Testimony in Favor of SB-1019, Maryland Share the

Uploaded by: Alonzo Washington
Position: FAV

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THE SENATE OF MARYLAND
Annapolis, Maryland 21401

Testimony in Favor of SB-1019, Maryland Share the Savings Act

When citizens across the country go to get their prescriptions filled today, they will have to pay exorbitant amounts for these life-saving medications—even with insurance. Insurance is designed to help people pay for their medical expenses, but as it currently stands, it is helping companies make an extra profit.

In 2022, health insurers made over $40 billion in profits off the necessities of people across the country needing medical care. There are a few reasons for these record-breaking revenue numbers. Firstly, the cost of medical care and prescriptions in the United States is one of the highest in the world. This high cost of care requires consumers to take out insurance plans to not go bankrupt paying for the care they need and deserve. However, this contract, often signed out of desperation, is not fair. As it currently stands, consumers pay much more than insurers for things they need, but in many cases, they cannot afford to pay out of pocket.

Now, it is getting more difficult for Marylanders to pay, even with insurance. This bill seeks to address this issue by creating a more equitable cost-sharing by requiring the insurer to provide at least 85% of the total amount of rebates to be subtracted from a prescription drug's listing price.

This allows the monetary benefits that companies receive to be passed on to the consumer, not just the drawbacks and price increases. It would be an essential win toward affordable prescription drugs for all Marylanders. By requiring price sharing between insurers and the insured, we can offset the inequality in pricing. This is because, in many cases, the consumer pays the full list price, while private entities often negotiate discounts but do not pass that discount on to their customers.

By passing this bill, Maryland would show a commitment to putting people over profit. After all, we cannot "leave no one behind" if we leave our citizens in debt and poverty as they try to pay for the prescriptions they need to exercise their rights to life, liberty, and the pursuit of happiness.

For these reasons, I request a favorable committee report on SB-1019.

MD SB1019 Written Testimony.pdf
Uploaded by: Claire Sachs
Position: FAV

TPAC CONSULTING
HEALTHCARE EXPERIENCE PATHFINDER

The Patient Advocate's CHRONICLE

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Maryland Senate Finance Committee
11 Bladen St.
Annapolis, MD 21401

Re: Support for SB 1019

March 13, 2024

Chair Beidle, Vice Chair Klausmeier, and members of the committee,

Thank you for the opportunity to testify about pharmacy benefits managers today. In addition to my oral testimony, I would like to submit for your information a blog post I wrote. It is an open letter to Cigna upon their acquisition of Express Scripts, pleading for a change in business practices. I have attached a copy, or it can be found here: https://tinyurl.com/484j9phv

Sincerely,
Claire Sachs

Founder, TPAC Consulting
Advocate-in-Chief, The Patient Advocate's Chronicle

An Open Letter to CIGNA

March 13, 2018 Claire Sachs

Dear Mr. Cordani,

I hear you are buying Express Scripts. This letter is a plea from a former Express Scripts customer to closely scrutinize their business practices, which, during the time I patronized them, were burdensome at best and actively harmful at worst. I am not talking about a "simple" denial of services, but policies that substituted the company's experts, whomever they were, for both the judgment of a provider who knew the case, and long-accepted medical standards.

Several years ago, my former employer switched pharmacy benefit management (PBM) organizations after only three years, from Express Scripts to CVS. For a company with over 20,000 employees, that was an incredibly short span for such a cumbersome change. I suspect it had more to do with employee complaints than some kind of better deal. In my account alone, the lighter transgressions consisted of: dropping two asthma medications in the space of a year, discontinuing access to the type of insulin that was specifically engineered to work well in insulin pumps, and changing the policy for blood glucose testing strips to go from rounding up to rounding down. The latter cost me 100 strips per quarter, which is a lot for someone who tested 8-10 times a day.

With my background, I always understood that plan coverage fluctuates. It is the literal cost of doing business. The real issue with all of those changes was that they were implemented in the middle of calendar years ***without notification***. In fact, I knew nothing of any of these changes until I tried to renew the various prescriptions.

But as I mentioned, this was not the most egregious thing Express Scripts did. No, that label is reserved for the fiasco that occurred around Aranesp. Aranesp is an expensive anemia treatment often administered to cancer patients by a physician to counteract the effects of chemotherapy. In July 2012, The Washington Post published an expose detailing how Amgen, which makes Aranesp, was inflating costs, and some medical providers were purposely misusing it to make a bigger profit. As a result (presumably), Express Scripts acted to limit access to Aranesp across the board, lumping all patients who used it into one group.

Huge violation all the way around, I know, and all of those who were taking advantage of the system should have been investigated and punished. However, there were those of us with milder conditions than cancer or kidney failure (another common cause of anemia) who self-administered very small doses. We required a blood test and prior authorization for each prescription refill. Under those circumstances, the chances of us abusing our insurance plans was virtually nil.

Shortly after that article was published, Express Scripts instituted a policy where they decided they knew better than the entire medical community, as well as the patient's (sometimes multiple) doctors, who were more familiar with the details of individual cases. Against the protests of both patients and doctors, they lowered the qualification for receiving Aranesp from a hemoglobin result of 11 to a 10, effectively putting it out of reach for those of us without severe anemia. No matter how many appeals Express Scripts received, they would make no exceptions for me or any of my doctors' other patients.

Maybe to Express Scripts, it didn't seem like such a big deal. It was just a point's difference. Many of us with chronic condition-induced anemia fell into that category. We had mild cases, but we couldn't fix it with more leafy greens and red meat. And I can't take iron pills or liquid. They all give me a rash. Ironic, isn't it? An anemic who can't tolerate taking iron. I even tried putting the liquid in Jell-O. Tasted like I was sucking on pennies. And it still gave me a rash.

What did that mean for me? Sometimes I struggled for breath, and I felt sluggish and foggy all the time, which affected my job performance. It wasn't a great quality of life then, and so easily fixable. The low likelihood of misuse should have warranted at least an individual assessment. But no, Express Scripts lumped us all together, as if all patients and all diseases were equal. But we are individuals, with individual needs and diseases that are as unique as fingerprints.

As far as I am concerned, what Express Scripts did in 2012 was ethically and morally wrong. So, please, as our healthcare system turns to a more value-based, patient-inclusive model, I implore you to closely evaluate all of Express Scripts' harmful policies and decide what is right, not just for your business, but also for the patients who have no other choice but to use it.

Sincerely,
Claire Sachs
Founder, The Patient Advocate's Chronicle

SB1019_FAV_MedChi_Health Benefit Plans - Prescript

Uploaded by: Danna Kauffman

Position: FAV

MedChi

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TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Alonzo T. Washington

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone

DATE: March 13, 2024

RE: **SUPPORT** – Senate Bill 1019 – *Health Benefit Plans – Prescription Drugs – Rebates and Calculation of Cost Sharing Requirements*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 1019. Among other provisions, this bill requires a carrier and a pharmacy benefits manager (PBM) that provides services on behalf of a carrier to base the calculation of an enrollee's contribution toward cost sharing for a prescription drug on the list price of the drug reduced by at least 85% of the reasonable estimated total amount of rebates to be received by the carrier or PBM. The contribution must be calculated at the point of sale.

Ensuring that patients have access to affordable health care is a priority of MedChi. This Session, there have been several bills aimed at reducing costs. Senate Bill 1019 provides one tool in the continuum to ensure that any rebates received by the carrier or PBMs from the manufacturer are passed to patients and are accounted for in their cost sharing, which should translate into immediate financial relief for patients. We urge a favorable report on Senate Bill 1019.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

SB1019_FAV_MTC_Health Benefit Plans - Prescription
Uploaded by: Drew Vetter
Position: FAV

MARYLAND TECH COUNCIL

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Alonzo T. Washington

FROM: Andrew G. Vetter
Pamela Metz Kasemeyer
J. Steven Wise
Danna L. Kauffman
Christine K. Krone
410-244-7000

DATE: March 13, 2024

RE: **SUPPORT** – Senate Bill 1019 – *Health Benefit Plans – Prescription Drugs – Rebates and Calculation of Cost Sharing Requirements*

The Maryland Tech Council (MTC) writes in **support** of *Senate Bill 1019: Health Benefit Plans – Prescription Drugs – Rebates and Calculation of Cost Sharing Requirements*. We are a community of nearly 800 Maryland member companies that span the full range of the technology sector. Our vision is to propel Maryland to become the number one innovation economy for life sciences and technology in the nation. We bring our members together and build Maryland's innovation economy through advocacy, networking, and education.

This bill would base a patient's share of a prescription drug on the list price of the drug reduced by at least 85% of the reasonable estimated total of rebates received by an insurance carrier or pharmacy benefits manager (PBM). Negotiations between drug manufacturers, insurance carriers, and PBMs result in significant rebates and discounts that go from manufacturers to the carriers and PBMs. Under current law, those carriers and PBMs are free to keep the entire benefit of that rebate amount. Under this legislation, however, those carriers and PBMs would have to share at least 85% of those savings with patients.

Prescription drug affordability has been a major focus of the Maryland General Assembly, and separate legislation is being considered to expand the authority of the Prescription Drug Affordability Board. As MTC testified during the hearing on that legislation, we do not believe such an expansion will have the intended effect of lowering costs for patients. We believe that the solution offered in Senate Bill 1019 would provide immediate relief to patients. If insurers and PBMs are required to share the savings they negotiate with manufacturers with patients, patients see an immediate benefit. We urge a favorable report on Senate Bill 1019.

ATAP Support Letter - MD SB 1019 03.13.24.pdf

Uploaded by: ELENI VALANOS

Position: FAV

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

March 13, 2024

Re: Support for Maryland SB 1019

Dear Chairperson Beidle, Vice Chairperson Klausmeier, and Members of the Senate Finance Committee:

On behalf of the Alliance for Transparent and Affordable Prescriptions (ATAP), a coalition of twenty-five patient and provider groups, I am writing to express our support for **Maryland SB 1019** and ask that the committee advance this legislation. **SB 1019** seeks to ensure that patients do not pay inflated costs for their prescriptions by increasing transparency and accountability for Pharmacy Benefit Managers (PBMs).

ATAP is concerned about the role PBMs play regarding the alarming price increases in the total cost and out-of-pocket costs of prescription drugs for patients, resulting in the loss of patient access to affordable and life-saving medications. As you may be aware, PBMs are third-party entities that are hired by insurers and health plan sponsors to manage and administer prescription drug benefit plans. Using their intermediary position, Pharmacy Benefit Managers (PBMs):

- Negotiate rebates and discounts with pharmaceutical manufactures in exchange for including the manufacturer's drug on the PBMs tiered formulary.
- Determine which patient medication the PBM will cover and how much the patient will pay for their medication per the tiered formularies.
- Negotiate rebates and discounts for medications, meant to drive down the cost of medications for patients, which are pocketed by the PBMs within opaque contracts.
- Prohibit pharmacists from informing patients that the copayment amount for their medications may be higher than paying the retail ("cash") price for their medication.

SB 1019 seeks to remedy these practices by requiring that 85 percent of rebates received by PBMs are passed through to patients. These reforms are an important effort to contain drug prices and discourage abuses by PBMs. ATAP would also encourage the committee to increase ATAP would also encourage the commitee to consider amending the language to require that 100 percent of rebates to be passed through—which would ensure patients are even beter able to afford their prescription medications at the pharmacy counter.

ATAP is happy to be a resource as the committee considers **SB 1019.** If you have any questions about our position, or if you would simply like to learn more about how PBMs operate in the marketplace, please contact: Eleni Valanos at evalanos@hhs.com.

Sincerely,

Robert W. Levin, MD

President, Alliance for Transparent and Affordable Prescriptions (ATAP)

NMSS Shannon Wood SB 1019 Testimony Favorable.pdf
Uploaded by: Shannon Wood
Position: FAV

National Multiple Sclerosis Society: Testimony in Support of SB 1019
Shannon Wood, Director of Advocacy and Policy
Senate Finance Committee

Chair Beidle, members of the Senate Finance Committee. Thank you for the opportunity to offer testimony in support of SB 1019 on behalf of the National Multiple Sclerosis Society.

Multiple sclerosis (MS) is a disease of the central nervous system characterized by inflammation, demyelination and degenerative changes. Symptoms vary by individual and range from numbness or tingling, to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis as well as cognitive dysfunction. People with MS may experience relapses and remissions of neurological symptoms, or symptoms may progress over time. Nearly 1 million people in the United States— more than twice the previously reported number—are living with MS, according to a landmark study.

As we discuss access to prescription drugs, it is important to note that less than 5% of the Society's annual revenues come from pharmaceutical companies. We do not take any corporate funding tied to our advocacy issues or outcomes.

Studies show that early and ongoing treatment with a disease-modifying therapy (DMT) is the best way to prevent disease progression, relapses and worsening disability. Approximately 20 different DMTs can currently be used to treat MS.

As of July 2023, the median brand price of MS DMTs was over $103,000. Time on the market also does not guarantee a reduction in cost as 5 out of 7 of the DMTs that have been on the market for at least 13 years are priced over $100,000 annually. The rising costs of drugs and changing insurance coverage disproportionately affect people with MS, causing delays and disruptions in treatment.

A study recently released by the National MS Society showed 40% of people surveyed who take a DMT altered or stopped taking their medication due to the high cost, and more than half of respondents are concerned about being able to afford their DMT over the next few years.

We support SB 1019 because it would require PBMs to pass 85% of rebate savings directly to patients at the pharmacy counter. By passing this bill, lawmakers would ensure that patients pay significantly less for essential prescriptions, improving affordability and accessibility for Marylanders.

We are grateful for the opportunity to testify on this important legislation and urge a favorable report. For any questions regarding the Society's position, please contact Shannon Wood, Director of Advocacy and Policy at shannon.wood@nmss.org.

MD Senate Finance Committee - SB1019.pdf

Uploaded by: Stephen Shaul
Position: FAV

Madam Chair, members of the committee, thank you for holding this hearing today. I speak in support of **SB1019**.

My name is Stephen Shaul. I'm a former member of the Maryland State Advisory Council on Health and Wellness. My wife and I have been Baltimore County residents for 30 years this coming September. And I've been living with Type 1 Diabetes for 33 years.

As anyone who's lived with diabetes can tell you, it requires constant work on a daily basis to maintain as healthy a condition as one can muster while requiring insulin every day. I wear an insulin pump and a continuous glucose monitor, all of which are dispensed through a Pharmacy Benefit Manager.

Rebates for PBMs on these and the drugs my wife takes for her AFib can average 48 percent, on insulin exceeding 80 percent at times. That means we overpay for prescriptions. But I have a good job now, we can afford to pay the extra money. Others aren't so lucky. They're where I was twenty-five years ago when decisions had to be made between buying another vial of insulin and paying the utilities. They're living with diabetes, with AFib, cancer, MS, and any number of other conditions and they're experiencing the same issues today that I was a quarter century ago.

Because PBMs hang onto those rebates I mentioned. Instead of using them to lower patient costs, they use them to increase corporate profits. **SB1019** calls for PBMs and health plans to actually rebate a percentage of the rebates they receive back to the patients they serve. That means hundreds of dollars every year back into the budget of Marylanders.

How will this affect premiums in the future? We know that West Virginia and Arkansas have passed similar bills, and rate filings for each state showed no increase in premiums in 2023 or 2024.

In the strongest terms possible, I'm asking that this committee help move the legislation forward. Everyone deserves access to the medications they need, and this will help them do that. Thank you for your consideration of this bill.

AHIP Comments_MD SB 1019 POS rebates_3.12.24.pdf
Uploaded by: Keith Lake
Position: UNF

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March 12, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
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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
Regional Director, State Affairs
klake@ahip.org / 220-212-8008

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.