

**S.P. 621: “An Act To Require Health Insurance Carriers and Pharmacy Benefits Managers To Appropriately Account for Cost-sharing Amounts Paid on Behalf of Insureds.”**

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Senator Sanborn and members of the Committee on Health Coverage Insurance and Financial Services, I am Carole Florman of Edgecomb, Maine and a policy fellow at CancerCare, the leading national organization providing free, professional support services and information to help people manage the emotional, practical, and financial challenges of cancer. I am writing in support of S.P. 621: “An Act To Require Health Insurance Carriers and Pharmacy Benefits Managers To Appropriately Account for Cost-sharing Amounts Paid on Behalf of Insureds.”

This bill is vitally important to people with cancer, a disease that will strike at least 40 percent of Americans in their lifetime. Over the last decade, we’ve seen significant breakthroughs in cancer treatment, including targeted therapies that use genetics to identify the right drug for a particular patient. These innovative treatments are often pricey however, with some costing as much as \$100,000 to \$300,000 annually.

The patient’s cost share for these life-saving drugs, even those with good health insurance coverage, may be thousands of dollars for a 30-day supply. These patients often rely on financial copay assistance, which may be in the form of a coupon from the drug manufacturer or help from a copay foundation or other charity. The copay assistance is paid to the insurance company on behalf of the patient, and until recently, was treated no differently than if the payment came from the patient’s own pocket. This means these copayments counted toward the patient’s annual deductible and out-of-pocket cap.

Increasingly however, insurance companies are implementing policies that exclude copayments made by third parties from counting toward deductibles and out-of-pocket caps. They require the patient, no matter how many thousands of dollars have been paid to the company on their behalf, to pay their deductible and out-of-pocket cap a second time from their own funds – an obligation that many patients who rely on expensive drugs cannot afford.

Imagine if someone tried to apply such a policy to another part of your life. Let’s say you lost your income due to COVID and needed help with your mortgage. You qualify for an assistance program and your lender accepts the money for your mortgage payment, but then tells you that they’ve decided not to count the payment made with financial assistance toward your outstanding balance. Sounds crazy, right? Yet, that’s exactly the situation that many people are facing when it comes to their healthcare insurance.

These schemes, known by a variety of names including “copay accumulators,” “coupon adjustment,” or “variable copayments,” allow insurers to double-dip by requiring a patient to pay their share of costs twice. They also make it extremely difficult for patients to ever reach

their out-of-pocket cap, undercutting a critical protection provided by the Affordable Care Act, designed to keep patients from going bankrupt due to medical expenses.

Under a plan with a copay accumulator, when a patient's financial assistance runs out – and no financial assistance program is unlimited – the patient is back at square one, needing to come up with the full amount of their deductible before their needed drug will be covered. Many patients simply stop their treatments, a result known as financial non-adherence. I recently worked with Rita, an insured breast cancer patient who faced a \$3,000 bill for the first month of her prescribed oral chemotherapy drug. She couldn't afford the copayment and had to go seven months without this before she was able to access the drug. During that time, her cancer progressed significantly, greatly reducing her chance of survival. Did her insurance company save money? Well, it didn't have to pay for her prescribed drug, but they will likely pay far more as Rita needs additional surgery, radiation, and chemotherapy due to her delayed treatment.

Insurance companies claim copay accumulators save money by steering patients away from higher priced drugs, but the reality is that lower priced options often don't exist. And, as treatments become increasingly personalized and targeted, substituting drug A for drug B could mean delivering a far less effective treatment.

Another argument insurers make is that copay accumulators ensure that patients have “skin in the game” by requiring them to pay their deductibles and other cost-shares with personal funds. Somehow, I think Rita, the cancer patient I described above, has plenty of skin in the game – as do her children. Her out of pocket costs – not counting those related to prescription drugs -- are substantial and include transportation to treatment, healthier food, baby sitting services, over-the-counter remedies for symptoms and side effects, and salary loss due to missing work.

And, as for any concerns that S.P. 621 would allow patients to circumvent their insurer's formulary to access expensive and unnecessary drugs, it's simply not true. Patients will still be subject to their insurance company's formulary and utilization management controls such as step therapy and prior authorization.

What S.P 621 would do is restore a fair and common-sense world in which a payment made to an insurer, regardless of its source, is counted toward a patient's cost sharing obligations. I urge the members of this committee to support cancer patients and their families by voting in favor of S.P. 621.

Thank you for the opportunity to submit this testimony.