**Mailing Address:**

Attn: Jen Laws
PO Box 3009
Slidell, LA 70459

**Chief Executive Officer:**

Jen Laws
Phone: (313) 333-8534
Fax: (646) 786-3825
Email: jen@tiicann.org

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PDAB Action Center

Transgender Leadership in HIV Advocacy

HIV/HCV Co-Infection Watch

**National Groups:**

Hepatitis Education, Advocacy & Leadership (HEAL) Group

Industry Advisory Group (IAG)

National ADAP Working Group (NAWG)

January 10, 2025

Oregon Prescription Drug Affordability Board
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97309-0405

**RE: Clarification and Conflict of Interest Concerns**

Dear Honorable Members of the Oregon Prescription Drug Affordability Board,

The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Today, we write with exceptional concern regarding conflicts of interest and clarifying points from the December 2024 meeting.

## More Focused Awareness of Conflicts of Interest is Needed

During the last meeting, the conflicts of interest of board member Robert Judge were concerning, if not alarming. Mr. Judge recused himself, due to conflicts of interest, on voting on policy recommendation number five. Yet, he actively contributed input and commentary to the discourse that led up to the vote. We feel that he also should have recused himself from participating regarding policy recommendation number 9 regarding the dispensing fees and pharmacy reimbursements. Unfortunately, he adamantly contributed his commentary against the measure, participated in the discussion about the measure, and ultimately voted on it. This vote was highly related to profits associated with his employer.

Conflicts of interest should preclude a member not only from voting on an issue but also from contributing to the discourse of an issue, which can erroneously

influence the decision-making. Inappropriate actions of board members risk the public trust of the board and should result in censure or removal.

## Copay Accumulators and Maximizers are Theft in Action

In the last meeting, there were several points of confusion as well as misleading information presented concerning copay accumulators and copay maximizers. We would like to clear the informational palate and present clarity.

Copay accumulators and copay maximizers do not have any value in the marketplace for consumers. They do not establish the payment obligations of enrollees with their insurers. They only financially benefit the profit margins of insurers and cause financial harm to enrollees. Operationally, these programs border on theft.

Copay accumulators and copay maximizers result in insurers 'double-dipping' padding their profit margins while causing patients financial harm and access challenges. It should not matter where funds originate as long as a patient's copay and deductible obligations are met. If a family member or friend paid a patient's copays, those payments would be applied to contractually required cost-sharing. The same should apply to payments made via copay assistance programs.

Copay accumulators redirect manufacturer copay assistance from the patient to the insurer. Many manufacturers provide copay assistance programs to individuals utilizing commercial insurance. The programs offer copay cards that patients use to pay their contractually obligated copay for their medications based on their plan design. However, under copay accumulators, insurers do not apply the paid copayments to enrollees' deductibles or out-of-pocket maximums, as they would any other third-party payment.

Once the copay assistance funds are depleted, patients are still responsible for the entirety of their deductibles and other cost-sharing amounting to their out-of-pocket maximums. Copay accumulators effectively pay insurers twice for the same thing.

After copay cards are depleted, patients must pay the full price of their medications out of pocket until they reach their deductibles and out-of-pocket maximums. This can equate to thousands of dollars per month.

Copay maximizer programs manipulate the system, taking advantage of manufacturer copay assistance. With copay maximizers, insurers use third-party vendors to research the maximum copay assistance allowed by a manufacturer's copay assistance program for a particular drug. They then set a patient's copay to equal the maximum permitted copay assistance. Insurers spread the amounts out evenly to receive the entire allowed amount throughout the year or institute higher initial copays to max out the copay assistance early. They then adjust the copay down to zero after all of the funds are depleted.

Problems with copay maximizers also arise because delays occur as patients are required to enroll in third-party maximizer programs. Additionally, there are issues when the third-party vendors do not communicate properly to downwardly adjust patient copays after manufacturer assistance funds are depleted. Patients can be saddled with exorbitant copay costs or forego medication entirely if they can't afford it in the interim of third-party vendors correcting the issue.

**We applaud the discussion surrounding pharmacy protection**

We would like to thank Mr. John Murray for emphasizing the importance of protecting pharmacies and keeping them in business as a part of ensuring affordability and access for Oregonians. He stated that it doesn't matter how affordable a medication is if a patient can't access it. His highlight of the billions of dollars of healthcare costs incurred as a result of medication non-adherence was very poignant, as part of non-adherence is due to lack of access to pharmacies.

These statements reflect CANN's ongoing concern regarding the establishment of an Upper Payment Limit, particularly as it relates to the sustainability of safety-net providers, like Federally Qualified Health Centers and Ryan White-funded HIV clinics. As previously stated and shared as a matter of fact in the Meyer-Stauffer report, the reduction of 340B revenues as a result of a UPL dramatically impacts a safety net provider's ability to reach and serve highly vulnerable populations. The financial harm caused to safety net providers under a UPL threatens ready access to prescribing providers – if a patient cannot meaningfully and readily access their provider, they cannot acquire necessary prescriptions in order to acquire medications, regardless of how "affordable" those medications might be on paper.

In a related matter, we would also like to thank Chair Bailey and Mr. Dan Kennedy for emphasizing the existence of documented data on significant losses for pharmacies in the adjudicated claim amount versus acquisition costs. The example presented by Mr. Kennedy of the pharmacist who lost over $27K in 2024 from being reimbursed below cost for filling Ozempic prescriptions is not an isolated incident.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

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On behalf of
Jen Laws
President & CEO
Community Access National Network