MonicaBetagnolli_FAV_SB0623

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ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

February 26, 2020

Chair, Senator Delores Kelley
Senate Committee on Finance
Maryland State Senate
11 Bladen Street
Annapolis, MD 21401

Dear Chair Kelley and Honorable Members of the Senate Committee,

The Association for Clinical Oncology (ASCO) is pleased to **support SB 623: Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation** which would prohibit health carriers in the state from utilizing co-pay accumulator programs within their plans. ASCO is a national organization representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care.

ASCO is committed to supporting policies that reduce cost while preserving quality of cancer care; however, **it is critical that such policies be developed and implemented in a way that does not undermine patient access.** Copay accumulator programs target specialty drugs for which manufacturers often provide copay assistance. With a co-pay accumulator program in place, a manufacturer's assistance no longer applies toward a patient's co-pay or out-of-pocket maximum. This means that patients will experience increased out of pocket costs and take longer to reach required deductibles. **By prohibiting these funds from counting toward patient premiums and deductibles, co-pay accumulators negate the intended benefit of patient assistance programs and remove a safety net for patients who need expensive specialty medications but cannot afford them**.

While co-pay accumulator programs are described as a benefit for patients, these programs in effect prevent patients from reaching their deductibles sooner while increasing cost-sharing for patients. These programs lack transparency and are often implemented without a patient's knowledge or full understanding of their new "benefit." Increases in out of packet costs for the patient can result in significant adverse impacts on patient finances, which contributes to medical bankruptcies and disproportionately affects low-income populations. In this manner **co-pay accumulator programs could jeopardize outcomes, as patients may decide to forego or discontinue treatment or seek different treatment for non-medical reasons**. If a patient does forego care, this could lead to poorer health outcomes and potentially higher costs to the health care system.

ASCO is encouraged by the steps that SB 623 takes toward eliminating co-pay accumulator programs in Maryland and we therefore urge the committee to pass the measure. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the ASCO Policy Brief on Co-Pay Accumulators by our affiliate, the American Society of Clinical Oncology. We welcome the opportunity to be a resource for you. Please contact Allison Rollins at ASCO at allison.rollins@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Monica A. Bertagnolli, MD

Monica Bertagnolli, MD, FACS, FASCO
Chair of the Board
Association for Clinical Oncology

BenjaminChandhok_FAV_SB0623

Uploaded by: Chandhok, Benjamin

Position: FAV

Arthritis Foundation

ARTHRITIS FOUNDATION

www.arthritis.org

February 26, 2020

Chair Delores G. Kelley
Senate Finance Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

Dear Chair Kelley and Senate Finance Committee Members,

On behalf of the approximately 1.1 million people in Maryland who suffer from doctor-diagnosed arthritis, the Arthritis Foundation writes in support of S623, legislation addressing patient cost-sharing calculations.

Health care access and affordability have become increasingly difficult issues facing people with chronic diseases like arthritis. Patients already face a significant physical, financial, emotional, and administrative burden in navigating a complex health care system that is becoming more and more unpredictable. Yet, insurers and pharmacy benefit managers are routinely moving to policies that prohibit using copay assistance to pay the deductible or maximum out-of-pocket limit. S623 would address this issue by prohibiting this practice.

Research and surveys consistently demonstrate that unexpected increases to monthly medication costs lead to a decrease in treatment adherence. A recent Arthritis Foundation survey of 600 patients found that 84 percent of patients surveyed stated a large unexpected charge for a prescription drug would impact their household budget. Additionally, 46 percent had received a large unexpected charge for a prescription drug and, of those, 25 percent reacted by not filling their prescription.

In turn, a decrease in adherence leads to worse symptoms and higher utilization of high-cost services and procedures such as emergency department visits and surgeries. The consequences of not being able to access recommended medications can be catastrophic for those with chronic illnesses. Prohibiting the application of copay assistance to a deductible only contributes to the likelihood that patients stable on effective treatments will forgo their medication.

This bill can address these issues by requiring all payments received from or on behalf of an individual be applied towards their cost-sharing obligations. For these reasons, we respectfully ask for your support of S623 on behalf of the 1.1 million people with arthritis that we represent.

Thank you for your consideration. For more information, please contact Ben Chandhok, Senior Director of State Legislative Affairs with the Arthritis Foundation, at bchandhok@arthritis.org or 513-484-7623.

Sincerely,

Benjamin Chandhok

Ben Chandhok
Senior Director of State Legislative Affairs
Arthritis Foundation

ACS CAN_FAV_SB 623

Uploaded by: Collins, Jocelyn

Position: FAV

American Cancer Society
Cancer Action Network
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www.fightcancer.org

February 26, 2020

TO: **The Honorable Delores G. Kelley, Chair**
The Honorable Brian J. Feldman, Vice Chair
Members of the Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

FROM: **Jocelyn Collins, Maryland and DC Government Relations Director**
American Cancer Society Cancer Action Network
555 11th St. NW, Suite 300
Washington, DC 20004
jocelyn.collins@cancer.org
(301) 254-0072 (cell)

SUBJECT: **SB 623 Health Insurance—Out-of-Pocket Maximums and Cost-Sharing Requirements—Calculation**

POSITION: **SUPPORT**

The American Cancer Society Cancer Action Network (ACS CAN) is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. On behalf of our constituents, many of whom have been personally affected by cancer, we stand in support of SB 952.

Many cancer patients have difficulty affording the cost of their prescription drugs, regardless of whether they are insured. This is especially true for newer drugs – including cancer drugs – that do not yet have a generic equivalent. To help temper high prescription costs, many individuals living with cancer receive copay assistance offered through manufacturer programs and charitable patient assistance programs.

Manufacturer programs and charitable patient assistance programs help many cancer patients afford their medications. In many cases a cancer patient needs a drug that does not yet have a modestly priced generic or other alternative to drug treatment. A patient assistance program's financial support can give patients access to a life-saving drug that they otherwise could not afford. Without these programs many cancer patients are left with few options to pay for their therapies and many of the programs exist for drugs without generic alternatives.

Further, even lower cost drug treatments, especially over a period of months, can be out of-reach for many low-income people. Studies of patients with certain treatment types report a significant drop in adherence when co-pays increase to a range of $30 to $90.[1] Of economically vulnerable patients with any condition surveyed with various levels of coverage, nearly 60 percent projected they were extremely concerned they would be unable to cover out-of-pocket medication costs over the next 12 months.[2]

Copay accumulators are a relatively new insurance benefit design, mostly being implemented in the employer-sponsored insurance market. These programs allow the enrollee to use a copay support or a coupon, but the amount of the support does not count towards the enrollee's maximum out-of-pocket (MOOP). Only the funds spent directly by the beneficiary (and not on her behalf) would count towards the beneficiary's MOOP.

However, with the implementation of SB 623/HB 1360, it would remove copay accumulators' barriers by requiring all payments made by patients—directly or on their behalf - be counted toward their overall out-of-pocket maximum payment or deductible. Requiring health insurance carriers to do so will protect Marylanders from surprise bills and treatment delays as well as allowing individuals to utilize the full benefit of co-pay assistance programs. Therefore, ACS CAN asks for a "favorable" committee report.

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[1] Neugut, AI, Subar M, Wilde ET, Stratton S, Brouse CH, Hillyer GC, et al. Association between prescription copayment amount and compliance with adjuvant hormonal therapy in women with early-stage breast cancer. Journal of Clinical Oncology. Vol 29, no 18. June 20, 2011.

[2] Narang, AK, Nicholas, LH. Out-of-Pocket Spending and Financial Burden Among Medicare Beneficiaries with Cancer. JAMA Oncology. November 23,2016.

JosieCooper_FAV_SB0623

Uploaded by: Cooper, Josie

Position: FAV

AfPA | Alliance for Patient Access

February 25, 2020

The Honorable Delores G. Kelley
Chair
Senate Finance Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

The Honorable Shane E. Pendergrass
Chair
Health and Government Operations Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

The Honorable Brian J. Feldman
Vice Chair
Senate Finance Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

The Honorable Joseline A. Pena-Melnyk
Vice Chair
Health and Government Operations Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

Re: SB 0623 and HB 1360 - Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Dear Delegates and Senators,

On behalf of the Alliance for Patient Access (AfPA), I am writing in support of SB 0623 and HB 1360, companion bills that would ensure that all payments made to insurance companies for medicines, including co-pay coupon payments, are applied to patients' out-of-pocket expense obligations. The bills will allow patients to continue using co-pay coupons to access their medications, while also being protected from surprise out-of-pocket costs.

Founded in 2006, AfPA is a nonprofit, national network of physicians and other health care providers dedicated to patient-centered care. AfPA advocates for health policies that support clinical decision making, protect the physician-patient relationship, and ensure patients' access to approved therapies and appropriate clinical care.

Co-pay coupons are often of critical importance for certain patients with chronic or rare diseases. The coupons provide payment toward the prescription co-pay requirements that patients face, helping increase access to treatment options. These programs are particularly helpful for patients struggling to afford the medication they need, playing an important role in helping patients cover their out-of-pocket expenses. Most drugs that have co-pay coupons available do not have any lower-cost generic alternatives. For the few that do, the alternatives might not fit the patient's specific disease state, or the patient may have already tried and failed the alternative treatment.

Recently, though, some health plans have instituted a practice in which patient payments made using co-pay coupons are allowed for payment but then excluded from being counted towards a patient's annual deductible, or out-of-pocket cost limit. These practices are known as co-pay accumulator programs, and they can effectively limit access for patients.

These programs can hinder patient care by increasing costs for patients, leading to patients – regardless of their health status – switching medications based on unforeseen expense, or abandoning their medication altogether. Co-pay accumulator programs can also leave patients with unanticipated medical bills of hundreds or even thousands of dollars. All of these consequences put patients at risk for re-emerging symptoms and new side effects and place an undue burden on patients already managing complex conditions. More information about co-pay accumulator programs can be found in the Institute for Patient Access' Co-Pay Accumulator Policy Paper.

SB 0623 and HB 1360 will protect access by ensuring that all payments made on behalf of an insurance plan member – including those made using co-pay coupons – will count toward that patient's out-of-pocket maximum. This will protect patients by ensuring they can continue to access the medication they need - without facing surprise out-of-pocket costs later.

On behalf of Maryland patients and the Alliance for Patient Access, I urge your support for SB 0623 and HB 1360 throughout the legislative process to ensure patients can access the treatments they need.

Sincerely,

Josie Cooper

Josie Cooper
Executive Director
Alliance for Patient Access

RyanGough_FAV_SB0623

Uploaded by: Gough, Ryan

Position: FAV

PARTNERSHIP TO ADVANCE
Cardiovascular
Health

February 25, 2020

The Honorable Delores G. Kelley
Chair
Senate Finance Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

The Honorable Shane E. Pendergrass
Chair
Health and Government Operations Committee
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The Honorable Brian J. Feldman
Vice Chair
Senate Finance Committee
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The Honorable Joseline A. Pena-Melnyk
Vice Chair
Health and Government Operations Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

Re: Support for SB 0952 and HB 1359 – Health Insurance – Requirements for Establishing Step Therapy Protocol and Requesting Exceptions

Dear Senators and Delegates,

On behalf of the Partnership to Advance Cardiovascular Health (PACH), I am writing in support of SB 0952 and HB 1359. These bills that will help patients access appropriate and timely treatment by providing clear guidelines on health care plans' use of step therapy, a common utilization management tool.

PACH is a 501(c)(4) nonprofit advocacy coalition of stakeholder groups that represent patients, patient advocates, health care providers and medical researchers in the cardiovascular space. On behalf of its members, PACH advocates for patient access to FDA-approved therapies and promotes innovation in cardiovascular health care for the millions of Americans who are at high risk for heart disease. SB 0952 and HB 1359 would protect patients' access to care by establishing guidelines around health insurers' use of step therapy protocols, helping to ensure patient-centered care and preserving physician-patient decision making health care treatment.

Step therapy is a utilization management tool known as "fail first" that requires patients to follow an insurance dictated treatment path that favors low cost medicines over other treatment options. It is used by insurers as a way to contain health care cost but does not recognize that that treatment may not be appropriate for a patient, may have already been tried and failed or is contraindicated to other medications being taken. Patients are prevented from accessing the medication prescribed by their health care provider, leading to delays in accessing treatment for many patients.

Limits on step therapy protocols are especially important to patients with cardiovascular disease, the number one killer in the state of Maryland, the United States, and around the world. Our nation is currently in a health crisis and today's CVD patient is drastically different from those of previous decades. Patients are younger and have comorbidities such as diabetes, high blood pressure, and obesity. The window for prevention has become much smaller and optimal treatment for patients must begin as soon as possible.

More and more patients are being considered high-risk by health care providers, and delays in appropriate treatment for them are life-threatening. One of the most egregious examples where market access has been systemically restricted for consumers is the PCSK9 inhibitor (PCSK9i) drug class. These medications have come to market in the last five years and have proven to significantly reduce the rates of heart attack, stroke and even death. More recently, data has shown that PCSK9is can also reverse atherosclerosis. This medication is very effective for those with severely elevated LDL-cholesterol, who have familial hypercholesterolemia (FH), and who are unable to tolerate first-line LDL lowering therapies. For some patients, other medicines have proven to be ineffective.

SB 0952 and HB 1359 provide guardrail reforms that give the health care provider and patient a path to satisfy step therapy protocols by outlining clear exception criteria and an exception request approval timeline. PSCK9is are not for every patient, but when it is deemed necessary by a physician to save their patients' lives, timely access is important. This legislation does not prevent insurance companies from using step therapy, nor does it limit the number of steps required by the insurer. However, it serves as an important step toward protecting the provider-patient relationship that is critical to successful care by providing clear guidelines, improved accessibility, and faster response times to step therapy appeals.

Health care innovations, like PCSK9is, have revolutionized the management of CVD. Going forward [patients can expect more and new therapies that aim to reduce and, in the long term, eliminate CVD altogether.. If insurers are allowed to install barriers to accessing these therapies, we will never reach our population health goals to ensure citizens live long, healthy lives. Access to these important treatments now, along with primary prevention measures for our future generations, is crucial to tackling our nation's CV health crisis.

On behalf of the Partnership to Advance Cardiovascular Health and its coalition members, we ask that you support SB 0952 and HB 1359 to create patient access protections in the use step therapy procedures.

Sincerely,

Ryan Gough
Executive Director

MedChi_Danna Kauffman_FAV_SB0623
Uploaded by: Kauffman, Danna
Position: FAV

MedChi

The Maryland State Medical Society

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TO: The Honorable Delores G. Kelley, Chair
Members, Senate Finance Committee
The Honorable Joanne C. Benson

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Richard A. Tabuteau

DATE: February 26, 2020

RE: **SUPPORT** – Senate Bill 623 – *Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 623. Senate Bill 623 requires carriers, when calculating the overall contribution to an out-of-pocket maximum or a cost-sharing requirement, to include any payments made by, or on behalf of, the insured, subscriber, or member, which includes copay assistance programs. Simply stated, Senate Bill 623 prohibits a carrier from excluding the amount paid by a copay assistance program or similar program in determining when the patient reaches his/her out-of-pocket maximum or other cost-sharing requirement, such as his/her deductible.

Copay assistance programs help patients with the out-of-pocket costs of deductibles, coinsurances and copays. For example, using a copay assistance program, if the out-of-pocket charge to fill a prescription for the patient is $50, the patient may pay $10 and a copay assistance program would pay the remaining $40. If the patient’s carrier has adopted an accumulator program, then rather than applying the full $50 towards the patient’s deductible, the carrier only applies the $10 paid by the patient, making it significantly more difficult for a patient to meet their annual deductibles and be provided with full drug coverage. Essentially, accumulator programs simply shift the benefit of the program from patients to the carriers since the patient must still meet the same deductible but without the benefit of the copay assistance program.

As more and more patients move into high-deductible health plans, this concern becomes more pronounced. According to the U.S. Centers for Disease Control and Prevention, high deductible health plans now cover approximately 40% of Americans. For patients with chronic conditions and high health care costs, the benefit of copay assistance programs is essential in receiving their medications. Senate Bill

623 is a consumer protection bill that protects patients from unfair practices where the carrier reaps the benefits of the copay assistance program AND the full cost-sharing requirement of the patient before having to pay for the full drug coverage of the patient. We urge a favorable vote.

For more information call:
Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Richard A. Tabuteau
410-244-7000

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STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL
CONSUMER PROTECTION DIVISION

WILLIAM D. GRUHN
Chief
Consumer Protection Division

Writer's Direct Dial No.
(410) 576-6515

February 26, 2020

To: The Honorable Delores G. Kelley
Chair, Finance Committee

From: Patricia F. O'Connor, Health Education and Advocacy Unit

Re: Senate Bill 623 (Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation): Support

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 623 which would require carriers to apply the value of manufacturer drug coupons to a deductible; other cost-sharing requirements; and out-of-pocket (OOP) maximums, subject to federal laws which are in flux. 'Copay accumulator programs' that prohibit such credits had been implemented by some Maryland carriers in recent years to the detriment of consumers, and the bill would prohibit the programs.

The HEAU has received complaints about copay accumulator programs from consumers requiring brand drugs to treat AIDS, HIV and other chronic conditions, where there is no medically equivalent generic that is suitable or available. These consumers have been unable to afford the brand drugs without the drug coupons and the deductible credits, leaving them the choice of doing without life-sustaining drugs or taking on crippling medical debt.

HHS's Final Notice of Benefit and Payment Parameters for 2020 ("the 2020 Final Rule") issued on April 25, 2019, added section (h) to 45 CFR § 156.130 (Cost-sharing requirements):

> (h) *Use of drug manufacturer coupons*. For plan years beginning on or after January 1, 2020:
> (1) Notwithstanding any other provision of this section, and to the extent consistent with state law, amounts paid toward cost sharing using any form

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Health Advocacy Unit Toll Free (877) 261-8807 ♦ Home Builders Division Toll Free (877) 259-4525 ♦ Telephone for Deaf (410) 576-6372
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> of direct support offered by drug manufacturers to enrollees to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have an available and medically appropriate generic equivalent are not required to be counted toward the annual limitation on cost sharing (as defined in paragraph (a) of this section).

84 Federal Register 80 at 17567-8; https://www.govinfo.gov/content/pkg/FR-2019-04-25/pdf/2019-08017.pdf

In its response to comments about proposed 45 CFR § 156.130(h) asserting that "the final language should expressly provide that these limitations on coverage only apply to the extent consistent with state law," the Centers for Medicare and Medicaid Services (CMS) stated:

> In response to comments, we clarify that the ability to exclude amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent from being counted toward the annual limitation on cost sharing is subject to applicable state law. **This means that states can require that such amounts be counted toward the annual limit on cost sharing. We are modifying the final regulation text to state this explicitly.**

(Emphasis added). 84 Federal Register 80 at 17546.

States are free to legislate in this area, subject to evolving federal regulations that may have future preemptive effect. We believe consumers require the protections offered by the bill now, particularly when no generics are available, and are hopeful the federal laws and regulations will be sorted out in a manner favorable to Maryland consumers.[1] The proposed 2021 payment rule is expected later this fall and is expected to clarify ambiguity about compliance with the 2020 Final Rule and IRS rules for high deductible health plans (HDHPs). See "HHS Walks Back New Policy On Drug Coupons," Katie Keith, Health Affairs Blog (8/28/19), https://www.healthaffairs.org/do/10.1377/hblog20190828.555588/full/

For these reasons, we ask the Committee for a favorable report.

cc: Senator Benson, Sponsor
Members of the Finance Committee

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[1] We acknowledge the federal regulation's balance between cost control and patient access achieved by treating drug coupons for brand drugs *without* available and medically appropriate generics differently than coupons for brand drugs with such generics.

Senator Benson_FAV_SB623

Uploaded by: Senator Benson, Senator Benson

Position: FAV

JOANNE C. BENSON
Legislative District 24
Prince George's County

Finance Committee
Chair, Rules Committee

Joint Committees
Children, Youth, and Families
Ending Homelessness
Fair Practices and State Personnel Oversight
Management of Public Funds

Chair, Prince George's County
Senate Delegation

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

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Testimony of Senator Joanne C. Benson

SB 623: Health Insurance- Out-of-Pocket Maximums and Cost-Sharing Requirements Calculation

Good Afternoon Madam Chair and esteemed members of the Finance Committee. Senate Bill 623: Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation requires all payments made by patients – either directly or on their behalf – to be counted towards their overall out of pocket maximum requirement or towards their deductible. This protects patients from receiving unexpected bills or treatment delays since their insurance company only count payments made directly by the patient towards cost-sharing requirements.

Charities and drug manufacturers offer co-pay assistance programs for individuals living with rare, chronic conditions to help temper high prescription costs. At times, these costs can be as high as 20% to 50% of the costs of their medication. However, insurers are increasingly implementing "co-pay accumulator programs." Co-pay accumulator programs stipulate that the insurer will not count co-pay assistance towards the patient's deductible or out-of-pocket maximum. In effect, this means that the insurer is double dipping: by being paid once by the co-pay assistance program and then again from the patient's own pocket.

Accumulator programs render co-pay assistance programs useless. Many individuals are unaware that their insurance company undergo this practice until it's too late. Worse, those with high deductible health plans are most at risk.

I believe in protecting our most vulnerable citizens- the helpless, the hopeless, and the homeless. This bill protects those who are truly at their most vulnerable state, those living with chronic and often rare conditions who suffer enough trying to live a normal lifestyle with their condition. The last thing one should have to worry about is whether their insurance company will cover the cost of the treatment that will save their life. Yet, when insurance companies utilize these co-pay accumulator programs patients think they have met their deductible when in fact they haven't. This puts an unnecessary burden on patients to figure out how to come up with the additional funds to pay for their treatment. This threatens continuity of the treatment and the patient's well-being.

This bill has nothing to do with the cost of drugs. Senate Bill 623 is simply about fairness and equity for patients – especially those with chronic, costly conditions and those with limited means. This bill has no fiscal note and has bipartisan support.

Thus, I respectfully urge the committee for a favorable report on Senate Bill 623.

Kaiser Permanente_Letter of Concern_SB 623

Uploaded by: Taylor, Allison

Position: UNF

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 26, 2020

The Honorable Delores G. Kelley
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 623 – Letter of Concern

Dear Chair Kelley and Members of the Committee:

Thank you for the opportunity to provide comments on SB 623, Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 755,000 members. In Maryland, we deliver care to over 430,000 members.

This bill requires carriers, when calculating the overall contribution to an out-of-pocket (OOP) maximum or a cost-sharing requirement, to include any payments made by, or on behalf of, the insured, subscriber, or member.

KP supports opportunities to maintain the lowest cost share for medications to its members. However, while coupon programs have risen steadily and may offer some benefit to offset increasing patient cost exposure, they incentivize market forces to drive the prices of drugs and other services higher by reducing the incentive to maintain or lower costs. This is particularly evident when coupons are promoted and provided for brand name drugs when more cost-effective clinically appropriate medications are readily available. In addition, when coupon-based discount programs conclude, patients are either required to begin paying the higher cost share or switch to an alternative medication. KP seeks to ensure patients receive the most clinically sound and cost-effective care throughout an entire course of therapy.

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

The 2021 Centers for Medicare & Medicaid Services proposed standards clarify that carriers are permitted, but not required, to count toward the annual limitation on cost sharing amounts paid toward reducing out-of-pocket costs using direct support offered by drug manufacturers to enrollees for specific prescription drugs. While we continue to look at voluntarily adopting policies where coupons can be applied, KP does not support their use for branded medications when generic formulations are available. Unless a brand drug is deemed medically necessary – which is not often relative to all prescriptions filled – providing brand coupons when less costly alternatives exists is not a responsible practice and only contributes to the ever-increasing cost of health care.

Thank you for the opportunity to comment. Please feel free to contact Wayne Wilson at Wayne.D.Wilson@kp.org or (301) 816-5991 with questions.

Sincerely,

Wayne D. Wilson
Vice President, Government Programs and External Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.