2023 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1413

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
01/25/2023

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Louser called to order 9:32 AM

Members Present: Chairman Louser, Representatives Boschee, Christy, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.
Member Absent: Vice Chairman Ostlie

Discussion Topics:
- Prescription coupons
- Affordable drugs
- PBM
- Co-payments
- HSA exemptions

In favor:
Representative Karen Karls, District 35 prime bill sponsor, #16796

Opposed:
Jack McDonald, American's Health Insurance Plans (AHIP), #16621
Megan Houn, Blue Cross & Blue Shield of North Dakota (no written testimony)

Neutral
Scott Miller, Executive Director, NDPERS, #16480
Chrystal Bartuska, ND Insurance Department, proposed amendment, #16794

Additional written testimony:
Donene Feist, Family Voices of North Dakota, #16100
William Robie, National Hemophilia Foundation, #16546
Matt Schafer, Medica, #16452
Michelle Mack, Pharmaceutical Care Management Association (PCMA), #16533
Dylan Wheeler, Government Affairs for Sanford Health Plan, #16560
Karen Cossette (emailed testimony, #17501

Chairman Louser adjourned the hearing 10:03 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
01/31/2023

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Louser called to order 9:35 AM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Christy, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Discussion Topics:

- Co-payments
- Mandate
- Additional regulation

Representative Ruby moved proposed amendment #18535 and moved to adopt LC #23.0392.01003
Representative Kasper seconded.

Roll call vote:

Representatives	Vote
Representative Scott Louser	Y
Representative Mitch Ostlie	Y
Representative Josh Boschee	AB
Representative Josh Christy	Y
Representative Hamida Dakane	Y
Representative Jorin Johnson	Y
Representative Jim Kasper	Y
Representative Ben Koppelman	AB
Representative Dan Ruby	Y
Representative Austen Schauer	Y
Representative Paul J. Thomas	Y
Representative Bill Tveit	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

Motion passed 12-0-2

Chairman Louser adjourned the hearing 9:51 AM

Diane Lillis, Committee Clerk

23.0392.01003
Title.02000

Prepared by the Legislative Council staff for the House Industry, Business and Labor Committee
January 31, 2023

2-7-23

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1413

Page 1, line 2, remove "; and to amend and"

Page 1, remove line 3

Page 1, line 4, remove "health care plans"

Page 1, line 10, remove "<u>, copayment,</u>"

Page 1, remove lines 23 and 24

Page 2, remove lines 1 through 16

Renumber accordingly

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
02/072023

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Louser called to order 2:48 PM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Christy, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Discussion Topics:
- Coupons
- Co-payment
- Rebates
- Accumulator program
- Uninsured coupon

Mike Schwab, ND Pharmacist Association (no written testimony) available to answer questions.

Representative Ruby moved a do not pass as amended.
Representative Wagner seconded.

Roll call vote:

Representatives	Vote
Representative Scott Louser	Y
Representative Mitch Ostlie	N
Representative Josh Boschee	N
Representative Josh Christy	N
Representative Hamida Dakane	N
Representative Jorin Johnson	N
Representative Jim Kasper	AB
Representative Ben Koppelman	Y
Representative Dan Ruby	Y
Representative Austen Schauer	N
Representative Paul J. Thomas	Y
Representative Bill Tveit	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	N

Motion fails 6-7-1

Representative Ruby moved a do pass as amended.
Representative Koppelman seconded.

Roll call vote:

Representatives	Vote
Representative Scott Louser	Y
Representative Mitch Ostlie	N
Representative Josh Boschee	N
Representative Josh Christy	N
Representative Hamida Dakane	N
Representative Jorin Johnson	Y
Representative Jim Kasper	AB
Representative Ben Koppelman	Y
Representative Dan Ruby	Y
Representative Austen Schauer	Y
Representative Paul J. Thomas	Y
Representative Bill Tveit	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

Motion pass 9-4-1

Representative Thomas will carry the bill.

Chairman Louser adjourned the hearing 3:39 PM

Diane Lillis, Committee Clerk

REPORT OF STANDING COMMITTEE

HB 1413: Industry, Business and Labor Committee (Rep. Louser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (9 YEAS, 4 NAYS, 1 ABSENT AND NOT VOTING). HB 1413 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "; and to amend and"

Page 1, remove line 3

Page 1, line 4, remove "health care plans"

Page 1, line 10, remove ", copayment,"

Page 1, remove lines 23 and 24

Page 2, remove lines 1 through 16

Renumber accordingly

2023 SENATE HUMAN SERVICES

HB 1413

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1413
3/20/2023

Relating to out-of-pocket expenses for health care services.

2:45 PM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Hogan, Weston** were present.

Discussion Topics:
- Expensive
- Miracle drugs
- Out of pocket limit
- Lifesaving medication.

2:47 PM **Representative Karls**, introduced the HB 1413, testified in favor, and proposed an amendment. #25867, #25962

2:51PM **Karen Cossette, patient Cystic Fibrosis**, testified in favor. #25807

2:57 PM **Alex Kelsch, Attorney, American Health Insurance Plan, on behalf Karlee Tebbutt, Reginal Director,** testified in opposition #25973

3:05 PM **Meghan Houn, Vice President Public Policy and Government Affairs, North Dakota Blue Cross Blue Shield,** testified in opposition. #25969

3:13 PM **Rebecca Fricke, Chief Benefits Officer, North Dakota Public Employees Retirement System,** testified in neutral #25686

3:19 PM **Chrystal Bartuska, Life Health and Medicare Division Director, North Dakota Insurance Department,** verbally testified neutral.

Additional Testimony:
Emily Ouellette, Executive Director, Bleeding Disorders Alliance of North Dakota, in favor #25750
Daviney McKay, in favor #25799
Michelle Mack, Senior Director, State Affairs, PCMA, in opposition #25823

3:25 PM **Madam Chair Lee** closed the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

HB 1413
3/27/2023

Relating to out-of-pocket expenses for health care services.

4:57 PM **Madam Chair Lee** called the meeting to order. **Senators Lee, Clemens, K. Roers, Hogan, Weston** are present. **Senator Cleary** was absent.

Discussion Topics:
- Coupons
- Co-pay
- Benefit plan

Senator Lee calls for discussion.

4:58 PM **Meghan Houn, Vice President of Public Policy and Government Affairs, ND Blue Cross Blue Shield,** provided information verbally.

Senator K. Roers moved to **adopt amendment,** replacing policy with Health Benefit Plan in the bill and add definition of Health Benefit Plan.

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	AB
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

The motion passed 5-0-1.

Senator K. Roers moved **DO NOT PASS** as **AMENDED.**

Senator Hogan seconded the motion.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	AB
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	Y
Senator Kent Weston	Y

The motion passed 5-0-1.

Senator Weston will carry HB 1413.

Additional Written Testimony:
Lacee Anderson, Chief Executive Officer and Founder, The Birch Group LLC
neutral #26787, 26788

5:10 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

23.0392.02003
Title.03000

Adopted by the Senate Human Services Committee

March 27, 2023

AG 3-27-23 (1)

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

Page 1, line 10, after "c." insert ""Health benefit plan" has the same meaning as provided in section 26.1-36.3-01.

d."

Page 1, remove lines 13 and 14

Page 1, line 16, replace "policy" with "health benefit plan"

Page 1, line 17, replace "policy" with "health benefit plan"

Page 1, line 18, replace "policy" with "health benefit plan"

Renumber accordingly

REPORT OF STANDING COMMITTEE

HB 1413, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1413 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 1, line 10, after "c." insert ""Health benefit plan" has the same meaning as provided in section 26.1-36.3-01.

d."

Page 1, remove lines 13 and 14

Page 1, line 16, replace "policy" with "health benefit plan"

Page 1, line 17, replace "policy" with "health benefit plan"

Page 1, line 18, replace "policy" with "health benefit plan"

Renumber accordingly

2023 CONFERENCE COMMITTEE

HB 1413

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/13/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 10:38 AM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Insurance mandate
- Pharmacy coupons
- Uninsured
- Deductibles
- Study

Committee discussion.

Chairman Ruby adjourned the hearing 11:01 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/14/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 8:07 AM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Insurance market
- Generic drugs
- Allowed in 17 States
- Affordable drugs
- Deductible
- Study

Committee discussion.

Chairman Ruby adjourned the hearing 8:30 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/17/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 3:30 PM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Therapy
- Deductible
- Costs
- Tiers
- Co-pay

Chairman Ruby presented possible amendment language, #27687.

Chrystal Bartuska, Division Director, Life/Health /Medicare, of ND Insurance Department (no written testimony)
Rebecca Fricke, Chief Benefits Officer, NDPERS (no written testimony)

Chairman Ruby adjourned the hearing 4:02 PM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/18/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 3:30 PM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:

- Deductible
- Prescriptions
- Copayment
- Coinsurance
- Coupons
- Costs
- Study
- Expansion

Jon Godfread, Commissioner, ND Insurance Department (no written testimony)
Chrystal Bartuska, Division Director, Life/Health /Medicare, of ND Insurance Department (no written testimony)
Rebecca Fricke, Chief Benefits Officer, NDPERS (no written testimony)

Senator Roers moved the Senate recede from Senate amendments and amend as follows, #27685
Senator Weston seconded.

Vote suspended due to 1-2-0 vote on the House side.

Chairman Ruby adjourned the hearing 4:22 PM

Diane Lillis, Committee Clerk

Date: 4/18/2023
Roll Call Vote #: 1

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Roers Seconded by: Weston

Representatives	4-18			Yes	No		Senators	4-18			Yes	No
Chairman Ruby	X			X			Chairman Roers	X				
Wagner	X				X		Weston	X				
Ostlie	X				X		Cleary	X				
Total Rep. Vote				1	2		Total Senate Vote					

Vote Count Yes: 1 No: 2 Absent: 3

House Carrier Ruby Senate Carrier Roers

LC Number _______________ . _______________ of amendment

_______________ . _______________ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/19/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 2:35 PM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Complex topic
- Informed consumer
- Generic drugs
- IRS compliance
- Coupon information
- Insurance accumulators
- Costs
- Discount drugs
- Study
- Open market

Committee discussion.

Chairman Ruby adjourned the hearing 2:55 PM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB 1413
04/20/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 3:59 PM

Members Present: Chairman Ruby, Representatives Wagner, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Committee work

Representative Ostlie moved the Senate recede from Senate amendments and amend as follows with LC #23.0392.02002
Senator Weston seconded.

Motion failed 3-3-0

Representative Ostlie moved the House accede to the Senate amendments.
Representative Wagner seconded.

Motion failed 2-4-0

Senator Roers moved the Senate recede from Senate amendments and amend as follows; #27772, LC #23.0392.02004
Senator Weston seconded.

Motion passed 4-2-0

House carrier is Representative Ruby
Senate carrier is Senator Roers

Chairman Ruby adjourned the hearing 4:08 PM

Diane Lillis, Committee Clerk

23.0392.02004
Title.04000

Adopted by the Conference Committee

April 20, 2023

DK 1 of 1 4-20-23

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

That the Senate recede from its amendments as printed on pages 1429 and 1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to prescription drug coupon and financial assistance program utilization.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG COUPON AND FINANCIAL ASSISTANCE PROGRAM UTILIZATION. During the 2023-24 interim, the legislative management shall consider studying the prevalence and usage of third-party payments to reduce or eliminate North Dakota patients' cost sharing and out-of-pocket costs for prescription drugs, including programs offered by the manufacturer of a prescription drug. The study must include the prevalence and usage of third-party payments by the manufacturer of prescription drugs and in the North Dakota commercial insurance market. The study must also include the prevalence and usage of third-party payments in government programs and the availability of those programs to uninsured residents, eligibility criteria, and the impact of these programs on health care costs and prescription drug pricing. In conducting the study, input must be received from health insurance carriers, patients or patient groups, prescription drug manufacturers, pharmacy benefit managers, pharmacies or pharmacy association representatives, government and independent academic sources, and any other stakeholder with relevant information. Participants shall disclose any ties or financial compensation received by any entities in the prescription drug supply chain. The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty-ninth legislative assembly. "

Renumber accordingly

Date: 4/20/2023
Roll Call Vote #: 1

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken
☐ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: *Ostlie* Seconded by: *Weston*

Representatives	*4-19*	*4-20*		Yes	No		Senators	4-19	*4-20*		Yes	No
Chairman Ruby	X	X			X		Chairman Roers	X	X			X
Wagner	X	X		X			Weston	X	X			X
Ostlie	X	X		X			Cleary	X	X		X	
Total Rep. Vote				2	1		Total Senate Vote				1	2

Vote Count Yes: 3 No: 3 Absent: 0

House Carrier Ruby Senate Carrier Roers

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

LC # 23.0392.02002

Date: 4/20/2023
Roll Call Vote #: 2

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken ☒ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☐ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: *Ostlie* Seconded by: *Wagner*

Representatives	4-20			Yes	No		Senators	4-20			Yes	No
Chairman Ruby	X				X		Chairman Roers	X				X
Wagner	X			X			Weston	X				X
Ostlie	X			X			Cleary	X				X
Total Rep. Vote				2	1		Total Senate Vote				0	3

Vote Count Yes: 2 No: 4 Absent: 0

House Carrier Ruby Senate Carrier Roers

LC Number ________ . ________ of amendment

LC Number ________ . ________ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

Date: 4/20/2023
Roll Call Vote #: 3

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**

- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: *Roers* Seconded by: *Weston*

Representatives	4-20			Yes	No		Senators	4-20			Yes	No
Chairman Ruby	X			X			Chairman Roers	X			X	
Wagner	X				X		Weston	X			X	
Ostlie	X			X			Cleary	X				X
Total Rep. Vote				2	1		Total Senate Vote				2	1

Vote Count Yes: 4 No: 2 Absent: 0

House Carrier Ruby Senate Carrier Roers

LC Number 23.0392 . 02004 of amendment

LC Number 23.0392 . 04000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

To include the study language presented by Representative Ruby on 4-17-23

Insert LC: 23.0392.02004
House Carrier: D. Ruby
Senate Carrier: K. Roers

REPORT OF CONFERENCE COMMITTEE

HB 1413, as engrossed: Your conference committee (Sens. K. Roers, Weston, Cleary and Reps. D. Ruby, Wagner, Ostlie) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1429-1430, adopt amendments as follows, and place HB 1413 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1429 and 1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to prescription drug coupon and financial assistance program utilization.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG COUPON AND FINANCIAL ASSISTANCE PROGRAM UTILIZATION. During the 2023-24 interim, the legislative management shall consider studying the prevalence and usage of third-party payments to reduce or eliminate North Dakota patients' cost sharing and out-of-pocket costs for prescription drugs, including programs offered by the manufacturer of a prescription drug. The study must include the prevalence and usage of third-party payments by the manufacturer of prescription drugs and in the North Dakota commercial insurance market. The study must also include the prevalence and usage of third-party payments in government programs and the availability of those programs to uninsured residents, eligibility criteria, and the impact of these programs on health care costs and prescription drug pricing. In conducting the study, input must be received from health insurance carriers, patients or patient groups, prescription drug manufacturers, pharmacy benefit managers, pharmacies or pharmacy association representatives, government and independent academic sources, and any other stakeholder with relevant information. Participants shall disclose any ties or financial compensation received by any entities in the prescription drug supply chain. The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty-ninth legislative assembly. "

Renumber accordingly

Engrossed HB 1413 was placed on the Seventh order of business on the calendar.

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

HB1413
04/25/2023

Conference Committee

Relating to out-of-pocket expenses for health care services; and to amend and reenact section 26.1-36.6-03 of the North Dakota Century Code, relating to self-insurance health care plans.

Chairman Ruby called to order 2:10 PM

Members Present: Chairman Ruby, Representatives Louser, Ostlie, Senators Roers, Weston, Cleary

Discussion Topics:
- Committee work

Chrystal Bartuska, Division Director, Life/Health /Medicare, of ND Insurance Department (no written testimony)

Senator Cleary moved the Senate to recede from Senate amendments and amend as follows; to adopt amendment LC #23.0392.02002 minus section 3 and add "The requirements of this section apply to all health benefit plans issued or renewed after December 31, 2023."
Representative Ostlie seconded.

Motion failed 2-4-0

Senator Roers moved Senate recede from Senate amendments and amend as follows: LC #23.0392.02006, #27908
Senator Weston seconded.

Motion passed 4-2-0

House carrier is Representative Ruby
Senate carrier is Senator Roers

Chairman Ruby adjourned the hearing 2:30 PM

Diane Lillis, Committee Clerk

Adopted by the Conference Committee

April 25, 2023

4-25-23

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

That the Senate recede from its amendments as printed on pages 1429 and 1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to accumulator adjustment programs.

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCUMULATOR ADJUSTMENT PROGRAM BANS. During the 2023-24 interim, the legislative management shall consider studying the impact of third-party payments and accumulator adjustment programs on North Dakota patients' out-of-pocket costs, medications adherence, and health care systems costs and impacts. The study shall assess health benefit participants' usage and prevalence of third-party payments in North Dakota. The study shall also review data from states with accumulator adjustment program bans since 2019 and shall seek input from all relevant stakeholders in the health care industry. The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty-ninth legislative assembly."

Renumber accordingly

Date: 4/25/2023
Roll Call Vote #: 1

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken
☐ **HOUSE accede to Senate Amendments**
☐ **HOUSE accede to Senate Amendments and further amend**
☐ **SENATE recede from Senate amendments**
☒ **SENATE recede from Senate amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Cleary Seconded by: Ostlie

Representatives	4-25			Yes	No		Senators	4-25			Yes	No
Chairman Ruby	X				X		Chairman Roers	X				X
Louser	X				X		Weston	X				X
Ostlie	X			X			Cleary	X			X	
Total Rep. Vote				1	2		Total Senate Vote				1	2

Vote Count Yes: 2 No: 4 Absent: 0

House Carrier ______ Senate Carrier ______

LC Number ______ . ______ of amendment

LC Number ______ . ______ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

LC #23.0392.02002 minus section 3 and add “The requirements of this function apply to all health benefit plans issued or renewed after December 31, 2023”.

Date: 4/25/2023
Roll Call Vote #: 2

2023 HOUSE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL NO. HB 1413 as engrossed

House Industry, Business and Labor Committee

Action Taken
- ☐ **HOUSE accede to Senate Amendments**
- ☐ **HOUSE accede to Senate Amendments and further amend**
- ☐ **SENATE recede from Senate amendments**
- ☒ **SENATE recede from Senate amendments and amend as follows**
- ☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Roers Seconded by: Weston

Representatives	4-25			Yes	No		Senators	4-25			Yes	No
Chairman Ruby	X			X			Chairman Roers	X			X	
Louser	X			X			Weston	X			X	
Ostlie	X				X		Cleary	X				X
Total Rep. Vote				2	1		Total Senate Vote				2	1

Vote Count Yes: 4 No: 2 Absent: 0

House Carrier Ruby Senate Carrier Roers

LC Number 23.0392 . 02006 of amendment

LC Number 23.0392 . 05000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment:

To add study language

Insert LC: 23.0392.02006
House Carrier: D. Ruby
Senate Carrier: K. Roers

REPORT OF CONFERENCE COMMITTEE

HB 1413, as engrossed: Your conference committee (Sens. K. Roers, Weston, Cleary and Reps. D. Ruby, Louser, Ostlie) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1429-1430, adopt amendments as follows, and place HB 1413 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1429 and 1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to accumulator adjustment programs.

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCUMULATOR ADJUSTMENT PROGRAM BANS. During the 2023-24 interim, the legislative management shall consider studying the impact of third-party payments and accumulator adjustment programs on North Dakota patients' out-of-pocket costs, medications adherence, and health care systems costs and impacts. The study shall assess health benefit participants' usage and prevalence of third-party payments in North Dakota. The study shall also review data from states with accumulator adjustment program bans since 2019 and shall seek input from all relevant stakeholders in the health care industry. The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty-ninth legislative assembly."

Renumber accordingly

Engrossed HB 1413 was placed on the Seventh order of business on the calendar.

TESTIMONY

HB 1413

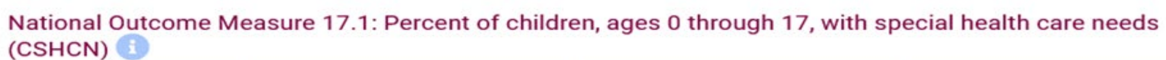
Dear Committee Members,

My name is Donene Feist, I am the Director for Family Voices of North Dakota. I am writing today to urge you to support HB 1413, to ban the use of Accumulator Adjustment Programs (AAPs).

Family Voices of North Dakota is statewide family to family health information and education center who serves families of children with special health care needs in ND. Each state in the country and our territories has one family organization that has been designated as a family to family health information and education center by HRSA federally. We are that entity for ND.

According to the 2020-2021 National Survey of Children's Health, there is approximately 34,412 children and youth who have a special health care need in North Dakota. FVND follows the Maternal and Child Health definition of children with special health care needs, which is those children and youth who have a chronic condition of at least one year, a physical disability or mental health/behavior health diagnosis.

Additionally, there are many children and youth who may have a physical disability and a chronic health illness but also may have a co-occurring mental health diagnosis. Because of many families have a co-occurring condition, it often leaves families having to understand and navigate many systems and complicated silos.


National Outcome Measure 17.1: Percent of children, ages 0 through 17, with special health care needs (CSHCN)

	Children with special health care needs (CSHCN)	Children without special health care needs (Non-CSHCN)	Total %
%	**19.4**	**80.6**	**100.0**
C.I.	16.9 - 22.1	77.9 - 83.1	
Sample Count	334	1,240	
Pop. Est.	34,412	143,176	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

Unbeknownst to many North Dakota patients including the families we serve, many insurance companies have begun using AAPs to prevent third-party co-pay assistance from counting toward their out-of-pocket spending requirements. For North Dakotans living on tight budgets finding out their prescriptions are more

expensive because their third-party assistance or coupons no longer count toward that cost can be a big shock. A shock that could keep some patients from properly filling and adhering to their prescribed medicines.

By supporting HB 1413 you will ensure that North Dakota patients are better able to afford their medicines by preventing insurance companies from using Accumulator Adjustment Programs.

We thank you for your consideration.

Donene Feist
FVND Director
701-493-2634; fvnd@drtel.net

#16452

PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

MEDICA®

January 25, 2023

Representative Karen Karls
North Dakota State Capitol
2112 Senate Drive
Bismarck, ND 58501-1978

Re: HB 1413 Drug Co-Pay Coupons - Opposed

Dear Representative Karls:

I am writing today to convey Medica's opposition to House Bill 1413 mandating insurers include amounts not paid by our members in drug coverage accumulators.

Medica is an independent and nonprofit health care organization with approximately 1.5 million members in twelve states, and has offered individual health insurance coverage in the state of North Dakota since the early 1990's. Medica's mission is to be the trusted health plan of choice for our customers, members, partners, and our employees.

Background on this issue is important in order to understand my organization's concern with HB 1413. First and foremost, it is important to understand that a drug's market share, and therefore revenue for the pharmaceutical company, is driven in large part by the amount consumers pay out of pocket for the product. For example, if a drug is placed on the "preferred brand" tier on a formulary (lower cost-sharing), prescribers will more likely drive more patients to the drug and patients will more likely request the drug because it costs less. If a drug is off formulary or in a less desirable formulary tier (higher cost-sharing), there will likely be less demand for the drug and, therefore, it will generate less revenue for the pharmaceutical company.

In many classes of drugs, brand name drugs compete with each other for placement on a pharmacy benefit manager's (PBM's) formulary and pharmaceutical companies compete to have the lowest cost-sharing applied to their products. If a pharmaceutical company has a bad outcome in their negotiations with a PBM and their drug is placed in a less desirable tier (higher patient cost-sharing), pharmaceutical companies use drug co-pay coupons to try to keep or grow their market share. Pharmaceutical companies give co-pay coupons to patients in order to incent patients to remain on the company's drug and not switch to their competitor's drug with the lower out-of-pocket cost. It is a defensive tool used by pharmaceutical companies to retain market share and revenue.

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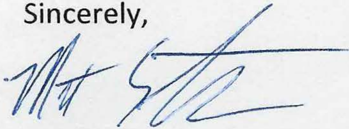
Medica does not recognize drug co-pay coupons in our members' accumulators for specialty drugs because it is a tool pharmaceutical companies use to avoid and circumvent competition. Our organization has sympathy for the patients and pharmacies caught in the middle of this pharmaceutical company strategy to drive revenue. At the same time, drug co-pay coupons were not the invention of insurers. My organization is simply responding to actors in our health care system that are attempting to rewrite the rules of competition and pull patients into the middle of their scheme.

I respectfully request the North Dakota Legislature not enact HB 2678 this year in order to maximize competition among pharmaceutical companies and discourage pharmaceutical companies from raising drug prices to pay for these co-pay coupons. Thank you for your consideration and please contact me if you would like to discuss this issue further.

Sincerely,



Matt Schafer
Government Relations Director
matthew.schafer@medica.com | 612.701.5637

TESTIMONY OF SCOTT MILLER

House Bill 1413 – Out of Pocket Maximums

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1413.

The bill creates and enacts a new section to chapter 26.1-36 of the North Dakota Century Code relating to out-of-pocket expenses for health care services. The proposal requires that all cost-sharing requirements, defined to include coinsurance, copayment, and deductibles (page 1, line 10), must be included in the calculation of the health insurance policy out-of-pocket maximum (page 1, lines 17-22).

Note that to the extend HB 1413 creates a mandate, the bill does not comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS.

- Consultant Notes:
  - The health insurance plan options offered by the uniform group insurance program to active enrollees include a "grandfathered" health plan (PPO/Basic Grandfathered Plan) and two "non-grandfathered" health plans (PPO/Basic Non-Grandfathered Plan and High Deductible Health Plan (HDHP)).
  - In the PPO/Basic Grandfathered Plan enrollee paid copays do not accumulate (count towards) to an enrollee's out-of-pocket maximum. The proposed legislation would amend the plan provision to change this provision such that copays do accumulate to an enrollee's out-of-pocket maximum.
  - The non-grandfathered plans already include copays in the out-of-pocket maximum and as a result there would be no change.
  - Deloitte Consulting estimates the financial impact on the uniform group insurance plan to be $18,191,000 in the biennium ending 6/20/2023 and $20,827,000 in the 2023-2025 biennium assuming a 7.0% aggregate annual healthcare trend (medical and prescription drug).
  - The change to the plan provision produces a 3.0% increase to the expected costs paid by the uniform group insurance program.
  - In general, changes to plan design provisions for grandfathered health plans results in the loss of grandfathered status. Since the proposed change increases the value of the plan, it would not forfeit its grandfathered status.

January 24, 2023

The Honorable Scott Louser, Chair House Industry, Business and Labor Committee
The Honorable Mitch Ostlie, Vice Chair House Industry, Business and Labor Committee
North Dakota House Industry, Business and Labor Committee
North Dakota State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **HB 1413 – Relating to Out-of-Pocket Expenses for Health Care Services**
PCMA Testimony in Opposition to HB 1413

Dear Chair Louser, Vice Chair Ostlie and Members of the Committee:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs

PCMA appreciates the opportunity to provide testimony on HB 1413, a bill which would require insurers to count any amount paid by enrollees (directly or on their behalf) toward an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the policy. PCMA respectfully opposes HB 1413.

I want to emphasize at the outset that **PCMA does *not* oppose true means-tested patient assistance programs that help individuals afford their prescription drugs.** There is an important difference between means-tested patient assistance programs and copay coupons, which are targeted to individuals with health insurance.

The unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays and deductibles. While health plans pay the vast amount of their members' prescription drug costs, drug manufacturers' price increases have forced health plans to create new benefit designs that keep monthly premiums as low as possible—but require some members to shoulder more of the cost before their deductible is met.

Pharmaceutical Care Management Association
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Drug manufacturers encourage patients to disregard formularies and lower cost alternatives by offering "coupons" to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternatives and towards more expensive brand drugs (with higher cost sharing obligations), completely undermining the formulary offered by a plan sponsor.

Here are the facts when it comes to manufacturer coupons:

- The prices for drugs with manufacturer coupons **increase faster (12-13% per year)** compared to non-couponed drugs (7-8% per year).[1]
- If Medicare's ban on coupons were not enforced, costs to the program would **increase $48 billion** over the next ten years.[2]
- Coupons were responsible for a **$32 billion increase** in spending on prescription drugs for commercial plans.[3]
- For every $1 million in manufacturer coupons for brand drugs, **manufacturers reap more than $20 million in profits (20:1 return).**[4]

By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still permitted in the commercial market.

Supporters of coupons say that they decrease costs for patients. While they can decrease an individual patient's cost at the pharmacy counter, they do not reduce ***actual*** costs. **Coupons are temporary—the individual patient likely pays more when the coupon goes away, instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.**

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to increase copay assistance rather than just making their medications more affordable. The simplest, most effective way to reduce patient cost on drugs is for manufacturers to drop the price of the drug.

Copay accumulator programs are health plan programs designed to thwart drug manufacturers' efforts to force employers, unions, and public programs to pay for

[1] Leemore Dafny, Christopher Ody, and Matt Schmitt. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. The National Bureau of Economic Research. October 2016.
[2] Visante. Drug Manufacturer Coupons Raise Costs in Medicare Part D, Hurting Vulnerable Beneficiaries. May 2020.
[3] Visante. How Copay Coupons Could Raise Prescription Drug Costs By $32 Billion Over the Next Decade. November 2011.
[4] Dafny et al. October 2016

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expensive, unnecessary brand medications through the use of copay coupons. Accumulators typically disallow the counting of the manufacturer's coupon towards the patient's out-of-pocket maximum and deductible because the patient hasn't actually incurred the cost. This ensures that the patient has the incentive to use the plan formulary to get to the lowest net cost and that the plan functions as it was designed.

It is for these problematic provisions noted above that we must respectfully oppose HB 1413.

Thank you for your time and consideration. Please contact me should you have any questions or concerns.

Sincerely,

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

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www.pcmanet.org

NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

January 24, 2023

North Dakota House Industry, Business, and Labor Committee

RE: Committee Hearing on HB 1413

Dear Chairman Louser and members of the Committee,

The National Hemophilia Foundation (NHF) is a national non-profit organization that represents individuals with bleeding disorders across the United States. Our mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence. Please accept these comments in support of HB 1413 for the hearing record.

About Bleeding Disorders

Hemophilia is a rare, genetic bleeding disorder affecting about 20,000 Americans that impairs the ability of blood to clot properly. Without treatment, people with hemophilia bleed internally, sometimes due to trauma, but other times simply as a result of everyday activities. This bleeding can lead to severe joint damage and permanent disability, or even – with respect to bleeds in the head, throat, or abdomen – death. Related conditions include von Willebrand disease (VWD), another inherited bleeding disorder, which is estimated to affect more than three million Americans.

Patients with bleeding disorders have complex, lifelong medical needs. They depend on prescription medications (clotting factor or other new treatments) to treat or avoid painful bleeding episodes that can lead to advanced medical problems. Current treatment and care are highly effective and allow individuals to lead healthy and productive lives. However, this treatment is also extremely expensive, costing anywhere from $250,000 to $1 million or more annually, depending on the severity of the disorder and whether complications such as an inhibitor are present.

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NATIONAL HEMOPHILIA FOUNDATION

for all bleeding disorders

Importance of Financial Assistance to Patients

Many individuals with bleeding disorders rely on patient assistance programs to ensure access to their life-saving specialty drugs. And because patients with bleeding disorders require ongoing medication therapy for the course of their lifetimes, many such patients face the prospect of hitting their out-of-pocket maximum each and every year (in 2023, up to $9.100 for an individual, or $18,200 for a family).[1] Copayment assistance programs play an essential role in mitigating this weighty financial burden – and allow patients to remain adherent to their prescribed treatment regimen, preserving their long-term health and thereby avoiding medical complications that could increase their overall health care spending.

Patients with bleeding disorders cannot select alternative treatments: no generic drugs exist for hemophilia or related conditions. The vast majority of copayment assistance programs are for drugs without generic alternatives. A recent University of Southern California Schaeffer Center analysis found that 71 out of 90 high-expenditure brand drugs that offered coupons had no generic equivalent. The analysis concludes, "these results suggest that most copay coupons are not affecting generic substitution, and many may help patients afford therapies without good alternatives. As such, the copay coupon landscape seems more nuanced, and proposals to restrict coupons should ensure that patients who currently rely on them are not harmed."[2]

In addition, all manufacturers of hemophilia specialty biologics offer copayment assistance programs; as a result, assistance for these products do not influence patients to use one product over another. To use the U.S. Department of Health and Human Services' own formulation from the federal 2021 Notice of Benefit Payment and Parameters (NBPP), hemophilia copay assistance programs do not "disincentivize a lower cost alternative" nor do they "distort the market."[3]

Copay Accumulator Adjustment Programs

Copay accumulator adjustment programs (CAAP) limit the utility of copayment assistance programs to consumers, by excluding the financial assistance from the calculation of a person's deductible and annual out-of-pocket maximum.

Consumers have little choice when it comes to evaluating health plans in advance for the existence of a CAAP. There is a distressing lack of transparency around plan implementation of CAAPs. Typically, language allowing a plan to implement a CAAP is buried deep in the contract, which can be difficult or impossible to find if you only have access to the marketing materials on a health plan's web site. Manufacturers also are typically unaware of whether a patient's

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for all bleeding disorders

health plan has adopted an accumulator adjustment program. Moreover, individuals covered by a self-funded large group plan may find that their plan changes its policy on copay assistance mid-way through the plan year (this is problematic in its own right; it would also be unknown to the manufacturer).

Conclusion

The use of CAAPs dramatically increases patient out-of-pocket costs and threatens adherence to treatment for vulnerable individuals affected by serious health conditions. People who live with chronic conditions like bleeding disorders rely on access to quality care, and to accessible and affordable coverage to pay for that care. CAAPs place those patients at risk of being unable to pay for their life saving medication. HB 1413 places necessary and appropriate restrictions on the use of CAAPs by requiring insurers to count all contributions by or on behalf of an insured individual toward their annual cost-sharing requirement.

Thank you for considering our comments and making them part of the record. If you have any additional questions, or need any additional information, please contact Nathan Schaefer, NHF Vice President for Public Policy.

Sincerely,

Nathan M. Schaefer

Nathan Schaefer

[1] Since bleeding disorders are genetic conditions, there are many families that include more than one affected individual. These families may thus be subject to the family OOP maximum year after year – an unsustainable financial burden for almost any family. See, e.g., Jake Zuckerman, "A New Battle Between Insurers and Big Pharma is Costing Sick People Thousands," Ohio Capital Journal (Feb. 13, 2020), https://ohiocapitaljournal.com/2020/02/13/a-new-battle-between-insurers- and-big-pharma-is-costing-sick-people-thousands/.

[2] Van Nuys, et al. "A Perspective on Prescription Drug Copayment Coupons." USC Leonard D. Schaeffer Center for Health Policy and Economics (emphasis added), February 2018. Available online at: https://healthpolicy.usc.edu/wp-content/uploads/2018/02/2018.02_Prescription20Copay20Coupons20White20Paper_Final-2.pdf.

[3] 84 Fed. Reg. 17545.

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January 24, 2023

Chairman Louser and Members of the House Industry, Business and Labor Committee –

My name is Dylan Wheeler, Head of Government Affairs for Sanford Health Plan, respectfully submitting remarks in **opposition** to HB1413. We generally support initiatives that would increase access to affordable medications for our patients and members. However, HB1413, as written, does not address the root cause of access to medications - the rising price of prescription drugs. Rather, it would likely shift rising prescription drug costs onto health plans, members, and patients.

HB1413 would require health plans to apply payments made on behalf of an enrollee to that enrollee's out of pocket accumulators or cost-sharing. For example, if a member received a drug discount coupon issued by a manufacturer to help pay for the medication at the counter. The amount paid by the member, plus the couponed amounted, would be required to be applied to a member's out of pocket accumulators under the benefit plan. Having a drug manufacturer issue a coupon on its own medications that help afford the medication, itself is an underlying issue that warrants additional discussion. This practice incentivizes increased drug prices and increased utilization, which ultimately may be passed onto health plans and members in the form of increased premium.

I appreciate the time and diligence of the committee and please don't hesitate to contact me should there be any questions.

Respectfully Submitted,

Dylan Wheeler, JD, MPA
Head of Government Affairs
Sanford Health Plan

January 25, 2023

HOUSE INDUSTRY, BUSINESS & LABOR COMMITTEE
HB 1413

CHAIRMAN LOUSER AND COMMITTEE MEMBERS:

My name is Jack McDonald, and I am testifying today on behalf of America's Health Insurance Plans (AHIP).[1]

AHIP respectfully opposes HB 1413, which would require health insurance providers to count copay coupons[2] and other third-party payments towards an enrollee's cost sharing or out-of-pocket maximum.

Everyone should be able to get the medications they need at a cost they can afford. However, drug prices continue to rise out of control, and pharmacy costs now represent over 22 cents[3] out of every dollar of premium spent on health care.

Unfortunately, HB 1413 does not control the soaring prices of prescription drugs for patients. Instead, it would financially reward drug manufactures for steering patients towards expensive brand-name drugs.

Drug manufacturers intentionally use copay coupons to keep drug prices high

Drug manufacturers acknowledge their drugs are unaffordable for patients. But rather than simply lowering their prices, they offer copay coupons to offset cost-sharing expenses.

Drug manufacturers offer these promotions only to very specific patients for a very short period of time. Once a patient hits their deductible, drug manufacturers discontinue the patient's coupons – which hides the underlying prices from patients, enticing them to continue with the most expensive drug, when there are less expensive drugs available.

These tactics incent patients to use very expensive drugs rather than equally effective, less expensive alternatives (such as generics, biosimilars, and other therapeutic substitutes). As stated by the editor of Kaiser Health News, Dr. Rosenthal writes "coupons

---

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

[2] Here, the term "copay coupons" is used to represent all payments provided by a third party towards a patient's cost sharing (copay, coinsurance, deductible). This includes coupons directly from drug manufacturers, but also third-party payments and discount programs from patient assistance programs.

[3] *Where Does Your Health Care Dollar Go?* America's Health Insurance Plans. November 12, 2020. https://www.ahip.org/health-care-dollar/

create a mirage that perpetuates our system's reckless spending. They cover up a drug's true price, much of which our insurers pay… and contributes to our escalating insurance premiums and deductibles year after year."[4]

It is important to note, the federal government considers copay coupons illegal kickbacks in federal health care programs like Medicare and Medicaid because these coupons induce a patient to use a specific drug.[5]

Because the commercial market is the only market where drug manufacturers may offer copay coupons, they are aggressively seeking policy proposals, like HB 1413, that would codify their financial gains.

These promotions are used to increase sales, raising costs for everyone

Rather than protecting North Dakotans from high drug prices, copay coupons are another way for drug companies to insulate themselves from public scrutiny, skirt transparency, and maximize profits by protecting their out-of-control pricing practices.

There are multiple studies by Harvard[6], the Congressional Research Service[7], and others, that found that Pharma uses patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on branded drugs after a generic is introduced, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the high-priced drug.

- For example, a recent study found that for just one category of drugs used to treat multiple sclerosis, the study estimates that coupons raise negotiated prices by 8% and result in just under $1 billion in increased U.S. spending annually.[8]
- The United States House Oversight Committee's investigation into drug pricing found that for one cancer treatment, one manufacturer projected a potential rate of return of $8.90 for every $1 spent on their copay assistance program.[9]

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[4] Is My Drug Copay Coupon a Form of Charity – Or a Bribe? Kaiser Health News, April 21, 2022 https://khn.org/news/article/drug-companies-copay-assistance-program-charity-or-bribe/

[5] *See 42* U.S.C § 1320a-7b; *Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons*. HHS Office of the Inspector General. September 2014. https://oig.hhs.gov/documents/special-advisory- bulletins/878/SAB_Copayment_Coupons.pdf.

[6] Dafny, et. al. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. American Economic Journal: Economic Policy 9, no. 2 (May 2017): 91–123. https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf

[7] Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs). Congressional Research Service. June 15, 2017. https://crsreports.congress.gov/product/pdf/R/R44264/5.

[8] Dafny, et.al. *How do copayment coupons affect branded drug prices and quantities purchased?* NationalBureauofEconomicResearch.February2022. https://www.nber.org/system/files/working_papers/w29735/w29735.pdf.

[9] Drug Pricing Investigation: Majority Staff Report. US House Committee on Oversight and Reform. December 2021. %20APPENDIX%20v3.pdf.

Health insurance providers have limited tools to hold drug manufacturers accountable for their high prices

Employers and health insurance providers have worked hard to develop programs to hold drug companies accountable, to shed light on these pricing schemes, and keep costs low for North Dakotans. One such program allows patients to save money with a coupon but does not count the coupon's value toward patients' out-of-pocket cost obligations. The Centers for Medicare & Medicaid Services (CMS) agrees that these programs are important to protect taxpayers. In addition to deeming coupons illegal kickbacks in federal programs, CMS explicitly allowed such programs to continue in the Exchange Marketplaces.[10]

Legislation banning these programs by requiring health plans to count all third-party payments towards an enrollee's cost sharing obligations will eliminate incentives for drug companies to lower prices. As a result, drug companies will make more money while North Dakota families and businesses continue to foot the bill through higher premiums, higher out-of-pocket expenses, and higher federal insurance subsidies.

Policymakers can take steps to protect North Dakotans from bait and switch gaming that threatens health care affordability.

Instead of taking away the few tools that health plans have to lower drug spending, we recommend that North Dakota legislators focus on fixing the market distortion caused by pricing schemes, including copay coupons.

AHIP stands ready to work together with policymakers on real solutions to ensure every patient has access to the high-quality drugs that they need and improve health care affordability.

Thank you for your time and consideration. I'd be glad to answer any questions.

[10] *Notice of Benefit and Payment Parameters for 2021*. Centers for Medicare & Medicaid Services. June 13, 2020. https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10045.pdf.

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1413

Page 1, line 10 , replace "policy" with "health benefit plan"

Page 1, line 11, replace "policy" with "health benefit plan"

Page 1, line 15, replace ""Policy" means an accident and health insurance policy, contract, or evidence of" with ""Health benefit plan" has the same meaning as provided in section 26.1-36.3-01."

Page 1, remove line 16

Page 1, line 18, replace "policy" with "health benefit plan"

Page 1, line 19, replace "policy" with "health benefit plan"

Page 1, line 20, replace "policy" with "health benefit plan"

Page 1, remove lines 23 through 24

Page 2, remove lines 1 through 16

Renumber accordingly

HB 1413
House Industry, Business & Labor Committee
January 25, 2023
Testimony of Rep. Karen Karls, District 35, Bismarck

For the record, my name is Rep. Karen Karls. I represent District 35 in central Bismarck. My husband Ken was executive director of the Cystic Fibrosis Association of ND many years.

Recently, I visited with Karen, an adult with Cystic Fibrosis, a hereditary, chronic, fatal disease. People with CF typically have frequent lung infections and require hospitalization an average of a week, 2 times per year to receive concentrated IV antibiotics and medicated breathing treatments.

Within recent years, amazing progress has been made by Vertex attacking the source of the disease in the mutated chromosome that causes cystic fibrosis. Karen now takes Trikafta a 3-drug combo. She no longer requires a twice a year tune-up and recently her nebulizer treatments were discontinued.

The problem with miracle medications like Trikafta is that they are very expensive to develop and to receive as a patient. Her monthly dose costs $25,000. Her healthcare insurance covers $20,000, but requires an annual $5,000 out-of-pocket maximum. She does not receive the kind of wage to afford this. To help her out, Vertex issued her a $5,000 VISA gift card which she used to cover that $5,000 cost. However, her insurance company refused to apply it against her out-of-pocket expense and requires her to pay it. Most people who hear the story wonder why the insurance company would care about a 3rd-party paying her out-of-pocket maximum.

Karen heard about a plan in Virginia seeking to remedy this Catch 22 situation. I brought the concept to the Legislative Council. The bill before you mimics that Virgina plan. There is one word however, that we missed and it gave the PERS folks major heartburn. I have an amendment for
P. 1, line 10: after the word coinsurance, delete the word "copayment" and the comma before it. A group representing pharmaceutical companies requested another amendment. (23.0392.01002) and I included a copy of both amendments.

The intent of this bill is not to eliminate co-payments, but to allow a third-party to assist with the out-of-pocket maximums…to help people who suffer from chronic diseases. Thank you Mr. Chairman and members of the committee.

23.0392.01002
Title.

Prepared by the Legislative Council staff for
Representative Karls
January 23, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1413

Page 1, after line 22, insert:

"3. If application of this section would result in health savings account ineligibility under section 223 of the Internal Revenue Code [26 U.S.C. 223], this section applies to health savings account-qualified high-deductible health plans with respect to the deductible of the plan after the enrollee has satisfied the minimum deductible under section 223, except for an item or service that is preventative care pursuant to section 223(c)(2)(C), in which case this section applies regardless of whether the minimum deductible under section 223 has been satisfied."

Renumber accordingly

23.0392.01001
Title.

Prepared by the Legislative Council staff for
Representative Karls
January 20, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1413

Page 1, line 10, remove ", copayment,"

Renumber accordingly

HB1413
House Industry, Business & Labor Committee
January 25, 2023
Testimony of Karen M Cossette, Bismarck

Good morning Chairman Louser and members of the committee. I support HB1413.

Let me quickly tell you about myself. I was born with cystic fibrosis. I was hospitalized the first time for a "tune-up" the summer I was age 16. A "tune-up" is 10 to 14 days of hospitalization with intense IV antibiotic treatment, numerous breathing treatments and chest physiotherapy each day, nutrition support and rest. My next "tune-up" wasn't until college. Then in 1996, I started needing a "tune-up" every 3 months. This continued for over 20 years. In 2012, a new drug, Orkambi, became available that fixed my cystic fibrosis on a cellular level. My hospitalizations dropped to once every other year or so. As the years have passed, there have been newer drugs that work even better. The current iteration, called Trikafta, is simply a miracle. My last "tune-up" was in March 2019. In September 2022, all of my nebulized medications were removed from my active medications list. I am able to maintain normal lung function without breathing treatments!

As with all new medications, Orkambi was very expensive, $20,000 per month. However, I have good insurance and the pharmaceutical company, Vertex, has a copay assistance program that covered the initial copay, which for me was $5,000. Now Trikafta is $28,000 per month. Vertex still covers the copay, but my insurance has changed and copay assistance programs do not count toward my deductible. In order to fill my medication the first month of the insurance year, I have to come up with $5,000 to get my medication. I'm lucky in that I also have the support of Cystic Fibrosis Association of North Dakota. CFA of ND reimbursed my $5,000.

This isn't just about me and my expensive miracle drug. This applies to any drug that has a copay assistance program. If insurance companies are allowed to do this, our seniors on fixed incomes will face the same problem. They will have to choose whether they can afford the medication or not. As we already know, many will choose to not pay the high copay for the medication.

We pay for insurance so it will cover the expensive things like hospitalizations, ER visits and medications. Now the insurance companies are trying to save money by getting the deductible paid twice.

Thank you for allowing me to tell my story.

Respectfully submitted,

Karen M. Cossette, Bismarck, ND

23.0392.01003
Title.

Prepared by the Legislative Council staff for the House Industry, Business and Labor Committee
January 31, 2023

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1413

Page 1, line 2, remove "; and to amend and"

Page 1, remove line 3

Page 1, line 4, remove "health care plans"

Page 1, line 10, remove ", copayment,"

Page 1, remove lines 23 and 24

Page 2, remove lines 1 through 16

Renumber accordingly

TESTIMONY OF REBECCA FRICKE

House Bill 1413 – Out of Pocket Maximums

Good afternoon, my name is Rebecca Fricke. I am Chief Benefits Officer of the North Dakota Public Employees Retirement System, or NDPERS. I am here to testify in a neutral position regarding House Bill 1413.

The bill creates and enacts a new section to chapter 26.1-36 of the North Dakota Century Code relating to out-of-pocket expenses for health care services. The proposal requires that all cost-sharing requirements, defined to include coinsurance and deductibles (page 1, line 10), must be included in the calculation of the health insurance policy out-of-pocket maximum. The calculation must include any amount paid by the enrollee or paid on behalf of the enrollee by another person (page 1, lines 17-22).

Note that to the extent HB 1413 creates a mandate, the bill does not comply with the statutory requirement in NDCC section 54-03-28(3) that health insurance plan mandates first apply to NDPERS.

"When a bandage is not enough, we're here."

March 20, 2023

North Dakota Senate Human Services Committee

RE: Committee Hearing on HB 1413

Dear Chairwoman Lee and members of the Committee,

The Bleeding Disorders Alliance of North Dakota and the National Hemophilia Foundation (NHF) are state and national non-profit organizations, respectively, that represent individuals with bleeding disorders across North Dakota and the United States. Our collective mission is to ensure that individuals affected by hemophilia and other inherited bleeding disorders have timely access to quality medical care, therapies, and services, regardless of financial circumstances or place of residence. Please accept these comments in support of HB 1413 for the hearing record.

About Bleeding Disorders

Hemophilia is a rare, genetic bleeding disorder affecting about 30,000 Americans that impairs the ability of blood to clot properly. Without treatment, people with hemophilia bleed internally, sometimes due to trauma, but other times simply as a result of everyday activities. This bleeding can lead to severe joint damage and permanent disability, or even – with respect to bleeds in the head, throat, or abdomen – death. Related conditions include von Willebrand disease (VWD), another inherited bleeding disorder, which is estimated to affect more than three million Americans.

Patients with bleeding disorders have complex, lifelong medical needs. They depend on prescription medications (clotting factor or other new treatments) to treat or avoid painful bleeding episodes that can lead to advanced medical problems. Current treatment and care are highly effective and allow individuals to lead healthy and productive lives. However, this treatment is also extremely expensive, costing anywhere from $250,000 to $1 million or more annually, depending on the severity of the disorder and whether complications such as an inhibitor are present.

Bleeding Disorders Alliance of North Dakota
(701) 381-0670 | director@bdand.org
P.O. Box 548 | Fargo, ND 58107
www.bdand.org

BDAND IS A REGISTERED NON-PROFIT CORPORATION (TAX ID# 47-1684681) UNDER THE LAWS OF THE STATE OF NORTH DAKOTA, AND IS A QUALIFIED CHARITABLE NON-PROFIT ORGANIZATION UNDER SECTION 501(C)(3) OF THE INTERNAL REVENUE SERVICE

Importance of Financial Assistance to Patients

Many individuals with bleeding disorders rely on patient assistance programs to ensure access to their life-saving specialty drugs. And because patients with bleeding disorders require ongoing medication therapy for the course of their lifetimes, many such patients face the prospect of hitting their out-of-pocket maximum each and every year (in 2023, up to $9,100 for an individual, or $18,200 for a family).[1] Financial assistance programs play an essential role in mitigating this weighty financial burden – and allow patients to remain adherent to their prescribed treatment regimen, preserving their long-term health and thereby avoiding medical complications that could increase their overall health care spending.

Patients with bleeding disorders cannot select alternative treatments: no generic drugs exist for hemophilia or related conditions. The vast majority of patient assistance programs are for drugs without generic alternatives. A recent University of Southern California Schaeffer Center analysis found that 71 out of 90 high-expenditure brand drugs that offered coupons had no generic equivalent. The analysis concludes, "these results suggest that most copay coupons are not affecting generic substitution, and many may help patients afford therapies without good alternatives. As such, the copay coupon landscape seems more nuanced, and proposals to restrict coupons should ensure that patients who currently rely on them are not harmed."[2]

In addition, all manufacturers of hemophilia specialty biologics offer financial assistance programs; as a result, assistance for these products do not influence patients to use one product over another. To use the U.S. Department of Health and Human Services' own formulation from the federal 2021 Notice of Benefit Payment and Parameters (NBPP), hemophilia copay assistance programs do not "disincentivize a lower cost alternative" nor do they "distort the market."[3]

Copay Accumulator Adjustment Programs

Copay accumulator adjustment programs (CAAP) limit the utility of patient assistance programs to consumers, by excluding the financial assistance from the calculation of a person's deductible and annual out-of-pocket maximum.

Consumers have little choice when it comes to evaluating health plans in advance for the existence of a CAAP. There is a distressing lack of transparency around plan implementation of CAAPs. Typically, language allowing a plan to implement a CAAP is buried deep in the contract, which can be difficult or impossible to find if you only have access to the marketing materials on a health plan's web site. Manufacturers also are typically unaware of whether a patient's health plan has adopted an accumulator adjustment program. Moreover, individuals covered

by a self-funded large group plan may find that their plan changes its policy on financial assistance mid-way through the plan year (this is problematic in its own right; it would also be unknown to the manufacturer).

Conclusion

The use of CAAPs dramatically increases patient out-of-pocket costs and threatens adherence to treatment for vulnerable individuals affected by serious health conditions. People who live with chronic conditions like bleeding disorders rely on access to quality care, and to accessible and affordable coverage to pay for that care. CAAPs place those patients at risk of being unable to pay for their life saving medication. HB 1413 places necessary and appropriate restrictions on the use of CAAPs by requiring insurers to count all contributions by or on behalf of an insured individual toward their annual cost-sharing requirement.

Thank you for considering our comments and making them part of the record. If you have any additional questions, or need any additional information, please contact Nathan Schaefer, NHF Vice President for Public Policy or Emily Ouellette, Bleeding Disorders Alliance of North Dakota Executive Director.

Sincerely,

Emily Ouellette
Executive Director, Bleeding Disorders Alliance of North Dakota
PO Box 548, Fargo, ND 58107
director@bdand.org | 701-381-0670

Nathan Schaefer
Vice President for Public Policy, National Hemophilia Foundation
7 Penn Plaza · Suite 1204, New York, NY · 10001
(800) 42.HANDI · (212) 328.3700 · fax (212) 328.3777
www.hemophilia.org · info@hemophilia.org

[1] Since bleeding disorders are genetic conditions, there are many families that include more than one affected individual. These families may thus be subject to the family OOP maximum year after year – an unsustainable financial burden for almost any family. See, e.g., Jake Zuckerman, "A New Battle Between Insurers and Big Pharma is Costing Sick People Thousands," Ohio Capital Journal (Feb. 13, 2020), https://ohiocapitaljournal.com/2020/02/13/a-new-battle-between-insurers- and-big-pharma-is-costing-sick-people-thousands/.

[2] Van Nuys, et al. "A Perspective on Prescription Drug Copayment Coupons." USC Leonard D. Schaeffer Center for Health Policy and Economics (emphasis added), February 2018. Available online at: https://healthpolicy.usc.edu/wp-content/uploads/2018/02/2018.02_Prescription20Copay20Coupons20White20Paper_Final-2.pdf.

[3] 84 Fed. Reg. 17545.

HB 1413
Senate Human Services Committee
March 20, 2023
Insurance practice hurts access to life-saving medicines
DAVINEY MCKAY-GOLDEN VALLEY, ND

I live with a deadly chronic disease called Cystic Fibrosis. Thankfully, I also live a full life, because I take medications that keep my lungs healthy. Without all these medications, patients like me would have a completely different life. My medication and treatment plan allows me to live my life to the fullest, play sports, and plan for a jam-packed future.

It was heartbreaking to learn that recently, health insurers and pharmacy benefit managers (PBMs) are classifying medicines like the ones that have saved my life as "non-essential health benefits." Calling the medicines "non-essential" has allowed these companies to find loopholes that allow them to make a profit off of money intended to help patients afford these life-saving medicines. By deeming life-saving medicines as "non-essential," PBMs have changed a rule that no longer counts patient assistance toward their customer's annual out-of-pocket maximum. This means the insurance companies keep collecting the money from pharmaceutical manufacturers or charities (intended to benefit patients) until it runs out, and then they force patients to pay thousands more to reach their out-of-pocket maximum. Many of my medications come with a hefty co-pay and there have been times that our pharmacy would not fill a prescription knowing the co-pay would break us. My family has also had to refuse prescribed medication because we were unable to afford the co-pay.

For example: If a patient has a $250 copay for a drug, but is enrolled in an assistance program, this often allows the patient to owe $50, with the manufacturer paying the remaining $200. In a traditional insurance plan, the entire $250 ($50 from the patient and $200 from the drug manufacturer) would count toward the patient's deductible and the maximum annual out-of-pocket cost. With these new loopholes, payments made by a coupon from a manufacturer, or even a charitable organization, are excluded from the deductible and the annual maximum-out-pocket cost. The Cystic Fibrosis Foundation — and many others — have done so much for our family, and CF patients across North Dakota would be devastated if we couldn't accept their charity.

In the example above, the patient's $50 payment would count toward the deductible and maximum out-of-pocket cost, even though the total copay amount was $250. Now, the patient keeps paying over and over, as does the manufacturer, without ever hitting the maximum out-of-pocket cost.

Even worse, most Cystic Fibrosis patients have no idea their plan has an accumulator or maximizer until they get an unexpected bill in the mail, sometimes for thousands of dollars. CF medication can cost $25,000 per month depending on the medication and the severity of the disease. Insurers and middlemen have hidden these new terms in the fine print of their plan documents, and oftentimes, even insurance experts have a hard time spotting maximizers and accumulators when they review a plan's paperwork. This is immoral and will hurt CF patients across the nation if we don't do something about it.

Lawmakers in states across the country have thankfully taken notice. State and federal bills have been introduced to ban this practice and ensure financial assistance meant for patients is applied to their out-pocket maximum. These bans would end the practice of using copay maximizers, accumulators or other predatory practices being utilized by insurance companies and PBMs.

We are so grateful that in Bismarck, Representative Karen Karls has introduced House Bill 1413, which would limit out-of-pocket payment obligations under health insurance plans, and enhance the ability for patients across the state to afford their prescriptions. Representative Karls has shared testimony of loved ones who fight with Cystic Fibrosis on the House floor, sharing how many CF patients would be forced to pay thousands of dollars a month out of pocket if they weren't able to continue to use their coupons from their medication's manufacturer.

Last year, legislation H.R. 5801 was in Congress. The Help Ensure Lower Patient (HELP) Copays Act had bipartisan support and had more than 60 co-sponsors but unfortunately did not move this past session. We need to try again and encourage members of the North Dakota Delegation to support H.R. 5801 and pass the bill in the new Congress this year. Families across North Dakota need to join to put an end to copay accumulator programs that have harmed our families, friends, and neighbors. Please join our family in supporting House Bill 1413 here in our state and asking our Members of Congress to support the HELP Copays Act.

McKay, of Golden Valley, is a junior at Beulah High School. She was born with Cystic Fibrosis, a chronic disease that

she has learned to embrace and conquer.

HB1413
Senate Human Services Committee

March 20, 2023

Testimony of Karen M Cossette, Bismarck

Good morning Madame Chair and members of the committee. I support HB1413.
Let me quickly tell you about myself. I was born with cystic fibrosis. I was hospitalized the first time for a "tune-up" the summer I was age 16. A "tune-up" is 10 to 14 days of hospitalization with intense IV antibiotic treatment, numerous breathing treatments and chest physiotherapy each day, nutrition support and rest. My next "tune-up" wasn't until college. Then in 1996, I started needing a "tune-up" every 3 months. This continued for over 20 years. In 2012, a new drug, Orkambi, became available that fixed my cystic fibrosis on a cellular level. My hospitalizations dropped to once every other year or so. As the years have passed, there have been newer drugs that work even better. The current iteration, called Trikafta, is simply a miracle. My last "tune-up" was in March 2019. In September 2022, all of my nebulized medications were removed from my active medications list. I am able to maintain normal lung function without breathing treatments!
As with all new medications, Orkambi was very expensive, $20,000 per month. However, I have good insurance and the pharmaceutical company, Vertex, has a copay assistance program that covered the initial copay, which for me was $5,000. Now Trikafta is $28,000 per month. Vertex still covers the copay, but my insurance has changed and copay assistance programs do not count toward my deductible. In order to fill my medication the first month of the insurance year, I have to come up with $5,000 to get my medication. I'm lucky in that I also have the support of Cystic Fibrosis Association of North Dakota. CFA of ND reimbursed my $5,000.
This isn't just about me and my expensive miracle drug. This applies to any drug that has a copay assistance program. If insurance companies are allowed to do this, our seniors on fixed incomes will face the same problem. They will have to choose whether they can afford the medication or not. As we already know, many will choose to not pay the high copay for the medication.
We pay for insurance so it will cover the expensive things like hospitalizations, ER visits and medications. Now the insurance companies are trying to save money by getting the deductible paid twice.
Thank you for allowing me to tell my story.

Respectfully submitted,
Karen M. Cossette, Bismarck, ND

#25823

March 19, 2023

The Honorable Judy Lee, Chair Senate Human Services Committee
The Honorable Sean Cleary, Vice Chair Senate Human Services Committee
North Dakota Senate Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **HB 1413 – Relating to Out-of-Pocket Expenses for Health Care Services**
PCMA Testimony in Opposition to HB 1413

Dear Chair Lee, Vice Chair Cleary and Committee Members:

My name is Michelle Mack and I represent the Pharmaceutical Care Management Association commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs

PCMA appreciates the opportunity to provide testimony on HB 1413, a bill which would require insurers to count any amount paid by enrollees (directly or on their behalf) toward an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the policy. PCMA respectfully opposes HB 1413.

I want to emphasize at the outset that **PCMA does *not* oppose true means-tested patient assistance programs that help individuals afford their prescription drugs.** There is an important difference between means-tested patient assistance programs and copay coupons, which are targeted to individuals with health insurance.

The unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays and deductibles. While health plans pay the vast amount of their members' prescription drug costs, drug manufacturers' price increases have forced health plans to create new benefit designs that keep monthly premiums as low as possible—but require some members to shoulder more of the cost before their deductible is met.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

Drug manufacturers encourage patients to disregard formularies and lower cost alternatives by offering “coupons” to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternatives and towards more expensive brand drugs (with higher cost sharing obligations), completely undermining the formulary offered by a plan sponsor.

Here are the facts when it comes to manufacturer coupons:

- The prices for drugs with manufacturer coupons **increase faster (12-13% per year)** compared to non-couponed drugs (7-8% per year).[1]
- If Medicare’s ban on coupons were not enforced, costs to the program would **increase $48 billion** over the next ten years.[2]
- Coupons were responsible for a **$32 billion increase** in spending on prescription drugs for commercial plans.[3]
- For every $1 million in manufacturer coupons for brand drugs, **manufacturers reap more than $20 million in profits (20:1 return).**[4]

By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still permitted in the commercial market.

Supporters of coupons say that they decrease costs for patients. While they can decrease an individual patient’s cost at the pharmacy counter, they do not reduce ***actual*** costs. **Coupons are temporary—the individual patient likely pays more when the coupon goes away, instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.**

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to increase copay assistance rather than just making their medications more affordable. The simplest, most effective way to reduce patient cost on drugs is for manufacturers to drop the price of the drug.

Copay accumulator programs are health plan programs designed to thwart drug manufacturers’ efforts to force employers, unions, and public programs to pay for

[1] Leemore Dafny, Christopher Ody, and Matt Schmitt. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. The National Bureau of Economic Research. October 2016.
[2] Visante. Drug Manufacturer Coupons Raise Costs in Medicare Part D, Hurting Vulnerable Beneficiaries. May 2020.
[3] Visante. How Copay Coupons Could Raise Prescription Drug Costs By $32 Billion Over the Next Decade. November 2011.
[4] Dafny et al. October 2016

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

expensive, unnecessary brand medications through the use of copay coupons. Accumulators typically disallow the counting of the manufacturer's coupon towards the patient's out-of-pocket maximum and deductible because the patient hasn't actually incurred the cost. This ensures that the patient has the incentive to use the plan formulary to get to the lowest net cost and that the plan functions as it was designed.

It is for these problematic provisions noted above that we must respectfully oppose HB 1413.

Thank you for your time and consideration. Please contact me should you have any questions or concerns.

Sincerely,

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
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HB 1413 - Senate Human Services Committee - March 20, 2023

For the record, my name is Rep. Karen Karls. I represent District 35 in central Bismarck. My husband Ken was executive director of the Cystic Fibrosis Association of ND for many years.

Recently I visited with Karen, an adult with cystic fibrosis, a hereditary, chronic, fatal disease. She is here today to share her testimony. I will attempt to explain the problem she has run into recently. (Please note: there is submitted testimony from the Blood Disorders Alliance of ND with a similar story.)

Needless to say, medications used to treat chronic diseases like CF and hemophilia are extremely expensive. Why? Because the pharmaceutical company that takes on the research for this disease faces YEARS of lab testing, clinical research, and then faces the rigors of winning FDA approval. There is a very small market for these medications, even though they are "miracle" drugs—there are no generic alternatives for them! Thus the extremely high costs.

To help patients better afford their medications (and stay on them) many 3rd-party entities, including the drug manufacturers, offer cost-sharing assistance such as discount coupons (AKA "copay assistance".) Historically, commercial health insurance plans have counted these coupons 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 medications.

Unfortunately, health insurance carriers have adopted policies, often referred to as "accumulator adjustment programs" (AKA "copay accumulators") that block manufacturer coupons from counting towards deductibles and out-of-pocket limits. This means patients could be paying thousands more at the pharmacy. Many have relied on this assistance and have no idea that their health insurer no longer counts these coupons. This can result in unpleasant surprises at the pharmacy counter where they may face thousands of dollars of unexpected costs.

If companies are willing to create a miracle drug and help patients obtain it via drug assistance programs, these should be accessible to them. We need to update our laws to prohibit insurers from continuing this practice and enable patients to access and afford the lifesaving medications they need to manage their chronic illness. HB 1413 hopes to accomplish this.

After reading and studying this bill, I have a proposed amendment to clarify that this deals only with the prescription drug part NOT the health care services side which the original bill dealt with. Subsection 3 covers the ERESA concerns we heard after the hearing in the House committee. I provided you all a paper copy of the proposed amendment plus the "Christmas Tree" version of the amended bill for your convenience.

Madam Chair and member of the committee, I will stand for questions.

23.0392.02002
Title.

Prepared by the Legislative Council staff for
Representative Karls
March 20, 2023

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

Page 1, line 2, replace "health care services" with "prescription drugs"

Page 1, line 6, replace "**Health care services**" with "**Prescription drugs**"

Page 1, line 8, after "coinsurance" insert ", copayment,"

Page 1, line 8, replace "policy" with "health benefit plan"

Page 1, line 9, replace "health care services" with "prescription drug coverage"

Page 1, line 9, replace "policy" with "health benefit plan"

Page 1, line 10, remove ""Health care services" means items or services furnished to an enrollee for the"

Page 1, replace lines 11 through 14 with ""Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.

d. "Prescription drug" means a drug for which a prescription is required:

(1) Without a generic equivalent; or

(2) With a generic equivalent and the enrollee has obtained access to the drug through prior authorization, a step therapy protocol, or the health care insurer's exceptions and appeals process."

Page 1, line 16, replace "policy" with "health benefit plan"

Page 1, line 16, replace "health care services" with "prescription drug"

Page 1, line 17, replace "policy" with "health benefit plan"

Page 1, line 18, after "requirement" insert "for a prescription drug"

Page 1, line 18, replace "policy" with "health benefit plan"

Page 1, line 19, replace "calculation must include" with "health benefit plan provides for the inclusion of"

Page 1, line 20, after the underscored period insert "The health benefit plan may not vary the out-of-pocket maximum or cost-sharing requirement, or otherwise design benefits in a manner that takes into account the availability of a cost-sharing assistance program for a prescription drug.

3. If application of this section would result in ineligibility of a health benefit plan that is a qualified high-deductible health plan to qualify as a health savings account under section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of this section do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223."

Renumber accordingly

23.0392.02002

FIRST ENGROSSMENT

Sixty-eighth
Legislative Assembly
of North Dakota

ENGROSSED HOUSE BILL NO. 1413

Introduced by

Representatives Karls, Kiefert, Rohr, Satrom, Steiner

Senator Dever

A BILL for an Act to create and enact a new section to chapter 26.1-36 of the North Dakota Century Code, relating to out-of-pocket expenses for ~~health care services~~prescription drugs.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. A new section to chapter 26.1-36 of the North Dakota Century Code is created and enacted as follows:

Out-of-pocket expenses - ~~Health care services~~Prescription drugs.

1. As used in this section:
   a. "Cost sharing" means any coinsurance, copayment, or deductible under a ~~policy~~health benefit plan.
   b. "Enrollee" means an individual entitled to ~~health care services~~prescription drug coverage under a ~~policy~~health benefit plan.
   c. ~~"Health care services" means items or services furnished to an enrollee for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.~~
   ~~d. "Policy" means an accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.~~"Health benefit plan" has the same meaning as provided under section 26.1-36.3-01.
   d. "Prescription drug" means a drug for which a prescription is required:
      (1) Without a generic equivalent; or
      (2) With a generic equivalent and the enrollee has obtained access to the drug through prior authorization, a step therapy protocol, or the health care insurer's exceptions and appeals process.
2. To the extent permitted by federal law and regulation, an insurer may not deliver, issue, execute, or renew a ~~policy~~health benefit plan that provides ~~health care~~

1 ~~services~~prescription drug coverage unless that ~~policy~~health benefit plan provides
2 when calculating an enrollee's overall contribution to any out-of-pocket maximum or
3 any cost-sharing requirement for a prescription drug under the ~~policy~~health benefit
4 plan, the ~~calculation must include~~health benefit plan provides for the inclusion of any
5 amount paid by the enrollee or paid on behalf of the enrollee by another person. The
6 health benefit plan may not vary the out-of-pocket maximum or cost-sharing
7 requirement, or otherwise design benefits in a manner that takes into account the
8 availability of a cost-sharing assistance program for a prescription drug.
9 3. If application of this section would result in ineligibility of a health benefit plan that is a
10 qualified high-deductible health plan to qualify as a health savings account under
11 section 223 of the Internal Revenue Code [26 U.S.C. 223], the requirements of this
12 section do not apply with respect to the deductible of the health benefit plan until after
13 the enrollee has satisfied the minimum deductible under section 26 U.S.C. 223.

Good afternoon, Madam Chair and members of the Senate Human Services Committee, my name is Megan Houn with Blue Cross Blue Shield of North Dakota.

I stand today in opposition of House bill 1413, relative to copay coupons. Copay coupon legislation is two things, one a balloon squeezer, meaning if passed, it may simply lower costs in one area but cause them to grow in another, and secondly, a wolf in sheep's clothing.

- Copay coupons are coupons given by pharmaceutical manufacturers to keep our members on very expensive drugs.

- The goal of pharmaceutical companies in this situation is to appear to make their drugs more affordable, while still getting reimbursed the full amount from insurance companies.

- Brand name coupons increase spending by $32 billion nationally in commercial markets.

- Coupons are time limited, so our member pays the full amount once the coupon expires.

- Federally, drug coupons are illegal. Anti-kickback legislation prevents use of drug coupons on Medicare, Medicaid, and any of the federal insurance plans.

- Maybe most importantly, pharmaceutical companies do not offer drug coupons to the uninsured. Arguably, those who need them the most, do not receive any relief on their prescription drugs. Pharmaceutical companies target people with private, commercial, non-federal coverage for these coupons.

- Additionally, with respect to the copay accumulator portion of the legislation, CMS ruled that for some of the 2023 individual ACA plans, copayments cannot contribute towards the deductible, so those plans would be pre-empted from this bill and result in this law not applying to all copayment plans even in the fully insured markets. Given that state-imposed health insurance mandates already only apply to fully insured business, and now some of those plans have also been excluded by law, the margin of folks who would benefit from the proposed legislation is even narrower.

- We do believe that this is a mandate, given the language in line 19, so respectfully ask that the PERS trial language be added on. It might be noted that in its original hearing in Employee Benefits on the original bill, there was an $18 million-dollar fiscal note for PERS alone. It would be worthwhile to study the impacts of this in any case.

- Blue Cross Blue Shield of North Dakota did dig into potential cost impacts of the bill as it currently stands and found that there would be a roughly $30-$130 premium impact for a fully insured member regardless of whether they receive a copay coupon. There would also be some substantial administrative costs to make changes to our plans based on the copay accumulator language.

Thank you for your consideration today, Madam Chair and I would stand for any questions.

#25973

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March 20, 2023

Senator Judy Lee, Chairman
Senate Human Services Committee
North Dakota State Capitol
600 East Boulevard Avenue
Bismarck, North Dakota 58505

RE: AHIP Concerns on HB 1413 *Relating to out-of-pocket expenses for health care services*

Dear Chairman Lee and Committee members,

On behalf of AHIP, we offer the following concerns regarding HB 1413, which encourages drug manufacturers to employ practices that are explicitly forbidden in federal health programs, like Medicare and Medicaid, because they have been deemed as illegal kickbacks.[1] We appreciate the opportunity to provide feedback on this legislation and your consideration of our concerns discussed below.

Drug Manufacturers Intentionally Use Copay Coupons and Patient Assistance Programs to Keep Drug Prices High, Raising Costs for Everyone.

Everyone should be able to get the medications they need at a cost they can afford. However, drug prices continue to rise out of control, and pharmacy costs now represent over 22 cents[2] out of every dollar of premium spent on health care.

Drug manufacturers acknowledge their drugs are unaffordable for patients. But rather than simply lowering their prices, they offer copay coupons, vouchers, discounts, or payments to offset cost-sharing expenses (collectively, "copay coupons") to hide their exorbitant prices. Copay coupons are yet another way for drug companies to insulate themselves from public scrutiny, skirt transparency, and maximize their profits by protecting their out-of-control pricing practices.

These tactics incent patients to use very expensive drugs rather than equally effective, less expensive alternatives (such as generics, biosimilars, and other therapeutic substitutes). Drug manufacturers strategically offer these promotions for a narrow selection of drugs and often only for a limited period, after which the full price of the drug is passed on to the patient's insurance, raising costs for everyone.

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[1] *See 42* U.S.C § 1320a-7b; *Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons*. Department of Health and Human Services, Office of the Inspector General. September 2014. Available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/2014/SAB_Copayment_Coupons.pdf.

[2] *Where Does Your Health Care Dollar Go?* America's Health Insurance Plans. September 6, 2022. https://www.ahip.org/resources/where-does-your-health-care-dollar-go

As stated by the editor of Kaiser Health News, Dr. Rosenthal writes "coupons create a mirage that perpetuates our system's reckless spending. They cover up a drug's true price, much of which our insurers pay… and contributes to our escalating insurance premiums and deductibles year after year."[3]

The federal government considers copay coupons to be an illegal kickback if used by an enrollee in federal health programs, including Medicare and Medicaid, because they induce a patient to use a specific drug.[4] Because the commercial market is the only market where drug manufacturers may offer copay coupons, they are aggressively seeking policy proposals, like HB 1413, to protect their financial gains.

Data Proves That Drug Coupons Are Used by Drug Manufacturers to Increase Sales.

There are multiple studies by Harvard[5], Congress, the nonpartisan Congressional Research Service[6], and others, that found that drug manufacturers use patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on branded drugs after a generic is introduced, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the high-priced drug. For example:

- A recent study found that for just one category of drugs used to treat multiple sclerosis, the study estimates that coupons raise negotiated prices by 8% and result in just under $1 billion in increased U.S. spending annually.[7]
- The U.S. House Oversight Committee's two-year investigation into drug pricing found that for one cancer treatment, one manufacturer projected a potential rate of return of $8.90 for every $1 spent on their copay assistance program.[8]
- A case study done conducted by economists at Harvard, Northwestern, and UCLA, on the effect of copay coupons in Massachusetts (who had banned coupons) and their neighboring state New Hampshire (which allowed coupons) found:
  - Prices for brand name drugs with copay coupons rose 12% per year compared to price increases of 7% to 8% per year on brand name drugs that did not offer coupons;
  - A 60% (or more) increase in brand utilization than if patients had switched to a generic competitor; and
  - After reviewing a sample of 23 medications, coupons increased total spending by $700 million in the five years after generic entry.[9]

[3]Is My Drug Copay Coupon a Form of Charity – Or a Bribe? Kaiser Health News, April 21, 2022 https://khn.org/news/article/drug-companies-copay-assistance-program-charity-or-bribe/

[4]See 42 U.S.C § 1320a-7b; Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons.

[5] Dafny, et. al. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. American Economic Journal: Economic Policy 9, no. 2 (May 2017): 91–123. https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf

[6] Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs). Congressional Research Service. June 15, 2017. https://crsreports.congress.gov/product/pdf/R/R44264/5.

[7] Dafny, et.al. How do copayment coupons affect branded drug prices and quantities purchased? National Bureau of Economic Research. February 2022. https://www.nber.org/system/files/working_papers/w29735/w29735.pdf.

[8] Drug Pricing Investigation: Majority Staff Report. US House Committee on Oversight and Reform. December 2021. https://oversight.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf.

[9] Dafny, et. al. *When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization.* American Economic Journal: Economic Policy 9, no. 2 (May 2017): 91–123. Available at https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992c3e03bc8cc4.pdf

Health Insurance Providers Have Limited Tools to Hold Drug Manufacturers Accountable for Their High Prices.

Employers and health insurance providers have worked hard to develop programs to hold drug companies accountable, to shed light on these pricing schemes, and keep costs low for North Dakotans. One such program allows patients to save money with a coupon but does not count the coupon's value toward patients' out-of-pocket cost obligations, known as accumulator programs. These programs help to restore the balance in the system by allowing the patient to use manufacturer coupons, but not counting the coupon towards the deductible – since the drug manufacturer is paying the amount of the coupon.

The Centers for Medicare and Medicaid Services (CMS) has explicitly allowed accumulator programs to continue in the Exchange Marketplaces as part of their efforts to combat the high and rising out-of-pocket costs for prescription drugs, recognizing the "market distortion effects related to direct drug manufacturer support amounts when consumers select a higher-cost brand name drug over an equally effective, medically appropriate generic drug[10]."

The U.S. House Oversight Committee stressed in their investigation that these programs "do not provide sustainable support for patients and do not address the burden that the company's pricing practices have placed on the U.S. health care system."[11]

Legislation banning accumulator programs by requiring health plans to count all third-party payments towards an enrollee's cost sharing obligations will eliminates incentives for drug companies to lower prices. As a result, drug companies will make more money while North Dakota families and businesses continue to foot the bill through higher premiums, higher out-of-pocket expenses, and higher federal insurance subsidies.

The Legislature Should Focus on Solutions that Forbid Market Manipulation

Instead of taking away the few tools that health plans have to lower drug spending, we recommend that North Dakota legislators focus on fixing the market distortion caused by pricing schemes, including copay coupons.

AHIP supports a ban on copay coupons, especially in cases where less expensive generic alternatives are available, as California did in 2017.[12] This has been proposed as a major step by a group of prestigious health care scholars looking at ways offer evidence-based steps for reforming health care spending in the US.[13]

If you wish to allow the use of coupons to continue, we urge you to consider reforms that require fair and equitable distribution of coupons with sufficient oversight and transparency. This includes:

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[10] *Notice of Benefit and Payment Parameters for 2021*. Centers for Medicare & Medicaid Services. June 13, 2020. Available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10045.pdf.

[11] [11] Drug Pricing Investigation: Majority Staff Report. US House Committee on Oversight and Reform. December 2021. https://oversight.house.gov/sites/democrats.oversight.house.gov/files/DRUG%20PRICING%20REPORT%20WITH%20APPENDIX%20v3.pdf.

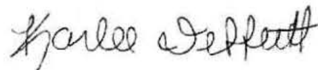
[12] CA AB 265 (2017).

[13] Dafny, et. al. *Eliminating Prescription Drug Copay Coupons. 1% Steps for Health Care Reform*. Available at https://onepercentsteps.com/policy-briefs/eliminating-prescription-drug-copay-coupons/

- Requiring promotions be provided to all patients prescribed the drug for the entire plan year and requiring manufacturers to inform patients to be informed when a promotion will be ended in a subsequent plan year.
- Requiring drugmakers to disclose the amount that they spend on these promotions and other patient assistance programs.
- Requiring patient assistance groups to annually report the contributions they receive from entities in the pharmaceutical supply chain.
- Requiring drugmakers providing a promotion, or other third-party program providing assistance, to notify an insurance provider when their enrollee is receiving these payments so that health insurance providers can better understand the impact of these payments.

AHIP stands ready to work together with policymakers on real solutions to ensure every patient has access to the high-quality drugs that they need and improve health care affordability. We appreciate the opportunity to share our concerns and your consideration of our comments.

Sincerely,



Karlee Tebbutt
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AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Copay Coupons

A BRAND-NAME BAIT & SWITCH

Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, and hardworking families feel the consequences every day. Copay coupons[1] are just one more Big Pharma scheme to price gouge patients. Health insurance providers are fighting against Big Pharma's price gouging to make health care more affordable for every single American.

Copay coupons are a "bait & switch" game that increase the cost of care for everyone.

- These Big Pharma tactics incent patients to use very expensive drugs rather than equally effective, less expensive alternatives (such as generics, biosimilars, and other therapeutic substitutes).
- These promotions are offered only to very specific patients for a very short period of time. Once the patient hits their deductible – and will not see the drug's cost at the pharmacy counter – drugmakers stop providing their coupons. This scheme allows Big Pharma to keep their prices high, with patients, employees, and employers paying the cost.

Big Pharma could simply lower the prices of their prescription drugs. But they won't. Health insurance providers fight for patients and consumers to make health care and prescription drugs more affordable.

Studies prove that these promotions are used to increase sales, fueling increased drug spending.

- The House Oversight Committee's investigation into drug pricing found that Big Pharma uses patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on branded drugs after a generic is introduced, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the high-priced drug.
- Drugs with coupons had a higher annual price growth (12-13%) than drugs without coupons (7-8%).
- Big Pharma uses coupons to keep prices high, even after lower-cost generics come to market. After a generic alternative entered the market, coupons increased spending on branded drugs by $30-$120 million per drug over 5 years.

The U.S. House Oversight Committee stressed that these programs "do not provide sustainable support for patients and do not address the burden that the company's pricing practices have placed on the U.S. health care system."

- Copay coupons increase market share and increase sales of brand name drugs after a generic enters the market.
- For one cancer treatment, one manufacturer projected a potential rate of return of $8.90 for every $1 spent on their copay assistance program.

1 Here, the term "copay coupons" is used to represent all payments provided by a third party towards a patient's cost sharing (copay, coinsurance, deductible). This includes coupons directly from drug manufacturers, but also third-party payments and discount programs from patient assistance programs.

JANUARY 2022

AHIP
Guiding Greater Health

These bait & switch tactics are kickbacks to Big Pharma.

- The federal government considers copay coupons to be an illegal kickback. That's why they are not allowed to be used in federal health programs like Medicare or Medicaid.
- Health insurance providers are completely removed from this bait & switch process. They do not know when these promotions are used unless a pharmacist reports them.
- This type of system gaming is only seen from Big Pharma. Patients do not receive promotional discounts to encourage them to receive infusion chemotherapy at one hospital over another. If doctors and hospitals do not do this, why should Big Pharma be allowed to?

Letting drugmakers put money into patients' pockets to pay for their own expensive medicines "does induce people to get a specific product...it's kind of the definition of a kickback."

Policymakers can take steps to protect Americans from bait & switch gaming that threatens health care affordability.

- Ban these promotions and other third-party payments for brand-name drugs when patients can choose a less expensive alternative.
- Require a promotion to be provided to all patients prescribed the drug for the entire plan year. Require that drugmakers warn patients if they will end the promotion or third-party payment in a subsequent plan year.
- Require drugmakers providing a promotion, or other third-party program providing assistance, to notify an insurance provider when their enrollee is receiving these payments, including any associated terms and conditions.
- Require drugmakers to disclose the amount that they spend on these promotions and other patient assistance programs.
- Require patient assistance programs to annually report the contributions they receive from entities in the pharmaceutical supply chain.

Health insurance providers fight to protect Americans from the harmful effects of Big Pharma promotions.

- Health insurance providers are clear: Big Pharma should lower the prices that they (and they alone) set.
- Big Pharma's bait & switch games manipulate patients – and the market – for their own profits. That is why health insurance providers sometimes will allow patients to save money with a Big Pharma promotion, but do not count the promotion toward patients' out-of-pocket cost obligations.
- CMS agrees. CMS allowed health insurance providers to use such an approach in the individual market because of the "market distortion effects related to direct drug manufacturer support."

Lawmakers should not allow Big Pharma to play bait & switch games to manipulate the market, keep their prices high, and avoid transparency into the prices that they set. Let's work together on real solutions to improve health care affordability, access, and choice.

#26787

Correcting the Record on Copay Assistance and Accumulator Adjustment Policies

MYTH

Copay assistance provided by pharmaceutical manufacturers keeps drug prices high, by incentivizing the use of high-cost treatments instead of lower cost generic equivalents.

FACT

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 for specialty medications where copay assistance was used, only 3.4% of those claims were for a product that may have a generic alternative available.[1] If copay assistance programs were intended to drive patients away from generic alternatives, then this share would be significantly higher.

The truth is that copay assistance is a critical lifeline that helps ensure 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.[2]

MYTH

Copay assistance enables patients to circumvent plan design and go right to the highest-cost drugs.

FACT

Patients taking specialty medications must first go through utilization management (UM) protocols imposed by their health plan, such as prior authorization and step therapy, before being granted access to the medication their doctor has prescribed. It is only *after* receiving approval for his/her medication from the health plan that patients can request copay assistance.

MYTH

If patients don't like accumulator policies, they should be better health care consumers and choose a health plan that works better for them.

FACT

When it comes to choosing a health plan, most patients do not have a choice. Plans with copay accumulators are either all that is offered, or all they can afford. For many Americans, it all comes down to the cost of the premium, and sadly, the lowest premium plans come with the highest out-of-pocket cost burden. In fact, many employers only offer high deductible health plans (HDHPs) which can require a deductible of up to $8,700 – which many patients cannot afford without assistance.

With more than 80% of commercially insured plans having copay accumulator policies, millions of Americans are insured, but left unable to exercise their health plan benefits to get the medications they need.[3]

Correcting the Record on Copay Assistance and Accumulator Adjustment Policies

MYTH

When patients are allowed to use copay assistance, they have less "skin in the game."

FACT

Patients living with chronic illnesses don't have the luxury of forgoing certain health care treatments and services. Copay assistance helps shoulder the increasingly high burden of out-of-pocket costs for needed medicines.

In recent years, **patients are being forced to pay more out of pocket than ever before.** More than half of all Americans are now in HDHPs, and the average deductible has increased 90% since 2015.[4,5] While 56% of Americans report being unable to cover an unexpected expense of over $1,000, Affordable Care Act (ACA)-compliant plans are allowed to charge $8,700 out of pocket for an individual and $17,400 for a family in 2022.[6,7] **This is not a matter of choosing smarter – it is an impossible financial situation.**

MYTH

Internal Revenue Service (IRS) guidance stands in the way of the Centers for Medicare & Medicaid Services (CMS) disallowing copay accumulator adjustor policies.

FACT

This is a misreading of the IRS guidance. **Although critics often point to 2004 IRS informal guidance as preventing CAAP bans, the guidance does no such thing.**

The IRS informal guidance itself does not address copay assistance at all. What's more, the 2004 informal guidance predated patient cost-sharing protections that were set in the ACA, prior to the emergence of accumulator adjustor policies.

The IRS has since clarified its position on the use of copay cards for enrollees on a HDHP paired with a health savings account (HSA) that wish to contribute to their HSA, stating that the enrollee is only required to meet the minimum deductible to be considered to have met their financial responsibility. **Claiming IRS rules block copay help from counting towards a patient's deductible is simply untrue and harms America's most vulnerable patients.**

To set the record straight, **CMS should require that insurers and pharmacy benefit managers (PBMs) *count all copayments made by or on behalf of an enrollee* toward that enrollee's annual deductible and out-of-pocket limit.** CMS can do this in their annual updated guidance, known as the Notice of Benefit and Payment Parameters (NBPP), which informs health insurance plan design and implementation.

REFERENCES

1. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization
2. https://www.sciencedaily.com/releases/2018/04/180402160613.htm?utm_source=H2Rminutes
3. https://www.ajmc.com/view/contributor-providers-and-patients-push-back-payers-push-forward-co-pay-mitigation-programs
4. https://www.hemophilia.org/sites/default/files/document/files/NHF - National Patients and Caregivers Survey on Copay Assistance %28Key Findings%29.pdf
5. https://aidsinstitute.net/documents/2021_TAI_Double-Dipping_Final-031621.pdf
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7. https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

Wolf, Sheldon

From: Lee, Judy E.
Sent: Wednesday, March 22, 2023 2:22 PM
To: Wolf, Sheldon
Subject: FW: HB 1413 Co-Pay accumulator information
Attachments: ACCC_MythFact_11.18.pdf

Do you think this can be loaded?

Senator Judy Lee
1822 Brentwood Court
West Fargo, ND 58078
Home phone: 701-282-6512
Email: jlee@ndlegis.gov

From: Lacee Anderson <lacee@birchgroupnd.com>
Sent: Wednesday, March 22, 2023 9:05 AM
To: Lee, Judy E. <jlee@ndlegis.gov>; Cleary, Sean <scleary@ndlegis.gov>; Clemens, David <dclemens@ndlegis.gov>; Hogan, Kathy L. <khogan@ndlegis.gov>; Roers, Kristin <kroers@ndlegis.gov>; Weston, Kent <kweston@ndlegis.gov>
Subject: HB 1413 Co-Pay accumulator information

Members of Senate Human Services-

A couple of your members requested additional information on the copay accumulator bill, so I felt it best to share with all of you.

Below are a few links (as well as an attachment) regarding copay accumulators (policies put in place by some insurance companies to avoid applying cost sharing assistance to patients' deductibles). It includes myths v. facts and the numerous groups and states supporting this legislation (if proposed amendments are adopted).

https://allcopayscount.wpengine.com/state-legislation-against-copay-accumulators/

You'll find that in a number of the states that have passed this legislation, there has been no fiscal note. Practically speaking, there should not be. Where the money comes from for the drug should not be factored in by insurance to set premiums. Putting a large fiscal note on the bill has been a common tactic by insurance in other states to kill the bill. However, if there are concerns about a fiscal note, this bill could be amended to only apply to private insurance.

I also found this analogy given in testimony in Missouri helpful:

It's like your son or daughter being accepted to a university that costs $40K a year and receiving a scholarship from a third party for $20K a year. When you arrive they tell you they will not accept the scholarship on your behalf. However, they then keep the scholarship money and charge you the full $40K.

Despite some confusion in committee, this is what is happening in many instances.

Here is a link to the over 80 non-profit, non-partisan patient groups supporting this legislation:

https://allcopayscount.org/about-us/

In addition, both the Insurance Commissioner and LC have said this legislation is not a mandate. I believe they are going to follow up with the committee.

I hope the links and information are helpful. There is lots of additional information out there as well. I'm happy to chat further.

Thanks,
Lacee

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1413 Amendment Idea:

1. As used in this section
   a. "Cost sharing" means any coinsurance or deductible under a health benefit plan.
   b. "Enrollee" means an individual entitled to health care services under a health benefit plan.
   c. "Health benefit plan" has the same meaning as provided under section 26.1-36.3-01
   d. "Prescription Drug"
      i. Without a generic equivalent; or
      ii. With a generic equivalent and the enrollee has obtained access to the drug through prior authorization, a step therapy protocol, or the health care insurer's exceptions and appeals process.

2. To the extent permitted by federal law and regulation, an insurer may not deliver, issue, execute, or renew a health benefit plan that provides prescription drug coverage unless that health benefit plan provides, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement for a prescription drug under the health benefit plan, the health benefit plan provides for the inclusion or any amount paid by the enrollee (remove "paid on behalf of the enrollee by another person"). The health benefit plan may not vary the out-of-pocket maximum or cost-sharing requirement, or otherwise design benefits in a manner that takes into account the availability of a cost-sharing assistance program for a prescription drug.

3. If application would result of this section would result in ineligibility of a health benefit plan that is a qualified high-deductible plan to qualify as a health savings account under section 223 of the IRS Code, the requirements of this section do not apply with respect to the deductible of the health benefit plan until after the enrollee has satisfied the minimum deductible under section 26 USC 223.

4. This goes into effect upon renewal of a health benefit plan.

5. All coupons must be offered, regardless of payer source, unless otherwise prohibited by federal law.

6. This Act applies to public employees retirement system health benefits coverage that begins after June 30, 2023, and which does not extend past June 30, 2025.

SECTION 1. LEGISLATIVE MANAGEMENT STUDY – PRESCRIPTION DRUG COUPON AND FINANCIAL ASSISTANCE PROGRAM UTILIZATION

During the 2023-2024 interim, the legislative management shall consider studying the prevalence and usage of third-party payments to reduce or eliminate North Dakota patients' cost-sharing and out-of-pocket costs for prescription drugs, including programs offered by the manufacturer of a prescription drug. The study shall include the prevalence and usage of third-party payments, including by the manufacturer of a prescription drug, in the North Dakota commercial insurance market, government programs, the availability of such programs to uninsured North Dakotans, eligibility criteria, and the impact of these programs on health care costs and prescription drug pricing.

In conducting the study, input shall be received from the following, but not limited to, groups: health insurance carriers, patients or patient groups, prescription drug manufacturers, pharmacy benefit managers, pharmacies or pharmacy association representatives, government and independent academic sources, and any other stakeholder with relevant information to the study. Participants shall disclose any ties or financial compensation received by any entities in the prescription drug supply chain.

The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-ninth legislative assembly.

23.0392.02004
Title.04000

Adopted by the Conference Committee

April 20, 2023

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

That the Senate recede from its amendments as printed on pages 1429-1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

"**SECTION 1. LEGISLATIVE MANAGEMENT STUDY - PRESCRIPTION DRUG COUPON AND FINANCIAL ASSISTANCE PROGRAM UTILIZATION.** During the 2023-2024 interim, the legislative management shall consider studying the prevalence and usage of third party payments to reduce or eliminate North Dakota patients' cost sharing and out of pocket costs for prescription drugs, including programs offered by the manufacturer of a prescription drug. The study shall include: the prevalence and usage of third party payments by the manufacturer of prescription drugs and in the North Dakota commercial insurance market. The study shall also include the prevalence and usage of third party payments in government programs and the availability of those programs to uninsured residents, eligibility criteria, and the impact of these program on health care costs and prescription drug pricing.

In conducting the study, input shall be received from the following groups: health insurance carriers, patients or patient groups, prescription drug manufacturers, pharmacy benefit managers, pharmacies or pharmacy association representatives, government and independent academic sources, and any other stakeholder with relevant information. Participants shall disclose nay ties or financial compensation received by any entities in the prescription drug supply chain.

The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty-ninth legislative assembly."

Renumber accordingly

23.0392.02006
Title.05000

Adopted by the Conference Committee

April 25, 2023

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1413

That the Senate recede from its amendments as printed on pages 1429-1430 of the House Journal and page 1181 of the Senate Journal and that Engrossed House Bill No. 1413 be amended as follows:

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to provide for a legislative management study relating to accumulator adjustment programs.

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - ACCUMULATOR ADJUSTMENT PROGRAM BANS. During the 2023-24 interim, the legislative management shall consider studying the impact of third party payments and accumulator adjustment programs on North Dakota patients' out of pocket costs, medications adherence, and healthcare systems costs and impacts. The study shall assess health benefit participants' usage and prevalence of third party payments in North Dakota. The study shall also review data from states with accumulator adjustment program bans since 2019 and shall seek input from all relevant stake holders in the healthcare industry. The legislative management shall report its findings and recommendations, together with any proposed legislation required to implement the recommendations, to the sixty ninth legislative assembly."

Renumber accordingly