Revised date: 3/18/26

2026 Spring National Meeting
San Diego, California

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP
Monday, March 23, 2026
11:45 a.m. – 12:45 p.m.
Manchester Grand Hyatt—Grand Hall D—Level 1

ROLL CALL

Joylynn Fix, Chair	West Virginia	Cheryl Wolff	Nebraska
Ashley Scott, Vice Chair	Oklahoma	Ralph Boeckman/ Erin Porter	New Jersey
Kelli Littlejohn Newman	Alabama		
Kayla Erickson/Sarah S. Bailey/ Molly Nollette	Alaska	Sahar M. Hassanin/ Alejandro Amparan/ Viara Ianakieva	New Mexico
Tolanda McNeal	Arizona		
Tricia Davé	Connecticut	Sylvia Lawson/Gail A. Ross	New York
Howard Liebers	District of Columbia	Robert Croom/ Charles Whitehead	North Carolina
Sheryl Parker/Samantha Heyn	Florida		
Shannon Hohl	Idaho	TK Keen	Oregon
Matthew Pickett	Illinois	Lindsi Swartz	Pennsylvania
Andria Seip	Iowa	Carlos Vallés	Puerto Rico
Vicki Schmidt/Julie Holmes	Kansas	Scott McAnally/Jud Jones	Tennessee
Shaun Orme	Kentucky	Tanji J. Northrup	Utah
Frank Opelka	Louisiana	Jennifer Kreitler/ Sofia Pasarow	Washington
Joe Stoddard	Michigan		
Norman Barrett/T.J. Patton	Minnesota	Lori Luder	Wisconsin
Amy Hoyt	Missouri	Lauren White	Wyoming
David Dachs	Montana		

NAIC Committee Support: Jolie H. Matthews

AGENDA

1. Consider Adoption of its Dec. 15, 2025, and 2025 Fall National Meeting Minutes—*Joylynn Fix (WV)* — Attachment A

2. Hear Presentations on Prescription Drug Formularies, Consumer Protections, and State Enforcement—*Wayne Turner (National Health Law Program [NHeLP]) and Carl Schmid (HIV+Hepatitis Policy Institute)*

3. Hear a Presentation on Prescription Drug Discount Cards and Related Issues—*Kelli Littlejohn Newman (AL)*

4. Discuss Any Other Matters Brought Before the Working Group
   —*Joylynn Fix (WV)*

5. Adjournment

Agenda Item #1

Consider Adoption of its Dec. 15, 2025, and 2025 Fall National Meeting Minutes
—Joylynn Fix (WV)

Draft: 2/2/26

Prescription Drug Coverage (B) Working Group
Virtual Meeting
December 15, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met Dec. 15, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Kayla Erickson and Sarah S. Bailey (AK); Dusty Smith (AL); Lena Bahar and Michael Shanahan (CT); Howard Liebers (DC); Mike Milnes (FL); Johanna Nagel (IA); Shannon Hohl (ID); Matthew Pickett (IL); Craig VanAalst (KS); Daniel McIlwain (KY); Frank Opelka (LA); Renee Campbell (MI); Norman Barrett (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Eric Dunning and Cheryl Wolff (NE); Erin Porter and Ralph Boeckman (NJ); Sahar M. Hassanin (NM); Sylvia Lawson and Gail A. Ross (NY); Keith Turner (OR); Lindsi Swartz (PA); Jud Jones (TN); Tanji J. Northrup (UT); Jennifer Kreitler (WA); Lori Luder (WI); and Tana Howard (WY). Also participating was: Grant Lindman (IN).

1. Heard a Presentation from PhRMA on the 340B Drug Pricing Program and Anticipated Changes Beginning Jan. 1, 2026

Jessica Lynch (Pharmaceutical Research and Manufacturers of America—PhRMA) provided an overview of the 340B Drug Pricing Program (Program) and anticipated changes to it beginning Jan. 1, 2026. She said the Program is an outpatient drug program administered by the federal government intended to help vulnerable patients gain better access to medicines at certain qualifying hospitals and clinics. She said that when the U.S. Congress (Congress) established the Program, it envisioned it as a small safety net program requiring drug manufacturers to sell medicines at a reduced price to covered entities—certain qualifying hospitals (e.g., Disproportionate Share Hospitals [DSHs], children's and rural hospitals) and safety-net clinics (e.g., community health centers)—known as grantees who Congress envisioned would use the money saved to help patients.

Lynch discussed how sales under the Program have skyrocketed over the years and what is driving the growth. She explained that the Program is currently the second-largest prescription drug program administered by the federal government, behind only Medicare Part D. She explained how the Program drives up costs for employers, states, and consumers. Lynch discussed the Program's lack of transparency and state actions taken, such as in Hawaii, Indiana, Maryland, and Minnesota, to increase transparency.

Lynch discussed congressional investigations and efforts to reform the Program. She said the Health Resources and Services Administration (HRSA) 340B Rebate Pilot set to start Jan. 1, 2026, is a first step toward increasing transparency and Program integrity. She described the components of the rebate pilot, explaining that the HRSA approved rebate model plans for all eligible manufacturers. Approved plans for nine drugs have a Jan. 1, 2026, effective date, and one has an April 1, 2026, effective date. She noted, however, that the American Hospital Association (AHA), along with four hospital systems, filed suit in Maine on Dec. 1 to block the pilot.

Matt Walker (Walker & Stevens) asked Lynch to explain the Program's duplicate discount prohibition, which he said confuses many people, particularly as it relates to Medicaid. Lynch said the Program's duplicate discount prohibition forbids drug manufacturers from giving both a 340B discount and a Medicaid rebate for the same drug. Covered entities, such as hospitals, must prevent this by either using 340B drugs for Medicaid fee-for-service (FFS) patients or buying drugs for them through other means. She said that some estimates put the cost of duplicate discounts at between $3 and $5 billion a year, which drug manufacturers pay even though they are not federally required to and are prohibited from doing so under federal law. Lynch said she knows state Medicaid departments are working diligently to address this issue, but in the commercial market, it is less clear whether drug manufacturers are paying duplicate discounts.

Lindman asked how the rebate pilot will work with sub-ceiling pricing arrangements. Lynch said the rebate pilot is meant to be separate from any sub-ceiling prices. She said the goal of the rebate pilot is, in part, to eliminate duplicate discounts because drug manufacturers will have so much more access to claims data and, as such, the state will receive either the rebate or the discount, but not both.

Having no further business, the Prescription Drug Coverage (B) Working Group adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/PDCWG/PDCWG MtgMin 12-15-25.docx

Draft: 12/14/25

Prescription Drug Coverage (B) Working Group
Hollywood, Florida
December 9, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Hollywood, FL, Dec. 9, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Sarah S. Bailey, Kayla Erickson, and Molly Nollette (AK); Jimmy Gunn and Anthony Williams (AL); Tolanda McNeal and Gio Espinosa (AZ); Lena Bahar and Tricia Dave (CT); Howard Liebers (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Chris Heisler and Ryan Gillespie (IL); Craig Van Aalst (KS); Shaun Orme and Daniel McIlwain (KY); Frank Opelka (LA); Joe Stoddard (MI); Norman Barrett and T.J. Patton (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Cheryl Wolff and Maggie Reinert (NE); Ralph Boeckman and Erin Porter (NJ); Alejandro Amparan (NM); Sylvia Lawson (NY); Lindsi Swartz (PA); Maria Morcelo (PR); Jud Jones (TN); Shelley Wiseman and Ryan Jubber (UT); Jane Beyer (WA); Lori Luder and Coral Manning (WI); and Lauren White (WY). Also participating were: Kevin P. Beagan (MA); Marti Hooper (ME); Tony Bonofiglio (OH); and Jill Kruger (SD).

1. Adopted its Summer National Meeting Minutes

Hohl made a motion, seconded by Beyer, to adopt the Working Group's Aug. 11 minutes *(see NAIC Proceedings – Summer 2025, Regulatory Framework (B) Task Force, Attachment Two)*. The motion passed unanimously.

2. Heard a Presentation from The INS Companies on Prescription Drug Formularies and Specialty Medications

Matthew Sankey (The INS Companies) discussed prescription drug formularies and specialty medications. He discussed how formularies are developed and designed, including how pharmacy and therapeutics (P&T) committees are set up and formulary considerations related to rebate optimization. Sankey highlighted the considerations in designing the formulary related to formulary tiering as well as prior authorization and step therapy requirements. He also discussed how specialty medications are treated under prescription drug formularies, including accessibility, costs, rebates, and reimbursement. Sankey discussed how consumers may be impacted by the types of medications health plans choose to include in their formulary and formulary design, and the lack of transparency. He highlighted how the increase in some medication exclusions raises concerns about patient access. He also discussed state oversight over formulary design and specialty medications. Sankey concluded his presentation with a few key points: 1) formularies are becoming more complex with increased numbers of tiers; 2) patients are required to try and fail therapy or pay higher costs to remain on treatment; and 3) specialty medications may not always be "specialty."

Beagan said that while he agrees that consumers' accessibility to the prescription drugs they need is an issue, he believes Massachusetts's biggest problem is the cost. He stated that, in looking at recent rate filings in Massachusetts, the trends for pharmaceutical benefits include cost increases of 14% and 18%. He said Massachusetts is also trying to find ways to improve transparency, particularly by making sure better information is available to all.

Beagan asked Sankey to provide additional information about why certain drugs are excluded from formularies. Sankey said one issue is the proliferation of pharmaceutical drug advertisements, which lead consumers to request certain drugs that might not be appropriate for them. However, he noted that that is a side issue. Sankey said that, as specifically related to his presentation on the reason certain drugs are excluded, he believes this

might occur because pharmacy benefit managers (PBMs) are incentivized to promote brand-name drugs over generic drugs due to rebates and other incentives, which likely results in higher costs for consumers.

Beagan said he believes there is a lack of understanding and clear definition of what a generic drug is versus a brand-name drug. He said there is also a lack of clear understanding of the terms "biosimilar" and "biologics." He said this issue arose recently in Massachusetts regarding insulin. Beagan asked Sankey to discuss this issue and whether there was some sort of commonality between the terms. Sankey explained the progression of a brand-name drug to a generic drug. He said a generic drug that is manufactured exclusively by one drug manufacturer is considered a brand-name drug. A multi-source generic drug, which is manufactured by multiple drug manufacturers, is a true generic drug. Sankey stated that, with respect to biologics and biosimilars, a biologic drug, such as Humira, is considered a brand-name drug. He said a biosimilar can be created from this biologic brand-name drug, but when it is compounded, the molecules are so small and so precise that the biosimilar cannot qualify as a substitutable generic. Sankey explained that the biosimilar is a generic product that, therapeutically, does the same thing as the biologic brand-name drug; however, the way it is constituted does not allow it to be a substitutable generic. Sankey explained the difficulties a consumer could encounter in trying to obtain the biosimilar to Humira as a cheaper alternative.

Amparan asked Sankey about multi-source and single-source generics and the seemingly increasing exclusion of single-source generics from drug formularies. Sankey discussed the incentives for preferring brand-name drugs on the formulary, and the potential impact of certain contract language and patents drug manufacturers use in manufacturing single-source generics, which leads to the exclusion, at least temporarily, of single-source generics from the drug formulary.

Carl Schmidt (HIV+Hepatitis Policy Institute) expressed appreciation for Sankey's presentation. He said the issues discussed in the presentation, particularly those related to formulary design, are extremely important for consumers. He asked that the Working Group consider holding another meeting in the near future to allow for additional discussion of these issues from a consumer perspective. Fix agreed to consider holding such a meeting in early 2026.

3. Discussed a Future Meeting on Prescription Drug Discount Cards

Fix said the Working Group would like to hold a meeting to hear an educational presentation on drug discount cards, including how they are set up, the main process of how they are adjudicated, how pharmacies get paid, and how the discount company gets paid. She asked that anyone with suggestions for a presenter on the topic reach out to her or Scott.

Having no further business, the Prescription Drug Coverage (B) Working Group adjourned.

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Agenda Item #2

Hear Presentations Prescription Drug Formularies, Consumer Protections, and State Enforcement—*Wayne Turner (National Health Law Program [NHeLP]) and Carl Schmid (HIV+Hepatitis Policy Institute)*

Drug formularies, consumer protections, and state enforcement

Prescription Drug Coverage Working Group

NAIC Spring National Meeting

March 23, 2026

Wayne Turner, Senior Attorney

NATIONAL HEALTH LAW PROGRAM

Insurers' formularies must comply with ACA nondiscrimination protections

- ACA § 1557
  - "coverage denial or limitation must not be based on unlawful animus or bias, or constitute a pretext for discrimination." 42 U.S.C. § 18116; 45 C.F.R. § 92.207(c)
- Essential Health Benefits (EHB)
  - "a non-discriminatory benefit design that provides EHB is one that is clinically based" 42 U.S.C. §§ 300gg-6, 18022; 45 C.F.R. § 156.125(a)
- Qualified Health Plans (QHPs)
  - "not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs" 42 U.S.C. § 18031

The New York Times

Bias Claims for Insurers in Coverage of H.I.V.

Give this article 84

By Katie Thomas

May 29, 2014

Health care advocates said on Thursday that four insurers offering plans in the new federal marketplace discriminated against people with H.I.V. or AIDS by requiring them to pay high out-of-pocket costs for drugs to treat H.I.V., including generic medications.

Two groups, the AIDS Institute and the National Health Law Program, filed a complaint on Thursday with the Department of Health and Human Services' Office for Civil Rights, saying the insurers had violated a provision in the new health care law that prohibits discriminating against consumers because of their medical conditions. They said the insurers had subjected people

- Survey of Florida silver plans found four insurers placed all HIV treatments, including generics, in the highest cost-sharing tier
- HHS Office for Civil Rights and Florida Office of Insurance Regulation took action
- Researchers found "adverse tiering" widespread w/HIV and other serious/chronic conditions - See New England Journal of Medicine, Using Drugs to Discriminate (Jan. 2015)

Ending discriminatory benefit design in Rx

- Practices identified as "presumptively discriminatory" by HHS – NBPP 2023, 87 Fed. Reg. 27295
  - "placing most or all drugs that treat a specific condition on the highest cost tiers"
  - "refusing to cover a single tablet drug regimen or extended release product that is customarily prescribed"
- CMS plan review
  - "adverse tiering review assesses whether submitted formularies associate higher cost sharing to all or a majority of drugs needed to treat certain chronic medical condition(s)" – See CMS, 2026 Final Letter to Issuers in the Federally-facilitated Exchanges (Jan. 15, 2025)

Ensuring consumer access to necessary prescription drugs

- QHP certification – See CMS **Prescription Drug FAQs**
  - Clinical appropriateness
  - Formulary outlier
  - Cost sharing
- However, many plans certified "compliant" fall short

State regulators can bring greater transparency to:

- P&T Committees to ensure comprehensive, up-to-date formularies
- Exceptions processes to access non-formulary drugs
- Independent review of Rx coverage denials
- Up-to-date formulary info including tiering structure and "access restrictions" should be easy to access

Pharmacy and Therapeutics (P&T) Committees

- Establish and review/update plan formularies
- Ensure formularies are evidence-based and reflect broadly accepted treatment guidelines
- Cover a range of drugs that treat all disease states, and **does not discourage enrollment by any group of enrollees**
- Review and approve all clinical criteria for prior authorization, step therapy, and other utilization management
- Maintain written documentation of the rationale for all decisions regarding formulary development and revision
- Beginning January 1, 2026, must include a consumer/patient representative

See 45 C.F.R. § 156.122(a)(3)

How state regulators can help

Transparency for P&T Committees

- Membership, meetings, minutes, conflict-of-interest disclosure
- Prospective enrollee access to clinical criteria used for:
  - formularies
  - exceptions processes, and
  - utilization management including prior authorization
- Info on P&T committee consumer/patient representative

Consumer Rx rights: Accessing non-formulary drugs

- Since 2016, all EHB plans must have an exceptions process so enrollees can access non-formulary drugs
- Standard exceptions process
  - Plan must decide within 72 hours
  - Coverage for the duration of prescription including refills
- Expedited exceptions process
  - Exigent circumstances incl. health condition that jeopardizes life, health, maximum function, or undergoing current course of treatment
  - Plan must decide within 24 hours
  - Coverage of non-formulary drug for duration of the exigency
- Plans must have process for enrollee, designee, or prescriber to request review by independent review organization if plan denies exceptions request
  - Determination within 72 hours for standard and 24 hours for expedited

See 45 C.F.R. § 156.122(c)

Data and monitoring of Rx exceptions processes

- How do plans inform consumers and providers of how to access non-formulary drugs?
- Data on standard and expedited exceptions
  - How often are enrollees requesting? Plans approving/denying?
  - How often are enrollees appealing exceptions denials?
  - How often do independent review organizations overturn exceptions denials?
- Info on accessing non-formulary drugs should be included in plan notices of mid-year formulary changes
- High use of exceptions processes could indicate inadequate formularies
- Exceptions processes do not obviate the need for adequate formularies

Contact Wayne Turner at turner@healthlaw.org

Visit the Consumer Reps' website:
https://consumeradvocacyforhealth.org/

Connect with National Health Law Program online:

www.healthlaw.org

@NHeLProgram

@NHeLP.bsky.social

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3/18/2026

Prescription Drug Formularies, Consumer Protections, and State Enforcement:

Focus on HIV Treatment & Prevention

Carl Schmid
Executive Director
HIV+Hepatitis Policy Institute

NAIC Prescription Drug Coverage (B) Working Group
March 23, 2026

HIV+HEP
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HIV Treatment Formulary Issues

- **Community Health Choice of Texas**
  - Regulated by CCIIO
  - Does not cover HIV treatment guideline Rx's
    - 1 plan doesn't cover any of the 6 recommended HIV STRs
    - Requires people to take multiple drugs
      - CCIIO said this is discrimination in the past
    - Removed most widely prescribed HIV drug
  - Puts a majority (68%) of HIV Rx's on highest tier
  - Filed initial complaint Sept. 2023
    - Another org. filed complaint in 2016

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Community Health Choice of Texas

- **CMS response completely unacceptable**
  - "Appear to offer sufficient coverage"
  - Adverse tiering review just began in 2024
    - But rule has been in place since 2016
  - Acknowledges 1 plan puts all STR's on highest tier
  - Another plan places at least one STR on a lower tier
    - But standard is discrimination is all or a majority of Rx's to treat a condition on highest tier

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Community Health Choice of Texas

- **Mtgs. w/CCIIO & additional letters & media**
  - Tiering Improved:
    - 2024: 48% of ARVs highest tier
    - 2026: 26% or 10% depending on plan
  - Still lack sufficient coverage
    - 1 plan covers 0/6 recommended STRs
    - the other 2/6

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Harvard Pilgrim

- Plans in NH, RI, & ME changed formulary for 2025
  - Removed HIV recommended Rx's, including most widely prescribed drug
  - Only covering 4/8 Rx's on national treatment guidelines
  - Plan in MA continued to cover 8/8
- Filed Complaint in November 2024-media coverage
  - Rhode Island did not see an issue "no authority to review clinical appropriateness"
  - ME Superintendent acted quickly
    - Worked w/issuer, drugs added back to formulary
    - Plan made same changes in the other states

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Medica MN & IA

- Filed complaints in Nov. 2024 for:
  - Failure to cover sufficient HIV Rx's
    - Only covered 3/12 STRs; 3/8 recommended Rx's
  - 84% of HIV Rx's on highest tier
- Plans are in 6 additional states
- Meeting w/MN to present our side, no other response to date

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Medica MN & IA

- IA engaged w/issuer; resulted in improvements for 2026
  - Now covers 10/12 STRs and 5/8 recommended Rx
  - 71% of HIV Rx's on highest tier
- Still insufficient
  - Medica remains an outlier; other plans in MN & IA cover all Rx's & % of Rx's on highest tier range from 2.3% to 12%
- Continued engagement w/IA
  - Conclude CCIIO tools inadequate-requires minimal drug coverage.

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Preventive Medications

- **Formularies Often Lack Transparency**
  - No consistency in tiering or in naming
  - Best practice to include separate pages detailing all ACA preventive services
    - Especially important for PrEP
      - Now have orals & injectables (which can be a medical benefit)
- Awareness of medical benefit Rx's also important for other classes (e.g. oncology)

Preventive Medications

- **Lack of Coverage**
  - Plans not covering all PrEP drugs in accordance with CMS FAQ (Oct. 2024)
    - All 3 Drugs w/o cost-sharing or prior authorization
  - New longer-acting Rx approved & more expected
    - USPSTF is for PrEP
  - State laws & regulations

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Highmark Blue Cross Blue Shield West Virginia

Brand Name generic name	Therapeutic Class *Sub-Class*	Dose/Strength	Status	Notes & Restrictions
emtricitabine-tenofovir (tdf) oral tablet 200-300 mg ©	Anti-Infective Agents *Antiretroviral - Nucleoside And Nucleotide Analog Rtis Combinations*	Tablet 200-300 mg	TIER 3	$0 more info
Descovy Oral Tablet 200-25 Mg	Anti-Infective Agents *Antiretroviral - Nucleoside And Nucleotide Analog Rtis Combinations*	Tablet 200-25 mg	TIER 3	QL Quantity Limit
Yeztugo Oral Tablet 300 Mg	Anti-Infective Agents *Antiretroviral - Pre-Exposure Prophylaxis (Prep)*	Tablet 300 mg	TIER 3	QL Quantity Limit

- Apretude (2-month injection) policy for providers Medical benefit, zero cost sharing, PA??
- Yeztugo (6-month injection) ??

https://client.formularynavigator.com/Search.aspx?siteCode=6571849149

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Covered Drugs Must be EHB

Highmark Blue Cross Blue Shield West Virginia

Biktarvy Oral Tablet 50-200-25 Mg	Anti-Infective Agents *Antiretroviral-Integrase Inhibitor,Nucleoside And Nucleotide Rtis Comb*	Tablet 50-200-25 mg	TIER 3	QL Quantity Limit	more info
	Copay Armor	Copay Armor, powered by PillarRx, helps members afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars.			

§ 156.122(f) If a health plan covers prescription drugs in excess of the prescription drugs required to be covered under paragraph (a)(1) of this section, the additional prescription drugs are considered an essential health benefit and subject to requirements including the annual limitation on cost sharing and the restriction on annual and lifetime dollar limits, …

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What Can Regulators Do

- CCIIO Needs to update tools
- Fully Review Plans for Drug Coverage
  - Based on clinical guidelines
- Fully Review Plans for Tier Placement
- Ensure all drugs are part of EHB
- Review plans for Utilization Mgmt. Measures
- Ensure no cost for Preventive Services
- Ensure plan documents are clear and transparent
- Respond to consumer complaints

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Thank you!

Carl Schmid
Executive Director
HIV+Hepatitis Policy Institute
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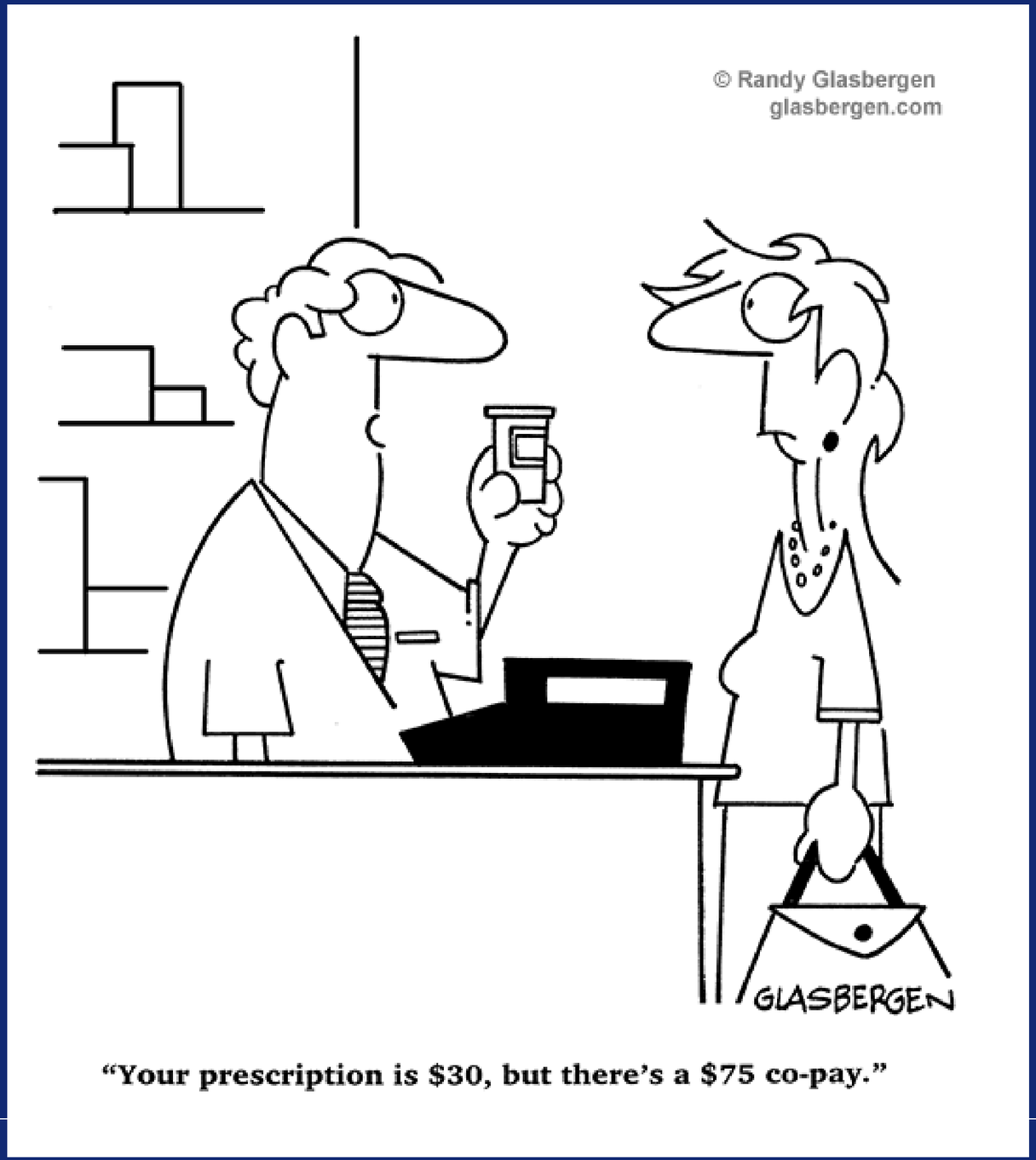
Agenda Item #3

Hear a Presentation on Prescription Drug Discount Cards and Related Issues
—Kelli Littlejohn Newman (AL)

From Counter to Copa
Adjudication, Accumulators, and Accountability

Presented by:
Kelli Littlejohn Newman, Pharm.D.
Senior Director, PBM Compliance

PGH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GLASBERGEN
"Your prescription is $30, but there's a $75 co-pay."

Disclosure

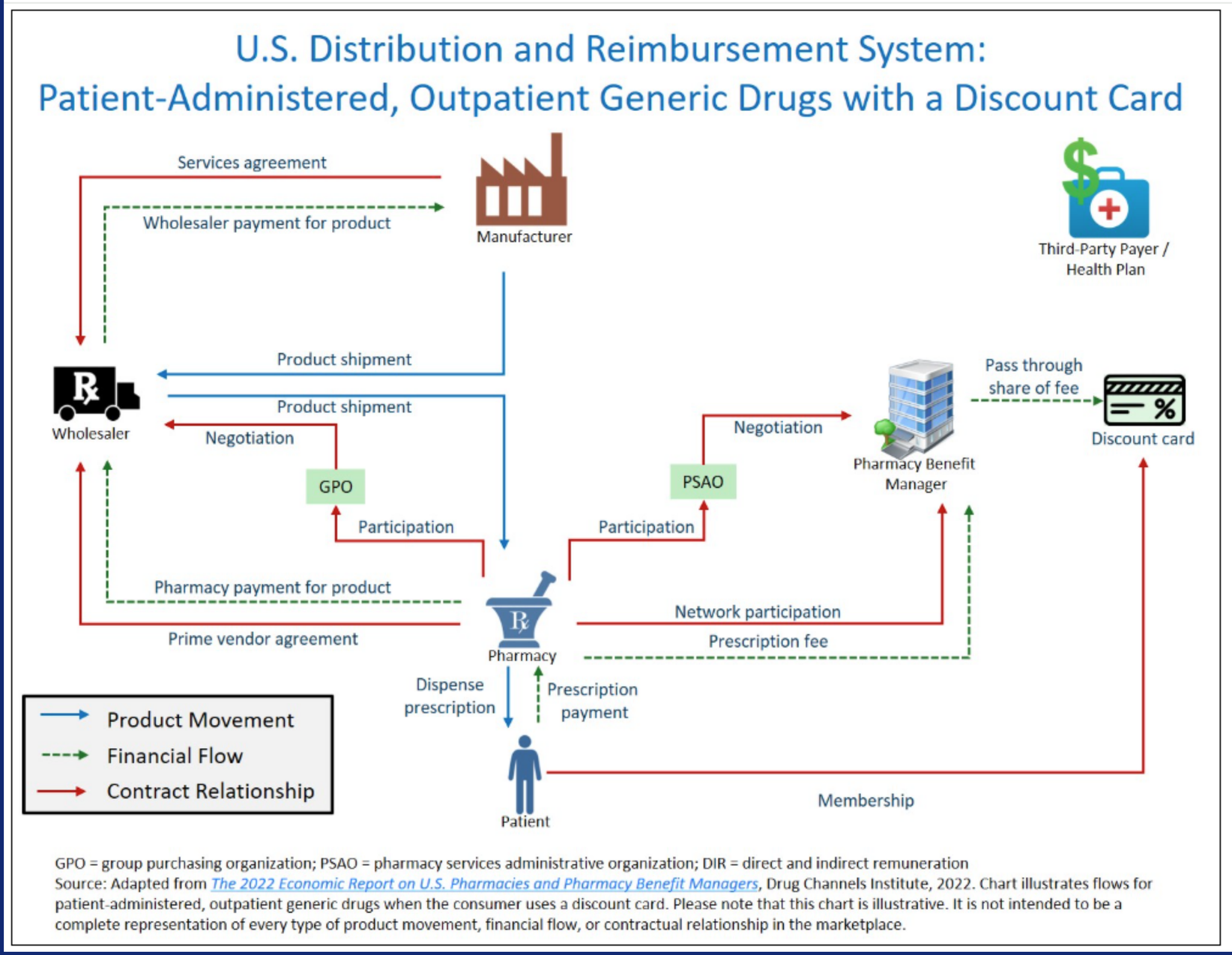
The presenter certifies that there are no relevant financial relationships, conflicts of interest, or potential sources of financial gain related to the subject matter of this presentation.

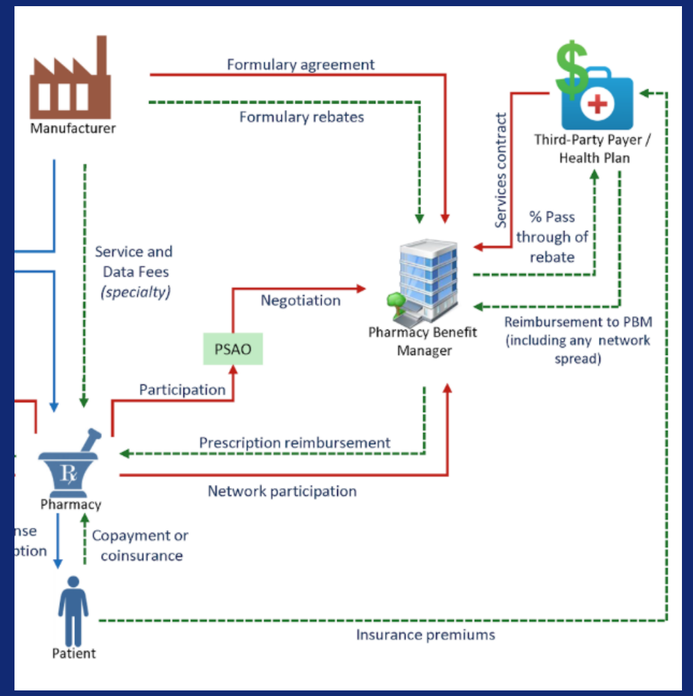
Objectives

- Prescription Claim Ecosystem/Flow
- Various Copay Assistance Programs
- Regulatory Movement

WARNING:
High-Volume Learning Ahead

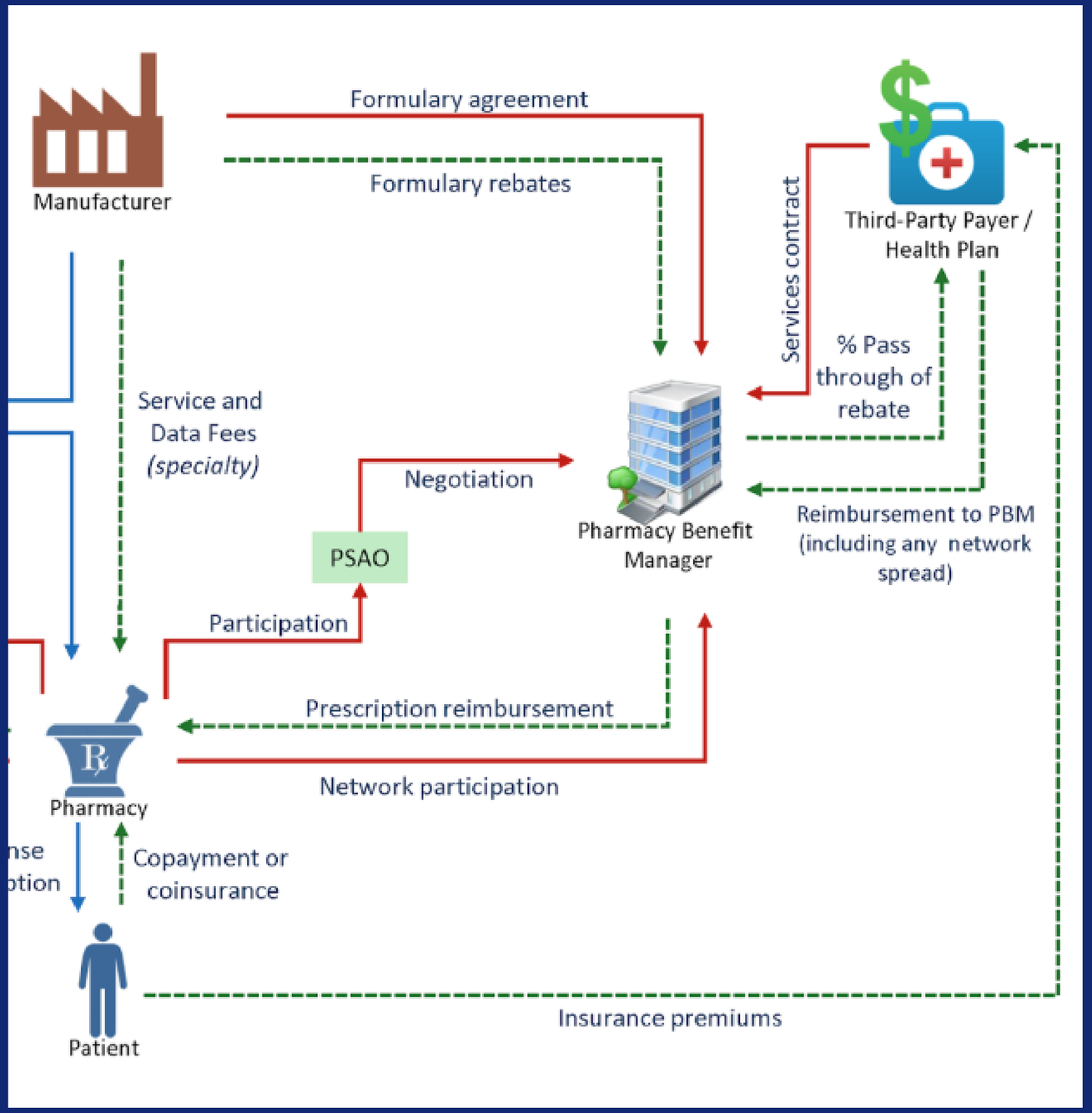
Background: Prescription Claim Ecosystem





Source: Adam Fein, Drug Channels Institute

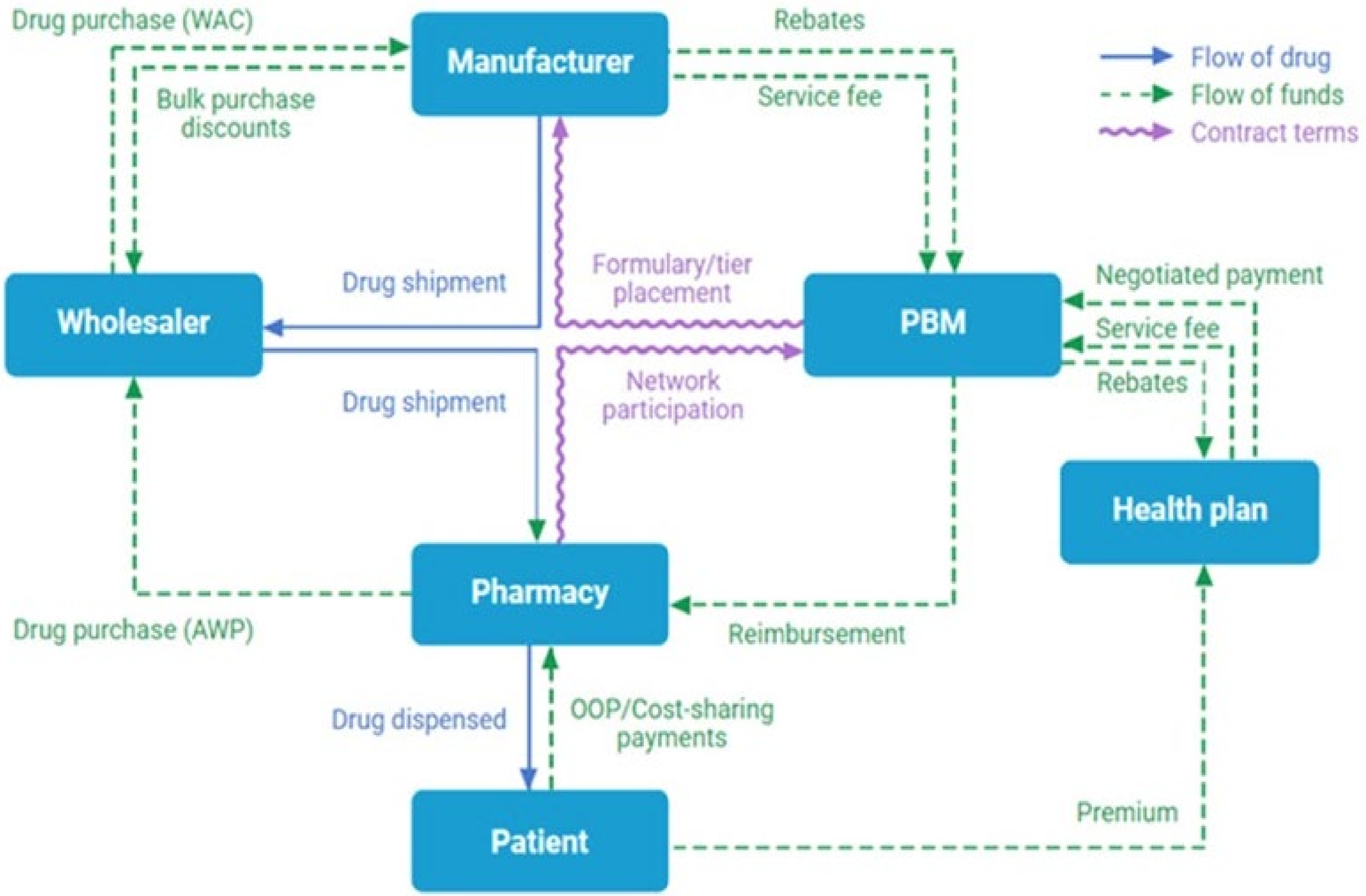
Background: Prescription Claim Ecosystem



Source: Adam Fein, Drug Channels Institute

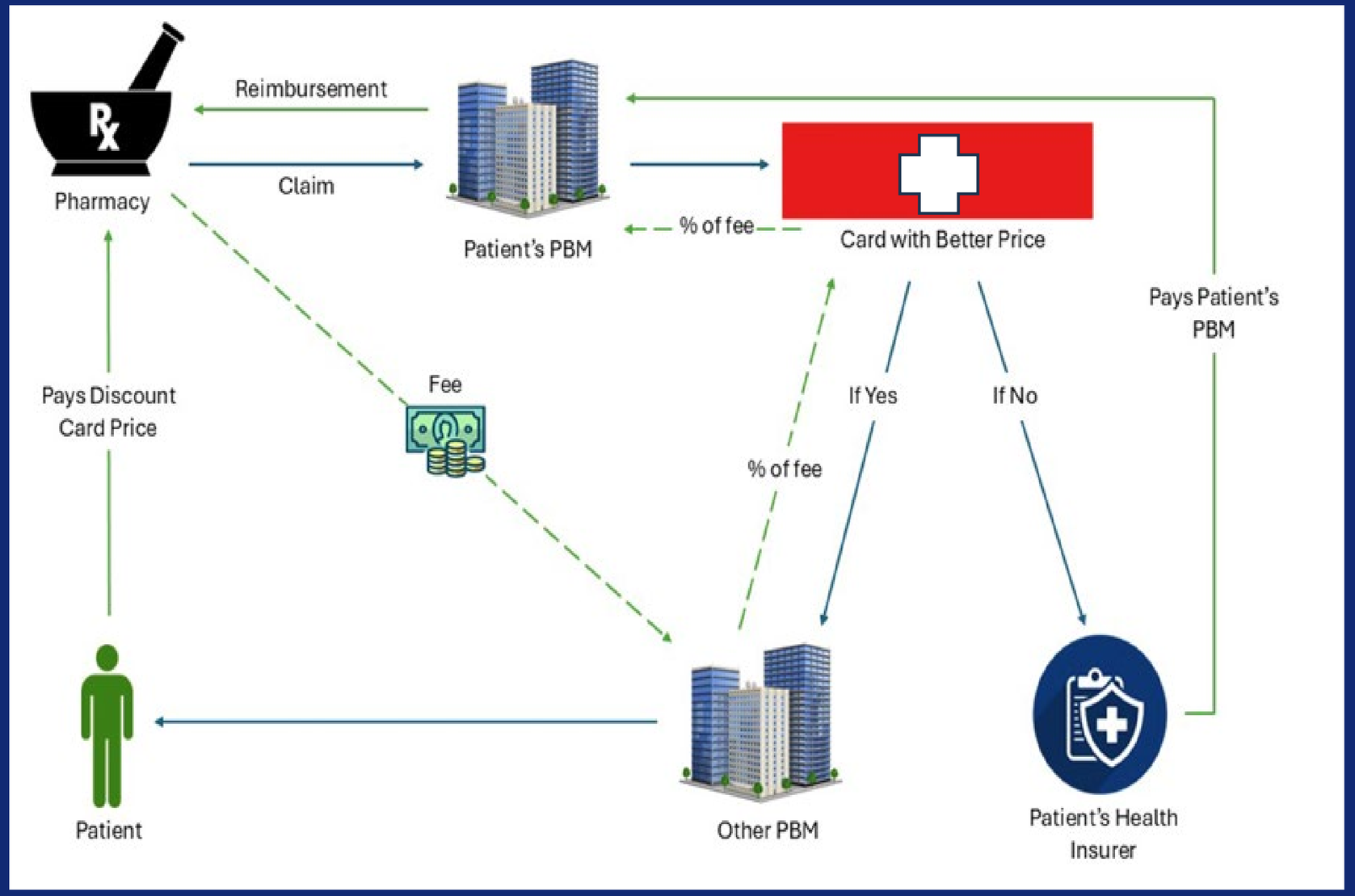
Background: Prescription Claim Ecosystem

Figure 1: Illustration of Typical Prescription Drug Transaction



Source: US District Court for Rhode Island, Class Action Complaint; Old Baltimore Pike Apothecary et al v. GoodRx, CVS Caremark, Express Scripts, MedImpact , Navitus

Background: Prescription Claim Ecosystem



Source: US District Court for Rhode Island, Class Action Complaint; Old Baltimore Pike Apothecary et al v. GoodRx, CVS Caremark, Express Med Impact , Navitus

Co-Pay/ Rx Assistance Programs

Manufacturer Copay Cards & Coupons:	• Provided by drug mfgs; commercial insurance; out of pocket costs
Independent Charitable Foundations/Grants:	• Non-profit organizations; chronic/rare diseases; grants to patients with financial need
State Pharmaceutical Assistance Programs (SPAPs)	• State-run; often seniors (SeniorRx)
Drug Discount Cards/Programs:	• Historically uninsured/underinsured; movement to work alongside PBMs
Patient Assistance Programs (PAPs):	• Usually provided by drug mfgs; low-income/uninsured
Retail Pharmacy Savings Clubs	• Membership; 90-day supply

Co-Pay Assistance Programs

Key Considerations

- **Eligibility**
  - Insurance coverage (commercial vs govmt); income levels
- **Limitations:**
  - Maximum annual dollar amounts (benefit limit); ‘accumulator adjuster’
- **Criteria**
  - Mail order; integrated pharmacy; other criteria

Drug Discount Cards

- GoodRx
- Single Care
- Optum Perks
- ScriptSave WellRx
- RxSaver

Pepper Fun Facts

“Pepper X”
World’s hottest pepper with avg 2.69 million Schoville Heat Units (SHU)

“Carolina Reaper”
Previous world champion with 2.2 million SHU; 200 times hotter than jalapeno

Both created by Ed Currie from South Carolina

Source: PepperHead.com

Copay Accumulators

What are copay accumulators ?

- Programs that allow patients to use drug manufacturer coupons to help with out of pocket costs (ie copays)
- Usually used with specialty/expensive medications
- Some plans / PBMs prevent that assistance from counting toward the patient's deductible or out of pocket maximum
- PBMs may bill the drug mfg coupon the full amount of the drug instead of the actual copay, which eats up the patient's annual benefit

What are copay maximizers ?

- Programs that adjust the copay to match the maximum amount provided by a drug mfg coupon; [do not] count toward deductible

Copay Accumulators

Understanding your Out of Pocket Costs with and without Copay Accumulators

Without a copay accumulator

	Expenses covered by $4,000 copay card	Patient out of pocket	What insurer pays	Amount applied to $7,000 deductible
Jan	$1,000	$0	$0	$1,000
Feb	$1,000	$0	$0	$1,000
Mar	$1,000	$0	$0	$1,000
Apr	$1,000 ↑ Value of copay card is met	$0	$0	$1,000
May		$1,000	$0	$1,000
Jun		$1,000	$0	$1,000
Jul		$1,000	$0	$1,000 ↑ Deductable is met
Aug		$0	$1,000	
Sept		$0	$1,000	
Oct		$0	$1,000	
Nov		$0	$1,000	
Dec		$0	$1,000	
Patient out of pocket: $3,000				

With a copay accumulator

	Expenses covered by $4,000 copay card	Patient out of pocket	What insurer pays	Amount applied to $7,000 deductible
Jan	$1,000	$0	$0	$0 ⚠
Feb	$1,000	$0	$0	$0 ⚠
Mar	$1,000	$0	$0	$0 ⚠
Apr	$1,000 ↑ Value of copay card is met	$0	$0	$0 ⚠
May		$1,000	$0	$1,000
Jun		$1,000	$0	$1,000
Jul		$1,000	$0	$1,000
Aug		$1,000	$0	$1,000
Sept		$1,000	$0	$1,000
Oct		$1,000	$0	$1,000
Nov		$1,000	$0	$1,000 ↑ Deductable is met
Dec		$0	$1,000	
Patient out of pocket: $7,000				

*Deductible: The amount you pay for your healthcare services/medication before your health insurance begins to pay

⚠ Manufacturer's assistance (value of copay card) is NOT applied to your deductible

"A dollar is a dollar"

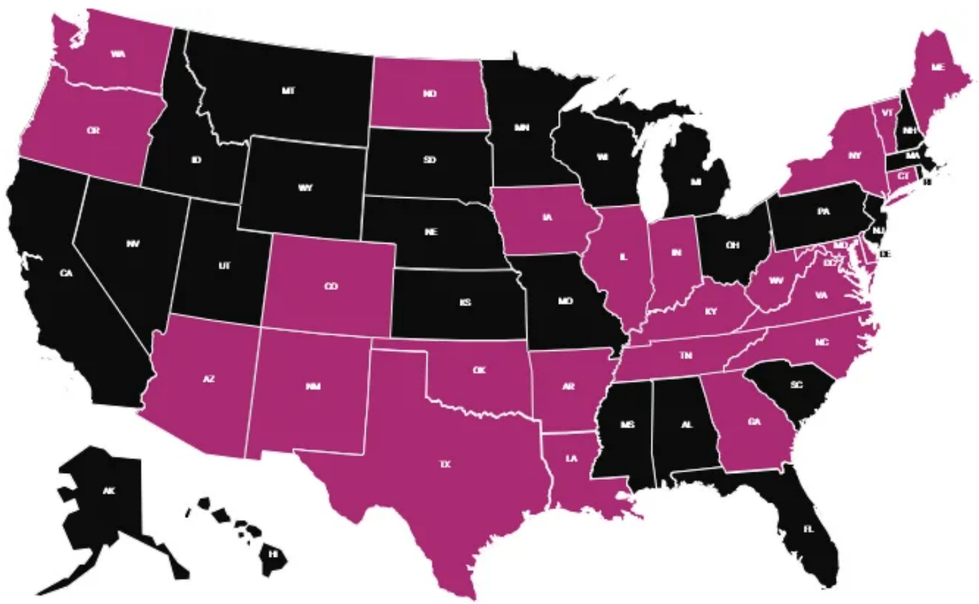
Source: Crohn's & Colitis Foundation

Copay Accumulators: Regulatory

As of early 2026, 2 7 states (+ DC and Puerto Rico) have passed legislation banning or limiting the use of copay accumulator programs:

Arizona	Louisiana	Oregon
Arkansas	Maine	Tennessee
Colorado	Maryland (Effective 1/1/26)	Texas
Connecticut	Nevada	Vermont
Delaware	New Jersey	Virginia
Georgia	New Mexico	Washington
Illinois	New York	West Virginia
Indiana (Effective 12/31/25)	North Carolina	Puerto Rico
Iowa (Effective 7/1/25)	North Dakota (Effective 1/1/26)	Washington D.C.
Kentucky	Oklahoma	

Figure 1: Enacted State Laws Limiting Copay Adjustment Programs



In 2023, 43% of commercially insured beneficiaries were enrolled in plans with copay accumulators available in the plan design. (Avalere)

Source: Avalere Health: https://advisory.avalerehealth.com/insights/state-copay-accumulator-bans-now-affect-at-least-17-of-commercial-lives

Copay Accumulators: Regulatory

- Prior to Sept 2023, HHS allowed CAs to be included or not included in deductible
- Sept 2023 District Court in District of Columbia Decision and Dec 2023 Clarification: HHS rule struck down, reverted to 2020 Notice of Benefit and Payment Parameters (2020 NBPP)
- 2020 NBPP: all health plans are required to count copay assistance toward a consumer's annual cost-sharing requirements, unless for a brand med with generic avail

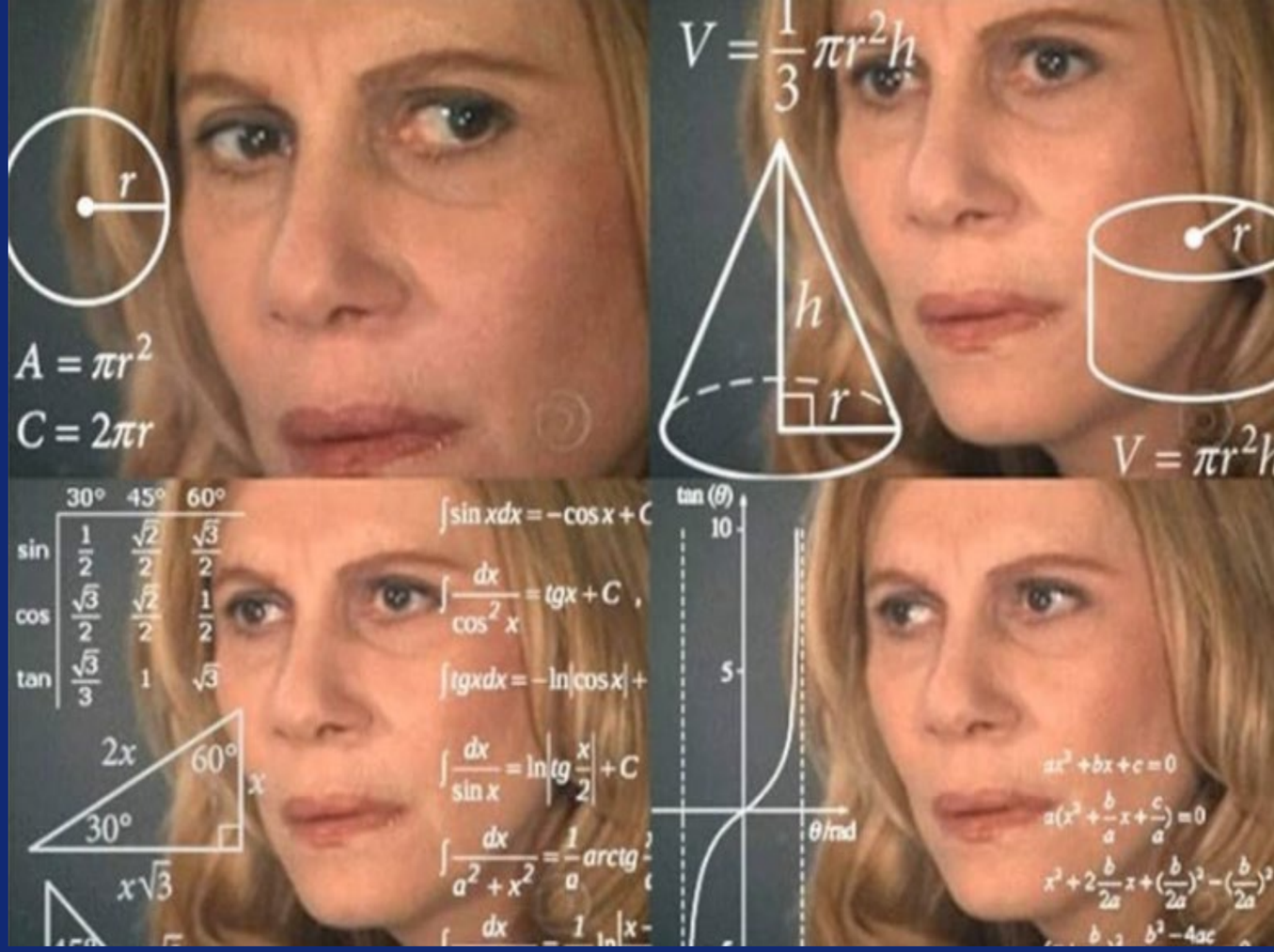
Source: AIMED Alliance letter to ALDOI, dated 2/6/26

Copay Accumulators: Case Study

- 52 year old female; autoimmune diseases
- Specialty medication $5k/month
- Under health plan contract, copay is $150
- Copay card is for maximum benefit $12k; $5 copay
- PBM billed copay card full amount; copay came back to patient $3k
- Patient exhausted assistance benefit in March

What do we do with this information?

- Awareness
- Regulation
- Transparency
- Patient Advocacy



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Agenda Item #4

Discuss Any Other Matters Brought Before the Working Group—*Joylynn Fix (WV)*