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Iowa State Capitol
1007 East Grand Avenue
Des Moines, Iowa 50319

Re: Support SF 383 / HF 852 – Copay Accumulator Adjustment Programs and Pass Drug Rebates

Members of the Iowa General Assembly:

The Coalition of State Rheumatology Organizations (CSRO) supports SF 383 / HF 852, which would require health plans to count third-party discounts and payments made on behalf of patients towards the patient's copayments, coinsurance, deductibles, or other out-of-pocket costs. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

Many rheumatologic patients are prescribed specialty drugs for chronic conditions after trying and failing all available lower cost alternatives and are often prescribed multiple medications for several conditions. These specialty medications can be very expensive, and many patients would go without treatment if they did not have access to copay assistance. Copay assistance may be provided to the patient through "copay cards", furnished by manufacturers to help cover a patient's cost sharing as well as through non-profit foundations, which offer monetary assistance to patients.

Until recently, health plans would count the value of the card towards the patient's deductible. However, health insurers and pharmacy benefit managers now regularly use programs known as "copay accumulator adjustment programs." In Iowa, 80.0% of individual health plans reviewed in 2025 include a copay accumulator adjustment program.[i] These programs allow the patient to continue using their copay card but do ***not*** allow the copay assistance to count towards the patient's deductible or maximum out-of-pocket limit, driving great patient out-of-pocket costs. Unfortunately, these copay accumulator adjustment programs impact patients living with chronic conditions who require high-cost specialty medications, including rheumatic diseases, as well as patients who can only afford high deductible health plans.

Through these accumulator programs, insurers pocket the value of the copay assistance, in addition to demanding the full deductible value from the patient. Many copay cards hit an annual limit, at which point the patient is often responsible for the full copay for

their medication if they have not met their plan's deductible or maximum out-of-pocket limit. Some patients may have cost sharing responsibilities of $5,000 a month or higher for their specialty medications or to cover multiple medications to treat their chronic conditions. When faced with these high out-of-pocket costs, many patients may abandon their treatment plan, forcing stable patients to discontinue their treatments. This can result in disease progression, flare ups, increased steroid use, and even loss of effectiveness of their original therapy if eventually restarted. Managing the results from non-adherence to their medication requires the use of substantially more resources than allowing for continuity of care from the start.[ii]

It is important to note that the Federal Employer Health Benefits prohibits the use of copay accumulator programs, according to a January 2024 letter. In this letter by the Federal Office of Personnel Management, the Office explicitly states that it will, "decline any arrangements which may manipulate the prescription drug benefit design or incorporate any programs such as copay maximizers, copay optimizers, or other similar programs as these types of benefit designs are not in the best interest of enrollees or the Government."[iii] We encourage the legislature to take a similar position on behalf of patients throughout Iowa.

PBM Practices Harm Patients

Rheumatology patients were among the first to experience the harmful repercussions of pharmacy benefit manager (PBM) business practices because rheumatologic conditions regularly require complex, and often expensive, specialty medications. These PBM business practices were built on a system of perverse incentives, where the higher a drug's list price, the greater the income potential for the PBM. As a result, prescription drug formularies are designed to maximize PBM revenues. Time and time again, we've seen our patients switched between different medications when PBMs change their formularies to higher-priced drugs when they have more to gain from rebates and fees set at a percentage of the list price. These tactics benefit the PBMs financially, while our patients see none of the savings accrued to the PBMs.

The three largest PBMs —Caremark Rx, Express Scripts (ESI), and OptumRx— control 80% of the prescriptions filled in the United States, according to the Federal Trade Commission. This vertical integration allows the PBMs to control which medication patients can take (through formulary construction), when they can take these medications (through utilization management), where they can purchase their medications (through pharmacy networks), and how much they must pay for their drugs (through cost-sharing). Currently, all of these decision points are leveraged to maximize PBM profits rather than provide the patient with the best care at the greatest savings. This consolidated healthcare system is not good for patients or the government as it causes competition that only raises drug prices.

Formulary design decisions are disastrous for patients who pay coinsurance because their out-of-pocket cost is based on list price of the medication – not what the PBM actually pays. An analysis by Drug Channels estimates that the spread between list and net price for insurers was over $200 billion in 2021. A 2021 report by the Texas Department of Insurance demonstrated that patients see marginal benefit from the supposed PBM "savings." Of $5,709,118,113 in rebates generated by PBMs for Texas insurers, only 21% made it back to patients in the form of direct savings.

Pass Manufacturer Rebates Directly onto Patients

PBMs claim to negotiate aggressive rebates and discounts that supposedly benefit employers and help keep premiums down. However, as demonstrated in the Texas report, those "savings" rarely trickle down to the patient. List prices appear to be fictional for everyone except the patient, whose cost-sharing is often based on the full price. It's time for rebates and other price concessions to benefit the patient – not the PBMs, especially as many patients are enrolled in health insurance plans that utilize high deductibles and/or significant cost sharing.

CSRO supports SF 383 / HF 852 as they would require manufacturer rebates to bypass the PBM and require rebates to go directly to the patient. Additionally, copay accumulator adjustment programs are harmful to patients and drive patient out-of-pocket costs. As the legislature continues to consider opportunities to address the cost of medications for patients throughout Iowa, we encourage you to protect patients and support SF 383 / HF 852. We thank you for your consideration and are happy to further detail our comments to the General Assembly upon request.

Respectfully,

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President
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Board of Directors

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[i] The Aids Institute. "Our Loss, Their Gain: Copay Accumulator Adjustment Policies in 2025." February 2025.
[ii] Rheumatol Ther. "The Economic Benefit of Remission for Patients with Rheumatoid Arthritis." October 2022.
[iii] U.S. Office of Personnel Management Healthcare and Insurance. "Pharmacy Benefits Management (PBM) Transparency Standards." January 2024.