf. An exception applies for people who must pay Medicare premiums because they worked fewer than 10 years while paying Medicare taxes. This applies to approximately 1% of Medicare beneficiaries.

[13] Medicare and the Marketplace, https://www.healthcare.gov/medicare/

[14] https://www.medicare.gov/Pubs/pdf/11694-Medicare-and-Marketplace.pdf

[15] CMS Marketplace Open Enrollment Period Public Use Files, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products.