CSRO - AAP - State - MD - Comments - HB 1246 Senat
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Position: FAV

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Coalition of State Rheumatology Organizations

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March 25, 2025

Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Re: Support HB 1246 – Copay Accumulator Adjustment Programs

Chair Beidle, Vice Chair Hayes and members of the Senate Finance Committee:

The Coalition of State Rheumatology Organizations (CSRO) supports HB 1246, which would require health plans to count third-party discounts and payments made on behalf of patients towards the patient's copayments, coinsurance, deductibles, or other out-of-pocket costs. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

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

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

Until recently, health plans would count the value of the card towards the patient's deductible. However, health insurers and pharmacy benefit managers now regularly use programs known as "copay accumulator adjustment programs." In Maryland, 50% of individual health plans reviewed in 2025 include a copay accumulator adjustment program.[i] These programs allow the patient to continue using their copay card but do ***not*** allow the copay assistance to count towards the patient's deductible or maximum out-of-pocket limit, driving great patient out-of-pocket costs. Unfortunately, these copay accumulator adjustment programs impact patients living with chronic conditions who require high-cost specialty medications, including rheumatic diseases, as well as patients who can only afford high deductible health plans.

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

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

Copay accumulator adjustment programs are harmful to patients and drive patient out-of-pocket costs. As the legislature continues to consider opportunities to address the cost of medications for patients throughout Maryland, we encourage you protect patients and support HB 1246. We thank you for your consideration and are happy to further detail our comments to the Committee upon request.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

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

DOCS-#239461-v1-HB_1246_Accumulator_in_FIN_League_

Uploaded by: Matthew Celentano

Position: FAV

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

March 27, 2025

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

House Bill 1246 - Health Benefit Plans - Calculation of Cost-Sharing Contribution - Requirements

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. **supports** *House Bill 1246 - Health Benefit Plans - Calculation of Cost-Sharing Contribution – Requirements* and urges the committee to give the bill a favorable report.

As the committee is aware, carriers and advocates spent a lot of time on the basis of this legislation during the 2024 Maryland General Assembly Session. House Bill 879 passed the chamber and was in possession of the Senate Finance Committee at the end of Session. Unfortunately, that legislation did not pass.

That bill would have, when calculating an insured's or enrollee's contribution to the insured's or enrollee's coinsurance, copayment, deductible, or out-of-pocket maximum, required a carrier to include any discount, financial assistant payment, product voucher, or other out-of-pocket expense made by or on behalf of the insured or enrollee for a prescription drug that: (1) is covered under the insured's or enrollee's health benefit plan: and (2) does not have an AB-rated generic equivalent or an interchangeable biological product preferred under the health benefit plan's formulary or, if there is such an alternative, the insured or enrollee has obtained access to a brand drug through a prior authorization, step therapy protocol, or exception or appeal process of the carrier.

This bill from last Session has been reintroduced as House Bill 1246. After lengthy debate and stakeholder engagement, HB 1246 passed out of the House with further consumer protections layered on the legislation from last year ensuring that Marylanders had the benefit of coupon dollars for an entire plan year, as well as provisions related to altering or setting conditions of the terms on a health benefit plan that was taken directly from Senate Bill 773.

HB 1246 represents a true compromise that protects consumers, and we urge a favorable report on this bill.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

HB1246_AllCopaysCountCoalition
Uploaded by: Matthew Prentice
Position: UNF

March 25, 2025

Dear Chair Beidle, Vice Chair Hayes, and honorable Senate Finance Committee Members,

The Maryland All Copays Count Coalition writes to you in <u>opposition</u> of the amended HB 1246. As advocates for millions of patients and their families, we are concerned that one amendment in HB 1246 will have unintended consequences. The language that concerns us is in section C (2), requiring pharmaceutical manufacturers to:

> *"Provide the discount, financial assistance payment, product voucher, or other out-of-pocket expense for the duration of the plan year."*

There has been considerable compromise achieved over the last two years with Senate and House versions of this legislation. We applaud the Senate for adding notification requirements to SB 773 that seek compromise with the efforts of the House.

However, with a myriad of amendments, the House is crafting a one-size-fits-all solution that will impact patients across disease states and treatment plans. **There is no precedent for this amendment in the country, thus we are understandably concerned about unintended negative consequences for Marylanders.**

On face value, we can understand the idea of requiring assistance for the duration of the plan year. It assumes that a patient will always need copay assistance and therefore will need it from the beginning to the end of their plan year. However, that isn't always the case. For many patients, their condition requires a specific treatment plan, perhaps only for a few months. In that situation, they only would seek assistance for the duration of their treatment. It is unclear how requiring assistance for the duration of the plan year would benefit these patients who only need assistance for a small amount of time.

This requirement also assumes that an individual *always* needs assistance. Patients often experience a financial hardship that creates the need for assistance. This language would suggest that if a patient receives copay assistance at any point in the plan year, the manufacturer would now be required to provide additional assistance (even if the patient isn't seeking additional assistance). Additionally, in the event a patient is on multiple medications from different manufacturers, this amendment requires that patients would be receiving "plan duration" assistance for multiple medications, even if they are no longer seeking assistance. Excessive and unwarranted amounts of assistance being provided to a

patient doesn't appear to be the goal of the amendment but could be a reality due to the varying circumstances that patients face.

The main goal of our effort for the last two years is to ensure that copay assistance counts towards a patient's out-of-pocket costs. For the communities we serve, affordability is based on their ability to reach their out-of-pocket maximum. Currently, patients will often receive a large amount of assistance at the moment they apply for it. To comply with this amendment, would manufacturers be expected to *spread* the assistance out through the plan year? We are concerned that this language results in patients not receiving the amount of assistance they need, when they need it.

A patient's condition, treatment plan, financial situation, and overall personal circumstances impact the assistance they seek and how it is provided. In the absence of a clear problem that this amendment seeks to address, we only have concerns about its eventual effect. While we understand the House Committee's intent of not wanting patients to "fall off a cliff" due to available assistance, we believe the offered solution will lead to many potential unintended consequences that would bring more confusion – and potentially harm – to patients.

For two years, the Coalition has advocated in Annapolis with the goal of ensuring that copay assistance counts for Marylanders. We've worked through numerous areas of contention and have found considerable compromise. We now find ourselves in the unfortunate position of debating how manufacturers provide assistance, instead of ensuring all copays count.

Please oppose this unnecessary amendment in HB 1246. Thank you for considering our perspective on this critical issue. We stand ready to work with you to advance policies that promote the health and welfare of all Marylanders.

Sincerely,

ALS Association
American Cancer Society Cancer Action Network
Arthritis Foundation
Chronic Care Policy Alliance
Crohn's & Colitis Foundation
EveryLife Foundation for Rare Diseases
Hemophilia Federation of America
Hemophilia Foundation of Maryland
HIV+Hepatitis Policy Institute
Immune Deficiency Foundation
Lupus and Allied Diseases Association
MedChi, The Maryland State Medical Society
National Bleeding Disorders Foundation

National Multiple Sclerosis Society
National Psoriasis Foundation
Spondylitis Association of America
Susan G. Komen
The AIDS Institute

MD HB1246_The AIDS Institute Written Testimony_Mar
Uploaded by: Naomi Gaspard
Position: UNF

March 25, 2025

Re: Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements

Dear Chair Beidle, Vice Chair Hayes and Honorable Senate Finance Committee Members:

The AIDS Institute, a non-partisan, nonprofit organization dedicated to improving and protecting health care access for people living with HIV, hepatitis, and other chronic health conditions, is writing in **opposition to the amended HB 1246.** As advocates for patients and their families, we are concerned that one amendment in HB 1246 will have unintended consequences. The language that concerns us is in section C (2), requiring pharmaceutical manufacturers to:

> *"Provide the discount, financial assistance payment, product voucher, or other out-of-pocket expense for the duration of the plan year."*

While we understand the House Committee's intent of not wanting patients to "fall off a cliff" due to available assistance, we believe the offered solution will lead to many potential unintended consequences that would bring more confusion – and potentially harm – to patients. There has been considerable compromise achieved over the last two years with Senate and House versions of this legislation. We applaud the Senate for adding notification requirements to SB 773 that seek compromise with the House. **However, there is no precedent for this amendment in the country, thus we are understandably concerned about unintended negative consequences for Marylanders.**

Even with insurance, many patients are unable to meet the high deductibles in marketplace plans, and the high coinsurance associated with specialty drugs. To help cover the cost of their copayment, patients often rely on copay assistance from manufacturers and charitable foundations. Access to these treatments is critical for individuals with serious, chronic conditions to stay healthy, remain in the workforce, and out of the emergency department. Without copay assistance, many patients abandon their prescriptions at the pharmacy, or take measures to ration their doses, to the detriment of their health.[1]

[1] Kaiser Family Foundation, Poll: Nearly 1 in 4 Americans Taking Prescription Drugs Say It's Difficult to Afford Their Medicines, including larger shares among those with health issues, with low incomes, and nearing Medicare age, March 1, 2019, https://www.kff.org/health-costs/press-release/poll-nearly-1-in-4-americans-taking-prescription-drugs-say-its-difficult-to-afford-medicines-including-larger-shares-with-low-incomes/

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17 Davis Blvd, Suite 403, Tampa, FL 33606 | Tallahassee, FL | 813-258-5929
theaidsinstitute.org

House Bill 1246 *should* address the negative effects of a policy that many insurers and pharmacy benefit managers are instituting that limits patients' ability to afford and access medications**.** Through copay accumulators and other copay diversion policies, insurers and PBMs divert copay assistance funds intended for the patient to their own bottom lines. Like underwriting tactics before the passage of the Affordable Care Act, these policies undermine coverage for the most serious conditions (HIV, hepatitis, multiple sclerosis, hemophilia, cancer, and lupus to name a few). By restricting access to these life-saving prescriptions, insurers and PBMs are costing the healthcare system more when patients seek care in emergency settings and their conditions have worsened to require more intensive interventions.

Please oppose this unnecessary amendment in HB 1246. Thank you for considering our perspective on this critical issue. We stand ready to work with you to advance policies that promote the health and welfare of all Marylanders.

Sincerely,

Naomi Gaspard,
Policy Manager
The AIDS Institute

HB1246 Cost Sharing LOI Crossover.pdf
Uploaded by: Irnise Williams
Position: INFO

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IRNISE WILLIAMS
Deputy Unit Director

March 25, 2025

TO: The Honorable Pamela Beidle, Chair
Senate Finance Committee

FROM: Irnise F. Williams, Deputy Director, Health Education and Advocacy Unit

RE: House Bill 1246- Health Benefit Plans - Calculation of Cost Sharing Contribution – Requirements - **LETTER OF CONCERN**

The Health Education and Advocacy Unit submits a letter of concern for the limited purpose of addressing section (C)(1) of House Bill 1246, which requires persons that provide discounts, financial assistance payments, product vouchers, or other out-of-pocket expenses made on behalf of an insured or enrollee that is used in the calculation of the insured's or enrollee's contribution to cost-sharing requirement or out-of-pocket maximums, to notify the insured or enrollee of material information related to the use of the funds. An amendment to this section also requires the entity offering the assistance to "provide the discount, financial assistance payment, product voucher, or other out-of-pocket expense for the duration of the plan year."

The bill provides that a violation of (C)(1) is a violation of the Consumer Protection Act (CPA). The CPA generally requires that material information be provided to consumers. Section (C)(1)(i) identifies specific material information that must be provided to consumers. Thus, this bill applies the general principle that already is present in the CPA and applies that principle to programs that provide discounts, financial assistance, or product vouchers. We are concerned about an amendment to the bill that requires material information be provided within 7 days after acceptance of the assistance, because it is at odds with traditional consumer protection principles - that details of the offer should be clear and conspicuous at the time of the offer.

Our office is also concerned about the amendment to this section that requires the entity offering the assistance to "provide the discount, financial assistance payment, product voucher, or other out-of-pocket expense for the duration of the plan year" because it could harm recipients and raises

enforcement questions. For example, consider a consumer who at the beginning of their plan year has a $6,000 deductible, their drug costs $6,000 to fill for a 30-day supply, and they are eligible to receive $6,000 in copay assistance. If the $6,000 copayment assistance is required to last for the "duration of the plan year," is the $6,000 pro rated, resulting in the consumer only receiving $500 a month in copay assistance, not the full $6,000 upfront? If the copayment assistance is prorated over the plan year, this could be a significant barrier to a patient being able to afford the drug on day 1 of their plan year. In this same scenario, it is also possible the patient might only need the drug for part of the plan year, but the consumer would be denied the full amount of copayment assistance because of the requirement that the financial assistance be available for the duration of the plan year. If the intent of the amendment is to require that the expiration date shall not be earlier than the end of the patient's plan year, it would be helpful to modify the amendment to clarify that intent. Otherwise, the amendment is likely to result in patients being denied the full benefit of the assistance programs. We hope this information is helpful to the Committee in considering House Bill 1246.

cc: The Honorable Vice Chair Cullison
The Honorable Steve Johnson