Section 2 – Legislative Purpose

(B) The legislature further finds that patients need cost sharing assistance because the high list prices of prescription drugs have led to increased ~~of the high~~ out-of-pocket costs for ~~of~~ medications.

> **Rationale:** Out of pocket costs for all services, drugs, and devices are based on the underlying cost of the product or service. It is vital to remember that out of pocket costs do not exist in a vacuum, but they are based by the prices set by other entities—in this case, the drug manufacturers themselves.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. ~~This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.~~

> **Rationale:** Accumulator adjustment programs still allow copay assistance to be used and patients to receive that benefit, but they ensure that patients' actual out-of-pocket spending is accurately represented. Moreover, the patient is still obtaining their medication at the rate negotiated by the plan with the manufacturer—which is typically lower than the listed price, even if the cost-sharing assistance is not counted toward the out-of-pocket limit. Additionally, numerous studies have shown the detrimental impact that copay assistance (including copay coupons) have on the entire market – accumulator adjustment programs protect the entire risk pool from the market manipulation and higher costs caused by copay assistance programs. In fact, the Medicare and Medicaid programs continue to prohibit cost sharing assistance from drug manufacturers to patients under the Anti-Kickback statute as an illegal inducement to purchase their products accordingly.

~~**(I) The legislature further finds that accumulator adjustment programs allow health insurers and PBMs to "double dip" by accepting funds from both the cost sharing assistance program and the patient beyond the original deductible amount and the annual out-of-pocket limit.**~~

> **Rationale:** This assertion is entirely untrue. When a copay coupon is used, the value of the coupon goes from the manufacturer (who issues the coupon) to the pharmacy (as a form of consumer payment) and then back to the manufacturer (as payment for the drug). That is why the federal government considers coupons an illegal kickback – drugmakers are paying themselves.
>
> At no point do health insurers or PBMs receive the value of the coupon. Health insurers and PBMs may not even be aware that a coupon is being used because coupons include their own identifying information (i.e., bin number, member ID, etc.) that results in them being processed separately from a consumer's insurance. Some insurers have established accumulator programs to increase transparency of and help them track third-party payments.

Section 4 – Cost Sharing Requirements

(A) When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person for a covered prescription drug unless

(1) there is a covered generic equivalent;
(2) there is a covered interchangeable bio-equivalent; or
(3) there is a covered drug in the same therapeutic class that may be preferred under the plan's formulary.

(B) A person that pays any amount on behalf of an enrollee for a covered prescription drug
(1) must offer the assistance for the full plan year;
(2) must notify the enrollee prior to an open enrollment period if the financial assistance will be discontinued in a subsequent plan year; and
(3) may not condition the assistance on enrollment in a specific health plan or type of health plan, to the extent permitted under federal law.

(C)
(1) A person that pays any amount on behalf of an enrollee for a covered prescription drug shall disclose to the enrollee's [CARRIER/INSURER/ISSUER]:
(a) the name of the enrollee on whose behalf a payment was made,
(b) the name of the prescription drug for which the payment was made,
(c) the amount of the payment that was provided, and
(d) any other terms and conditions that are attached to the assistance program under which the payment was made.
(2) The requirement in (1) may be accomplished if the third-party payment is processed in coordination with the enrollee's health insurance coverage at the point of sale.
(3) A person that pays any amount on behalf of an enrollee for a covered prescription drug may not provide the payment as a post-claim reimbursement.

(D) If a person that pays an amount on behalf of an enrollee for a covered prescription drug is a pharmaceutical manufacturer, that person shall provide to the [DEPARTMENT] and the enrollee's [CARRIER/INSURER/ISSUER] the following information about the patient assistance program offered by the manufacturer for the covered prescription drug:
(1) the number of consumers who participated in the program in the previous calendar year;
(2) the total value of the coupons, discounts, copayment assistance or other reduction in costs provided to consumers in this state who participated in the program;
(3) the number of refills that qualify for the program, if applicable;
(4) the period of time that the program is available to each consumer, if applicable; and
(5) the eligibility criteria for the program and how eligibility is verified for accuracy.

(E) If a person that pays an amount on behalf of an enrollee for a covered prescription drug is a third party that is not a pharmaceutical manufacturer, that person shall annually compile a report on the contributions that the person receives from the pharmaceutical supply chain.
(1) The report shall include:
(a) the amount and source of any contribution the person received from a pharmaceutical manufacturer, a pharmacy benefit manager, a health [CARRIER/INSURER/ISSUER], or a trade group or advocacy group for the above entities and
(b) the percentage of the person's total gross income that is attributable to the total contributions received from the entities listed in (a).
(2) The report shall be posted on the person's publicly accessible website.

Amendment (A) – Limit accumulator ban to covered drugs that have no other lower cost alternative.

The proposed NCOIL model is not specific to prescription drugs and, as written, could apply to third party payments for all drugs, services, or devices. The model language must be clarified so that drug manufacturers cannot use coupons to bypass a formulary.

Copay coupons under the circumstances identified by this amendment undermine health insurers' programs to incentivize use of generics and lower cost preferred drugs by masking the true cost of medications from the patient while shifting the financial burden to everyone in the system. By hiding the true cost of brand name drugs, manufacturers continue to operate in the "black box" of drug pricing.

Health plans use formulary placement to incent providers to prescribe, and patients to request, generic and/or lower-cost medications where clinically appropriate to do so. Manufacturers and other third-party payers use discounts, product vouchers, and other types of "copay coupons" to steer consumers into higher cost, brand name products when safe, effective, clinically equivalent alternatives are often available. We must minimize that drive towards more expensive drugs and incentivize the use of generic and lower-priced drugs where they exist, and it is clinically appropriate to do so.

Accumulator bans should be limited and not applicable where generic equivalents are available or in circumstances where other, non-generic drugs in the same therapeutic class may be available as they may be preferred by a plan's formulary or otherwise less expensive than a drug for which cost sharing assistance is offered. In these situations, there are still choices and significant price differences. For example, there are several treatments for Hepatitis C that are in the same therapeutic class and that may potentially be interchangeable depending on the patient's condition, but none are generic equivalents (e.g., Sovaldi, Harvonia, Viekira Pak).

The interchangeable bio-equivalent limitation also addresses situations where a manufacturer combines 2 OTC/generic drugs and markets them as a "new" expensive brand name medication (examples). For example, Duexis is a combination of ibuprofen (Advil) and famotidine (Pepcid); on GoodRX, the cheapest price for a one-month supply (90 pills) is over $2,400, while both drugs are available separately over the counter (OTC) at significantly lower prices individually.

Amendment (B) – Require third-party cost sharing assistance to be provided to all enrollees prescribed the drug for the entire plan year and requires advanced notification of discontinuation of assistance.

Drugmakers could provide copay coupons to every patient, for the entire time they need to take the medication, but they do not because that does not align with their financial motivations for providing coupons—to get the plan sponsor to pay for their drug for the entire plan year regardless of whether less costly (and/or more effective) alternatives are available at the expense of the entire plan's patient risk pool. These amendments are intended to change that and prevent the premium increases resulting from such manufacturer manipulations. Or manufacturers could just lower their prices across the board for all patients instead.

Patients are vulnerable to financial exposure or disruptions in care if payments stop in the middle of treatment. Requiring assistance to be provided for the entire plan year and requiring notice when that assistance will be discontinued provides predictability, ensures patients can focus on their health, and allows patients to choose the right health plan for their needs. These are the same types of consumer protections that California enacted in their third-party payment of premiums law (AB 290).

The amendment requiring assistance to be provided for an entire plan year also eliminates a common gaming of the system, whereby a third-party provides assistance for a brand-name drug before the patient has reached their deductible and then then intentionally discontinues the assistance, requiring the other patients to pay higher premiums. This allows pharmaceutical manufacturers to keep their prices high by hiding the true cost of their drugs from patients and allows them to reap higher profits over the course of the year – all while employers, consumers, and taxpayers are picking up the tab through higher premiums. This is especially vexing in situations where less costly and effective alternative medications may be available.

Instead of lowering costs for everyone by reducing the actual price of the drug, prescription drug manufacturers and patient assistance organizations target specific populations in specific types of health plans with advertising and discounts. If third-party cost sharing assistance is allowed and must be

counted towards the deductible, then it should be provided to all patients equally. We have included the language “to the extent permitted under federal law” because copay coupons are banned by the federal government for use in Medicare and Medicaid because they are considered an illegal kickback.

Amendment (C) – Provide additional transparency to assist in the administration of this act by requiring the person to notify the insurer that an enrollee is receiving the assistance and any terms & conditions of the assistance.

Health insurers and PBMs are often not aware that a coupon is being used because coupons include their own identifying information (i.e., bin number, member ID, etc.) that results in them being processed separately from a consumer’s insurance. Some pharmacy claims processing systems now include a feature that allows the insurer to track coupons and other third-party payments if they are processed in coordination with the patient’s insurance.

Third-party assistance can also take the form of a post-purchase reimbursement to the patient by a third-party entity. In these cases, the patient will pay cash and health insurers will not know that assistance has been provided after the fact. Additionally, we believe that these types of reimbursement schemes are only in place to hide the assistance that is being provided by third party entities. These entities must play their part to ensure that all third-party payments are transparent so that they may be correctly applied and their overall impact to health insurance spending be understood.

Amendments (D & E) – Provide additional transparency to understand the impact that third-party payments have on health care spending by requiring a third-party entity to disclose the amount that they spend on patient assistance programs and any contribution they receive from entities in the pharmaceutical supply chain.

AHIP commends NCOIL for understanding the importance drug price transparency. We wholeheartedly agree and believe transparency is vital to understanding more about the entities that are paying enrollees’ cost sharing, how they interact with members of the pharmacy supply chain, and the money that they spend on these programs.

When manufacturers are paying enrollees to use their drug, they must be transparent about the types of programs it provides and how much is spent on these programs, so that policymakers and insurers can better understand the scope of these programs and the impact that they have on the larger health care spending landscape.

Copay coupons and other types of cost-sharing assistance often come directly from pharmaceutical manufacturers, but they may also be provided from third-party patient assistance groups. Patients for Affordable Drugs recently reported on the extensive linkage between pharmaceutical manufacturers and patient assistance groups. We believe that these financial ties should be transparent and reported by the organizations themselves. To understand the relationship between these groups and the pharmaceutical supply chain, and the impact that this linkage has on drug prices, we believe that all third-party entities providing the cost sharing assistance should be required to disclose their financial ties to the pharmaceutical supply chain.