Alternative Funding schemes: What are they and what CAN WE DO TO STOP them?

Kollet Koulianos, MBA
Senior Payer Consultant
Hemophilia Alliance

Becky Burns, COO
Bleeding & Clotting Disorders Institute

U.S. HEALTHCARE LITERACY

- Only 9% of the U.S. population showed an understanding of all four of these basic health insurance terms. That’s a slight increase from just 7% last year.

Terms to Know

Premium

- The amount you pay to obtain a health plan. Does not count toward deductible, max out of pocket, or copay accumulator.

Deductible

- The amount you must pay before any of your insurance benefits kick in.

Copay

- Set amount you pay for prescriptions, doctor visits, and other types of care

Coinsurance

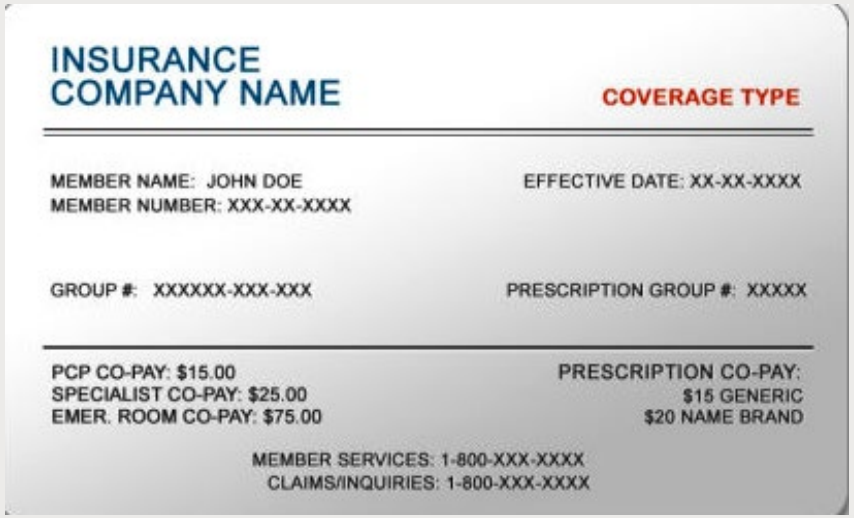
- Percentage of costs you pay after you have met your deductible.

Max Out of Pocket

- The maximum amount you will pay for covered services in a plan year.

Top Priorities for Employers:

High-Cost Claimant by Definition



- **HIGH-COST CLAIMANTS DEFINED >$50,000**

- **PRIVATE HEALTH INSURANCE HCC DATA**
- Avg $122,382 annually
- 29.3 times higher than average
- 1.2% of population are HCC’s
- Accounts for 31% of spend
- Tops List:
  - Cancer
  - Live Births/Perinatal
  - Blood Disease

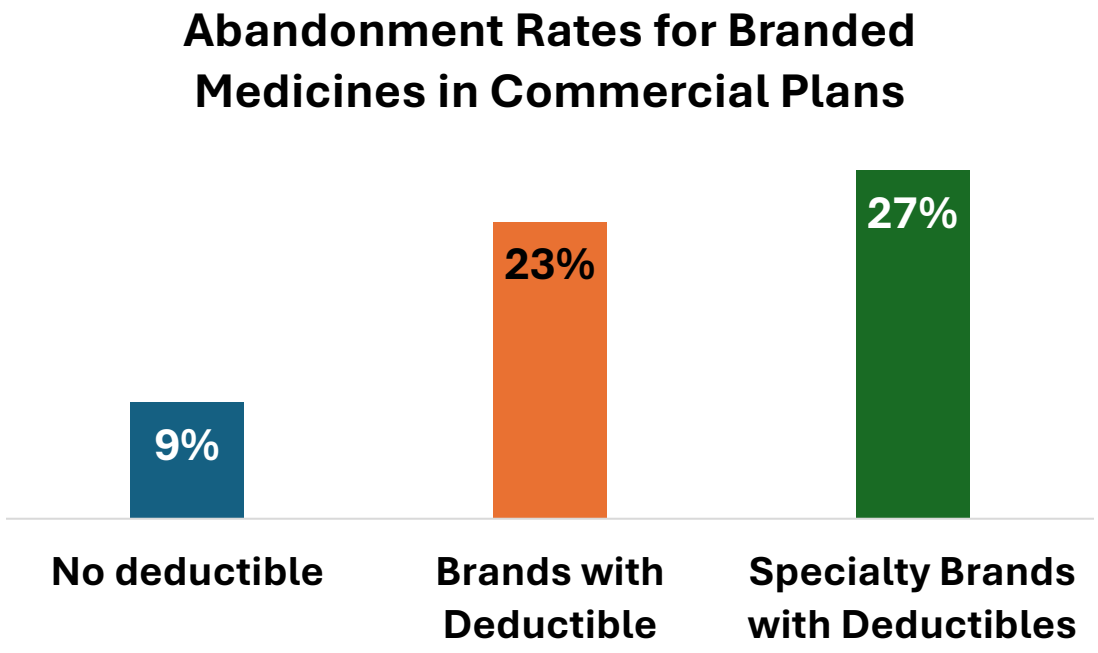
Copay Accumulator Adjusters

Copay Accumulator Adjusters

When a copay accumulator adjuster is in place, the plan does not count any dollars **NOT** paid by the member personally toward his/her health plan annual Accumulator (Accumulated out of pocket costs paid towards deductible, co-insurance and/or copays to the max out of pocket).

Consequences of High Patient Cost-Share

- **Increased nonadherence or even discontinuation of therapies:**
  - Progression of disease adds to health care costs
  - May create even greater affordability challenges for low-wage workers
- **Financial toxicity:**
  - Emotional and psychological distress in patients because of the added expense of medications
- **Patient concerns regarding accumulators:**
  - Many patients are not given any notice that copay accumulators are going into effect until pharmacists point it out



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2. Seeing accumulator adjustment programs through patients' eyes. ConnectiveRx 2018. https://www.mmm-online.com/wpcontent/uploads/sites/2/2018/09/AccumulatorAdjustmentProgramsThroughPatientsEyes.pdf. Accessed March 2022.
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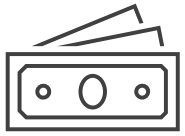
6. Medicines Use and Spending in the US: A Review of 2016 and Outlook to 2021. IQVIA website. https://www.iqvia.com/insights/the-iqvia-institute/reports/medicines-use-and-spending-in-the-us-a-review-of-2016 Published May 4, 2017. Accessed March 2022.

Copay Maximizers

Copay Maximizer Programs

Operate by claiming specialty meds are non-essential health benefits (EHB's), enabling them to move these medications outside of the ACA compliant pharmacy benefit to a covered non-EHB vendor (SaveOn SP, Prudent Rx, etc) without cost sharing limits.



Take advantage of funds available through manufacturer copay assistance programs. Set copays for each drug accordingly. Annual Avail / 12
Does NOT count towards members deductible or annual OOP

If the member chooses not to enroll, they must pay the associated copay established on that covered non-EHB formulary, and it DOES NOT count towards the members deductible or Max OOP.

Non-ACA compliant so can only be implemented on self-funded / large group plans

65% of all commercial plans self funded **73% of commercial plans have maximizers.**

EXPRESS SCRIPTS CLAIMS THAT SPECIALTY MEDICATIONS ARE NOT ONE OF THE 10 ESSENTIAL HEALTH BENEFITS

EXPRESS SCRIPTS®

Like all other medications, specialty medications require a prescription and are dispensed by a pharmacy or provider. By whose authority are they making the claim that specialty medications are not an EHB?

Specialty medications are not one of the ten Essential Health Benefits under the Affordable Care Act (ACA) and are therefore considered non-essential health benefits. As non-essential health benefits, the cost of specialty drugs that are part of the SaveonSP program will not apply towards satisfying the member's out-of-pocket maximum on the prescription drug plan, nor will they apply towards the out-of-pocket maximum on the member's medical plan. (Although the cost of the drugs under the SaveonSP program will not apply towards the member's out-of-pocket maximum, for APS members who qualify for and enroll in this program, the cost of these drugs will be reimbursed by the manufacturer and result in no cost to the member.)

The 2011 HHS guidance defining EHB's states that large group and self-insured employer

- Are not required to offer EHBs, but if they do, limits on cost-sharing apply.
- May modify the definition of EHB, but only in manner authorized by HHS.

The only carve-out authorized by HHS was in 2014 guidance – which permits plans to exclude cost of name brand prescriptions from maximum OOP limit when a medically appropriate generic is available.

What is an Essential Health Benefit?

All plans governed by the Affordable Care Act (ACA) must cover 10 essential health benefits:

- Outpatient Care
- Emergency Care
- Hospital Stays
- Mental Health Coverage
- Prescription Drug Coverage
- Rehab Services
- Lab Services
- Maternity and Newborn Care
- Pediatric Care (Including Vision and Dental)
- Free Preventative Care

Self-insured plans are not required to provide essential health benefits!

Self-Funded
& Large Group Health Plans

- 2011 HHS guidance defining EHBs for large group health plans and self-insured plans:
  - Not required to offer EHBs, but if they do, limits on cost-sharing apply
  - May modify the definition of EHB but only in manner authorized by HHS
  - Most make a good faith effort to comply with authorized definition of EHB
  - Only carve-out authorized by HHS was in 2014 guidance – permits plans to exclude cost of name brand prescriptions from maximum out-of-pocket limit when a medically appropriate generic is available
  - Drug list here: most drugs don’t have available generics

CAPs vs. PAPs

Specialty Cost Containment Version 1.0

CAP

Copay Assistance Program or Variable Copay Maximization Program

- Specialty Cost Containment version 1.0 – leverages manufacturers coupons to reduce cost to the employer.
- Maximizes the total value of the coupon by adjusting the copay or coinsurance for a given specialty drug.
- The member does not get credit toward deductible/MOOP for "phantom" costs.

Specialty Cost Containment Version 2.0

PAP

Patient Assistance Program or Specialty Alternative Funding

- Specialty Cost Containment version 2.0 – avoiding the specialty claim by seeking an alternative source of funding.
- These programs have been around since 2006 after the Medicare Modernization Act.

Alternative Funding /Specialty Drug Carve Outs

Specialty Drug Cost Containment Version 2.0: Alternative Funding

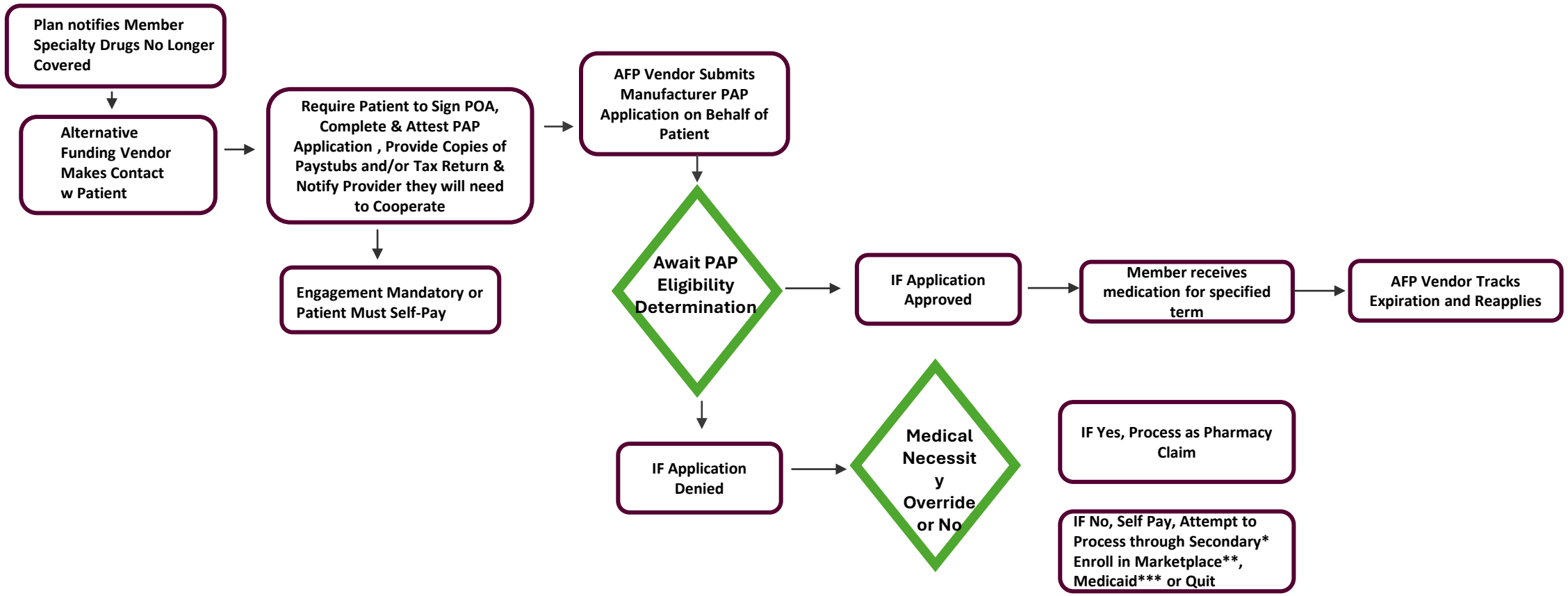
- Alternative Funding Solutions are targeted to employer self-funded health plans attempting to reduce their specialty drug spend and catastrophic claims exposure by partially or fully excluding coverage of specialty medications from their prescription drug benefit.

- The prior authorization is automatically denied by the PBM when a plan participant is seeking to obtain one or more of the carved-out meds. The participant is then referred to work with an alternative funding vendor that helps them pursue coverage of their drug(s) from another source, primarily manufacturer free-drug programs, charitable foundations, importation and medical tourism; with the hope that one of those options can help their members access the drug they need while avoiding the expense for the plan.

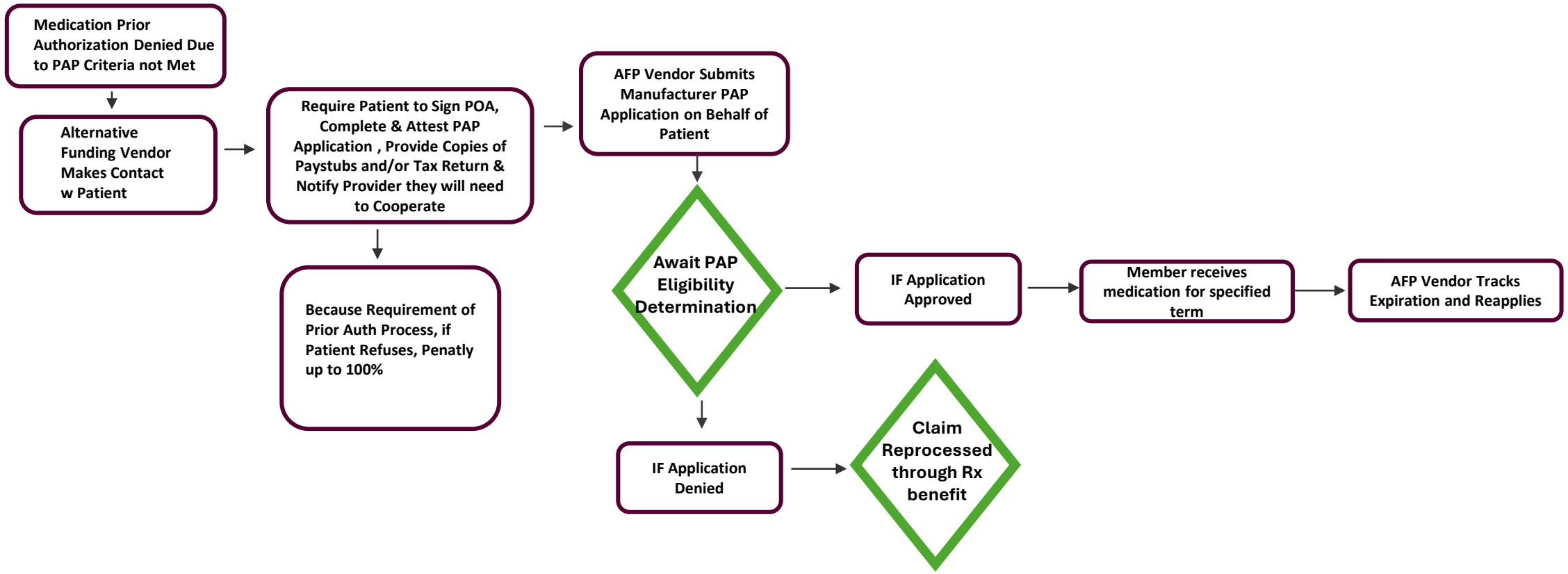
- This can be highly disruptive to the impacted members, but employers are reminded to keep in mind it's the 2% of their beneficiaries who represent up to 50% of their pharmacy spend.

    - Option 1: Specialty Drug Carve Out
    - Option 2: Avoids Exclusionary Language to 'preserve stop loss'.

Specialty Drug Carve Out



Version 2.0 - Prior Authorization Denial

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MagellanRx MANAGEMENT
Optime Care
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The smart way to save on prescriptions.
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Change the Conversation
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SHARX
HSRx HealthSmartRx Solutions
HealthSmart
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A Better Medication Experience
motivhealth
AscellaHealth
Innovative. Customizable. Sustainable.
ARMSRx PHARMACY BENEFIT CONSULTANTS
EHiM
OptiMed
NAVITUS
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cobaltRX
Pharmacy Benefit Consultant
medone
RX HELP CENTERS
scriptsourcing
Lumicera Health Services
PSP
Premier Solution PARTNERS
ScoutRx
Amalgamated Life
Group • Stop Loss • Voluntary

Who is Payer Matrix?

Payer Matrix is a team of dedicated healthcare professionals who partner with your employer to reduce the cost of your high dollar prescription drugs. We do that by working directly with you in order to obtain alternative funding though the manufacturer, foundations and grants.

What we do:

Payer Matrix advocates on your behalf with drug manufacturers, and our Care Coordinators facilitate with multiple entities to lower the cost of your prescription drugs. Often, members end up paying nothing out of their own pockets once they are admitted into our programs.

What this means for you:

Our goal is to obtain alternate funding for your specialty prescriptions. A Care Coordinator will be assigned to work directly with you, please prepare to have a call with them. They will ask a few verification questions to assure they have the correct person in order assist with your current drug needs. There is paperwork that will need to be completed by you, and your Care Coordinator will assist with any questions you may have about the process. Their function is to assist and facilitate your paperwork through the patient assistance process. If you are close to a drug fill, they will able to acquire that for you, as well

How do I find Payer Matrix?

You can call us or send us an email at – we are looking forward to working with you!

(877) 305-6202

customerservice@payermatrix.com

Payer Matrix

CONCORDIA UNIVERSITY WISCONSIN

Back to News Home

HUMAN RESOURCES

High-cost prescription assistance

Our efforts our focused on lowering costs for you...

If you currently take high-cost prescriptions, you may be contacted!

Payer Matrix is a new service that EmpiRx is using for 2021 that helps with cost assistance for certain members who are taking high cost drugs. Qualified employees will be identified and receive a letter indicating the following:

We recognize the heavy burden specialty medication expenses can be on you and your families. With costs expected to continue to rise, our efforts are focused on developing solutions that can reduce costs for specialty drug utilizers, making them more accessible and obtainable.

We are pleased to share that Concordia Plans will now provide an employee assistance program, for relief of select high dollar specialty drug costs. In partnership with EmpiRx Health, your Pharmacy Benefit Manager, we are implementing the Specialty Cost Containment Solution, powered by Payer Matrix, effective 1/1/2021. With this program, alternative funding for select high-cost specialty drugs may be obtained, where applicable, and your out-of-pocket costs could be reduced. Together, EmpiRx Health and Payer Matrix will utilize manufacturer assistance programs to help you, as members, receive the maximum value possible.

A Payer Matrix Care Coordinator will reach out if one of your medications has an available manufacturer assistance program. Care Coordinators are clinicians with specialty medication expertise. They coordinate the details with you and your physician if you qualify for assistance. The Care Coordinator also works on your behalf to help you receive your specialty medication on time, every month, once in the program.

If you receive a letter or phone call from this company, it is required that you sign up with them to process your prescriptions. If you are not contacted by this company, your prescription may not currently qualify for assistance.

—**Sarah Gartman**, Assistant Director-Human Resources

Ideal Solution is an Integrated Approach

MRx Select Savings

- Handles the financial aspects of specialty drug funding through knowledgeable advocates and case managers
- Benefits members with chronic diseases
- Provides access to care under the normal process members use today
- Maintains coverage for specialty drugs without using exclusionary language—preserves stop-loss policy coverage
- Includes plan document language that does not reduce the value of the benefit—maintains ACA compliance

Alternative Funding links Magellan Rx's clinical expertise with consultative advocacy partners

How PaydHealth works with a member:

- Once a prescription is submitted to Magellan and it meets the criteria, the prescription will deny.
- A prior authorization will be completed. If medical necessity is met the process will begin.
- The information is sent from Magellan to PaydHealth.
- CareFactor will send a letter and "frequently asked questions" to explain the program to the member.
- We follow up with a phone call to the member to answer any questions or concerns the member may have.
- PaydHealth will contact the member to begin the process.
- PaydHealth will gather information from the member which includes household size and income. The information is needed to apply for the funding programs. The process typically takes them about 30 days.
- Paydhealth will typically use a drug card to cover all or some of the member's medication cost while PaydHealth works to secure funding. This will ensure there is no disruption in the member obtaining their medication.
- If the member is approved for a free program, they will receive their medication from the manufacturer.
- Typically, when approved for a free program the approval is for 6-12 months. PaydHealth does monitor this and will reapply when needed.
- If a member is approved for partial funding, the prescription will be filled through Magellan. Partial funding will be applied as member responsibility (member does not pay when funding is applied).
- If the member does not qualify for a program the medication will go back through Magellan and be processed under the plan prescription benefit.
- If the member participates with the program, they will get their medication. Often it will be at no or little cost to them.

Paydhealth

Select Drugs and Products℠ Program

The Plan's Select Drugs and Products Program

allows you to take an active role in helping the Plan reduce your costs, while allowing the Plan to continue to offer generous healthcare benefits to all Participants. The Plan is sponsoring this program at no cost to you. If you are prescribed a drug included on the Paydhealth Select Drugs and Products List, you must enroll in the Program to comply with benefit requirements.

There are two reasons why you are receiving this important message

1. Your Plan has added an important program that includes the Paydhealth Select Drugs and Products List*

2. Your Plan is continuing to offer generous specialty drug benefits while attempting to reduce your costs and the Plan's.

Select Drugs and Products℠ Program

5. What is the Select Drugs and Products℠ Program?
    - The Select Drugs and Products℠ Program is a service to assist persons treated with listed specialty drugs and is paid for by a group health plan, health and welfare fund or trust. Enrollment in the Select Drugs and Products℠ Program is required in order to access the payable benefits available for specialty drugs under the Plan. Please call the Select Drugs and Products℠ Program at (877) 869-7772 for further information about your specialty drug needs. A case coordinator is available M-F 8AM to 8PM CT to speak to you.
6. Who is PaydHealth?
    - *PaydHealth* is a service company that administers the Select Drugs and Products℠ Program. Please call the Select Drugs and Products℠ Program at (877) 869-7772 for

Paydhealth

Select Drugs and Products℠ Program

What happens after I enroll in the Select Drugs and Products Program?

After enrolling in the Select Drugs and Products Program, you will be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program from you and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

Your Case Coordinator will help you obtain your eligible specialty drugs, products or services and reduce your out-of-pocket costs by coordinating alternative forms of funding. After your acceptance into an alternate funding program, your Case Coordinator will contact you before and after each refill to ensure there is no disruption in your treatment and the funding.

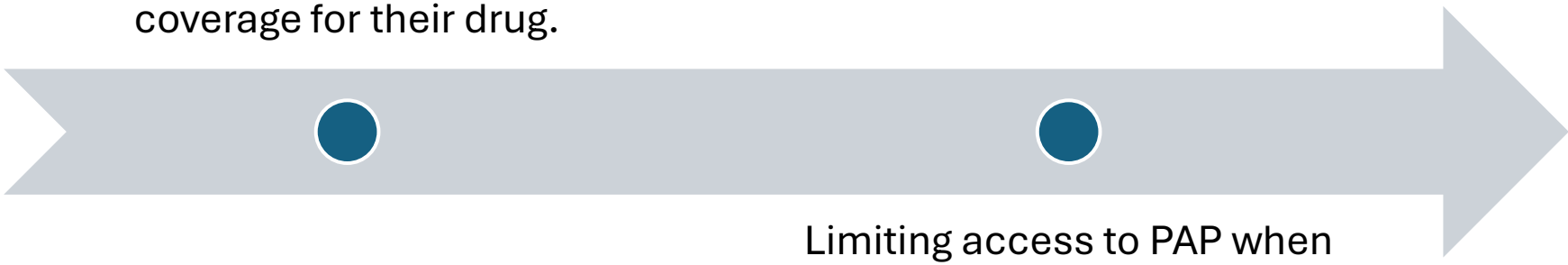
Select Drugs and Products℠ Program

Select Drugs and Products℠ Program
Questions & Answers

1. Is specialty *Drug X* covered by the Plan?
    - Yes, all brand specialty drugs are covered by the Plan. The member out-of-pocket is the full cost of the claim after the network rate is applied. Enrollment in the Select Drugs and Products℠ Program is mandatory, or a non-compliance penalty may apply resulting in the member's out-of-pocket charge being equal to the full cost excluding network rate. Please call the Select Drugs and Products℠ Program at (877) 869-7772 for further information about your specialty drug needs. A case coordinator is available M-F 8AM to 8PM CT to speak to you.
    - [For more detail, refer to the benefit summary and the Plan's Specialty Drug List.]
2. Is there a deductible for specialty drugs?
    - Yes, specialty drugs paid by the plan are subject to a deductible. However, non-compliance penalties are excluded from the deductible accumulator and members are subject to such penalties should they not completed enrollment and adjudication by the Select Drugs and Products℠ Program. Please call the Select Drugs and Products℠ Program at (877) 869-7772 for further information about your specialty drug needs. A case coordinator is available M-F 8AM to 8PM CT to speak to you.
    - [For more detail, refer to the benefit summary.]

Manufacturer Response:

Doing their own benefits investigations when a patient is shown to have insurance but not coverage for their drug.



Limiting access to PAP when alternative funding is identified.

Unintended Consequences:

- Manufacturers limiting eligibility for patient assistance programs.
- Cost increases for those who are paying for the drugs – commercial plans, Medicaid, and Medicare.
- Patients left without access to drug.

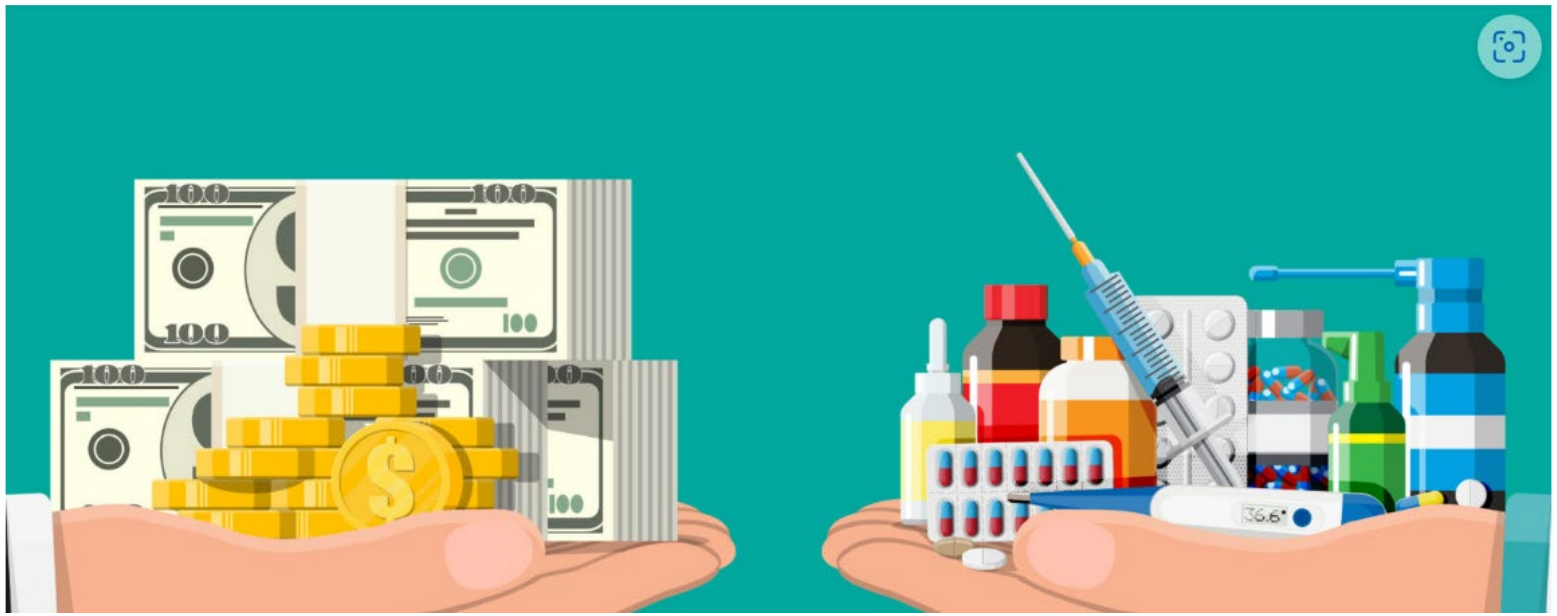
PHARMALOT

STAT+

AbbVie sues a behind-the-scenes company for exploiting its patient assistance program

By Ed Silverman May 11, 2023

Reprints



Payer Matrix Response:

Leading Patient Advocate Slams AbbVie's Moves to Deny Vital Drugs to Needy Patients

NEWS PROVIDED BY
Payer Matrix →
23 May, 2023, 08:03 ET

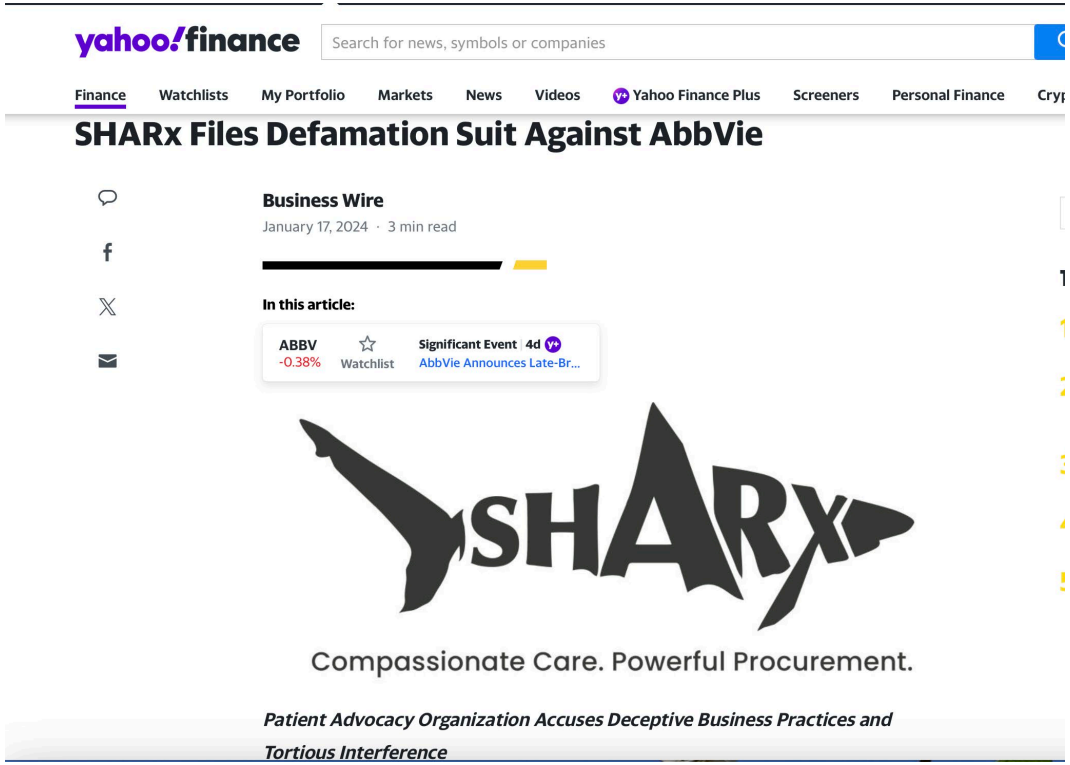
SHARE THIS ARTICLE

Payer Matrix vows to fight "meritless" lawsuit by $58 billion Pharma giant

MEDIA, Pa., May 23, 2023 /PRNewswire/ -- Payer Matrix, a patient advocacy company, responded publicly today for the first time since a lawsuit was filed against it by AbbVie, the $58 billion pharmaceutical giant.

"AbbVie's meritless lawsuit is based on a fundamental misunderstanding of what our company does and those we serve: people with very serious and complex illnesses who lack the means to pay for very costly specialty drugs," said Michael Jordan, Chief Business Officer of Payer Matrix. "We will vigorously defend our business and our clients against the scurrilous claims by AbbVie, and use this as an opportunity to demonstrate the tremendous value our advocacy services deliver for the people who depend on these exorbitantly priced medications."

AFVs Fight Back…

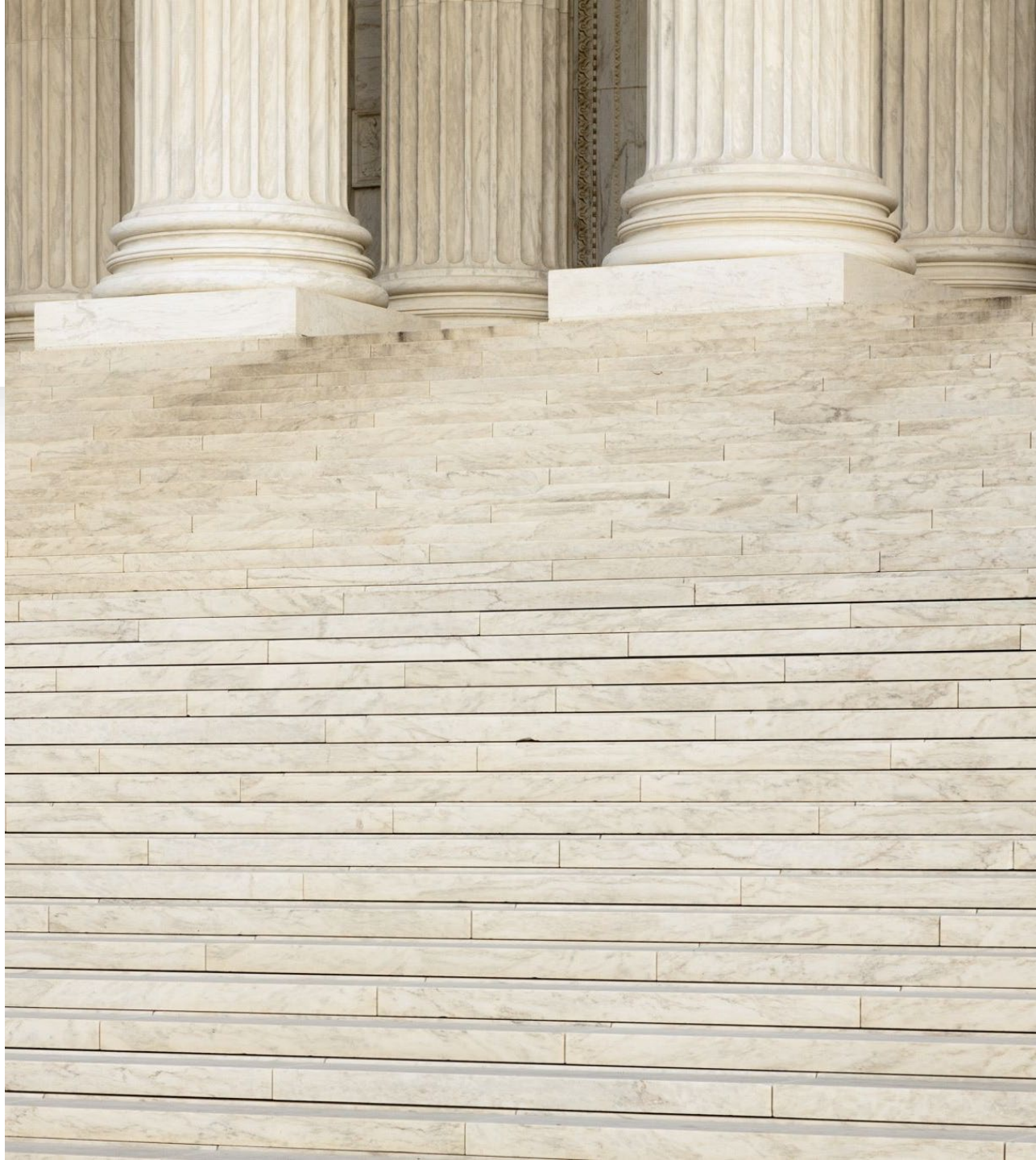


Paydhealth

sues patient advocate for defamation.

So what can we do?

- Meetings with agencies who have oversight authority over different areas of concern (DOL, FTC, etc.)
- Compile and share patient stories with the Hemophilia Alliance, NBDF to share with agencies.
- Contact your representative and senators to ask them to put pressure on the tri agencies to look into these schemes.
    - Legislation is the slowest option but the most likely to finallyut an end to these practices.
    - Request Congress hold hearings on these schemes to bring light to their operations.



If possible document timeline of events with corresponding exhibits.

TIMELINE OF EVENTS:

Oct 2023 – MEMBER received multiple open enrollment communications; each documenting the November 3rd deadline to make/change elections for the 2024 plan year including explicit language stating the following: *"If you do **NOT** go in and make any changes, you will have the same coverage as you do this year"* **(Exhibit A)**

11/03/2023 - MEMBER elected to make no changes during open enrollment to maintain the same benefits his family in 2023.

11/29/2023 – PATIENT received a postal letter dated 11/28/2023 **(Exhibit B)** from an Ai-ja Jackson of PAYER MATRIX, welcoming them to the PAYER MATRIX program. The letter states PATIENT would receive his specialty medications in the same manner he was receiving today and provided a check list of items, including the need to provide pay stubs, W2 or 1040 by December 6th to obtain financial support for his hemophilia medication KOVALTRY, (**Exhibit C)**

- MOM expressed serious concerns given they had no knowledge who PAYER MATRIX was, how they knew what medication their son was taking, or why they would be required to share sensitive financial data in order to access the plans pharmacy benefit; none of which was required to receive his medications today.

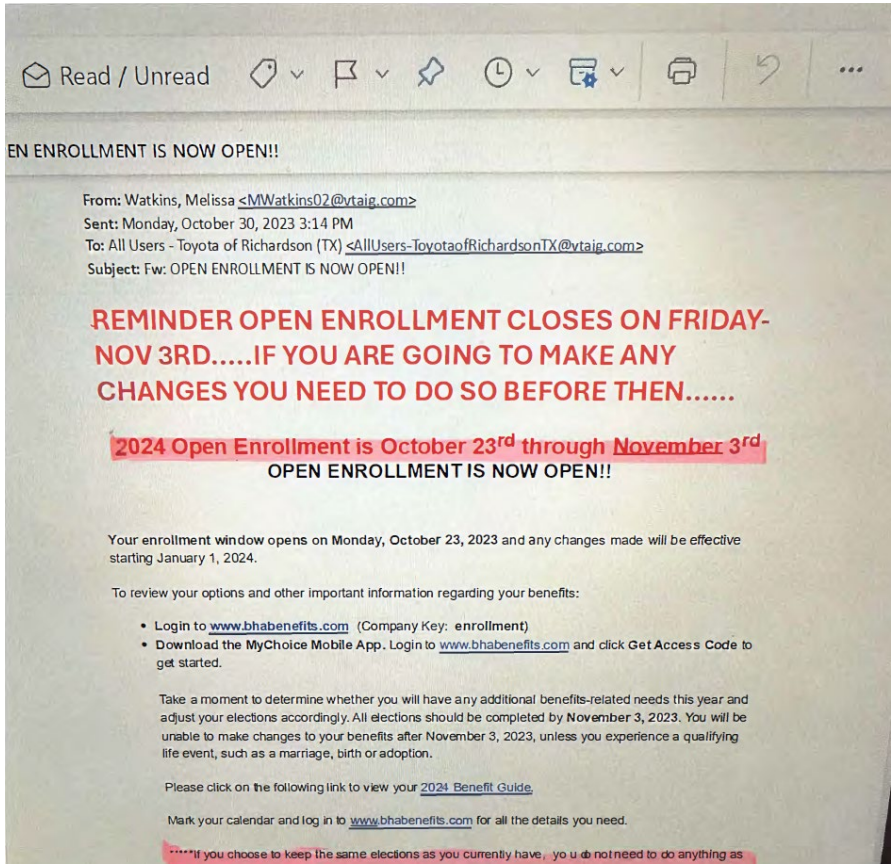
11/29/2023 – PAYER MATRIX's team members Aija Jackson and Haley Mesaros followed up the 'welcome letter' with a 'welcome phone call' with the PATIENT, to discuss the forms that would be required. Immediately after the call, the PATIENT received a follow up email **(Exhibit D)** with the attached required forms. **(Exhibit E)**

11/29/2023 – MOM places a call to EMPLOYER, to find out who PAYER MATRIX was. EMPLOYER directs MOM to Katherine Lopez at BHA. BHA directs MOM to Jackie Barber at DBP. MOM speaks with Nancy Austin, a member of Jackie Barbers team, who says she will investigate MOM's questions and get back with her.

11/30/2023 – MOM sends email to Haley Mesaros at PAYER MATRIX. **(Exhibit F)**

-Haley and Ai-Ja of PAYER MATRIX communicated directly with the PATIENT, during the welcome phone call, and subsequent email (Exhibit D) leaving the

Collect de-identified patient case documentation



Read / Unread

EN ENROLLMENT IS NOW OPEN!!

From: Watkins, Melissa <MWatkins02@vtaig.com>
Sent: Monday, October 30, 2023 3:14 PM
To: All Users - Toyota of Richardson (TX) <AllUsers-ToyotaofRichardsonTX@vtaig.com>
Subject: Fw: OPEN ENROLLMENT IS NOW OPEN!!

REMINDER OPEN ENROLLMENT CLOSES ON FRIDAY-NOV 3RD.....IF YOU ARE GOING TO MAKE ANY CHANGES YOU NEED TO DO SO BEFORE THEN.....

2024 Open Enrollment is October 23rd through November 3rd
OPEN ENROLLMENT IS NOW OPEN!!

Your enrollment window opens on Monday, October 23, 2023 and any changes made will be effective starting January 1, 2024.

To review your options and other important information regarding your benefits:

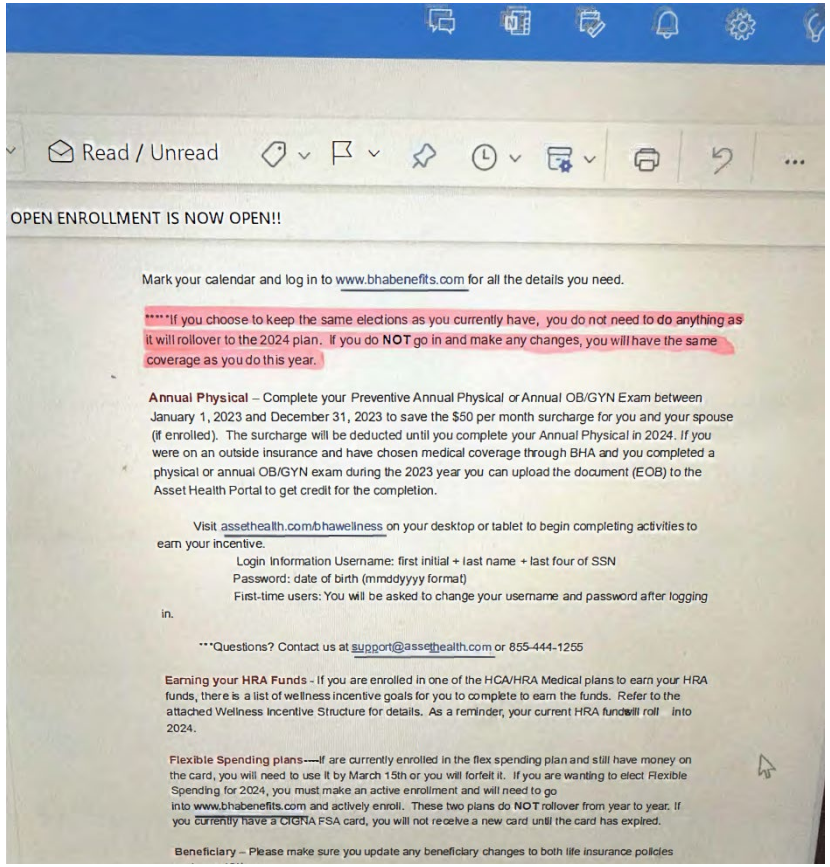
- Login to www.bhabenefits.com (Company Key: enrollment)
- Download the MyChoice Mobile App. Login to www.bhabenefits.com and click Get Access Code to get started.

Take a moment to determine whether you will have any additional benefits-related needs this year and adjust your elections accordingly. All elections should be completed by November 3, 2023. You will be unable to make changes to your benefits after November 3, 2023, unless you experience a qualifying life event, such as a marriage, birth or adoption.

Please click on the following link to view your 2024 Benefit Guide.

Mark your calendar and log in to www.bhabenefits.com for all the details you need.

*****If you choose to keep the same elections as you currently have, yo u do not need to do anything as



Read / Unread

OPEN ENROLLMENT IS NOW OPEN!!

Mark your calendar and log in to www.bhabenefits.com for all the details you need.

*****If you choose to keep the same elections as you currently have, you do not need to do anything as it will rollover to the 2024 plan. If you do **NOT** go in and make any changes, you will have the same coverage as you do this year.

Annual Physical – Complete your Preventive Annual Physical or Annual OB/GYN Exam between January 1, 2023 and December 31, 2023 to save the $50 per month surcharge for you and your spouse (if enrolled). The surcharge will be deducted until you complete your Annual Physical in 2024. If you were on an outside insurance and have chosen medical coverage through BHA and you completed a physical or annual OB/GYN exam during the 2023 year you can upload the document (EOB) to the Asset Health Portal to get credit for the completion.

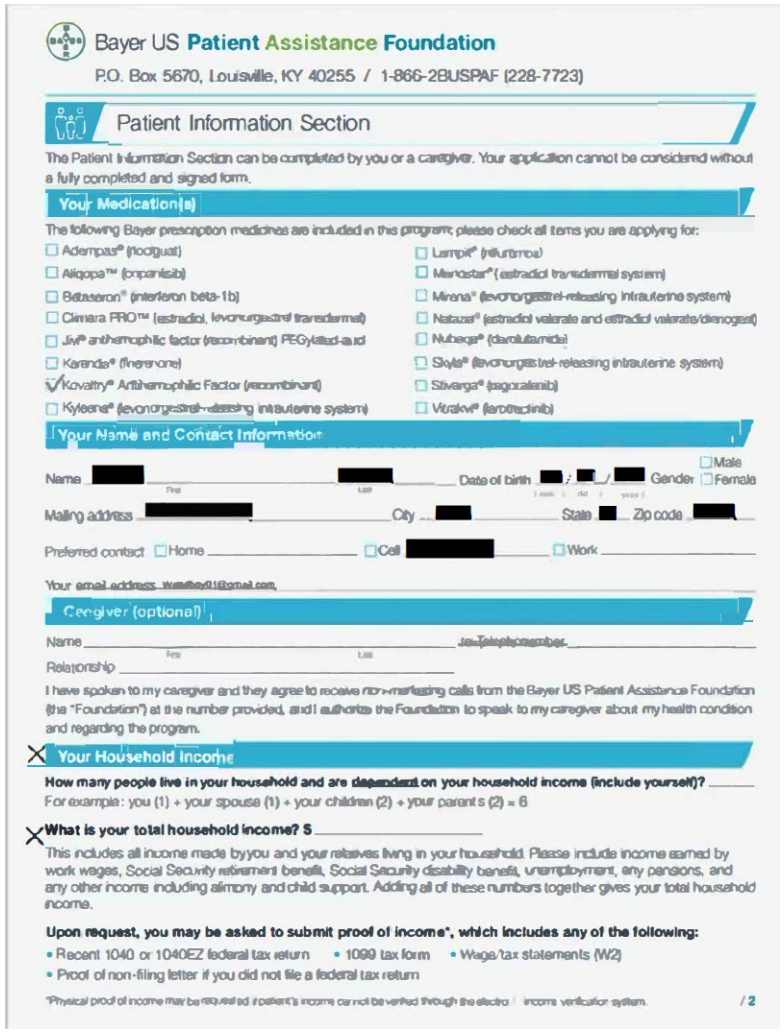
Visit assethealth.com/bhawellness on your desktop or tablet to begin completing activities to earn your incentive.
Login Information Username: first initial + last name + last four of SSN
Password: date of birth (mmddyyyy format)
First-time users: You will be asked to change your username and password after logging in.

***Questions? Contact us at support@assethealth.com or 855-444-1255

Earning your HRA Funds - If you are enrolled in one of the HCA/HRA Medical plans to earn your HRA funds, there is a list of wellness incentive goals for you to complete to earn the funds. Refer to the attached Wellness Incentive Structure for details. As a reminder, your current HRA funds will roll into 2024.

Flexible Spending plans----If are currently enrolled in the flex spending plan and still have money on the card, you will need to use it by March 15th or you will forfeit it. If you are wanting to elect Flexible Spending for 2024, you must make an active enrollment and will need to go into www.bhabenefits.com and actively enroll. These two plans do **NOT** rollover from year to year. If you currently have a CIGNA FSA card, you will not receive a new card until the card has expired.

Beneficiary – Please make sure you update any beneficiary changes to both life insurance policies



Bayer US **Patient Assistance Foundation**

P.O. Box 5670, Louisville, KY 40255 / 1-866-2BUSPAF (228-7723)

Patient Information Section

The Patient Information Section can be completed by you or a caregiver. Your application cannot be considered without a fully completed and signed form.

Your Medication(s)

The following Bayer prescription medicines are included in this program; please check all items you are applying for:

- ☐ Adempas® (riociguat)
- ☐ Aliqopa™ (copanlisib)
- ☐ Betaseron® (interferon beta-1b)
- ☐ Climara PRO™ (estradiol, levonorgestrel transdermal)
- ☐ Jivi® antihemophilic factor (recombinant) PEGylated-aucl
- ☐ Kerendia® (finerenone)
- ☑ Kovaltry® Antihemophilic Factor (recombinant)
- ☐ Kyleena® (levonorgestrel-releasing intrauterine system)
- ☐ Lumoxiti® (moxetumomab pasudotox-tdfk)
- ☐ Menostar® (estradiol transdermal system)
- ☐ Mirena® (levonorgestrel-releasing intrauterine system)
- ☐ Natazia® (estradiol valerate and estradiol valerate/dienogest)
- ☐ Nubeqa® (darolutamide)
- ☐ Skyla® (levonorgestrel-releasing intrauterine system)
- ☐ Stivarga® (regorafenib)
- ☐ Vitrakvi® (larotrectinib)

Your Name and Contact Information

Name [redacted] (First) (Last) Date of birth [redacted] Gender ☐ Male ☐ Female

Mailing address [redacted] City [redacted] State [redacted] Zip code [redacted]

Preferred contact ☐ Home ☐ Cell [redacted] ☐ Work

Your email address [redacted]

Caregiver (optional)

Name (First) (Last) Telephone number

Relationship

I have spoken to my caregiver and they agree to receive non-marketing calls from the Bayer US Patient Assistance Foundation (the "Foundation") at the number provided, and I authorize the Foundation to speak to my caregiver about my health condition and regarding the program.

Your Household Income

How many people live in your household and are dependent on your household income (include yourself)? _____

For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $ _____

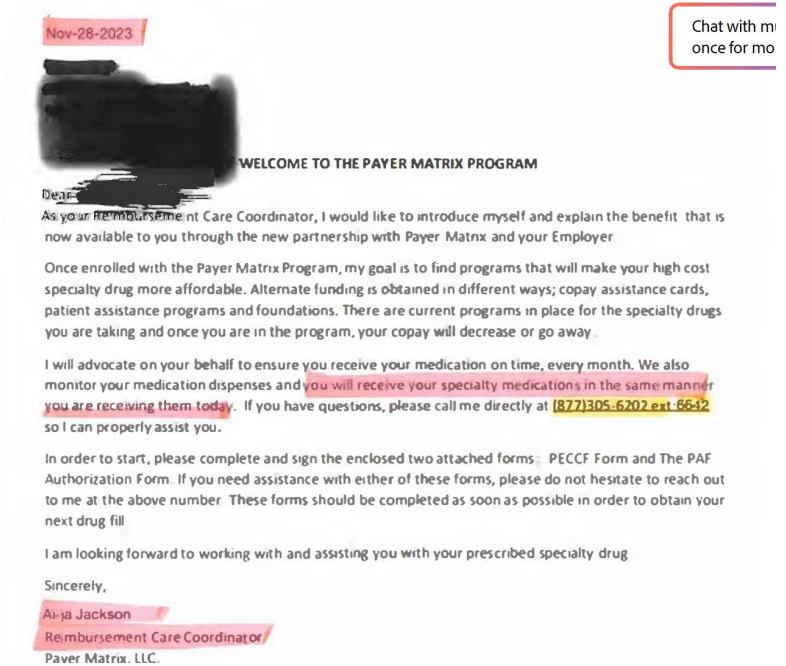
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

Upon request, you may be asked to submit proof of income*, which includes any of the following:

- Recent 1040 or 1040EZ federal tax return
- 1099 tax form
- Wage/tax statements (W2)
- Proof of non-filing letter if you did not file a federal tax return

*Physical proof of income may be required if patient's income cannot be verified through the electronic income verification system.

/ 2



Nov-28-2023

Chat with m
once for mo

[redacted]

WELCOME TO THE PAYER MATRIX PROGRAM

Dear [redacted]

As your Reimbursement Care Coordinator, I would like to introduce myself and explain the benefit that is now available to you through the new partnership with Payer Matrix and your Employer

Once enrolled with the Payer Matrix Program, my goal is to find programs that will make your high cost specialty drug more affordable. Alternate funding is obtained in different ways; copay assistance cards, patient assistance programs and foundations. There are current programs in place for the specialty drugs you are taking and once you are in the program, your copay will decrease or go away.

I will advocate on your behalf to ensure you receive your medication on time, every month. We also monitor your medication dispenses and you will receive your specialty medications in the same manner you are receiving them today. If you have questions, please call me directly at (877)305-6202 ext 6642 so I can properly assist you.

In order to start, please complete and sign the enclosed two attached forms: PECCF Form and The PAF Authorization Form. If you need assistance with either of these forms, please do not hesitate to reach out to me at the above number. These forms should be completed as soon as possible in order to obtain your next drug fill.

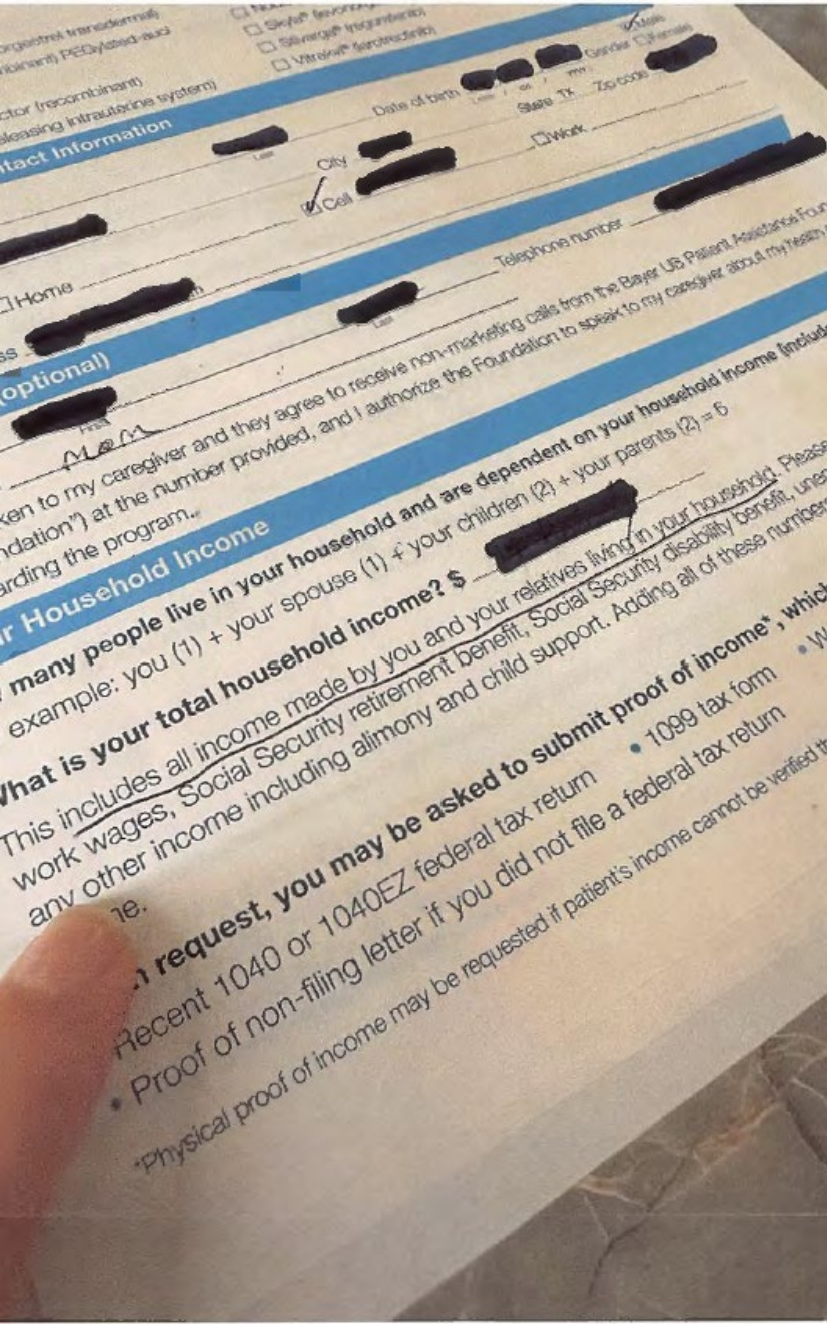
I am looking forward to working with and assisting you with your prescribed specialty drug.

Sincerely,

Aaja Jackson
Reimbursement Care Coordinator
Payer Matrix, LLC.

Collect de-identified patient case documentation

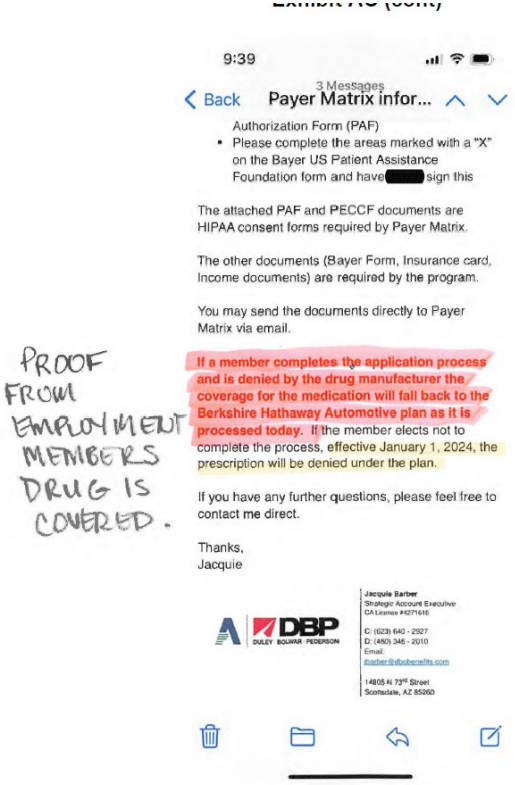
Collect de-identified patient case documentation



Ms Barber,

Spoke with Monica at Bayer patient assistance foundation about only submitting financials as you stated in your previous email. The application states total household income including parents and Lying on this application is insurance fraud . I refuse to commit fraud for financial gain by payer matrix or Berkshire Hathaway. Encouraging me or my son to lie isn't ethical.
Sincerely,

(1)



Previous page Payer Matrix states we are not a requirement of coverage. BUT here it is now stating if you don't engage with PM you will be denied. Proof it is covered and clearly the messaging from each party is not alligning.

Example patient required to sign authorization form and PM auto checked the boxes that member would release his mental health records.

PayerMatrix ! *Please complete, sign, and return to: Payer Matrix, LLC, 1400 N Providence Road, Suite 5000, Media, PA 19063*
Ph: (877) 305-6202 | Fax: (484) 494-6202 | Email: CustomerService@PayerMatrix.com

PATIENT AUTHORIZATION FORM

The purpose of this Authorization, to the extent my permission is required under HIPAA and any other applicable state and federal law, is to authorize the disclosure of my protected health information ("PHI") as set forth below for the purpose of Payer Matrix, LLC ("Payer Matrix") contacting Patient Assistance Programs or other private or public pharmaceutical assistance programs (collectively, "PAPs"), other pharmaceutical cost containment programs, copay card programs, and foundations (collectively, "Programs") to obtain free or reduced-charge medications on my behalf, provide a good faith effort to obtain cost reductions for me and my health plan(s), to determine my eligibility for participation in private or public Programs, if necessary, to account for and assist with my withdrawal from a Program and/or transfer to a separate Program, to act as my representative to a Program to confirm enrollment and to track my prescription dispenses and deliveries, and other activities reasonably related to a Program (collectively, "Services").

I specifically authorize my health care providers, health care insurers, pharmacies, and laboratory testing facilities who are reasonably connected with my receipt of the medications that are the subject of the Services, and Payer Matrix (each an "Entity" and collectively [redacted] isclose my PHI as necessary to perform the Services, except for the following parties (if any): ☐ _____

I specifically authorize the release of my medical records which relate to the prescription medications that are the subject of the Services (including patient history, office notes (except psychotherapy notes), billing records, insurance records, and records sent to the [redacted] by other health care providers), excluding the following (if any):
_____

I specifically authorize the release of the following information:
☒ Substance Abuse and Disorder Information, including Alcohol and Drug Use
☒ Mental Health Information ☐ Reproductive Health Information & STDs
☐ HIV/AIDS-Related Information ☐ Other: _____

I understand that any prescription drug access assistance received by me in the form of a product subsidy, or a medication dispensed to me at no cost is contingent upon my ability to meet the eligibility criteria of the Program.

In the event that I am eligible for a Program, I acknowledge that participation is temporary and that I may be asked to reapply at designated intervals as determined by the Program. I understand that a Program may be changed or discontinued at any time, and at such times those services will no longer be provided.

I understand that I am not required to sign this Authorization and that Entity will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. However, I understand that if I do not sign this Authorization, I will not be able to participate in the Payer Matrix Program.