



May 5, 2021

Representative Rachel Prusak
Chair, House Committee on Health Care
900 Court St. NE, H-489
Salem, OR 97301

Re: Support of SB 560 so that Patients can Afford their Prescription Medications

Dear Representative Prusak,

The **HIV+HEP Policy Institute** is a leading HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. **We strongly support Senate Bill 560, which would require health insurers and health care service contractors to accept and count payments made on behalf of patients towards deductibles and out-of-pocket maximums.**

Copay accumulators are harmful policies that many insurance plans, employers, and pharmacy benefits managers (PBMs) are implementing in which copay assistance does not count towards a beneficiary's out-of-pocket costs and deductible. By passing this bill, Oregon will join other states (Arizona, Georgia, Illinois, Kentucky, Oklahoma, West Virginia, and Virginia) and Puerto Rico in protecting consumers purchasing insurance on the private market by assuring their copay assistance will count towards cost-sharing obligations.

People with HIV, hepatitis, and others with serious and chronic conditions rely on medications to remain healthy and alive. People with HIV and hepatitis B rely on a daily drug regimen that they must take for the rest of their lives, while people with hepatitis C can be cured of their diseases in as little as 8 to 12 weeks. However, even though people may have health insurance, access to these medications is still insurmountable for many due to high deductibles and cost-sharing, often in terms of co-insurance. Copay assistance is critical for patients to afford and adhere to their medications. It is particularly important during the COVID-19 epidemic when so many individuals and families are hurting economically.

High Patient Cost-sharing: According to the Kaiser Family Foundation, average deductibles for covered workers increased 212% from 2008 to 2018. For qualified health plans, CMS reports that across all metal levels, deductibles are increasing. For Bronze plans, the median deductible will be \$6,992 in 2021, an increase of 11 percent from 2017; for Silver plans, it will be \$4,879, an increase of 31 percent since 2017. For plan year 2022, CMS is proposing that the maximum out-of-pocket be \$9,100 for an individual and \$18,200 for all others. Due to the proliferation of

HIV + HEPATITIS POLICY INSTITUTE

1602B Belmont Street NW | Washington DC 20009 | 202-462-3042
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high deductible plans, depending on the drug, a patient may be required to pay that total amount of \$9,100 all at once for their medication at the beginning of the year.

According to a study conducted by Ezra Golberstein examining National Health Expenditure Accounts data, in 2017 individuals were responsible for paying 14 percent of the total cost of prescription drugs. However, for hospital care, which accounts for nearly three and half times more total spending, patients were responsible for paying only 3 percent. For physician and clinical services, the next largest service category, patients paid 8.5 percent of the costs. This is one reason why people are complaining about how much they pay for their medications; insurers are requiring them to pay a high percent of the total costs.

Patient Cost-sharing Impacts Adherence: A recent analysis of branded prescription drug trends found that if patient out-of-pocket costs totaled between \$50 and \$74.99 per month that 30 percent of patients would not pick up their medications. If that amount were increased to \$250 or more, over 70 percent of patients would forego critical prescription drugs.¹ Another study highlighted the negative impact of copay accumulator programs finding that patients who are subject to the programs fill prescriptions 1.5 times less than patients in high deductible health plans. Additionally, patients subject to these programs experience a 13 percent drop in persistence between month 3 and 4 as they reach the cap in their annual benefits and terminate their therapies.²

Growth of Copay Accumulators: Health insurers and pharmacy benefits managers have increasingly included copay accumulator adjustment programs in their plan offerings over the last several years. According to the National Business Group of Health, in the next two years, accumulators and maximizers are expected to expand from approximately 25 percent of U.S. employers to as many as 50 percent. According to TrialCard, one of the leading administrators of copay assistance programs, clients taking infectious disease medications and subject to copay accumulator programs has increased from 7.3 percent in 2019 to 10.5 percent in 2020.

An analysis by **HIV + Hep** found that five of six health insurers offering plans on the Oregon Marketplace contained language barring at least some, if not all, copay assistance from counting towards patients cost-sharing obligations. For more details please see our analysis attached to this letter.

Copay Accumulators Allow Insurers to “Double Dip”: Perhaps the most overlooked aspect of the “copay accumulator” issue is that not only do patients pay much more money for their prescription drugs, but the insurers also collect more money. The insurer not only collects the value of the copay coupon, but then after it is maxed, the patient then has to pay the out-of-pocket costs, with the insurer collecting all that money as well. Additionally, the drug manufacturers end up paying more money. The only players that this policy is good for are the insurers and the PBMs.

¹ IQVIA National Prescription Audit, Formulary Impact Analyzer, January 2019.

² Steve Mink and Arran Standring, “Driving persistence among patients affected by copay accumulators with patient centric support,” *American Journal of Managed Care*, October 18, 2020.

Lack of Transparency: Patients often are not aware that their insurance policies contain these harmful policies until they pick up their medications at the pharmacy and are stuck with a several thousand-dollar bill that they did not expect. Insurers conceal copay accumulator language deep in plan documents. Additionally, there is no consistency among insurers on how the policies are displayed and plans use ambiguous language.

Consider **Oregon's Regence BlueCross BlueShield of Oregon** policy which includes a copay accumulator provision on page 16 of an 120 page [Medical Policy](#) document:

"Your payments of Copayment and/or Coinsurance for Prescription Medications count toward the Out-of-Pocket Maximum, however, any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of a drug manufacturer coupon does not apply toward the Out-of-Pocket Maximum when purchased through Our Specialty Pharmacy."

This language is confusing to patients as they will now need to understand if their regular pharmacy is a specialty pharmacy or if they will need to use a specialty pharmacy for their specific medication. Additionally, this information is buried in a very lengthy, not readily available, plan document.

For the benefit of patients who rely on prescription drugs to maintain their health, we urge you to support SB 560. If you have any questions or need any additional information, please do not hesitate to reach out via phone at (202) 462-3042 or email at cschmid@hivhep.org. Thank you very much.

Sincerely,



Carl E. Schmid II
Executive Director

HIV+HEP

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Oregon Health Plans

Insurer	Copay Accumulator?	Citation
Kaiser Permanente	No evidence of copay accumulator	
Providence Connect plan	“Drug coupons will accumulate to your Out-of-Pocket Maximum when used for a brand-name drug for which a generic equivalent is not available.	Pg. 43
Regence Regence BlueCross BlueShield	“Your payments of Copayment and/or Coinsurance for Prescription Medications count toward the Out-of-Pocket Maximum, however, any reduction in Your Copayment and/or Coinsurance for Prescription Medications resulting from the use of a drug manufacturer coupon does not apply toward the Out-of-Pocket Maximum when purchased through Our Specialty Pharmacy.”	Pg. 6
Moda Health Oregon Individual Policy – Standard Bronze	“Disallowed charges, copayments and manufacturer discounts and/or copay assistance programs do not apply to the annual deductible.” General Exclusions: “Services Otherwise Available Including those services or supplies - for which no charge is made (including reducing a charge due to a coupon or manufacturer discount), or for which no charge is normally made in the absence of insurance”	Pg. 17 Pg. 54
Pacific Source Oregon Standard Bronze Sample Contract	“For any such medication where third party co-payment assistance is used, the member shall not receive credit toward their maximum out-of-pocket or deductible for any co-payment or co-insurance amounts that are applied to a manufacturer coupon or rebate.”	Pg. 30
BridgeSpan BridgeSpan Health Company Policy	“Manufacturer Coupons Any reduction in Your cost-sharing resulting from the use of a drug manufacturer coupon does not apply toward the Out-of-Pocket Maximum when purchased through Our Specialty Pharmacy.”	Pg. 29

Analysis completed January 27, 2021

HIV+HEPATITIS POLICY INSTITUTE

1602B Belmont Street NW | Washington DC 20009 | 202-462-3042 | 202-365-7725 (cell)

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