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March 12, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

Re: AHIP Opposes SB 1019 (Rebates and Calculation of Cost Sharing Requirements)

Dear Chair Beidle:

On behalf of AHIP and our members, I appreciate the opportunity to provide comments to the Senate Finance Committee on Senate Bill 1019 concerning rebates and calculation of cost sharing requirements. AHIP opposes SB 1019 because it does nothing to help uninsured patients afford the drugs they need.

Drug prices continue to rise with no end in sight, and hardworking families feel the consequences every day. The original list price of a drug, determined solely by the drug manufacturer, drives the entire pricing process. The problem is the price: If the original list price is high, then the final cost patients pay will be high. This bill will increase health insurance premiums by requiring carriers to forfeit the savings achieved through manufacturer rebates, and instead provide point-of-sale (POS) rebates to a select group of enrollees. If pharmaceutical manufacturers wish to make drugs more affordable for patients, then the solution is easy: they should lower the price of their drugs.

POS rebates only benefit a small number of consumers. Rebates are generally offered by manufacturers only when there are two or more competing drugs within the same therapeutic class. To help lower costs, carriers and PBMs leverage these competing drugs when negotiating with manufacturers. The savings from rebates are passed on to all enrollees through improvements to benefit packages, reductions in premiums, and/or lower out-of-pocket costs. SB 1019 eliminates the shared benefit all consumers receive when carriers and PBMs negotiate rebates on costly drugs. POS rebates won't help most patients who take generic drugs, which account for more than 90% of the market.[1] This bill will also not help patients who take brand name drugs that do not have competition in their therapeutic class, since rebates are generally not offered for those drugs. The California Health Benefits Review Program (CHBRP) estimates that a similar bill would only impact 3.48% of all prescriptions.[2]

POS rebates will raise the cost of health insurance for Marylanders. The focus on how savings are distributed is a deliberate tactic by pharmaceutical manufacturers to avoid addressing the more serious issues surrounding the lack of competition, transparency, and accountability in the pricing of prescription drugs. POS rebate proposals have repeatedly been found to have a high price tag and AHIP has strong concerns about the impact these requirements will have on insurance costs in Maryland.

When a similar mandate was adopted in the Medicare Part D program, CMS's own actuaries estimated that ***it would increase premiums by 25%, cost taxpayers between $200 and $400 billion, and lead to a $137 billion windfall for pharmaceutical manufacturers.***[3] The California bill mentioned earlier was

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[1] NCSL. https://www.ncsl.org/research/health/generic-retail-drug-pricing-and-states.aspx

[2] Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing. California Health Benefits Review Program. www.chbrp.org/sites/default/files/bill-documents/AB933/AB%20933%20Abbreviated%20Report%2001042022%20FINAL.pdf.

[3] Rebate Rule a Big Pharma Bailout Paid For on The Backs Of American Seniors And Taxpayers. CSRxP. https://www.csrxp.org/rebate-rule-a-big-pharma-bailout-paid-for-on-the-backs-of-american-seniors-and-taxpayers/

estimated to ***increase health insurance premiums by $200 million annually.***[4] The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost; similarly, Congress has continually disallowed the federal "rebate rule" to take effect.

A mandate to provide POS rebates is incredibly difficult to operationalize. In addition to the cost of these programs, requiring rebates to be passed on to consumers at the point of sale represents an enormous administrative challenge because rebates are not paid by pharmaceutical manufacturers in real time. Rebates are paid retrospectively to carriers and PBMs based on several factors, including the volume of prescriptions utilized by the plan's members. Manufacturers have no requirement to pay rebates within a defined time, and they are often not paid until long after the plan year ends. At the end of the plan year, carriers and PBMs will need to account for any gaps between rebates anticipated and the amount of rebates actually received; this would likely have to be done through higher premiums or increased cost sharing.

Given these concerns, AHIP urges you to not move SB 1019 forward. AHIP's member plans are eager to continue to work to fight for more affordable medications for all Maryland patients, families, and employers. Unfortunately, this bill is not the answer.

Thank you for your consideration of our comments on this important issue.

Sincerely,

Keith Lake
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AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

[4] Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing. California Health Benefits Review Program. www.chbrp.org/sites/default/files/bill-documents/AB933/AB%20933%20Abbreviated%20Report%2001042022%20FINAL.pdf.