Testimony on HB 4113: Co-Pay Accumulator Legislation

February 7, 2024

Chair Nosse and Members of the Committee,

My name is Mary Anne Cooper, and I'm the Oregon Director of Government Relations at Cambia Health Solutions, which operates Regence BlueCross BlueShield of Oregon. Thank you for the opportunity to submit testimony on HB 4113.

We appreciated the early engagement from Rep. Levy on this bill and hope to continue conversations about this issue heading into the 2025 legislative session.

We recognize that high drug costs require consumers to increasingly rely on manufacturer coupons to help alleviate the impacts of unsustainable drug pricing. While HB 4113 will help patients meet their cost share obligations related to these drugs, it will also increase already significant profit margins for drug manufacturers and increase health insurance costs due to its failure to address inequities around use of manufacturer coupons. It may also keep patients on expensive drugs even if lower-cost, equally effective treatments are available on the market. In addition to HB 4113, we encourage the committee to consider other more patient-focused solutions to drug affordability that protect patients from high drug costs.

As one of the state's largest health insurers, Regence is committed to addressing both persistent and emerging health needs for the nearly one million Oregonians we serve. In keeping with our values as a tax-paying nonprofit, 85% of every premium dollar goes to pay our members' medical claims and expenses. In Oregon, prescription

drugs account for 20-30% of all plan spending.[1] These costs are largely driven by specialty-drug spending, where manufacturer coupons are often directed. Within Regence, specialty drugs account for only 3% of claims but over 62% of the total costs of prescription drugs.

Today our members can and do use manufacturer coupons to help offset their obligation at the pharmacy counter, but only the member's own out-of-pocket costs "count" toward their cost share obligation under their policy. This wouldn't be a problem if manufacturers consistently provided coupons throughout the calendar year, but some manufacturers have limits that appear to be more focused on incentivizing use of their drug, such as only making them available for a limited number of fills. HB 4113 requires insurers to count those coupons toward the members' cost-share obligations, which limits the value coupon assistance manufacturers would provide before the plan picks up 100% of the cost. This actually increases the price members pay for health care and can incentivize patients to stay on higher-cost drugs where coupons are available, even if equally effective alternative therapies are available or introduced to the market.

We know people in the United States pay twice as much for their prescriptions compared to 32 other developed countries.[2] We also know many people cannot afford the high costs of their medications without insurance. The skyrocketing price of prescription drugs is one of the main reasons the state has created the Prescription Drug Affordability Board and the Prescription Drug Price Transparency Board, which should have the opportunity to review this proposal for total consumer cost.

Over the years, manufacturers have aggressively raised prices on existing drugs and have continuously raised the price of new drugs. The Congressional Oversight Committee Investigation on Drug Pricing found that manufacturers raised the price of 12 drugs over 250 times with the median price of those drugs being almost 500% higher than when it was originally brought to market.[3] In 2008, the average cost of a

[1] Department of Consumer and Business Services. (2022, November 30). Prescription Drug Price Transparency Results and Recommendations – 2022. Retrieved March 9, 2023, from https://dfr.oregon.gov/drugtransparency/Documents/Prescription-Drug-Price-Transparency-Annual-Report-2021.pdf

[2] Drug pricing investigation: majority staff report. (2021). Committee on Oversight and Reform, U.S. House of Representatives.

[3] Drug pricing investigation: majority staff report. (2021). Committee on Oversight and Reform, U.S. House of Representatives.

new drug entering the market was $2,000 annually, in 2022 it was $220,000 annually.[4] It has only increased since then.

Manufacturers use copay coupons to mask these high prices. Coupons are given to patients to help them afford the unjustified cost of the medications that Americans pay more for than any other part of the world. These coupons have been associated with drug cost increases. According to a study done by researchers from Harvard, UCLA and Northwestern, "coupons are associated with faster branded price growth. Drugs without coupons experience real price growth of 7–8 percent per year, while drugs with coupons experience price growth of 12–13 percent per year."[5] Notably, government health plans such as Medicare and Medicaid have banned copay coupons as a form of an illegal kickback. Medicare's ban on copay coupons saved the Part D program an estimated $18 billion the past 10 years.[6]

Manufacturers have the power to lower drug prices and alleviate patient cost burden. We saw that recently when Eli Lily significantly lowered the price of their insulin by 70%. Yet manufacturers continue to tout coupons as the solution. Why? Because the coupons bolster ever-increasing revenue targets and incentivize patients to use expensive treatments. Copay coupons are not charity. Rather, they are a key part of drug manufacturers' strategy to distract from unreasonable and constant price increases. Nationally the continued use of copay coupons will raise overall drug spending by $32 billion for employers, unions and other plan sponsors while earning drug manufacturers a 4:1 to 6:1 return on investment.[7]

Utah's government-run Public Employee Health Plan completed a fiscal analysis of the impact of a bill similar to HB 4113 on the state's benefit plan. They concluded that state health care spending would rise by more than $2.7 million, with about 85% of the added cost directly benefiting drug manufacturers (because available assistance would no longer be maximized) and only 15% benefiting patients (who would hit their deductibles faster).

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[4] https://www.reuters.com/business/healthcare-pharmaceuticals/us-new-drug-price-exceeds-200000-median-2022-2023-01-05/#:~:text=The%20median%20annual%20price%20of,2022%2C%20the%20median%20was%20%24222%2C003

[5] Dafny, L., Ody, C., & Schmitt, M. (2017). When discounts raise costs: the effect of copay coupons on generic utilization. *American Economic Journal: Economic Policy*, *9*(2), 91-123.

[6] Visante Copay Coupon Study. "How Copay Coupons Could Raise Prescription Drug Costs by $32 Billion Over the Next Decade." October 2011.

[7] Wickersham, P. (2013). Sorting out the truth about copay coupons. Employee Benefit Plan Review, 67(10), 26.

As health plans continue to pay for increasingly costly drugs, the unwanted but necessary effect is rising health insurance costs. Of note, plans and employers must grapple with prohibitive costs of newer emerging drug therapies with list prices in the $2-3 million dollar range. Regence has seen its drug spending rise in recent years, from $90 PMPM in January 2022 to $125 PMPM in January 2024, with a total increase in our fully insured business of $43 million in the last year. HB 4113 would exacerbate this trend.

The federal government continues to grapple with how to address co-pay coupons, and we are awaiting further federal action on this issue in response to a recent lawsuit. Notably, the Court overturned some 2021 clarifications HHS made to their approach to copay accumulators due to a lack of HHS clarity on key terminology, but did not provide prescriptive clarification on how the approach to that terminology should be revised. Further, HHS stated in a motion in that case that it does not intend to take enforcement action while it considers future rulemaking. Though HHS has dropped its appeal, the Court did not address the motion and HHS has not yet made any statements updating that enforcement approach.[8] Given this federal uncertainty, it is prudent for Oregon to work on a state-specific solution that addresses both the issues facing consumers – the need to count coupons toward cost share, while protecting against manufacturer coupon abuses.

Several solutions would address our shared concern about patients' inability to afford their insurance cost share obligation for expensive specialty drugs and help address excessive drug prices from manufacturers. We have included a list of consumer protections we believe would significantly benefit consumers and could run concurrently with HB 4113. We would also encourage the legislature to look into authorizing an accumulator program to be used alongside a coupon maximizer program, which would allow plans to apply coupons toward the cost share obligation while ensuring that the patient's copay remains at their plan level (between $0-35) if the coupon runs out. We encourage the legislature to adopt these solutions alongside HB 4113 to address both sets of issues faced by consumers as it relates to manufacturer coupons.

We would appreciate the opportunity to work with this committee to find a solution that primarily benefits patients, not drug manufacturers.

[8] HHS Drops Appeal in Drug Coupon Case | Groom Law Group

As drafted, we oppose HB 4113, as the benefits would flow overwhelmingly to drug manufacturers and the bill fails to address unjustified high drug prices. We share the goal of the committee of easing the burden of skyrocketing drug prices on consumers and look forward to working with the committee on solutions.

Thank you for the opportunity to submit testimony, and please let me know if you have any questions.

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Co-Pay Accumulator Consumer Protections

Consumer Protections:

(1) If a manufacturer pays an amount on behalf of an enrollee for a covered prescription drug, such manufacturer:

(a) must provide the full value of the assistance to the enrollee until the enrollee meets its cost sharing requirements, and to the enrollee's health benefit plan thereafter;

(b) may not discontinue a coupon during a calendar year;

(c) must notify the insured prior to October 1 if the financial assistance will be discontinued in a subsequent calendar year;

(d) must base its decision to pay an amount to reduce or eliminate an insured's cost sharing requirement solely on the insured's financial need;

(e) may not condition the assistance on enrollment in a specific health benefit plan, except to ensure compliance with 42 U.S.C. § 1320a-7b(b) and related federal anti-kickback statutes;

(f) must provide assistance to an individual without health insurance coverage on terms no less favorable than those offered to insureds;

(g) may not adjust the amount of assistance it provides to an insured if the insured's health benefit plan eliminates the insured's cost sharing requirements when payments are made on an insured's behalf for a qualified prescription drug; and

(h) may not provide assistance in the form of a post claim reimbursement to an insured.

(2) A drug manufacturer may not offer a coupon for any drug where the manufacturer has triggered reporting obligations under ORS 646A.689(2)(b) in the prior year.

(3) On or before August 1, 2025, and on or before August 1 of each year thereafter, a manufacturer shall report the following information for the preceding calendar year for each prescription drug for which a discount, rebate, product voucher, or other reduction intended to lower an insured's cost sharing is offered:

(a) The number of patients in the state who received assistance;

(b) The total value of such assistance;

(c) The terms and conditions to qualify for assistance and how eligibility is verified for accuracy;

(d) The total sales of the prescription drug in the state, based on the prescription drug's wholesale acquisition cost; and

(e) The steps the manufacturer takes to comply with 42 U.S.C. § 1320a-7b(b).

(7) The report described in Subsection (6) shall be provided to the Division of Financial Regulation and each health benefit plan subject to this section.

(8) The Department of Financial Regulation may make rules to implement this Section.