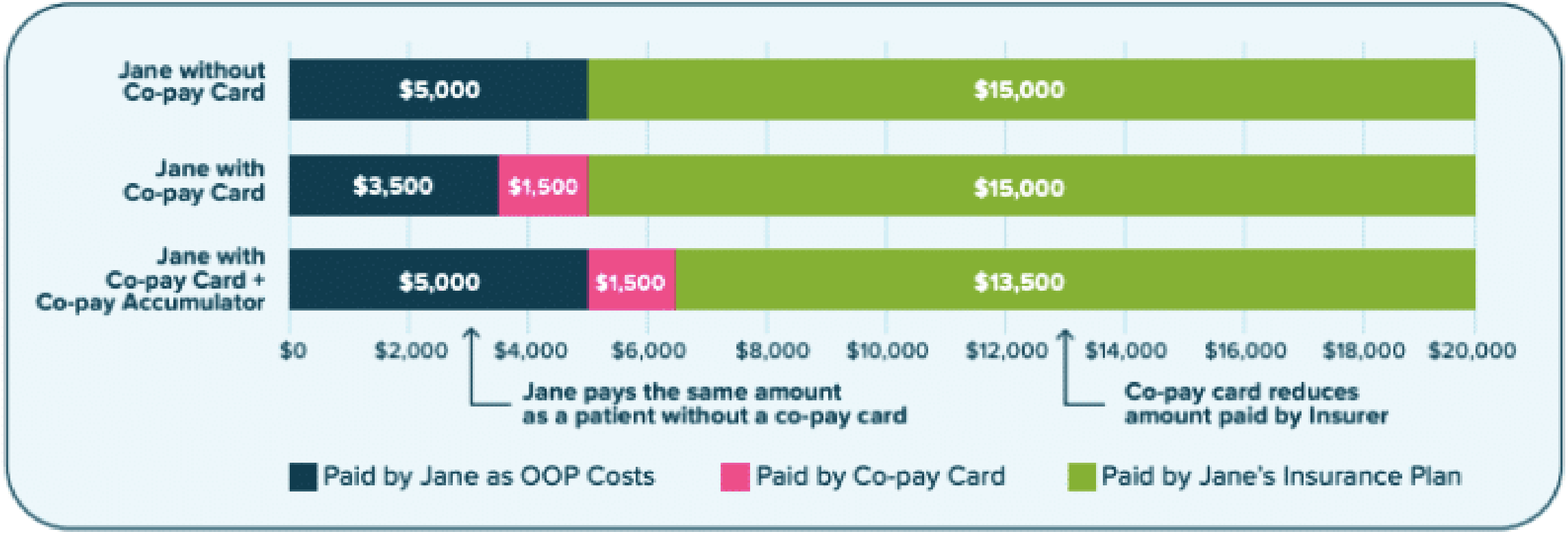
How the Money Flows



https://www.hepb.org/blog/copay-accumulators-mean-prescriptions/

This Bill is About Consumers

- This bill is to protect consumers. It does not address the overall cost of care in the health insurance market, which is a much more complex issue and currently being addressed in other legislation.

- The bill is not about the games insurance companies and pharmaceutical companies play with rebates and incentives, it is about Utahns getting their medications.

- This bill will more closely align state law with federal policy (see 1557 changes) by banning discrimination amongst people that are disabled. Enforcement will go into effect January 1, 2025.

- This bill deals with the out of pocket maximum (currently $9,200 for self-only and $18,400 per family) for the consumer, NOT the entirety of the cost of their medications.

What This Bill Does

- Ensures that funds paid on a consumer's behalf for medical expenses, are credited toward their **cost-sharing** in a non-discriminatory way.
- Ensures access to life-saving medications and services for those among us with health struggles. Consumers must still work through step therapy, prior authorizations and medical necessity. It does not subvert their physician's ability to direct care or the insurance company's ability to manage risk.

Stated Cost of this Bill as Supplied by The Insurance Lobbyist:

PEHP: $3,500,000 increase per year.
Members in 2022: 159,165
Average premium per member per year: $4,848
Total premium: $771,631,920
Stated increase in premium caused by this bill: 00.45%

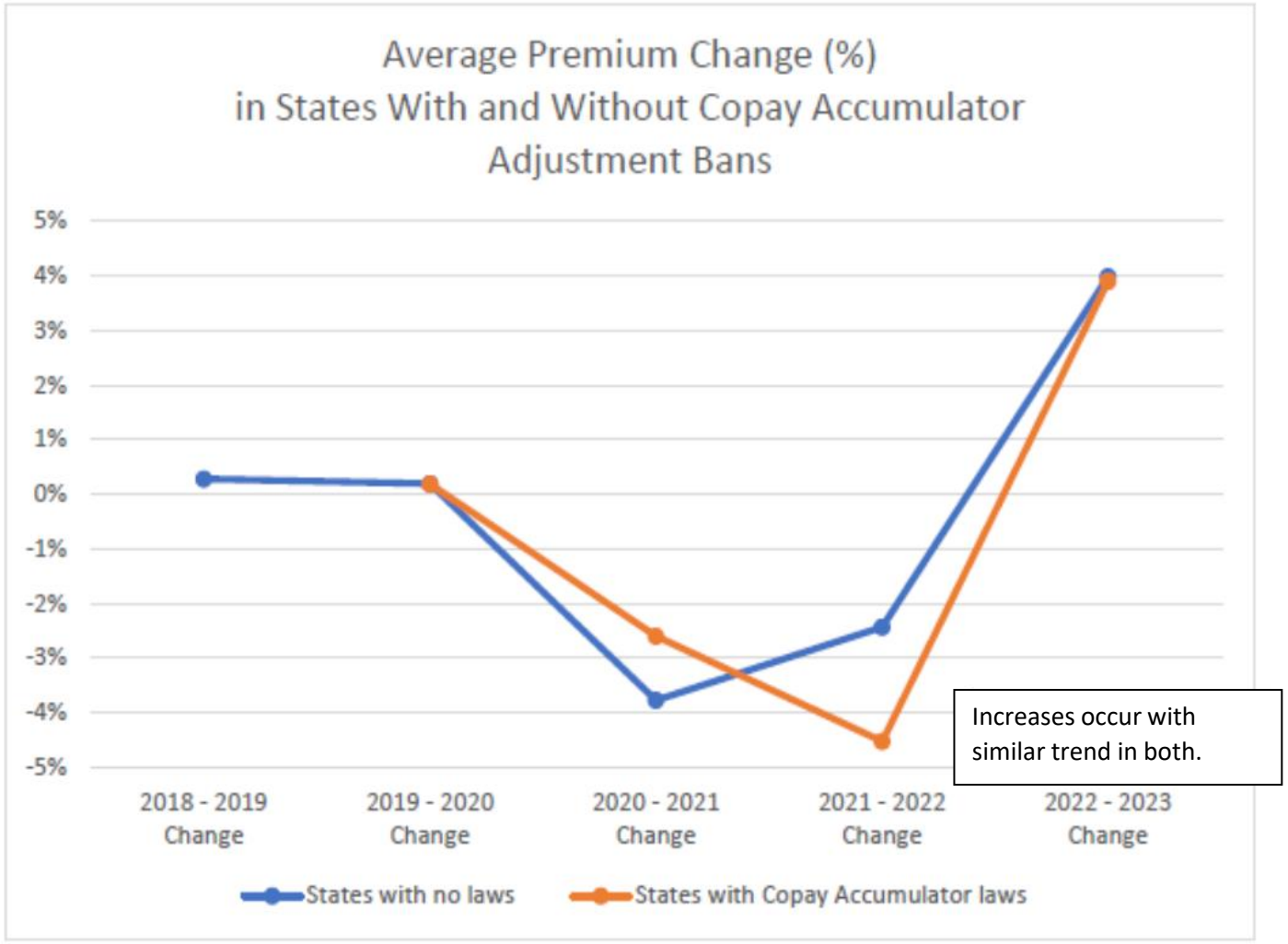
Small Employer Pool: $11,000,000
Average premium per member per year: $4,848
Total premium: $2,376,402,336
Stated increase in premium caused by this bill: 00.46%

Individual Pool: $5,600,000
Average premium per member per year: $4,848
Total premium: $1,347,525,840
Stated increase in premium caused by this bill: 00.42%

Conclusion: Large increases or pool spirals are not being caused by copay accumulators.

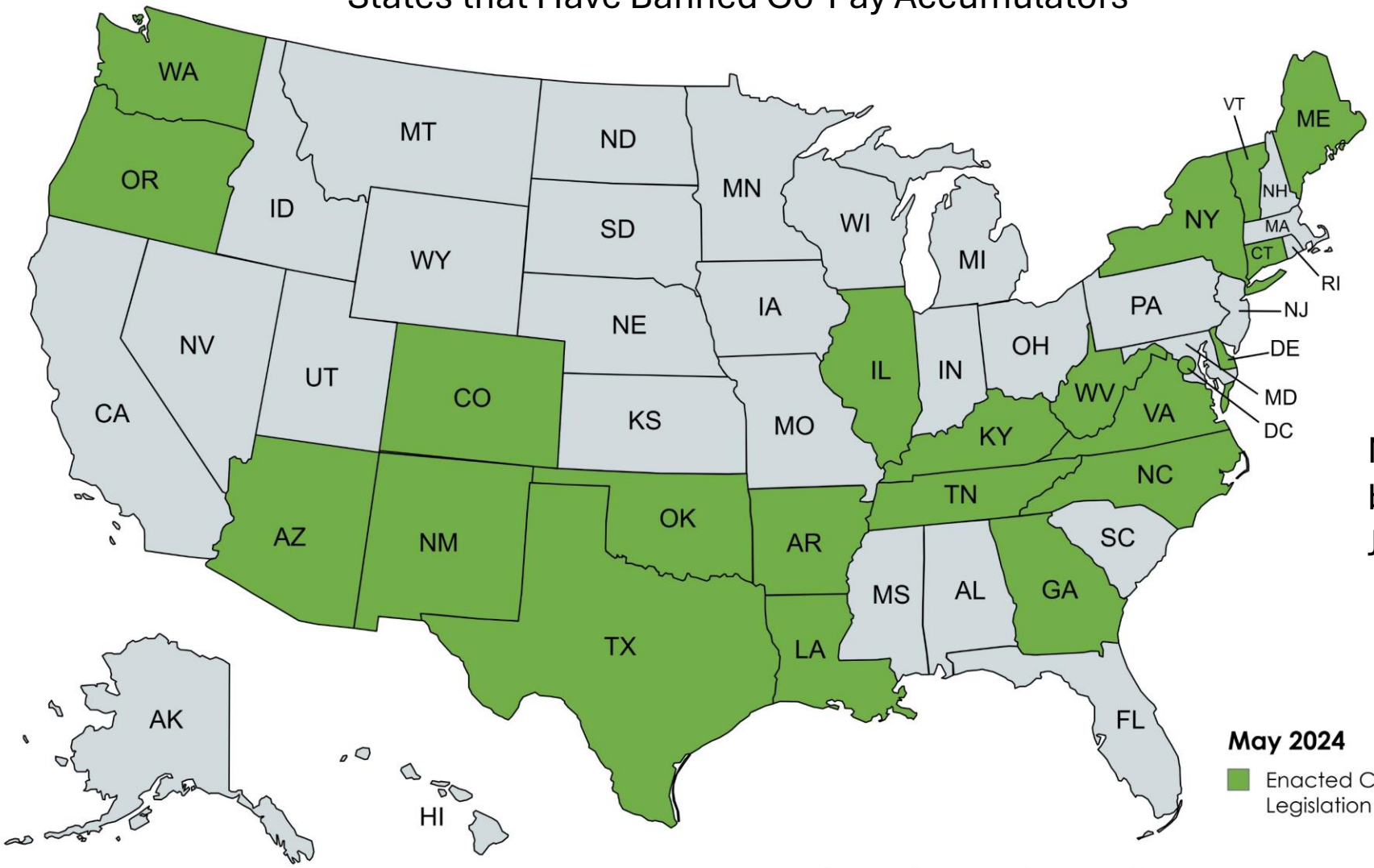
https://insurance.utah.gov/wp-content/uploads/2023HealthMarketReport.pdf

What will it do to premiums?



https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?activeTab=graph&currentTimeframe=0&startTimeframe=10&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

States that Have Banned Co-Pay Accumulators



Nevada will also begin a ban January 1, 2025

Created with mapchart.net

Legislative History

- 2010 – The Affordable Care Act (ACA) was signed into law.

- 2014 – Major provisions of the ACA go into effect including no pre-existing conditions, limitations on **cost-sharing** and essential health benefit coverage.

- April 25, 2019 – The Notice of Benefit and Payment Parameters (NBPP) for 2020 was issued first allowing, “to the extent permitted by state law”, carriers to create and implement co-pay accumulator and maximizer programs, but only if a generic was available. However, due to stakeholder confusion, on August 26, 2019 enforcement of the policy was deferred.

- May 7, 2020 – The Notice of Benefit and Payment Parameters (NBPP) for 2021 was issued with a final rule allowing, again according to applicable state law, plans to implement accumulator and maximizer plans regardless of availability of generics. It does specify that it can not be discriminatory.

- 2022 – Patient groups filed a lawsuit against HHS claiming the 2021 rule was illegal and asking to have it struck down.

Legislative History (cont.)

- September 29, 2023 – The District Court ruled in favor of the patient groups and found that the law was arbitrary and capricious. The court agreed that the rule conflicted with the ACA's definition of "**cost-sharing**".
- November 27, 2023 – HHS filed a motion for clarification.
- December 22, 2023 – Motion to clarify was granted explaining that the 2020 final rule had been reinstated.
- January 16, 2024 – HHS withdrew their appeal.
- July 5, 2024 – Section 1557 of the ACA was updated to include enforcement for discrimination regarding **cost-sharing** and benefit design beginning January 1, 2025. "*For example, a Medicare Advantage plan that imposes additional **cost-sharing** for health services related to a particular disease but not for other diseases would be investigated as potentially discriminatory under the 2020 Rule and under this final rule as of its general 60-day effective date.*"
- October 2, 2024 – The NBPP 2026 was released with a note that they intend to issue a future notice of proposed rulemaking addressing this issue.

https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

https://www.federalregister.gov/documents/2024/10/10/2024-23103/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2026-and

Why it’s potentially discriminatory:

My child has autism. If I apply for a United Health Care Children’s Foundation Grant, it will pay up to $10,000 toward our ABA therapy, which will completely cover her out of pocket maximum for the year. The insurance company will apply it, no questions asked.

My friend’s child has Cystic Fibrosis. If she applies for assistance to pay for the medications for her child and receives approval, that amount of up to $20,000 WILL NOT cover her out of out pocket maximum, causing the family to pay an additional $9,200 more in **cost-sharing**.

By subjectively applying outside assistance, the insurance carriers are using benefit design and **cost-sharing** to discriminate against people with disabilities like Cystic Fibrosis.

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% *after deductible is met*
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan ***Without*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$8,550
Patient Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Scenario 2: Plan ***With*** a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		$15,160
Patient Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met Copay assistance limit is met Out-of-Pocket maximum is met

http://aidsinstitute.net/documents/TAI-2024-Report-2.27.pdf

Assumes law impacted premiums the year after it was passed. Key: Blue cells = States with copay accumulator adjustment bans passed between 2019 and 2022; Orange font = Year law impacted premiums

Marketplace Average Benchmark Premiums by State Copay Assistance Accumulator Bans in Place by 2023

States	2018	2019	2020	2021	2022	2023
Arizona	$516	$471	$442	$436	$390	$410
Illinois	$486	$478	$451	$423	$418	$453
Virginia	$535	$555	$521	$479	$450	$371
West Virginia	$545	$596	$628	$654	$752	$824
Georgia	$483	$487	$463	$456	$394	$413
Arkansas	$364	$378	$365	$394	$387	$416
Connecticut	$545	$475	$570	$580	$581	$627
Kentucky	$422	$460	$471	$476	$387	$422
Louisiana	$474	$454	$500	$545	$541	$565
North Carolina	$627	$618	$558	$516	$504	$512
Oklahoma	$659	$696	$601	$554	$498	$510
Tennessee	$743	$548	$511	$466	$445	$473
Delaware	$589	$684	$548	$540	$548	$549
Maine	$588	$544	$513	$440	$427	$457
New York	$506	$569	$610	$597	$592	$627
Washington	$336	$406	$391	$388	$396	$395
Alabama	$558	$546	$553	$590	$597	$567
Alaska	$726	$702	$724	$675	$712	$762
California	$430	$439	$430	$426	$417	$432
Colorado	$470	$488	$358	$351	$358	$380
District of Columbia	$324	$393	$414	$415	$387	$428
Florida	$466	$477	$468	$457	$456	$471
Hawaii	$438	$493	$474	$478	$484	$469
Idaho	$478	$498	$520	$495	$461	$425
Indiana	$339	$339	$387	$421	$398	$397
Iowa	$713	$762	$742	$523	$502	$484
Kansas	$518	$552	$502	$491	$450	$471
Maryland	$487	$419	$397	$347	$328	$336
Massachusetts	$316	$332	$343	$363	$389	$417
Michigan	$381	$383	$360	$347	$340	$362
Minnesota	$385	$326	$309	$307	$327	$335
Mississippi	$519	$521	$487	$459	$448	$461
Missouri	$529	$499	$483	$479	$442	$473
Montana	$525	$561	$483	$471	$483	$477
Nebraska	$767	$838	$711	$699	$595	$550
Nevada	$432	$410	$374	$393	$383	$386
New Hampshire	$475	$402	$405	$357	$309	$323
New Jersey	$413	$352	$392	$405	$424	$441
New Mexico	$414	$365	$345	$339	$389	$445
North Dakota	$377	$457	$383	$493	$497	$475
Ohio	$371	$380	$375	$375	$375	$413
Oregon	$414	$443	$446	$437	$444	$462
Pennsylvania	$575	$484	$459	$455	$390	$433
Rhode Island	$311	$336	$332	$349	$361	$379
South Carolina	$520	$552	$509	$476	$444	$496
South Dakota	$521	$557	$593	$618	$601	$626
Texas	$434	$444	$432	$436	$424	$461
Utah	$550	$542	$486	$472	$456	$471
Vermont	$505	$622	$662	$669	$749	$841
Wisconsin	$569	$537	$491	$457	$429	$456
Wyoming	$865	$865	$881	$791	$762	$802

https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?activeTab=graph&currentTimeframe=0&startTimeframe=10&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

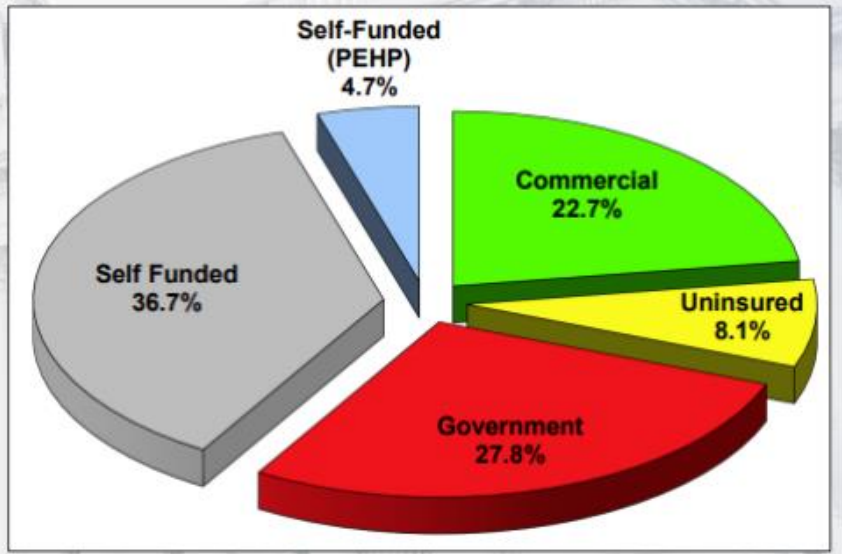
Utah Health Insurance Market Regulation

Government sponsored plans - Medicare - Medicaid - CHIP	**Employer Sponsored Self-Funded Plans** - Commercial Insurers - PEHP* - FEHBP - Other Self-Funded Plans	**Commercial Health Insurance Plans** - Group - Individual
Regulatory Systems:		
Federally Regulated – Centers for Medicare and Medicaid Services (CMS)	**Federally** Regulated – ERISA statute through the Department of Labor (DOL), CMS, and Internal Revenue Service (IRS)	**Federally and State** Regulated – HHS, DOL, Treasury Department – Utah Insurance Department
Medicaid/CHIP programs state operated within federal guidelines	*With the exception of PEHP, Employer Sponsored Self-Funded Plans are generally exempt from state laws	Subject to federal and state laws

https://le.utah.gov/interim/2024/pdf/00003308.pdf

Health Insurance Market Report – Estimate of Utah Health Insurance Coverage for 2022

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	**938,497**	**27.8%**
Medicare	439,708	13.0%
Medicaid	492,316	14.6%
Children's Health Insurance Program (CHIP)	6,473	0.2%
Employer Sponsored Self-Funded Plans	**1,401,166**	**41.4%**
Plans Administered by Commercial Insurers	808,540	23.9%
Public Employee Health Program (PEHP)	159,165	4.7%
Federal Employee Health Benefit Plan (FEHBP)	119,553	3.5%
Other Known Self-Funded Plans	61,915	1.8%
Other Self-Funded Plans (Estimated)	251,993	7.5%
Commercial Health Insurance Plans	**768,137**	**22.7%**
Group	490,182	14.5%
Individual	277,955	8.2%
Uninsured Estimate	**273,000**	**8.1%**
Total	**3,380,800**	**100.0%**



Source: *2023 Health Insurance Market Report. Utah Insurance Department*

https://le.utah.gov/interim/2024/pdf/00003308.pdf

Utah Insurance Market Effect

PEHP, Regence, the University of Utah, Aetna, and Cigna implemented quickly.

Select Health elected to NOT implement which meant Select Health was the carrier of last resort and thus received the majority of the risk. However, this was not sustainable and in 2024 they also implemented a Co-Pay accumulator leaving consumers with no alternative except the newest carrier to town, Imperial, who will not remain solvent if they take all of this risk.

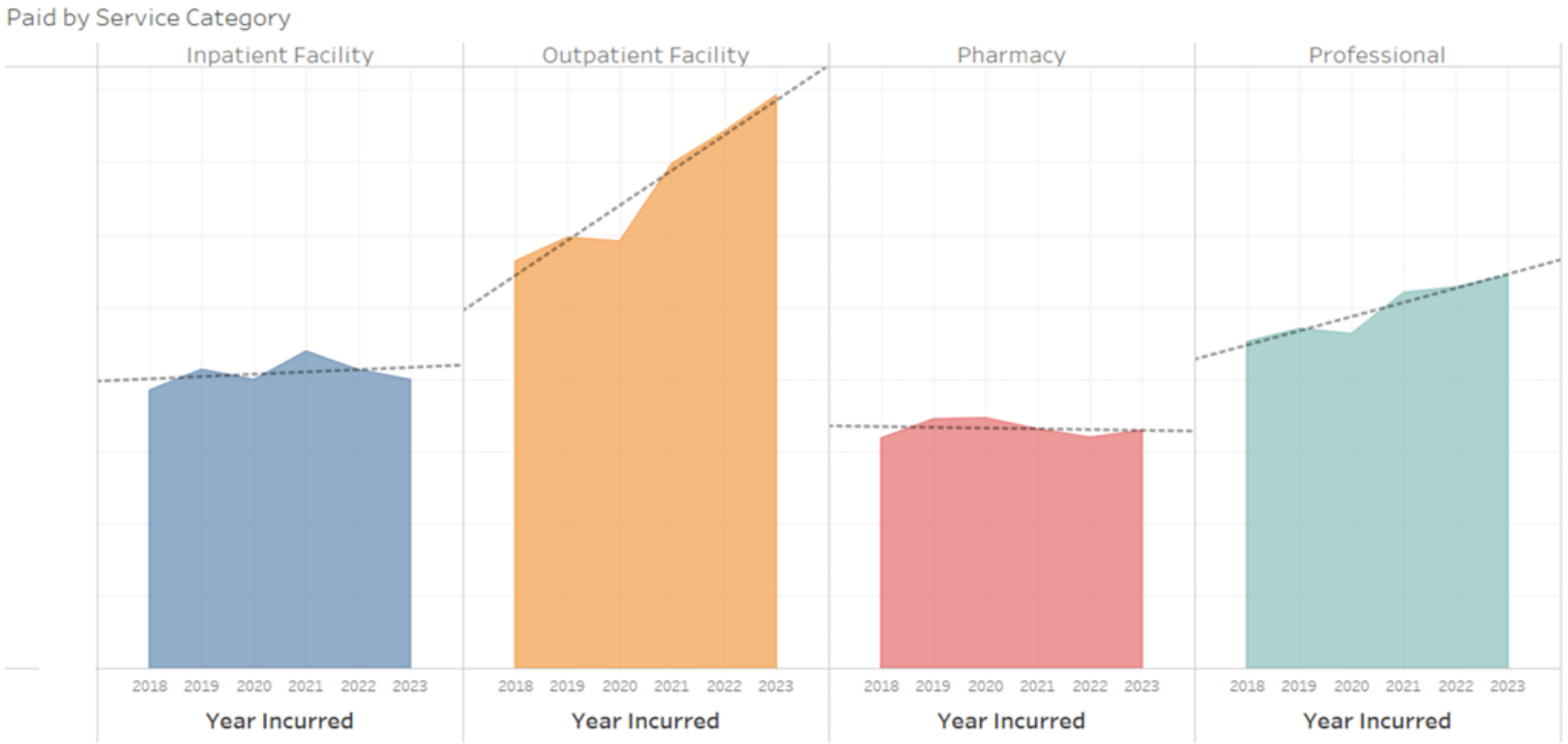
The risk needs to be spread evenly. This policy has allowed smaller carriers and self funded plans to risk shift, creating an unstable market and high increases in small employer and individual plans at Select Health who has over 66.84% of the market as reported by the DOI in 2022.

https://insurance.utah.gov/wp-content/uploads/2023HealthMarketReport.pdf

Per the PEHP report at the interim committee meeting on September 18, 2024 – Copay accumulator implementation does not appear to have caused a large savings in prescription costs, and so it stands to reason it would also not cause a large increase in cost to remove it. This is largely due to the fact that it is about the out of pocket $9,200 and not the full cost of the medication. **But it does create a massive legal risk.**

Outpatient is Outpacing

PEHP Health & Benefits



https://le.utah.gov/interim/2024/pdf/00003339.pdf

Potential Legal Risks of Allowing this Continue:

Lawsuits beginning January 1, 2025

Individual and class actions regarding potential and actual discrimination.

In § 92.207(b)(1), OCR specified that covered entities are prohibited from denying, cancelling, limiting, or refusing to issue or renew health insurance coverage or other health-related coverage, or denying or limiting coverage of a claim, or ***imposing additional cost sharing*** *or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability.*

https://www.federalregister.gov/d/2024-08711/p-1113

Credentials – Rebecca Yates

- Licensed Broker since 2004
- Serving on the agent/broker advisory committee for Healthcare.gov since 2017
- Served as expert panelist for multiple broker events with CMS' CCIIO
- Serving on advisory agent councils for multiple carriers (SelectHealth, Regence, etc)
- Utah legislative representative for Health Agents for America
- Member of the Utah Rare Disease Advisory Council (RDAC)
- Contracted broker partner with Utah Department of Health for the AIDS Drug Assistance Programs (ADAP)
- Bachelor of Arts in International Business from Westminster University

Summary:

If someone pays a medical bill on your behalf, it should count toward your medical out of pocket expenses. No matter what the diagnosis code is. Your diagnosis itself should be irrelevant regarding these practices. Allowing carriers to continue this discriminatory practice opens the State to lawsuits and other state and federal consequences. This is the right fiscal, legal and moral decision. Thank you.