Federal Court Strikes Down Copay Accumulator Programs



Summary:

On September 29, 2023, the U.S. District Court for the District of Columbia **vacated** a Trump-era rule from 2021 that allowed insurers to exclude drug manufacturer co-pay support coupons and assistance from a patient's annual cost-sharing caps. This practice, commonly referred to as a copay accumulator program, is typically used by insurance companies and pharmacy benefit managers to control drug spending, especially for high-cost specialty drugs, like those required by HIV patients.

Under typical prescription drug insurance programs, patients are obligated to pay a deductible and cost-sharing (i.e. a copay) throughout the plan year, up to an out-of-pocket spend cap. Once the patient hits that spend cap, the insurance company is responsible for the patient's prescription drug costs.

Under an accumulator program, on the other hand, an insurance company does not count a manufacturer's copay support (for example, a copay card that a patient presents at a pharmacy to cover the cost of the copay) towards a patient's annual deductible or out-of-pocket maximum. By excluding manufacturer copay support and coupons from patients' cost-sharing cap, this means that, even after a manufacturer's copay support is exhausted for the year, patients remain on the hook for all cost sharing obligations up to the insurance plan's out of pocket maximums. Many states have implemented laws to ban copay accumulator programs, asserting that such programs actually increase the financial burden on patients, especially with respect to specialty or more expensive drugs. As of June 2023, 19 states have implemented copay accumulator program bans.

HIV and Hepatitis Policy Institute et al v. HHS was brought by patient advocacy groups including the HIV and Hepatitis Policy Institute and the Diabetes Patient Advocacy Coalition, among others, who challenged a May 2020 rule from HHS, the "Notice of Benefit and Payment Parameters for 2021" (85 Fed. Reg. 29164, 29230-35, 29261 (May 14, 2020)) (the "2021 NBPP") that permitted insurers to impose accumulator polices. Plaintiffs opposed the accumulator program, asserting that manufacturer copay support should count *towards* calculating patients' cost sharing obligations and should not be excluded from such calculations.

In ruling in favor of the plaintiffs on their motion for summary judgment, the U.S. District Court set aside the 2021 NBPP, largely supporting plaintiffs' challenges that the 2021 NBPP rule's language is internally contradictory, that it runs counter to the statutory definition of "cost sharing" found in the Affordable Care Act, and that it runs counter to the agencies' pre-existing regulatory definition of "cost sharing." HHS had previously defined "cost sharing" in a 2012 regulation as "any expenditure required by or on behalf of an enrollee with respect to essential health benefits," which by its terms includes "deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services." *See* 45 C.F.R.

155.20. In other words, the regulation treats cost sharing is an "expenditure" by or on behalf of a plan enrollee. According to plaintiffs, and as affirmed by the court, this includes manufacturer copay assistance support.

The court disagreed with the government's technical arguments regarding the language of the 2021 NBPP (i.e. that manufacturer copay support is actually a "reduction" in the amount the patient owes towards cost sharing or a reduction in the "actual economic impact" on the drug manufacturer and not an "expenditure"), concluding that the 2012 regulation was likely intended to define "cost sharing" as costs that are (1) required of an insurance plan enrollee and (2) paid by or on behalf of that enrollee – including manufacturer copay coupons and assistance.

It is unclear if the ruling will be appealed; however, as a result of the District Court's ruling, the government will use an earlier 2020 version of the rule which allowed insurers to exclude from cost-sharing caps only copay support coupons for branded drugs that have available generic equivalents; if there is no generic equivalent, under the 2020 version of the rule, manufacturer copay support must be counted toward cost sharing.

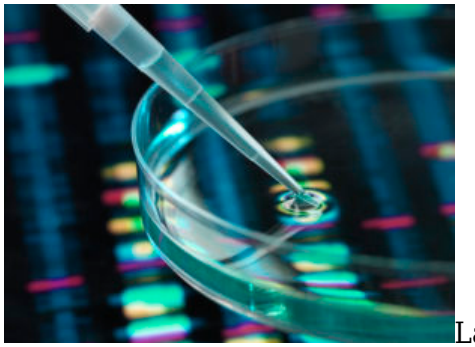
Conclusions: The U.S. District Court ruling is a significant development for drug manufacturers who offer copay support as a means of providing relief to patients with respect to cost-sharing requirements under their insurance coverage as opposed to offering significant rebates, discounts, or other contracting strategies. However, manufacturers of branded drugs with a generic equivalent will still need to consider how copay accumulator programs could affect access in those states that have not yet banned the practice. Notably, in the wake of this ruling, patient advocacy organizations have indicated that they will continue to advocate for a comprehensive state and federal level ban on copay accumulator programs (*e.g.* **Immune Deficiency Foundation**).

Goodwin will continue to monitor any further developments in this case and the impact of copay accumulator programs on the market.

A Look Ahead in Life Sciences: What We Are Tracking in Q4 2023 and Beyond

As the life sciences, medtech, and diagnostic industries continue to expand and grow increasingly complex, so do the legal, regulatory, and compliance landscape. To help companies and investors navigate the many evolving and emerging laws and regulations across pharmaceuticals, biologics, medical devices, diagnostics, and laboratory testing, our Life Sciences Regulatory & Compliance team has provided an overview of key developments. We update and publish a quarterly tracker detailing these developments. You can read about the Q4 2023 updates **here**.

Is it Biosimilar or Interchangeable? It Won't Be Easy to Tell Under FDA's Latest Draft Labeling Guidance



Last week, **FDA released** a draft guidance, "**Labeling for Biosimilar and Interchangeable Biosimilar Products**" that—when finalized—will revise and replace its July 2018 final guidance, "**Labeling for Biosimilar Products**." FDA noted that this 2023 Draft Guidance reflects recommendations based on the "valuable experience about labeling considerations" that FDA has gained through its approval of 42 biosimilar products, including four interchangeable biosimilar products.

Notably, the 2023 Draft Guidance provides further recommendations regarding when to use a biosimilar or interchangeable biosimilar product name, and when to use the reference product name in labeling:

- The biosimilar or interchangeable biosimilar product's proprietary name[1] (or if the product does not have a proprietary name, its proper name[2]) should be used when –
    - Information in the labeling is *specific to the biosimilar (or interchangeable biosimilar) product*, including such references to the product in the INDICATIONS AND USAGE, DOSAGE AND ADMINISTRATION, DESCRIPTION, and HOW SUPPLIED/STORAGE AND HANDLING sections, and/or
    - For "directive statements and recommendations for preventing, monitoring, managing, or mitigating risk," including such references to the product in the BOXED WARNING, CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS, and DRUG INTERACTIONS sections.

- When referring to the *drug substance* in the labeling, the biosimilar or interchangeable biosimilar product's proper name should be used.

- When information *specific to the reference product* is described in the biosimilar or interchangeable biosimilar product's labeling (for example, data from clinical trials of the reference product in the ADVERSE REACTIONS and CLINICAL STUDIES sections), the reference product's proper name should be used.

- In sections of the labeling containing *information that applies to both the biosimilar (or interchangeable biosimilar) product and the reference product*—such as BOXED WARNING, CONTRAINDICATIONS, WARNINGS AND PRECAUTIONS, ADVERSE REACTIONS—the

labeling should use the core name of the reference product followed by the word "products."[3]

FDA acknowledges that the application of these recommendations is highly context-dependent and may not always be clear, but recommends that biosimilar and interchangeable biosimilar product sponsors evaluate all statements in product labeling carefully to determine the most appropriate product identification approach in each instance.

Another noteworthy aspect of the 2023 Draft Guidance is the Agency's recommendation regarding the biosimilarity statement and footnote in the HIGHLIGHTS section of a biosimilar or interchangeable biosimilar product's labeling.[4] Previously, FDA recommended a biosimilarity statement for a biosimilar product and an interchangeability statement for an interchangeable biosimilar product. The 2023 Draft Guidance now recommends a statement and footnote in the HIGHLIGHTS section that the product is biosimilar to the reference product, *regardless of* whether the product is a biosimilar or an interchangeable biosimilar to the reference product. In the **Federal Register notice** announcing the 2023 Draft Guidance, FDA acknowledges that this marks an "evolution in our thinking" and explains that "a labeling statement noting that certain products within a 351(k) [Biologics License Application] have been approved as interchangeable, and explaining the interchangeability standard, is not likely to be useful to prescribers, who can prescribe both biosimilar and interchangeable biosimilar products in place of the reference product with equal confidence that they are as safe and effective as their reference products." FDA further states that "information about interchangeability is more appropriately located in the Purple Book rather than labeling."

Other notable elements of the 2023 Draft Guidance include recommendations regarding how to describe pediatric use data in a range of scenarios and how to incorporate immunogenicity data. With respect to immunogenicity data, the 2023 Draft Guidance suggests that a contextual paragraph[5] generally be included in the relevant CLINICAL PHARMACOLOGY subsection before describing the available immunogenicity data for the reference product and the biosimilar or interchangeable biosimilar product. The 2023 Draft Guidance also outlines the Agency's expectations for patient labeling—such as a Medication Guide, Patient Information, or Instructions for Use—for a biosimilar or interchangeable biosimilar product, if the reference product has such patient labeling.

Information on how to submit comments on the 2023 Draft Guidance can be found at **https://www.regulations.gov/docket/FDA-2016-D-0643.**

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[1] The proprietary name of a biosimilar product is a brand name determined by the sponsor. The fictitious example provided in the 2023 Draft Guidance is "NEXSYMEO."

[2] The proper name of a biosimilar product is the nonproprietary name designated by FDA that consists of a biological product's core name plus a unique four-letter suffix. The fictitious example provided in the 2023 Draft Guidance is "replicamab-cznm."

[3] The fictitious example provided by FDA in the 2023 Draft Guidance is "replicamab products".

[4] The fictitious example provided by FDA in the 2023 Draft Guidance is "NEXSYMEO (replicamab-cznm) is biosimilar* to JUNEXANT (replicamab-hjxf)" and the accompanying footnote is "Biosimilar means that the biological product is approved based on data demonstrating that it is highly similar to an FDA-approved biological product, known as a reference product, and that there are no clinically meaningful differences between the biosimilar product and the reference product. Biosimilarity of *[BIOSIMILAR OR INTERCHANGEABLE BIOSIMILAR PRODUCT'S PROPRIETARY NAME]* has been demonstrated for the condition(s) of use (e.g., indication(s), dosing regimen(s)), strength(s), dosage form(s), and route(s) of administration) described in its Full Prescribing Information."

[5] The Agency's suggested paragraph is, "The observed incidence of anti-drug antibodies is highly dependent on the sensitivity and

specificity of the assay. Differences in assay methods preclude meaningful comparisons of the incidence of anti-drug antibodies in the studies described below with the incidence of anti-drug antibodies in other studies, including those of [*proper name of reference product*] or of other [*core name*] products."

Modernizing the FDA's 510(k) Program for Medical Devices: Selection of Predicate Devices and Use of Clinical Data in 510(k) Submissions

On September 6, 2023, the US Food and Drug Administration (FDA) released a trio of draft guidances in its efforts to "strengthen and modernize" the 510(k) Program and provide for more "predictability, consistency, and transparency" for the 510(k) premarket review process. In this post, we discuss the two new draft guidances with broad applicability to the 510(k) Program:

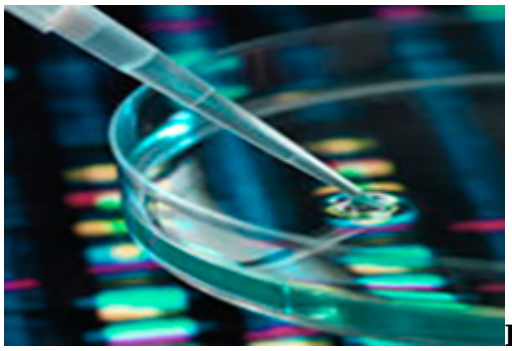
- "**Best Practices for Selecting a Predicate Device to Support a Premarket Notification [510(k)] Submission**"
- "**Recommendations for the Use of Clinical Data in Premarket Notification [510(k)] Submissions**"

The two draft guidances address a number of fundamental issues of concern with the 510(k) process.

Read the full client alert **here**.

UK's Medicines Regulator Announces Guidance on the New International

Recognition Procedure for the Approval of New Medicines from 1 January 2024



Background

Earlier this year, the UK's medicines regulator, the Medicines and Healthcare products Regulatory Agency (MHRA), announced that a new International Recognition Procedure (IRP) will be put in place for the approval of new medicines from 1 January 2024. On 4 September 2023, the MHRA announced the publication of detailed **guidance** on this new procedure, which will replace the **European Commission Decision Reliance Procedure** (ECDRP). The **Decentralised and Mutual Recognition Reliance Procedure** (MRDCRP), which allows the MHRA to have regard to approvals in the EU through the decentralised and mutual recognition procedures, will be incorporated under the umbrella of the IRP.

European Commission Decision Reliance Procedure

The ECDRP was introduced post-Brexit as a temporary measure to try and ensure continued access to new medicines from the EU for patients in Great Britain until 31 December 2023.

Under the ECDRP, the MHRA may rely on a decision taken by the European Commission on the grant of a new marketing approval in the EU through the centralized procedure, in order to grant a new marketing approval in Great Britain more quickly.

International Recognition Procedure

From 1 January 2024, the MHRA will have regard to decisions already made by medicines regulators in Australia, Canada, the European Union, Japan, Singapore, Switzerland and the United States (Reference Regulators).

The IRP will be open to applicants that have already received a marketing approval for the same product from one of the MHRA's specified Reference Regulators. The MHRA defines "same product" as "*as having the same qualitative and quantitative composition (active substance(s) and excipients), and the same pharmaceutical form, from applicants belonging to the same company or group of companies or which are licensees.*"

There are two procedures that can be used for initial applications for a new marketing approval using the IRP:

- **Recognition A** – applications under this procedure will be approved within 60 days (excluding clock stops), unless there are any major objections which cannot be resolved within 60 days. If this occurs, the timetable may revert to Recognition B. To qualify for this procedure, the Reference Regulator must have given approval for the product within the last two years, the

manufacturing process must be unchanged and the product must not meet any of the 24 listed conditions of Recognition B.

- **Recognition B** – applications under this procedure will be approved within 110 days (excluding clock stops), unless there are any major objections at day 110. If this occurs, the timetable will then revert to 210 days and formal advice from the Committee for Medicinal Products for Human Use will be sought on approvability. To qualify for this procedure, the Reference Regulator must have given approval for the product within the last ten years, and at least one of 24 listed conditions must apply. The conditions include if the product is: (i) designated as an orphan medicinal product in Great Britain, (ii) an advanced therapy medicinal product, (iii) a cutting-edge technology, or (iv) a first-in-class active substance.

Practical Implications

The IRP will allow the MHRA to take into account the expertise and decision-making of trusted medicines regulators when approving a new medicine from 1 January 2024.

It is unclear if there are any specific requirements for choosing the Reference Regulator if the product is approved by more than one eligible medicines regulator.

As a final note, the IRP will sit alongside the MHRA's current national procedures. Any ECDRP and MRDCRP applications for marketing approval received by the MHRA *after* 1 January 2024 will be assessed under the new IRP. Any ECDRP and MRDCRP applications for marketing approval received by the MHRA *before* 31 December 2023 will be assessed under the current ECDRP and MRDCRP respectively.

A Look Ahead in Life Sciences: What We Are Tracking in Q3 2023 and Beyond

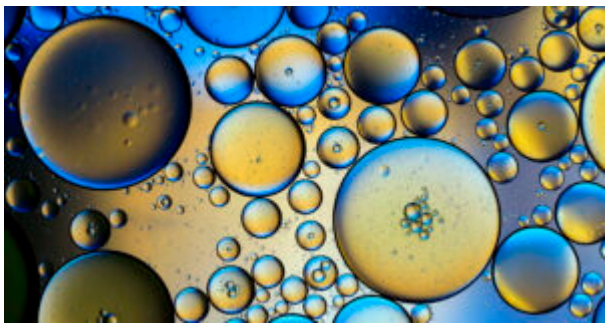


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The European Commission Proposes First Major Overhaul of the EU Medicines Regulatory Framework in 20 Years: Orphan Medicines

We recently published an **alert** in relation to the European Commission's legislative proposals to replace the current EU regulatory framework for all medicines (including those for rare diseases and for children). One of the major elements of the proposals is a change to the legislation governing orphan medicines for rare diseases, which we examine in more detail in the client alert **here**.

Psychedelics & Drug Development — Key Considerations for Healthcare Industry and Life Sciences Companies as Congress Seeks to Tap Into Psychedelics' Therapeutic Potential



Based on recent regulatory changes at the state and local level and the efforts by the federal government and certain foreign agencies, investors, clinical trial sponsors, life sciences companies, and investigators operating in the psychedelics industry may have reason to be optimistic about the future regulatory landscape for therapeutic psychedelic product candidate development, approval, and commercialization. The proposed Breakthrough Therapies Act is one such reason.

On March 8, 2023, US Sens. Cory Booker (D-NJ) and Rand Paul (R-KY) **introduced** an **updated version** of the Breakthrough Therapies Act. If passed, the bipartisan bill would amend the federal Controlled Substances Act (CSA) to enable the Drug Enforcement Administration (DEA) to reclassify from Schedule I to Schedule II drugs and biologics, including therapeutic psychedelics, that receive breakthrough therapy designation or are authorized for expanded access by the US Food and Drug Administration (FDA). Therapeutic psychedelics are Schedule I substances and include LSD, MDMA, and psilocybin. According to the bill's sponsors, the "legislation [would] remove regulatory hurdles that inhibit research and compassionate use access to potentially lifesaving treatments that are heavily restricted by Schedule I of the [CSA]."

The bipartisan effort behind the Breakthrough Therapies Act signals the federal government's evolving position on psychedelic substances, their therapeutic potential, and access. This evolution, discussed in greater detail in our Client Alert, presents an important opportunity for investors, clinical trial sponsors, life sciences companies, and investigators.

Accordingly, we have identified and answered 8 key questions that stakeholders should consider as they develop and innovate in the psychedelic space:

- What Is the Difference Between a Schedule I and a Schedule II Drug?
- What Diseases and Conditions Can Potentially Benefit From Therapeutic Psychedelics?
- What Are the Key Provisions of the Proposed Breakthrough Therapies Act?
- How Does a Drug or Biologic Obtain Breakthrough Therapy Designation From FDA?
- What Is Expanded Access?
- What Are Some Key Limitations in the Proposed Breakthrough Therapies Act?
- What Is the Status of Therapeutic Psychedelics at the State and Local Level?
- What Regulatory Changes Are on the Horizon for Therapeutic Psychedelics?

Read the full client alert **here**.

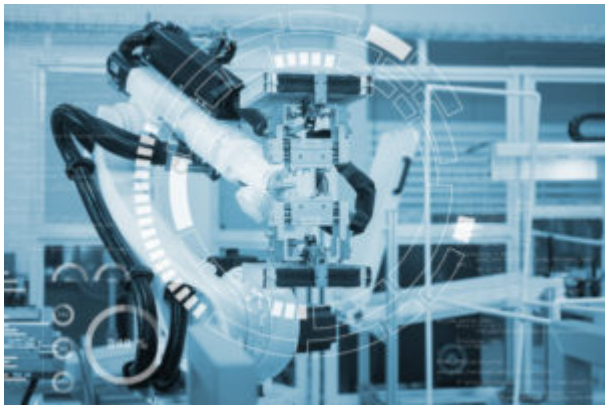
The European Commission Proposes First Major Overhaul of the EU Medicines Regulatory Framework in 20 Years: Regulatory Data Protection



We recently published an **alert** in relation to the European Commission's legislative proposals to replace the current EU regulatory framework for all medicines (including those for rare diseases and for children). One of the major elements of the proposals is a change to the period of regulatory data protection for medicines, which we examine in more detail in

the client alert **here**.

The MHRA Proposes to Extend the Period of Acceptance of CE Marked Medical Devices in Great Britain Beyond 30 June 2023



BACKGROUND

On 28 April 2023, the UK's medical devices regulator, the Medicines & Healthcare products Regulatory Agency (MHRA), announced its intention to extend the acceptance of CE marked medical devices in Great Britain (England, Scotland and Wales) beyond 30 June 2023.

Following the UK's departure from the EU, CE marked medical devices can currently be placed on the Great Britain market under the existing transitional arrangements until 30 June 2023. The proposed extension will support the ongoing safe supply of medical devices to Great Britain and ease the transition to the future regulatory framework for medical devices.

The government intends to introduce regulations in the future that will implement a substantial reform of the current regulatory framework for medical devices in the UK and is now aiming for core aspects of the UK's future regime for medical devices to apply from 1 July 2025.

PROPOSED EXTENSION TO TRANSITIONAL ARRANGEMENTS

The UK Medical Device Regulations 2002 (UK MDR) currently provide that the acceptance of CE marked medical devices on the Great Britain market will end on 30 June 2023. However, the MHRA intends to introduce legislation before 30 June 2023 which will provide that CE marked medical devices may be placed on the Great Britain market to the following timelines:

- General medical devices compliant with the EU medical devices directive (EU MDD) or EU active implantable medical devices directive (EU AIMDD) with a valid declaration and CE mark can be placed on the Great Britain market up until the sooner of (i) the expiry of the CE mark certificate or (ii) **30 June 2028**;

- In vitro diagnostic medical devices (IVDs) compliant with the EU in vitro diagnostic medical devices directive (EU IVDD) can be placed on the Great Britain market up until the sooner of (i) the expiry of the CE mark certificate or (ii) **30 June 2030**; and
- General medical devices, including custom-made devices, compliant with the EU medical devices regulation (EU MDR) and IVDs compliant with the EU in vitro diagnostic medical devices regulation (EU IVDR) can be placed on the Great Britain market up until **30 June 2030**.

The above extensions will not include class I medical devices and general IVDs (for which the conformity assessment under EU MDD or EU IVDD did not involve a notified body), which can only be placed on the Great Britain market if the involvement of a notified body would be required under the EU MDR or IVDR (i.e., if it is an up-classified device or a reusable surgical instrument Class I device). Similarly, the extensions will not include custom-made devices that are compliant with the EU MDD or EU AIMDD, which can no longer be placed on the Great Britain market.

WHAT HAPPENS NEXT?

The legislation to implement the proposed extension will now be considered by the UK Parliament, and final approval is expected before 30 June 2023.