Representative Dafna Michaelson Jenet
Chair, Public & Behavioral Health & Human Services Committee
200 E Colfax Avenue
Denver, CO 80203

April 24, 2023

Dear Representative Jenet:

Thank you for this opportunity to provide written testimony regarding SB 23-195, "Calculation Of Contributions To Meet Cost Sharing." I am writing on behalf of CORA Colorado, a statewide nonprofit organization whose mission includes promoting public health strategies that work in the real world to prevent HIV and provide access to effective treatment for those living with HIV.

Since 1990, Colorado has provided financial assistance for lower income People Living with HIV (PLHIV) to access live-saving medications to treat HIV and conditions associated with HIV. By recent estimates, over 25 percent of PLWH in Colorado depend on this "AIDS Drug Assistance Program (ADAP)", housed at Colorado Department of Public Health and Environment, on a regular basis. If they lack health coverage, ADAP provides the medications directly to them, through contract pharmacies. If they have health coverage, ADAP helps with copayments, coinsurance, and other out-of-pocket costs. ADAP operates with a diversified funding base, which includes federal funds, state general fund, and state Tobacco Master Settlement Agreement funds. More recently, starting in 2017, a similar drug assistance fund was created to assist people at very high risk of acquiring HIV to afford the costs of Pre-Exposure Prophylaxis, "PrEP," a highly effective medication regimen which can also be unaffordable for people who are uninsured or underinsured.

Regrettably, ADAP has been increasingly impacted by a growing practice by private health insurance companies to "not count" payments by ADAP made on behalf of its eligible clients toward client out-of-pocket deductibles and maximums. If not addressed, this practice would put financial stress on ADAP by removing all maximums on the amounts paid, while at the same time burdening ADAP with thousands of dollar of out-of-pocket costs for non-HIV health conditions even though their deductible and out-of-pocket maximums have already been met (with ADAP's assistance).

As originally drafted, SB 23-195 would intercede in this practice and allow ADAP to continue its life-saving support. However, recent amendments to the original bill are highly problematic for ADAP. Frist, our program should not be "lumped" with programs primarily run by the pharmaceutical companies. ADAP serves both a personal and public health purpose, in that people living with HIV who remain on their HIV medications achieve such low concentrations of virus that they cannot transmit it to others. Our program for PrEP also prevents HIV infection when taken as prescribed. Second, any prior authorization and step therapy requirements should not apply to ADAP because they interfere with adherence and would contradict already-enacted exemptions that were in recently passed legislation (SB 23-189). Third, since ADAP operates with state funding, this is essentially a "cost shift" from the health insurance companies to state funding. Fourth, ADAP's state and federal funding come with strict residency and income restrictions, making it illegal to guarantee anyone a full year of ADAP benefits.

Thank you for keeping these factors in mind as you debate this extremely important Bill

Sincerely,

Robert Bongiovanni

Robert Bongiovanni
Board Chair

House Public & Behavioral Health & Human Services Committee
200 E Colfax Avenue
Denver, CO 80203

April 25, 2023

Chair Dafna Michaelson Jenet and Members of the Public & Behavioral Health & Human Services Committee,

On behalf of the 1.2 million Colorado residents with doctor-diagnosed arthritis, thank you for the opportunity to submit testimony in support of SB 195, which addresses copay accumulator adjustment programs.

These programs prevent any co-payment assistance that may be available for high-cost specialty drugs from counting towards a patient's deductible or maximum out-of-pocket expenses. Many pharmaceutical manufacturers offer co-pay cards that help cover a patient's portion of drug costs. Traditionally, pharmacy benefit managers have allowed these co-payment card payments to count toward the deductible required by a patient's health insurance plan. With an accumulator adjustment program, patients are still allowed to apply the co-payment card benefits to pay for their medications up to the full limit of the cards, but when that limit is met, the patient is required to pay their full deductible before cost-sharing protections kick in.

Currently, the state of Colorado does not have a law to ensure that health insurers count co-payment assistance towards a patient's cost-sharing requirements. Now more than ever, it will be important for the Colorado State Legislature to act given 3 out of the 6 insurers in the state have an accumulator adjustment program.[1]

Legislation is necessary on this issue as patients are often unaware they are enrolled in one of these programs until they go to the pharmacy counter and realize they must pay the full cost of their medication, which can lead them to abandon or delay their prescription. These programs can be called different names, are often marketed as a positive benefit, and are disclosed many pages into plan materials, leading to a lack of awareness about them to patients.

In a recent Arthritis Foundation survey, 37% of patients reported they had trouble affording their out-of-pocket costs. Of those, 54% say they have incurred debt or suffered financial hardship because of it. The Arthritis Foundation also surveyed in 2017 asking patients about accumulator programs and found that if patients are faced

[1] Institute, T. A. (February 2023). Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness. National Policy Office. Washington, DC: The Aids Institute. Retrieved from https://aidsinstitute.net/documents/TAI-Report-Copay-Accumulator-Adjustment-Programs2023.pdf

with a large, unexpected charge for a prescription drug, the top three reactions would be: abandoning or delaying their prescription fill; lengthening the time between doses; and asking their provider to switch to another drug.

SB 195 resolves this issue by simply ensuring that when calculating a patient's overall contribution to any out-of-pocket maximum or any cost-sharing requirement, a health plan must include any amounts paid by the patient or paid on behalf of the patient by another person.

The Arthritis Foundation thanks the committee for their consideration of SB 195 and urges all members to support this critical legislation.

Melissa Horn
Director of State Legislative Affairs
Arthritis Foundation
1615 L St. NW Suite 320
Washington, D.C. 20036
240.468.7464 | mhorn@arthritis.org