STATEMENT

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In Support of North Dakota House Bill 1216
Patient Assistance
January 27, 2025

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) supports North Dakota House Bill (HB) 1216, which will help patients better access their medicines by prohibiting new tactics in pharmacy benefit designs by insurers that deny patients the benefit of patient assistance.

Spending on medicines is growing at the slowest rate in years. Average net prices for protected brand medicines grew 3.0% in 2023, below the rate of inflation for the fifth year in a row. Looking ahead, average net price growth is projected to be -1 to -4% per year through 2028.[1] Unfortunately, it doesn't feel that way for patients because health insurers are increasingly using deductibles and coinsurance, which results in patients paying the full list price for their medicines, not the discounted price paid by the insurer or pharmacy benefit manager (PBM). This higher cost sharing can impact patients' ability to adhere to their prescribed treatment, which can be devastating for patients with chronic conditions who rely on medicines to keep their symptoms in check. Moreover, new tactics implemented by insurers, PBMs, and third-party vendors to exploit patient assistance threaten to make it harder or even impossible for patients to get important treatments for chronic illnesses such as asthma, diabetes, HIV, arthritis, hemophilia, and others. By closing policy loopholes that allow accumulator adjustment programs (AAPs), maximizers, and alternative funding programs (AFPs) to get in the way of patients and their medicines, HB 1216 will protect patients' access to their medicines.

HB 1216 would help prohibit health insurance carriers from implementing AAPs that unfairly increase cost-sharing burdens on patients by refusing to count third-party assistance toward patients' cost-sharing contributions.

To help patients better afford and stay adherent to their medicine, many third-party entities, including pharmaceutical manufacturers, offer cost-sharing assistance. Historically, commercial health insurance plans have counted this cost-sharing towards a patient's deductible and maximum out-of-pocket limit, providing relief from high cost-sharing and making it easier for patients to get their medicines. Unfortunately, health insurance carriers and PBMs are increasingly adopting policies, often referred to as AAPs, that block manufacturer cost-sharing assistance from counting towards patient cost-sharing requirements.

When health plans implement such programs, they can substantially increase patients' out-of-pocket costs, financial burdens, and health risks. Many patients who have benefited from cost-sharing assistance to afford their medicines have no idea that health insurers and PBMs are no longer counting cost-sharing assistance toward their annual out-of-pocket limits. As a result, patients may face thousands of dollars in

[1] IQVIA, "The Use of Medicines in the U.S. 2024: Usage and Spending Trends and Outlook to 2028," May 7, 2024. https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/the-use-of-medicines-in-the-us-2024

surprise out-of-pocket costs for their prescription medicines because manufacturer cost-sharing assistance isn't counted as if paid by patients themselves. Surprise out-of-pocket costs are a significant problem for patients—44% of Americans say they could not cover emergency expenses costing $400 or more without selling something or borrowing money.[2]

Patients subject to these cost-sharing surprises have a significantly greater risk of treatment discontinuation and lower refill adherence. In many cases, patients leave the pharmacy empty-handed as a result. One recent study found that implementing AAPs for specialty autoimmune medicines was correlated with reductions in medication adherence among high deductible health plan enrollees. The research included patients subject to a deductible for their medicines and those not subject to a pharmacy deductible. Those patients subject to a deductible had four times higher treatment discontinuation and 12% lower refill adherence after implementing accumulators than patients in a plan that was not subject to a pharmacy deductible.[3]

Health plans claim that AAPs help prevent cost-sharing assistance from driving patients towards a more expensive branded drug when a generic equivalent is available. However, the influence of manufacturer assistance in allegedly undermining formularies and other utilization management methods that promote the use of low-cost therapies is overstated. In fact, cost-sharing assistance is most commonly used for medicines without a generic equivalent. In 2021-2022, cost-sharing assistance for a brand medicine where a generic equivalent was available accounted for less than one percent of all commercial market medicine claims.[4] Another study found that among the most utilized drugs by spending, a majority of brand drugs with manufacturer assistance had no generic substitute.[5]

HB 1216 would help prevent health insurers from implementing copay maximizer programs that inflate patients' cost-sharing to deplete cost-sharing assistance available to the patient.

As more states have passed laws to ban AAPs, insurers and PBMs have started implementing new programs, called copay maximizer programs, so they can continue to profit from cost-sharing assistance meant for patients. To implement a copay maximizer, plans and PBMs do two things: (1) use a loophole under the Affordable Care Act (ACA) (referred to as "the EHB (essential health benefits) loophole") to target and designate specific medicines with available manufacturer cost-sharing assistance as "non-essential health benefits" so that the ACA cost-sharing limitations do not apply, and (2) increase individual patient cost sharing obligations to exhaust the full value of the manufacturer-provided cost-sharing assistance available for those medicines.

By focusing on medicines with available cost-sharing assistance programs, these copay maximizer programs affect certain patients based solely on their medical condition or need for a specific medicine. This targeting of certain medicines—and thus certain patients—is concerning and could run afoul of federal nondiscrimination requirements. Copay maximizers can also result in patients paying more for other care because payments for drugs are excluded as EHBs, meaning these expenditures don't count toward the out-of-pocket maximum, which might otherwise be reached if the payments for the drugs were counted. In some cases, copay maximizers may even result in patients being denied coverage at the pharmacy as a lever to force enrollment in the maximizer program.

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[2] Report on Economic Well-Being of U.S. Households in 2015. The Federal Reserve Board Report. May 2016.
[3] PhRMA Catalyst Blog. Guest post: Copay accumulator adjustment programs lead to four times higher treatment discontinuation for patients with high deductible. February 21, 2019.
https://catalyst.phrma.org/guest-post-copay-accumulator-adjustment-programs-lead-to-four-times-higher-treatment-discontinuation-for-patients-with-high-deductibles.
[4] IQVIA analysis for PhRMA. 2023.
[5] Van Nuys, K, et al. USC Schaeffer. A perspective on prescription drug copayment coupons. 2018.
https://healthpolicy.usc.edu/wp- content/uploads/2018/02/2018.02_Prescription20Copay20Coupons20White20Paper_Final-2.pdf.

Policymakers should stop health insurers and PBMs from using copay maximizers and similar programs so that patient assistance benefits patients as intended, not middlemen.

Finally, HB 1216 would help stop the unethical practice of AFPs, which deplete funds meant for uninsured patients and harm patients taking specialty medicines.

Alternative funding programs use questionable means to allow commercially insured patients, who otherwise may not be eligible for manufacturer patient assistance or charitable programs meant for uninsured or underinsured patients, to access these funds.

To implement an AFP, an alternative funding vendor or PBM convinces an employer to drop coverage for some or all specialty drugs from a plan. Patients prescribed these drugs are then directed to the AFP vendor who enrolls them in a manufacturer patient assistance programs or other charities or foundations meant to assist uninsured or underinsured patients. Patients must provide personal financial details and sometimes sign a power of attorney so the vendor can enroll them in a patient assistance program. The AFP vendor may disguise the insured patient as "uninsured" so that they can qualify for these patient assistance programs. If the patient refuses to enroll in an AFP, they will be required to pay the entire cost of their prescription drug.

AFPs deplete funds meant for patients in need and harm patients with chronic and sometimes life-threatening diseases. AFPs exist only for specialty drugs and thus disproportionately target individuals living with chronic and rare conditions who rely on these life-saving medications. AFPs leave patients with almost no choice—provide personal financial details, sign a power of attorney, permit the AFP to enroll them in a patient assistance or charitable program, or pay for the entire cost of their prescription drug. Patients can face treatment delays while the AFP vendor initiates the application process and searches for funding. They may also be encouraged to use the product with a more favorable assistance program rather than the medication prescribed by their doctor, which puts them at risk of poorer health outcomes.

We encourage North Dakota policymakers to protect patients and enable them to better afford their medicines by prohibiting the administration of benefit designs and policies—including AAPs, maximizers, and AFPs—that exploit patient assistance and ultimately put patient's access to medicines at risk.

PhRMA is committed to promoting policies that protect North Dakota patients and enable them to better afford their medicines. PhRMA respectfully supports the passage of HB 1216, which offers patient-centered solutions that will help patients pay less for their medicines.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than $800 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.