AAN Testimony_MD SB290_HB167_Health Insurance - Ou

Uploaded by: Anderson, Charmayne

Position: FAV

Allergy & Asthma NETWORK

8229 Boone Boulevard, Suite 260, Vienna VA 22182 • 800.878.4403 • *AllergyAsthmaNetwork.org*

February 8, 2021

The Honorable Paul G. Pinsky, Chair
Senate Education, Health, and Environmental Affairs Committee
Maryland General Assembly
Annapolis, MD

Support for SB290/HB167 – Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Dear Chairman Pinsky and Members of the Committee,

Allergy & Asthma Network, a national nonprofit dedicated to protecting and improving the health of people with allergies, asthma and related conditions, supports SB290/HB167, which requires all payments made by patients, either directly or on their behalf, be counted toward their deductibles or out-of-pocket maximums. There are many people living with asthma and severe allergies who are not able to afford medications prescribed by their doctors to manage their chronic conditions and maintain health. The COVID-19 pandemic has only exacerbated the financial strain that high-cost treatments put on patients and their families as people with asthma, COPD and other chronic respiratory diseases are at greater risk for complications if they are diagnosed with this novel strain of coronavirus.

Insurers are increasingly implementing copay accumulator programs which allow patients to access and pay for high-cost prescription drugs but do not apply their value toward a patient's deductible or out-of-pocket costs. This is particularly concerning when there is no generic alternative for medications, which is the case for most drugs used to treat chronic illnesses. In these cases, failing to count co-pay coupons toward a patient's deductible leaves the patient with no affordable coverage option. Many must choose between the financial burden of covering these unexpected costs or not using their needed medications. Solutions that will make prescription drugs affordable is critical and SB290/HB167 will help Marylanders access their treatments through the help of copay assistance.

Thank you for your attention to this matter. If you have any questions, please contact me or our Director of Advocacy and Maryland resident Charmayne Anderson at 800-878-4403. Learn more about the Network at AllergyAsthmaNetwork.org.

Sincerely,

Tonya A. Winders

Tonya Winders
President and CEO

Cc: The Honorable Shane E. Pendergrass, Chair, House Health and Government Operations Committee

2021LADASB290MDAccAdj.pdf

Uploaded by: Arntsen, Kathleen

Position: FAV

LUPUS
and
ALLIED DISEASES
Association, Inc.

February 8, 2021

Chair Dolores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.
Annapolis, Maryland 21401

RE: SB 290 Letter of Support

Dear Chair Kelley and Senate Finance Committee Members,

On behalf of the Lupus and Allied Diseases Association and the millions of Maryland residents both directly and indirectly affected by autoimmune conditions and other diseases of unmet need, I urge you to **please support Senate Bill 290** an act to requiring, to the extent authorized under federal law, certain entities to include payments made by certain persons when calculating the overall contribution to an out-of-pocket maximum or a cost-sharing requirement for an insured, a subscriber, or a member; and applying the Act to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after January 1, 2022.

Copay accumulators are a relatively new insurance benefit design being adopted by health insurance plans that prevent patients from using copay cards or coupons to cover their out-of-pocket expenses. This cost-shifting mechanism changes the way an insured individual's out-of-pocket contributions for prescription drugs are calculated. Copay accumulators do not consider any discounts or coupons that the insured person receives from the drug manufacturer when calculating the insured’s out-of-pocket expenses and therefore do not count them toward the patient’s maximum out-of-pocket limit.

This practice shifts the cost towards patients as the insurance plans are essentially "double dipping" by requiring the individual to pay their normal copay while still receiving a discount or coupon from the drug manufacturer, in turn causing the individual to take longer to satisfy their deductible. This unfair design is especially challenging for individuals with high deductible or high copayment requirements in their health insurance plans.

Given the current global healthcare crisis in which Maryland residents and others throughout the world are experiencing hardship in dealing with the COVID-19 pandemic, individuals already struggling to manage their chronic and rare medical conditions are now facing additional challenges of covering the cost of their medication and accessing appropriate healthcare. Copay coupons and cards provide financial relief to patients through manufacturer programs created to offset the cost sharing associated with certain treatments while assisting patients in meeting their maximum out-of-pocket limits. Copay assistance programs provide patient access to life-sustaining and lifesaving medication that would otherwise be unaffordable while promoting treatment adherence.

Maryland has a longstanding record of providing access to affordable healthcare and developing some of the strongest patient protections in the country. The proposed legislation discontinues the use of copay accumulators statewide by requiring insurance companies and pharmacy benefit managers to apply price reduction instruments for out-of-pocket expenses when calculating an insured individual's cost-sharing requirement. We urge you to make Maryland the next state to protect its residents from insurmountable out-of-pocket costs and join the five other states who have passed similar legislation to ensure all copays count toward the deductible and out-of-pocket maximum.

The Lupus and Allied Diseases Association was founded in 1978 and is a national non-profit organization led by people with lupus and allied diseases and their loved ones who are dedicated to ensuring that the patient perspective is included and recognized as an equal stakeholder in the healthcare, regulatory and public policy arenas and across the research continuum. It is our goal to improve access to care and quality of life by fostering collaboration among stakeholders and by wielding the patient voice as a catalyst to advance innovative advocacy, education, awareness and biomedical research initiatives that will identify causes, advance better diagnostics, and discover superior treatments, and cures.

As patient stakeholders who represent patients and loved ones dealing with serious medical conditions on a daily basis who strongly support establishing essential patient protections that improve access to vital therapies, we passionately urge your support and passage of SB 290 to stop this unfair practice and to help individuals afford the medication they require to remain active. The urgent need for this legislation has only been intensified during the COVID-19 pandemic as countless Maryland families face financial uncertainty. We request that the Senate Finance Committee and state legislature to support this legislation and stand with patients by prohibiting copay accumulators and requiring health insurance plans to count all dollars towards an insured individual’s deductible or out-of-pocket maximum.

We must remain vigilant in protecting Maryland residents while promoting unfettered access to vital life-enhancing and lifesaving treatments.

Please contact me at 315-264-9101 or kathleen@ladainc.org if you have any questions.

We thank you for the opportunity to provide our unique patient viewpoint and for your support of strong patient safeguards.

Respectfully Submitted-

Kathleen A. Arntsen

Kathleen A. Arntsen
President & CEO

2021LADASB290MDAccAdj.pdf

Uploaded by: Arntsen, Kathleen

Position: FAV

LUPUS and ALLIED DISEASES Association, Inc.

January 18, 2021

Chair Dolores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.
Annapolis, Maryland 21401

RE: SB 290 Letter of Support

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We thank you for the opportunity to provide our unique patient viewpoint and for your support of strong patient safeguards.

Respectfully Submitted-

Kathleen A. Arntsen

Kathleen A. Arntsen
President & CEO

SB290 Testimony.pdf

Uploaded by: Benson, Joanne C.

Position: FAV

Joanne C. Benson
Legislative District 24
Prince George's County

Finance Committee

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

THE SENATE OF MARYLAND
Annapolis, Maryland 21401

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800-492-7122 *Ext.* 3148
Fax 301-858-3149 · 410-841-3149
Joanne.Benson@senate.state.md.us

Testimony of Senator Joanne C. Benson

SB 290: Health Insurance – Out of Pocket maximums and Cost-Sharing Requirements Calculation

Good afternoon Madam Chair and esteemed members of the finance Committee. Senate Bill 290: 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 manufactures offer co-pay assistance programs from 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 more 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 290 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 290.

SB290 Testimony.pdf

Uploaded by: Benson, Joanne C.
Position: FAV

Joanne C. Benson
Legislative District 24
Prince George's County

Finance Committee

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

THE SENATE OF MARYLAND
Annapolis, Maryland 21401

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Joanne.Benson@senate.state.md.us

Testimony of Senator Joanne C. Benson

SB 290: Health Insurance – Out of Pocket maximums and Cost-Sharing Requirements Calculation

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This bill has nothing to do with the cost of drugs. Senate bill 290 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 290.

National Psoriasis Foundation Support for SB 290 f

Uploaded by: Boles, Julia

Position: FAV

NATIONAL PSORIASIS FOUNDATION®

Our Mission: To drive efforts to cure psoriatic disease and improve the lives of those affected.

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.,
Annapolis, MD 21401

RE: National Psoriasis Foundation Support for SB 290

Dear Chair Kelley and Finance Committee Members,

The National Psoriasis Foundation (NPF) is a non-profit organization with a mission to drive efforts to cure psoriatic disease and improve the lives of those affected. The NPF is the leading patient advocacy group for over 8.3 million Americans and the more than 152,000 Marylanders living with psoriasis and psoriatic arthritis. I write to you today to express NPF's support for SB 290, Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation and respectfully request you vote SB 290 out of committee.

Non-treatment and under treatment of psoriatic disease remains a significant problem as health benefit plan's cost sharing leave many treatments unaffordable. To maintain their health and quality of life, patients seek copay assistance to help afford their high out-of-pocket costs. A 2020 NPF survey found that only 3 in 10 people with psoriatic disease with incomes between $50,000 and $99,999 could afford their treatments without copay assistance.

The financial impacts of the COVID-19 pandemic have only made affording treatments harder. Before hitting their deductible, patients are responsible for the full cost of their drug, often thousands of dollars. In the same 2020 NPF survey, nearly half reported worrying about having enough money to afford treatment at some point in the last 12 months.

Increasingly, health insurers are implementing "copay accumulator adjustment programs" which exclude payments made by copay assistance from drug manufacturers and nonprofits from patients' cost sharing requirements. Not only does this harm patients with complex chronic conditions, but it also benefits the insurer because the out-of-pocket costs are paid twice – first by the copay assistance and then by the patient. SB 290 will help Marylanders by ensuring copay assistance continues to count toward their deductibles and out-of-pocket maximums.

Patients cannot simply choose a cheaper medication and most copay assistance is for treatments that do not have generic alternatives. A study of claims data by IQVIA found that 99.6% of copay cards are used for branded drugs that do not have a generic alternative.[i] As you know, in 2014 Maryland passed a post deductible $150 per prescription copay cap. SB 290 will build on these existing patient protections by ensuring copay assistance continues to help patients afford their treatments by counting the assistance toward their cost-sharing obligations.

During this current pandemic, NPF is concerned that the Marylanders living with psoriasis and psoriatic arthritis are potentially at higher risk of complications or death from COVID-19. It is of utmost importance that unnecessary barriers to the appropriate treatments are removed for patients – such as high out-of-pocket costs. NPF appreciates the Committee's consideration of this important matter, and respectfully requests your support of SB 290. Should you have any questions regarding this issue please contact me at jboles@psoriasis.org.

Sincerely,

Julia Boles

Julia Boles
Grassroots and Advocacy Manager

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[i] IQVIA. An Evaluation of Co-Pay Card Utilization in Brands after Generic Competitor Launch. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization Accumulator

Support for SB 290 Maryland All Copays Count Coali

Uploaded by: Boles, Julia

Position: FAV

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.,
Annapolis, MD 21401

RE: SB 290 Letter of Support – The Maryland All Copays Count Coalition

Dear Chair Kelley and Finance Committee Members,

The undersigned organizations write to you in **support of SB 290** – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation. Our organizations represent and care for Marylanders living with chronic and rare conditions who rely on high-cost specialty drugs. In recent years, health insurers have been implementing new programs called "copay accumulator adjustment programs" that do not count payments from copay assistance toward patients' deductibles and out-of-pocket maximums. In other words, the assistance is not actually helping patients afford their high-cost treatments, forcing them to choose between their health and financial stability. SB 290 will help Marylanders continue to access the treatments they need by requiring that all payments made by or on behalf of a patient count toward their cost sharing obligations.

The COVID-19 pandemic has only exacerbated the financial strain that high-cost treatments put on patients and their families. To maintain their health and quality of life, patients turn to copay assistance from manufacturers and nonprofits to afford their medications. In a 2020 survey, 71% of people with psoriatic disease with incomes between $50,000 and $99,999 reported that they would be unable to afford their treatment without copay assistance.[i]

For people with arthritis, cancer, HIV, multiple sclerosis, psoriasis, and other chronic conditions, specialty medications are often the only effective treatment options available. The high-cost specialty medications required to manage these complex conditions are consistently placed on the highest cost-sharing tier of health plan formularies. When facing high out-of-pocket costs, patients do not use their medications appropriately, skipping doses to save money or abandoning treatment altogether. Studies have shown that patients are far more likely to abandon their treatment when out-of-pocket costs exceed $100.[ii] Unfortunately, patients who stop using their medications due to high costs end up having more emergency room visits and negative health outcomes, which increases overall health care costs.

Insurance carriers have said that copay accumulator adjustment programs reduce health care spending by encouraging patients to try cheaper alternatives; however, when patients do not have access to the medications they rely on, health care spending increases. A vast majority of copay assistance is used for treatments that do not have a generic alternative. A study of claims data by IQVIA found that 99.6% of copay cards are used for branded drugs that do not have a generic alternative.[iii] Patients often do not realize their copay assistance was not counted toward their deductible or out-of-pocket maximum until they are told they owe hundreds or thousands of dollars at the pharmacy.

Maryland has long been a leader in health care reform, including the 2014 passage of a $150 post-deductible cap on specialty drug copays to help reduce patients' out-of-pocket costs. SB 290 will continue this trend by ensuring Marylanders who rely on high-cost medications can continue to access their treatments through the help of copay assistance. This is especially important as deductibles continue to rise. We understand that there are many factors contributing to the cost of health care, but patients should not be punished for using copay assistance to help them afford the treatments they need.

To date, five other states including our neighbors in Virginia and West Virginia have passed similar legislation to ensure all copays count toward the deductible and out-of-pocket maximum. The federal Notice of Benefit and Payment Parameters (NBPP) for 2021 makes clear that it is up to individual states to regulate copay accumulator adjustment programs. We respectfully request that you make Maryland the next state to protect patients from unmanageable out-of-pocket costs through SB 290. Maryland patients cannot wait.

Sincerely,

Allergy & Asthma Network
Alliance for Patient Access
Aimed Alliance
American Cancer Society Cancer Action Network, Inc.
American College of Rheumatology
American Kidney Fund
American Society of Clinical Oncology
Arthritis Foundation
Chronic Care Policy Alliance
Chronic Disease Coalition
Coalition of State Rheumatology Organizations
Crohn's and Colitis Foundation
Epilepsy Foundation Maryland
Hemophilia Federation of America
Hemophilia Foundation of Maryland
HIV + Hepatitis Policy Institute
Immune Deficiency Foundation
Infusion Access Foundation
Lupus and Allied Diseases Association, Inc.
Maryland/District of Columbia Society of Clinical Oncology
MedChi, The Maryland State Medical Society
Multiple Sclerosis Association of America
National Eczema Association
National Infusion Center Association
National Multiple Sclerosis Society
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute

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[i] 2020 National Psoriasis Foundation Patient Survey.

[ii] Gleason PP, Starner CI, Gunderson BW, Schafer JA, Sarran HS. Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. J Manag Care Pharm. 2009;15(8):648-658. doi:10.18553/jmcp.2009.15.8.648

[iii] IQVIA. An Evaluation of Co-Pay Card Utilization in Brands after Generic Competitor Launch. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

Accumulator

ACS CAN_ FAV_ SB 290.pdf

Uploaded by: Collins, Jocelyn

Position: FAV

American Cancer Society
Cancer Action Network
555 11th St., Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

February 10, 2021

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 290 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. We support restrictions on copay accumulators' programs. On behalf of our constituents, many of whom have been personally affected by cancer, we stand in support of SB 290.

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. 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 290, 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.

ACS CAN_FAV_SB 290.pdf

Uploaded by: Collins, Jocelyn

Position: FAV

American Cancer Society
Cancer Action Network
555 11th St., Suite 300
Washington, DC 20004
202.661.5700
www.fightcancer.org

January 20, 2021

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The Honorable Brian J. Feldman, Vice Chair
Members of the Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

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Washington, DC 20004
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SB 290 Letter of Support.pdf

Uploaded by: Gill, Lindsay

Position: FAV

American Kidney Fund®

January 18, 2021

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.,
Annapolis, MD 21401

RE: SB 290 Letter of Support

Dear Chair Kelley and Finance Committee Members,

On behalf of the American Kidney Fund, including the 16,531 Maryland citizens currently living with end-stage-renal disease, we are writing to respectfully ask for your support of SB 290, which would require any carrier issuing a health plan to count any payments made by a person or on a person's behalf when calculating the enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under the carrier's health plan.

The American Kidney Fund (AKF), based in Rockville, Maryland is the nation's leading nonprofit organizations working on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease, from prevention through transplant. With programs that address early detection, disease management, financial assistance, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. We are also one of the nation's top rated nonprofits, investing 97 cents of every donated dollar in programs, AKF has also received the highest 4-Star rating from Charity Navigator for 18 consecutive years, as well as the Platinum Seal of Transparency from Guidestar.

Due to high cost-sharing requirements and the expensive cost of prescription medications, many patients with chronic and rare diseases depend on financial assistance for their specialty medications. Recently, health plans have been instituting a practice where copayment assistance is no longer counted towards their out-of-pocket cost limits. Known as accumulator programs, this practice coupled with the rise of high deductible health plans makes it difficult, if not impossible, for patients to adhere to their treatment plan.

Many of these plan changes have also been implemented with little to no notification to the member. Patients may not be aware of the change in their plan until they arrive at the pharmacy to pick up their prescription and find out that they must pay for the full cost of the drug. Often times, patients walk away without their needed medication because they simply cannot afford to pay. For those patients that do receive notification, the language can be difficult to understand, even for the most seasoned of healthcare experts. Further, some notifications mislead patients into believing that they will be protected when in fact they are not.

This bill seeks to address the issues above and would provide essential protections to ensure patients can both afford and stay stable on their medications. We ask for your support on SB 290.

Thank you in advance for your time and for your consideration of this important issue. If you have any questions or would like any additional information people do not hesitate to contact me directly at lgill@kidneyfund.org.

Sincerely,

Lindsay Gill

Lindsay Gill
Associate Director of State Policy and Advocacy
(240) 292-7062 direct | (210) 860-7407 cell
lgill@kidneyfund.org

SB 290 Letter of Support.pdf

Uploaded by: Gill, Lindsay
Position: FAV

American Kidney Fund®

February 8, 2021

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.,
Annapolis, MD 21401

RE: SB 290 Letter of Support

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11921 Rockville Pike | Suite 300 | Rockville, MD 20852
301.881.3052 voice | 301.881.0898 fax | 800.638.8299 toll-free | 866.300.2900 Español
Member: CFC 11404 | www.**KidneyFund**.org

Sincerely,

Lindsay Gill

Lindsay Gill
Associate Director of State Policy and Advocacy
(240) 292-7062 direct | (210) 860-7407 cell
lgill@kidneyfund.org

SB0290_FAV_MedChi - Out-of-Pocket & Cost-Sharing -

Uploaded by: Kauffman, Danna
Position: FAV

MedChi

The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915

1.800.492.1056

www.medchi.org

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

DATE: February 10, 2021

RE: **SUPPORT** – Senate Bill 290 – *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 290. Senate Bill 290 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 290 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, 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 high-deductible plans continue to be utilized by employers, this concern becomes more pronounced. For patients with chronic conditions and high health care costs, the benefit of copay assistance programs is essential in receiving their medications. Senate Bill 290 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. It is important to note that Senate Bill 290 does not negate utilization management tools. It is only after the carrier has approved the medication for coverage that copay assistance would be used. Therefore, the argument that copay programs direct patients to higher cost medications is really a moot point.

We urge a favorable vote.

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

SB0290_FAV_MedChi.pdf

Uploaded by: Kauffman, Danna
Position: FAV

MedChi

The Maryland State Medical Society

1211 Cathedral Street
Baltimore, MD 21201-5516
410.539.0872
Fax: 410.547.0915

1.800.492.1056

www.medchi.org

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

DATE: January 20, 2021

RE: **SUPPORT** – Senate Bill 290 – *Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation*

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

CF Foundation Testimony on SB 290 (Accumulators).p

Uploaded by: Kellermann, Adam

Position: FAV

CYSTIC FIBROSIS
FOUNDATION®

February 8, 2021

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

Dear Chairwoman Kelley and Members of the Finance Committee,

On behalf of the 550 people with cystic fibrosis (CF) in Maryland, we are writing to express our support for SB 290, which would require insurers to apply third party assistance to out-of-pocket maximums and other patient cost-sharing requirements. While copay assistance is a short-sighted fix for systemic issues that face our health care system, solutions to address affordability and sustainability cannot come at the expense of patients' health and financial wellbeing.

Please support SB 290 to help protect access to quality, specialty therapies for people with CF.

Cystic fibrosis is a life-threatening genetic disease that affects more than 30,000 children and adults in the United States. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. Cystic fibrosis is both serious and progressive; lung damage caused by infection is irreversible and can have a lasting impact on length and quality of life. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. While advances in CF care are helping people live longer, healthier lives, we also know that the cost of care is a barrier to access for many people with the disease.

Accumulator programs—which prevent third-party payments from counting towards deductibles and out-of-pocket limits—place additional financial strain on people with CF who are already struggling to afford their care. According to a survey conducted by George Washington University of over 1,800 people living with CF and their families, over 70 percent indicated that paying for health care has caused financial problems such as being contacted by a collection agency, having to file for bankruptcy, experiencing difficulty paying for basics like rent and utilities, or having to take a second job to make ends meet. And while 74 percent of people received some form of financial assistance in 2019 to pay for their health care, nearly half reported still having problems paying for at least one CF medication or service in that same year.

High out-of-pocket costs have a direct, negative effect on treatment adherence for people with CF, which can lead to adverse health outcomes. In the aforementioned survey, 18 percent of people with CF skipped medication doses, 24 percent took less medicine than prescribed, and 29 percent delayed filling a prescription—all due to cost concerns. Because CF is a progressive disease, patients who delay or forgo treatment face increased risk of lung exacerbations, irreversible lung damage, and costly hospitalizations.

We understand the challenge insurers face in managing the rising cost of drugs, and that copay assistance programs mask bigger cost and affordability issues in the health care system. However, cost containment strategies that place a further burden on patients are unacceptable. The CF Foundation supports efforts that allow third party assistance to count toward deductibles and out-of-pocket limits, particularly for patients with severe and chronic conditions like CF. The Foundation urges health insurers and pharmaceutical manufacturers to come to the table to discuss long-term solutions that do not place disproportionate financial pressure on patient and families.

We urge you to vote “yes” on SB 290. By supporting this bill, you will help ensure continued access to quality, specialty care for people with CF. The Cystic Fibrosis Foundation appreciates your attention to this important issue for the CF community in Maryland.

Sincerely,

Mary B. Dwight
Chief Policy & Advocacy Officer
Senior Vice President, Policy & Advocacy

Testimony - Copay Accumulators - MD SB 290.pdf

Uploaded by: King, Rebecca

Position: FAV

msaa Improving Lives Today!™
Multiple Sclerosis
Association of America

375 Kings Hwy North | Cherry Hill, NJ 08034 | Phone: (800) 532-7667 | Fax: (856) 661-9797 | mymsaa.org

February 8, 2021

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

Dear Chairwoman Kelley and Members of the Senate Finance Committee,

On behalf of the Multiple Sclerosis Association of America (MSAA) – a 501c3 focused on the mission of improving lives today within the greater multiple sclerosis community and nationwide – we respectfully request your support, and the support of your colleagues, for Maryland Senate Bill 290 to help protect medically vulnerable populations such as those living with multiple sclerosis (MS).

With over 50 years of dedicated service, MSAA has established an excellent record of fair and balanced public positions on various MS issues and prioritizing the needs of patients and their care partners. As a leading resource for the entire MS community, and dedicated to improving lives through vital services and support, we are strong advocates for lowering sky-rocketing drug costs that many individuals living with chronic diseases, like MS, are facing.

Copay accumulator programs that are now trending across the country deplete any financial assistance that copay cards can provide to lower- and middle-income families. According to a 20-year analysis published by Oregon State University, a significant portion of common medications used to treat MS have more than doubled their market price resulting in prescription costs reaching $100,000 or more. In return, patients on expensive disease modifying therapies (DMTs) are forced to either adjust their treatment plans or forgo filling their prescriptions entirely.

When patients are forced to ration their drug therapy treatments, the results can be costly for both their health and the economy. Medication adherence can be challenging for any chronic condition, but even more so for those who depend on their drug therapies to increase their daily quality of living by keeping severe symptoms at bay. Copay coupons from drug manufacturers can not only have a significant impact on an individual's economic viability, but also provide opportunity for patients to shift their focus to other meaningful areas of life such as work and helping their community. In contrast, non-adherence can lead to an increase in emergency department visits and hospital stays that are 100 percent preventable. A review published by the Annals of Internal Medicine estimates that non-adherence can cost the healthcare system anywhere between $100 and $289 billion annually.

At MSAA, we believe that we share a common goal – to lower the financial healthcare burden on families nationwide. No one should have to choose between buying food for their family, or paying to heat their home in the winter, over life-saving medications – especially with our current economy in the wake of COVID-19. While we have made tremendous strides in developing new drug therapy regimens over the past two decades, the benefit is lost if patients with MS cannot afford to access those medications. Copay accumulator programs create just another barrier to accessible treatments for anyone living with a chronic illness. Passing SB 290 (cross-filed with HB 167) will not only improve the lives of the MS community residing in the great state of Maryland but establishing state legislation that protects patients will ultimately influence these decisions at the national level as well.

Should you have any questions, we would be more than willing to provide further insight into our concerns about the impact copay accumulator programs may have on increasing drug costs for MS patients. I may be reached at (800) 532-7667, x144 or rking@mymsaa.org. Thank you for your time and considering our written testimony.

Respectfully,

Rebecca King

Rebecca King
Director of Education and Healthcare Relations
Northeast Region
Multiple Sclerosis Association of America
P: (800) 532-7667, x144
E: rking@mymsaa.org

Support SB 290 - Carrie Koenig .pdf

Uploaded by: Koenig, Carrie
Position: FAV

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing 11 Bladen St.,
Annapolis, MD 21401

RE: Support for SB 290

Dear Chair Kelley and Finance Committee Members,

My name is Carrie Koenig. I live in Odenton with my two children, including my oldest, Nicholas, who was diagnosed with hemophilia when he was 2 days old. I am also an employee of the Hemophilia Federation of America, but today I am writing to you in my personal capacity in support of support of SB 290 – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation.

Hemophilia is a rare genetic bleeding disorder. Without treatment, people with hemophilia bleed internally and into joint areas, sometimes due to trauma, but other times simply as a result of everyday activities. Because my father has hemophilia, I've always known I'm a carrier. While I was familiar with the disease, hearing that your own child has been diagnosed with a life-long, very serious chronic condition is not something that is taken easily. It didn't help that 2 days postpartum, you aren't exactly hormonally sound.

When Nicholas was an itty-bitty baby, he was prescribed what is called an "on demand" treatment plan, as he wasn't mobile. He would receive clotting factor, through IV infusions, before receiving immunizations and if he had an injury or bleeding episode. Any mother would feel helpless watching their 8-week-old child cry out while their physician attempted to access a vein in their scalp.

I knew that despite this diagnosis, Nicholas would be able to live a somewhat normal life thanks to treatment advancements. There's no cure for hemophilia, but there are now medications that can stop or prevent bleeding. When my father was a child, he had no treatment options available and was told he would not live past the age of 20. He was one of the lucky ones, he lived, but not without complications. Due to lack of treatment early on, he has two artificial knees and his ankles have self-fused together.

When Nicholas was 11 months old he had his first true bleed. He was at daycare and was crawling when he was injured. We ended up in the ER for infusions and imaging. Nicholas's first true bleed was heart wrenching to watch. Bleeds are excruciatingly painful and come with long term consequences emotionally; however, the financial costs were also great. As an infant, Nicholas' infusions ran about $2500-$5000 per dose.

After that, we knew it was time to start prophylaxis – a regimen of regular, ongoing infusions with clotting factor, intended to prevent and not merely treat bleeding. It is critically important to prevent bleeds while children are still young, as not doing so can lead to irreversible lifelong damage including the inability to walk as an adult.

Nicholas began prophylaxis at 15 months old, the first of many regular doses he would need for the rest of his life. There are no generic treatments for hemophilia, and no low cost options. The total cost for Nicholas' treatment is about $300,000 per year. Copay assistance is truly the only way we are able afford this life-saving treatment that has protected Nicholas from joint damage and other complications. Due to the cost and complexity of the treatment regimen, selecting insurance is a balancing act for our family. We have to make sure everything will be covered and that the premiums and out-of-pocket costs add up to something we can afford. Currently, we have a gold plan that we bought through the state exchange. Every year, we hit our deductible with our first prescription fill. Without copay assistance, our family could not afford our share of that cost despite the fact that both I and my husband work.

I worry about what would happen to Nicholas and our family if our plan were to begin a copay accumulator adjustment program, where the copay assistance was excluded from our deductible and out-of-pocket maximum. In other states, I know people with hemophilia whose plans have these restrictions. Some have lost their financial independence and because they can no longer afford their regular treatment; others have ended up in the ER for treatment of acute bleeding. This is bad for their health, bad for their ability to maintain employment or schooling, and expensive for the health system as a whole.

Without copay assistance, Nicholas's health and my family's financial security would be at great risk. Not being able to afford his prophylactic treatment would likely push us out of home treatment to being treated in the ER on a regular basis. That would force us into incredible, irreversible debt. I respectfully ask for your support of SB 290 so that my family and others like us can continue accessing life-saving treatment without jeopardizing our well-being and our financial stability.

Thank you,

Carrie M. Koenig

Carrie Koenig
1309 Waneta Ct
Odenton, MD 21113

SB 290 Testimony CCPA Final.pdf

Uploaded by: LaMotte, Lawrence

Position: FAV

Chronic Care Policy Alliance
State Advocates Working Together to Bridge the Gaps in Chronic Care

Testimony RE SB 290 (Benson): Health Insurance - Out-of-Pocket Maximum and Cost-Sharing Requirements – Calculation

Prepared by Lawrence A. LaMotte

Position: FAVORABLE

The Chronic Care Policy Alliance (CCPA) is a network of state and regional advocacy organizations advancing public policy that improves the lives of those living with chronic conditions and diseases.

CCPA is dedicated to ensuring people living with chronic diseases can have a better quality of life. We accomplish this by focusing on four key principles:

- Prevention
- Affordability
- Access to Care
- Quality Health Care

The CCPA urges you to support and pass SB 290 (Benson) to ensure that patients with chronic and/or rare diseases can afford pharmaceutical drug treatments to manage one or more of their medical conditions. In the last few years health insurers and Pharmacy Benefit Managers have developed Accumulator Adjustment Programs that have placed further financial burdens on patients.

Some medicines are expensive and needed by patients over long periods of time and over the course of their lifetime. Many patients cannot afford the high costs of their drug treatment. In those cases, patients have depended upon the help of financial assistance from drug manufacturers, family, friends, Go Fund Me, private charities, religious organizations, and others to help pay for their medicines and have those payments apply toward their out-of-pocket costs and deductible.

The Accumulator Adjustment programs will take the money from patients and third-party sources but will not count those funds towards deductibles or out-of-pocket costs. Thus, a patient and her/his family will never be able to meet their cost sharing obligations and will always be beholden to the health insurer – much like the old “company store” where workers were never able to get out of debt to the company store.

Insurers and PBMs benefit handsomely. The costs that they pass on to patients and their families are not based upon the significant discounts and rebates that drug companies give to Insurers and PBMs. Rather patient costs are based upon the “list or retail” price. As a result, patients are being gouged and insurers and PBMs are paying minimum costs and sharing profits with stockholders at the expense of patients.

These programs were invented by PBMs as part of the “war” between health insurers and pharmaceutical companies concerning the high cost of drugs. Insurers believe that payments from third parties on behalf of patients keep drug prices high and their drug spend high. They further believe that these types of programs will reduce costs and their drug spend. There is no evidence that these programs will reduce costs. Regarding insurers’ drug spend, there **will** be an impact because patients will not be able to afford their medicines and won’t get the drug therapies they need. There is no doubt that patients who cannot obtain their drug therapeutic treatments as a result of these accumulator programs will unfortunately be using and increasing their medical benefits instead. In this war, patients are pawns and collateral damage.

Health insurers and PBMs operate on the premise that if a person needs more health care services, they should pay more. In other words, sick people should be financially penalized for being sick. Government policy should be directed to helping those people who have limited means and chronic and/or rare diseases. Payors and PBMs should not be allowed to continue practices such as accumulator adjustment programs. Instead, government should end or prevent such predatory and discriminatory practices.

We urge your support of SB 290. Feel free to reach out to me at the contact information below.

Lawrence A. (Larry) LaMotte
CCPA
Senior Policy Advisor
3801 Canterbury Road
#417
Baltimore, Maryland 21218
Llamotte6394@gmail.com
410-458-8336

Support for SB 290 - Dr. Erinn Maury.pdf

Uploaded by: Maury, Erinn
Position: FAV

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.,
Annapolis, MD 21401

Re: Support for SB 290

Dear Chair Kelley and Finance Committee Members,

My name is Dr. Erinn Maury. I am a solo practitioner rheumatologist in Glen Burnie Maryland as well as the MedChi Delegate for Anne Arundel County. As a rheumatologist, I care for patients with autoimmune diseases and arthritis. Today, I write to you in support of SB 290 – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation – to help Maryland patients continue to afford the treatments they need by requiring copay assistance to count toward their deductibles and out-of-pocket maximums.

Every day I care for patients who need specialty medications to prevent the immune system from attacking and damaging the joints and internal organs. The most common diseases I treat are lupus, rheumatoid arthritis, and psoriatic arthritis. While some of the medications I prescribe are expensive, they are the standard of care and allow my patients to continue working, caring for their families, and maintain their quality of life. Most patients have health plans with a high deductible and need copay assistance to afford their medicine.

Increasingly, insurers are implementing copay accumulator adjustment programs that prevent patients from using copay assistance to meet their deductibles; meaning if the patient uses the copay assistance, that money will not count towards their deductible. The true effect of these accumulator programs is limiting access to essential, sometimes life-saving medications for patients. It should not matter where the money comes from for the patient to pay their copay or coinsurance, especially when the average price for a biologic is $10,000 a month.

Today, United Healthcare calls its program a “Coupon Adjustment: Benefit Plan Protection” which provides no benefit to the patient, it only benefits the insurer. Under these policies, insurers are double dipping by allowing copay assistance to pay for out-of-pocket costs but excluding it from the patient’s deductible. When the assistance runs out, patients must re-pay the out-of-pocket costs from their own pocket, harming their financial well-being and benefiting the insurer. These policies need to be nipped in the bud before they become commonplace and Maryland patients are harmed.

Further, the COVID-19 pandemic has caused a major financial crisis; lost jobs, lost income, and people at risk of being evicted. For example, take one of my patients who is in his 40’s, who takes a biologic for psoriatic arthritis, and has a $4,000 deductible. Because of the COVID-19 pandemic, his wife had to give up her job to stay home with their 2 kids, so they are now a one income family with a mortgage and other usual expenses. Fortunately, he can work from home. However, even before the pandemic, he would not have been able to afford his treatment without copay assistance. He is the kind of father who would consider stopping or cutting back his medication so that his family would have what they need to survive. Given how bad his arthritis was before his biologic, he would likely end up disabled without treatment. Currently, copay assistance is the only thing standing between him and this worst-case-scenario.

Insurance companies have said that doctors like me prescribe expensive medications because copay assistance is available. That is not true. I typically start with medications that are much less expensive and preferred on the insurance company formularies. I start with these cheaper effective medications because they are the standard of care for the diseases I treat. However, some patients require specialty medications to manage their disease. There are no cheaper or generic alternatives for these medications. When I prescribe a high-cost medication, I do so because it is in the best interest of my patient. I completely agree that drug prices are too high, however, when insurance companies exclude assistance, they only harm patients and limit access to the standard of care. My patients are stuck in the middle.

Thank you to Senator Joanne Benson for championing patient access and sponsoring this important bill. I respectfully request that you support SB 290 to help my patients afford their medications.

Sincerely,

Dr. Erinn Maury

Mid-Atlantic Rheumatology
7671 Quarterfield Rd
Suite 300
Glen Burnie, MD 21061

Komen_2021_Assumulator_MDState_Testimony_.pdf

Uploaded by: Raga, Steven
Position: FAV

susan G.
komen®
Where the end of breast cancer begins.™

Written Testimony Supporting SB 290
Submitted to the Finance Committee
February 8, 2021
By Susan G. Komen

Chairperson Kelley, Vice Chairman Feldman, and Members of the Committee, thank you for the opportunity to provide testimony in support of SB290, which relates to Out-of-Pocket Maximums and Cost-Sharing Requirements. My name is Steven Raga, and I am the Northeast Regional Manager of State Policy & Advocacy at Susan G. Komen®.

Susan G. Komen is the world's leading non-profit breast cancer organization representing the millions of women and men who have been diagnosed with breast cancer, including the 5,470 women who will be diagnosed and 860 who will die from the disease this year alone in Maryland.

We have a comprehensive 360-degree approach to fighting this disease across all fronts—we advocate for patients, drive research breakthroughs, improve access to high quality care, offer direct patient support and empower people with trustworthy information. Komen advocates for all women to have access to the tools and resources necessary to save their lives. We believe strongly that ensuring screening, diagnostic and treatment services are affordable and accessible for all increases the likelihood that women will have the ability to detect, diagnose and treat their breast cancer early - potentially saving their lives.

Recently, health insurers have instituted "copay accumulator adjustment programs" which prevent payments made by copay assistance from drug manufacturers and nonprofits from counting toward a patient's cost sharing requirements. SB 290 will help Marylanders continue to access the treatments they need by ensuring all expenses made by or on behalf of a patient count toward their cost sharing requirements.

According to a recent study of claims data, a vast majority of copay assistance is used for treatments that do not have a generic alternative.[1] Unfortunately, many patients are not aware that the copay assistance was not counted toward their deductible or out-of-pocket maximum until they have to pay hundreds to thousands of dollars out of pocket to continue their treatments.

A patient should not be forced to abandon their treatment or skip doses due to costs. Studies have shown that patients are far more likely to abandon their treatment when out-of-pocket costs exceed $100.[2] Unfortunately, we hear from patients who have been forced to stop using their medications due to the high out of pocket costs that end up having an increase in negative health outcomes and hospital visits- ultimately resulting in increases to overall health care costs.

As committed partners in the fight against breast cancer, we know how deeply important it is for Maryland breast cancer patients to not be punished for using copay assistance in helping them afford the necessary treatments they need. As such, we support SB290 and urge you to pass this critical legislation.

Thank you for your consideration,
Steven Raga, Northeast Regional Manager of State Policy & Advocacy at Susan G. Komen

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[1] IQVIA. An Evaluation of Co-Pay Card Utilization in Brands after Generic Competitor Launch. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization
Accumulator

[2] Gleason PP, Starner CI, Gunderson BW, Schafer JA, Sarran HS. Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. J Manag Care Pharm. 2009;15(8):648-658. doi:10.18553/jmcp.2009.15.8.648

SB0290 - Maximums - Cost-Sharing - FAV - Brian Hos

Uploaded by: RASMUSSEN, DENNIS

Position: FAV

02/10/2021 **SB 290**

EPIC Rx

A Network Of
Independently Owned
Pharmacies

Testimony offered on behalf of:

EPIC PHARMACIES, INC.

IN SUPPORT OF:

SB 290 – Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Hearing 2/10 at 1:00PM

EPIC Pharmacies Supports SB 290 – Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Since 2018, many plan sponsors have adopted “copay accumulator” programs where a manufacturer’s copay assistance payments do not count towards a patient’s deductible or out-of-pocket maximum obligations. Also, since 2018, the patient’s cost share has increased dramatically, especially with expensive Specialty Medication.

The negative consequences of allowing this trend to continue:

1. Patient become angry and confused: For years, manufacturer copay programs have helped patients deal with employers’ and health plans’ massive cost-shifting for specialty drugs. The abrupt patient out of pocket cost increase will be confusing,
2. Drug Spending will drop – for the wrong reasons: Massive cost shifting to patients will cause a decrease in utilization of expensive Specialty drugs. This is usually considered a bad thing because, though Specialty Prescription spending drops, medical spend will increase.
3. **Patient adherence will plummet**: The MD Health Exchange shows out-of-pocket maximums averaging about $8,000.00 per year. Cost sharing is used to incentivize more cost effective choices by the patient. Patients on expensive chemotherapeutics and other Specialty meds really can’t make more cost effective choices. Rather, when they can’t afford treatment, they will simply stop filling expensive specialty prescriptions. I see this 1st hand, and it is heart breaking. Eventually, the patient can deteriorate, and fall into public assistance plans like MADAP and Medicaid.

What is the consequence of copay accumulator programs to the plan sponsor? A 66% decrease in medication expenses by the plan sponsor. Often the plan will not pay the full cost of medication expenses until the last 2 months of the year.

As such, EPIC Pharmacies recommends a favorable report on SB 290.

Thank you,

Stephen Wienner, Pharmacist

Steve Wienner, Rph
EPIC PharmPAC Treasurer
Mt. Vernon Pharmacy and Mt. Vernon Pharmacy at Fallsway

MDCSCO_ASCO_Support_MD_SB_290 (1).pdf

Uploaded by: Rollins, Allison

Position: FAV

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA
SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

February 10, 2021

Chair, Senator Dolores 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 Maryland/District of Columbia Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are pleased to **support SB 290: 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. MDCSCO is an organization of over 400 members committed to improving the quality and delivery of care in medical oncology in the State of Maryland and the District of Columbia. 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.

MDCSCO and ASCO are 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.

MDCSCO and ASCO are encouraged by the steps that SB 290 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 Danna Kauffman at MDCSCO at dkauffman@smwpa.com or Allison Rollins at ASCO at allison.rollins@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Paul Celano

Paul Celano, MD, FACP
President
Maryland/DC Society of Clinical Oncology

Monica M. Bertagnolli, MD

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

MDCSCO_ASCO_Support_MD_SB_290.pdf
Uploaded by: Rollins, Allison
Position: FAV

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA
SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

January 20, 2021

Chair, Senator Dolores Kelly
Senate Committee on Finance
Maryland State Senate
11 Bladen Street
Annapolis, MD 21401

Dear Chair Kelly and Honorable Members of the Senate Committee,

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Chair of the Board
Association for Clinical Oncology

SB290LetterofSupport_HIVHepPolicyInstitute.pdf

Uploaded by: Schmid, Carl
Position: FAV

HIV + HEP
POLICY INSTITUTE

January 18, 2021

Chair Delores Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Re: Support of SB 2907 so that Patients can Afford their Prescription Medications

Dear Chair Kelley,

The **HIV+HEP Policy Institute** is a leading HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. **We strongly support *Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation* (House Bill 0167 and Senate Bill 0290), which would require health insurers to accept all forms of copay assistance for prescription medications and ban the use of copay accumulators in Maryland.**

Copay accumulators are harmful policies that many insurance plans, employers, and pharmacy benefits managers (PBMs) are implementing in which copay assistance does not count towards a beneficiary' out-of-pocket costs and deductible. By passing this bill, Maryland will join other states (Arizona, Georgia, Illinois, West Virginia, and Virginia) and Puerto Rico in protecting consumers purchasing insurance on the private market by assuring their copay assistance will count towards cost-sharing obligations.

People with HIV, hepatitis, and others with serious and chronic conditions rely on medications to remain healthy and alive. People with HIV and hepatitis B rely on a daily drug regimen that they must take for the rest of their lives, while people with hepatitis C can be cured of their diseases in as little as 8 to 12 weeks. However, even though people may have health insurance, access to these medications is still insurmountable for many due to high deductibles and cost-sharing, often in terms of co-insurance. Copay assistance is critical for patients to afford and adhere to their medications. It is particularly important during the COVID-19 epidemic when so many individuals and families are hurting economically.

High Patient Cost-sharing: According to the Kaiser Family Foundation, average deductibles for covered workers increased 212% from 2008 to 2018. For qualified health plans, CMS reports that across all metal levels, deductibles are increasing. For Bronze plans, the median deductible will be $6,992 in 2021, an increase of 11 percent from 2017; for Silver plans, it will be $4,879, an increase of 31 percent since 2017. For plan year 2022, CMS is proposing that the maximum out-of-pocket be $9,100 for an individual and $18,200 for all others. Due to the proliferation of high deductible plans, depending on the drug, a patient may be required to pay that total amount of $9,100 all at once for their medication at the beginning of the year.

According to a study conducted by Ezra Golberstein examining National Health Expenditure Accounts data, in 2017 individuals were responsible for paying 14 percent of the total cost of prescription drugs. However, for hospital care, which accounts for nearly three and half times more total spending, patients were responsible for paying only 3 percent. For physician and clinical services, the next largest service category, patients paid 8.5 percent of the costs. This is one reason why people are complaining about how much they pay for their medications; insurers are requiring them to pay a high percent of the total costs.

Patient Cost-sharing Impacts Adherence: A recent analysis of branded prescription drug trends found that if patient out-of-pocket costs totaled between $50 and $74.99 per month that 30 percent of patients would not pick up their medications. If that amount were increased to $250 or more, over 70 percent of patients would forego critical prescription drugs.[1] Another study highlighted the negative impact of copay accumulator programs finding that patients who are subject to the programs fill prescriptions 1.5 times less than patients in high deductible health plans. Additionally, patients subject to these programs experience a 13 percent drop in persistence between month 3 and 4 as they reach the cap in their annual benefits and terminate their therapies.[2]

Growth of Copay Accumulators: Health insurers and pharmacy benefits managers have increasingly included copay accumulator adjustment programs in their plan offerings over the last several years. According to the National Business Group of Health, in the next two years, accumulators and maximizers are expected to expand from approximately 25 percent of U.S. employers to as many as 50 percent. According to TrialCard, one of the leading administrators of copay assistance programs, clients taking infectious disease medications and subject to copay accumulator programs has increased from 7.3 percent in 2019 to 10.5 percent in 2020.

Copay Accumulators Allow Insurers to "Double Dip": Perhaps the most overlooked aspect of the "copay accumulator" issue is that not only do patients pay much more money for their prescription drugs, but the insurers also collect more money. The insurer not only collects the value of the copay coupon, but then after it is maxed, the patient then has to pay the out-of-pocket costs, with the insurer collecting all that money as well. Additionally, the drug manufacturers end up paying more money. The only players that this policy is good for are the insurers and the PBMs.

Lack of Transparency: Patients often are not aware that their insurance policies contain these harmful policies until they pick up their medications at the pharmacy and are stuck with a several thousand-dollar bill that they did not expect. Insurers conceal copay accumulator

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[1] IQVIA National Prescription Audit, Formulary Impact Analyzer, January 2019.

[2] Steve Mink and Arran Standring, "Driving persistence among patients affected by copay accumulators with patient centric support," *American Journal of Managed Care*, October 18, 2020.

language deep in plan documents. Additionally, there is no consistency among insurers on how the policies are displayed and plans use ambiguous language.

Consider **Maryland's United Health Care** policy which includes a copay accumulator provision on page 32 of an 85 page Medical Policy document:

> *Coupons: The value of any manufacturer coupons applied to member cost share may not apply to deductibles or total member out-of-pocket limits. You may find information on manufacturer coupons that apply to out-of-pocket limits through the internet at myuhc.com.*

Not only is the language ambiguous since it uses the term "may," but it requires the beneficiary to look up additional policy information on the internet through United Health Care's main website with no further direction.

For the benefit of patients who rely on prescription drugs to maintain their health, we urge you to support SB 290. If you have any questions or need any additional information, please do not hesitate to reach out via phone at (202) 462-3042 or email at cschmid@hivhep.org. Thank you very much.

Sincerely,

Carl E. Schmid II
Executive Director

SB290LetterofSupport_HIVHepPolicyInstitute.pdf

Uploaded by: Schmid, Carl
Position: FAV

HIV + HEP
POLICY INSTITUTE

January 18, 2021

Chair Delores Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Re: Support of SB 2907 so that Patients can Afford their Prescription Medications

Dear Chair Kelley,

The **HIV+HEP Policy Institute** is a leading HIV and hepatitis policy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions. **We strongly support *Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation* (House Bill 0167 and Senate Bill 0290), which would require health insurers to accept all forms of copay assistance for prescription medications and ban the use of copay accumulators in Maryland.**

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Sincerely,

Carl E. Schmid II
Executive Director

MD SB 290 - Senate Finance Committee - Feb. 10.pdf

Uploaded by: Schultz, Steven

Position: FAV

Arthritis Foundation®

arthritis.org/advocacy

Februrary 8, 2021

Honorable Senator Delores Kelley
Chair, Senate Finance Committee
Maryland General Assembly
Annapolis, MD

RE: Senate Bill 290

Dear Chairwoman Kelley,

On behalf of the 1.1 million adults living in Maryland with doctor-diagnosed arthritis, the Arthritis Foundation urges reform regarding accumulator adjustment programs. Accumulator adjustment programs prevent any co-payment assistance that may be available for high cost specialty drugs from counting towards a patient's deductible or maximum out-of-pocket expenses. Many pharmaceutical manufacturers offer co-pay cards that help cover a patient's portion of drug costs. Traditionally, pharmacy benefit managers have allowed these co-payment card payments to count toward the deductible required by a patient's health insurance plan. With an accumulator adjustment program, patients are still allowed to apply the co-payment card benefits to pay for their medications up to the full limit of the cards, but when that limit is met, the patient is required to pay their full deductible before cost-sharing protections kick in.

Currently, the state of Maryland does not have a law to ensure that health insurers count co-payment assistance towards a patient's cost-sharing requirements. However, Senator Joanne Benson has introduced legislation (SB 290) to protect patients against accumulator adjustment programs.

Legislation is necessary on this issue as patients are often unaware they are enrolled in one of these programs until they go to the pharmacy counter and realize they must pay the full cost of their medication, which can lead them to abandon or delay their prescription. These programs can be called different names, are often marketed as a positive benefit, and are often disclosed many pages into plan materials, leading to a lack of awareness about them to patients. In addition, accumulator adjustment programs are becoming increasing added to health insurance contracts. In a recent survey of employers, nearly 30% implemented a CAAP for 2019 and 21% were contemplating one for 2020 or 2021. In another recent employer survey, 54% of respondents did not credit third-party co-pay assistance toward patient deductibles. [1] In an Arthritis Foundation survey of more than 600 patients, 39 percent of patients on an employed sponsored health plan used a drug manufacturer co-pay card to help pay for their arthritis medications. Among these individuals, 59 percent reported that they can use it to pay for their deductibles, 27 percent reported they can't use it for their deductible, and 14 percent reported that they don't know.

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[1] American Journal of Managed Care, Impact of a Co-pay Accumulator Adjustment Program on Specialty Drug Adherence

Senate Bill 290 resolves this issue by simply ensuring that when calculating a patient's overall contribution to any out-of-pocket maximum or any cost-sharing requirement, a health plan must include any amounts paid by the patient or paid on behalf of the patient by another person.

For this reason, the Arthritis Foundation supports SB 290, which ensures that assistance counts towards a patient's cost-sharing, and encourages the Maryland General Assembly to pass this legislation to protect patients.

Sincerely,

Steven Schultz
Director, State Legislative Affairs
(916) 690-0098
sschultz@arthritis.org

MD SB 290 - Senate Finance Committee.pdf

Uploaded by: Schultz, Steven
Position: FAV

Arthritis Foundation®
arthritis.org/advocacy

January 18, 2021

Honorable Senator Delores Kelley
Chair, Senate Finance Committee
Maryland General Assembly
Annapolis, MD

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Sincerely,

Steven Schultz
Director, State Legislative Affairs
(916) 690-0098
sschultz@arthritis.org

MD SB 290 Testimony_The AIDS Institute.pdf

Uploaded by: Weinrich, Jacqueline

Position: FAV

THE AIDS INSTITUTE

Chair Delores G. Kelley
Senate Finance Committee
11 Bladen St.
Annapolis, MD 21401

February 8, 2021

RE: The AIDS Institute Testimony in Support of SB 290

Dear Chair Kelley and Committee Members:

The AIDS Institute, a non-partisan, a nonprofit organization dedicated to supporting and protecting health care access for people living with HIV, hepatitis, and other chronic and serious health conditions, is submitting our **support for SB 290.** The bill would require insurers to include payments made by, or on behalf of, the insured for prescription drugs toward the insured's cost-sharing requirement**.**

Even with insurance, medications to treat HIV, hemophilia, MS, cancer, lupus, and other complex, chronic diseases often remain unaffordable because of health plan deductibles that stretch above $6,000 and coinsurance which can often be 50% of the full price of the medication. Copay assistance provides a financial lifeline for patients who rely on rigorous treatment regimens made up of several specialty drugs. When insurers implement the policies addressed by this bill, commonly called "copay accumulator adjustment programs," patients' copay assistance is not counted toward their cost-sharing requirements and they are met with the full cost of their medications after the assistance runs out. This financial burden can lead to patients foregoing their medications. Pharmaceutical claims data reveals that 40% of patients will not fill a prescription if out-of-pocket costs reach $75-125, and 70% will abandon it if the costs go above $250. Specialty medications can run thousands of dollars per month, well beyond the financial budget of the average person.

The AIDS Institute is particularly concerned about the effects of copay accumulators on patients with HIV and Hepatitis C (HCV). Patients with HIV rely on consistent access to their medications to control disease progression, reduce viral transmission, and ultimately prevent death. Maryland has one of the highest rates of HIV prevalence in the United States and is home to three of the federally designated "Ending the HIV Epidemic" jurisdictions. Ensuring Marylanders have access to needed drugs is crucial to ending both the HCV and HIV epidemics. For HIV, HCV, and other serious chronic conditions, rationing prescriptions will result in irreversible disease progression and increased emergency room visits, which ultimately costs the healthcare system more.

In 2021, at least one of the three health insurance issuers in Maryland's ACA marketplace had a copay accumulator policy in their plan. However, a national review of issuers found that these policies are often excluded from plan documents, leaving patients unaware of this harmful practice. Passing SB 290 would ensure Maryland patients are unequivocally protected from copay accumulators.

When issuers use copay accumulators to deny patients’ copay assistance from counting towards their cost-sharing requirement, insurance companies collect from both the patient and copay assistance, increasing their profits at the expense of vulnerable patients. This practice can be likened to paying for your crab cakes at G&M with a gift card, only to be brought the bill a second time and being forced to pay again.

Patients are facing unprecedented financial pressures and public health threats due to the ongoing COVID-19 pandemic; and this harmful insurance practice seems even more exploitive of those with vulnerable health conditions during this time. Maryland’s action on this bill would ensure patients are not forced to forego their life-saving medications to put food on the table.

In conclusion, we urge you to support SB 290 ensuring copay assistance will count toward a beneficiary’s annual cost sharing and protect Maryland patients’ health.

Sincerely,

Stephanie Hengst
Manager, Policy & Research
The AIDS Institute

Maryland Hospital Association- SB 290- Health Insu

Uploaded by: Witten, Jennifer

Position: FAV

Maryland
Hospital Association

January 20, 2021

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

Re: Letter of Support- Senate Bill 290- Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 290.

Broad based, affordable and comprehensive health insurance is integral to hospitals' ability to provide high-quality care. It also is key to the state's success under the Total Cost of Care Model, which pushes accountability for whole-person care, including population health. Maryland hospitals are strong proponents of the state's efforts to expand health care coverage, supporting Medicaid expansion, offering subsidized individual and small group health plans through the Maryland Health Benefit Exchange, and most recently the creation of the individual market reinsurance program.

Yet, we know 357,000 Marylanders are uninsured, and even more are underinsured—which often prevents access to care and worsens health outcomes.[1] The State Health Access Data Assistance Center (SHADAC) notes that 43% of employees in Maryland are in enrolled in high-deductible health plans.[2]

The high out-of-pocket costs in these plans deter people from accessing appropriate upstream care and saddle patients with large bills for care they do receive. Maryland hospitals continue to urge a holistic solution to tackle the issue of underinsurance so individuals can access care that is most beneficial to them, and in the easiest way possible. Until then, this bill would allow individuals to leverage additional contributions, such as copay assistance programs, to help meet those high deductibles.

For more information, please contact:
Jennifer Witten, Vice President, Government Affairs
Jwitten@mhaonline.org

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[1] American Community Survey, Table HI-05_ACS: Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons: 2019. Available at: census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html

[2] State Health Access Data Assistance Center, State-Level Trends in Employer Sponsored Health Insurance, 2014-2018. Available at: shadac.org/sites/default/files/ESIReport2019/StateProfile/2014-2018_ALLstate.pdf

SB 290- Health Insurance - Out-of-Pocket Maximums

Uploaded by: Witten, Jennifer
Position: FAV

Maryland
Hospital Association

February 10, 2021

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

Re: Letter of Support- Senate Bill 290- Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation

Dear Chair Kelley:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on Senate Bill 290.

Broad based, affordable and comprehensive health insurance is integral to hospitals' ability to provide high-quality care. It also is key to the state's success under the Total Cost of Care Model, which pushes accountability for whole-person care, including population health. Maryland hospitals are strong proponents of the state's efforts to expand health care coverage, supporting Medicaid expansion, offering subsidized individual and small group health plans through the Maryland Health Benefit Exchange, and most recently the creation of the individual market reinsurance program.

Yet, we know 357,000 Marylanders are uninsured, and even more are underinsured—which often prevents access to care and worsens health outcomes.[1] The State Health Access Data Assistance Center (SHADAC) notes that 43% of employees in Maryland are in enrolled in high-deductible health plans.[2]

The high out-of-pocket costs in these plans deter people from accessing appropriate upstream care and saddle patients with large bills for care they do receive. Maryland hospitals continue to urge a holistic solution to tackle the issue of underinsurance so individuals can access care that is most beneficial to them, and in the easiest way possible. Until then, this bill would allow individuals to leverage additional contributions, such as copay assistance programs, to help meet those high deductibles.

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NMSS Letter of Support SB 290 2 8 21 .pdf

Uploaded by: Wood, Shannon

Position: FAV

National
Multiple Sclerosis
Society

The Honorable Delores G. Kelley
The Honorable Brian J. Feldman
Senate Finance Committee

Re: SB 290 Support

Dear Chair Kelley and Vice Chair Feldman:

I am writing today on behalf of the National Multiple Sclerosis Society (the Society) regarding Senate Bill (SB) 290. The Society supports SB 290, which addresses copay accumulator programs that impact access to health care for people living with multiple sclerosis. We commend Senator Benson for introducing this important legislation and we respectfully ask the Finance Committee to favorably report SB 290.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Recent studies estimate nearly 1 million in the United States are living with MS. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

MS is an expensive disease to live with and treat, impacting the healthcare system, health plans and of course, families affected by MS. A person with MS spends three times as much out-of-pocket than the average person in employer plans. Disease modifying treatments (DMTs) are approximately 75% of the cost of treating MS. Early and ongoing treatment with a disease modifying medication is the best way we know to slow the progression of MS, prevent the buildup of disability and protect the brain from damage due to MS. While there are over 20 DMTs available, they are not interchangeable and we do not yet know which medication will work best for each person.

These medications are very expensive, and people with MS often face a high deductible and later co-insurance—meaning they are often responsible for thousands of dollars in out-of-pocket costs. This poses a significant challenge in their ability to access these lifechanging medications.

Copay accumulators (or accumulator adjustment programs) began from the belief that drug manufacturers' patient assistance programs are discouraging patients and their doctors from choosing generics or less-costly prescription drug alternatives. These programs are used to prohibit prescription drug coupons or other forms of prescription drug manufacturer assistance from applying towards a patient's annual deductible or out-of-pocket maximum amounts.

In MS, copay accumulators make it more difficult for people to get the healthcare they need. As many as 40% of people living with MS rely on copay assistance programs to maintain access to their disease-modifying therapy. With the implementation of copay accumulator programs, people with MS are experiencing higher cost burdens as they struggle with unexpected expenses during their deductible period. It is well-known that people with chronic and high-cost conditions like MS face significant financial hardship each year until their deductible has been met and the full relief of their health insurance kicks in. This financial hardship existed prior to the current pandemic, but has certainly worsened due to the economic impact of COVID-19. Copay accumulator programs add to this financial hardship, as preventing copay assistance from applying to a person's deductible means it takes them longer to reach the end of the deductible period. Because patients are responsible for 100% of their health care costs until the deductible is satisfied, prolonging the deductible period can put other medical needs—such as doctors' visits, rehab therapies, MRIs, or other medications—financially out-of-reach.

The Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to escalating price increases, barriers to care and a system too complex to navigate. It is reasonable to question the role of copay assistance programs and the potential role they inadvertently play in raising costs or impeding access—but this should not be the first change that happens. Until we find real solutions to the challenges in our healthcare system that prevent people from affordably accessing the care and treatments they need, we cannot rip away the band-aids people have come to rely on—like copay assistance programs. Mechanisms like copay accumulators primarily impact people who are seeking whatever avenue they can find to be able to take their needed medication.

The Society supports solutions that help safeguard access for people who need life-changing medications, without getting them caught in the middle of struggles between other stakeholders. Please support SB 290.

Sincerely,

Shannon Wood
Senior Manager, Advocacy
National Multiple Sclerosis Society

SB 290 NMSS Support.pdf

Uploaded by: Wood, Shannon

Position: FAV

National
Multiple Sclerosis
Society

Chair Delores G. Kelley
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Re: SB 290 Support

Dear Chair Kelley and Finance Committee Members:

I am writing today on behalf of the National Multiple Sclerosis Society (the Society) regarding Senate Bill 290. The Society supports SB 290, which addresses copay accumulator programs that impact access to health care for people living with multiple sclerosis. We respectfully ask Senate Finance Committee to favorably report SB 290.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Recent studies estimate nearly 1 million in the United States are living with MS. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS.

MS is an expensive disease to live with and treat, impacting the healthcare system, health plans and of course, families affected by MS. A person with MS spends three times as much out-of-pocket than the average person in employer plans. Disease modifying treatments (DMTs) are approximately 75% of the cost of treating MS. Early and ongoing treatment with a disease modifying medication is the best way we know to slow the progression of MS, prevent the buildup of disability and protect the brain from damage due to MS. While there are over 20 DMTs available, they are not interchangeable and we do not yet know which medication will work best for each person.

These medications are very expensive, and people with MS often face a high deductible and later co-insurance—meaning they are often responsible for thousands of dollars in out-of-pocket costs. This poses a significant challenge in their ability to access these lifechanging medications.

Copay accumulators (or accumulator adjustment programs) began from the belief that drug manufacturers' patient assistance programs are discouraging patients and their doctors from choosing generics or less-costly prescription drug alternatives. These programs are used to prohibit prescription drug coupons or other forms of prescription drug manufacturer assistance from applying towards a patient's annual deductible or out-of-pocket maximum amounts.

In MS, copay accumulators make it more difficult for people to get the healthcare they need. As many as 40% of people living with MS rely on copay assistance programs to maintain access to their disease-modifying therapy. With the implementation of copay accumulator programs, people with MS are experiencing higher cost burdens as they struggle with unexpected expenses during their deductible period. It is well-known that people with chronic and high-cost conditions like MS face significant financial hardship each year until their deductible has been met and the full relief of their health insurance kicks in. This financial hardship existed prior to the current pandemic, but has certainly worsened due to the economic impact of COVID-19. Copay accumulator programs add to this financial hardship, as preventing copay assistance from applying to a person's deductible means it takes them longer to reach the end of the deductible period. Because patients are responsible for 100% of their health care costs until the deductible is satisfied, prolonging the deductible period can put other medical needs—such as doctors' visits, rehab therapies, MRIs, or other medications—financially out-of-reach. As one Maryland resident living with MS who recently lost his job stated:

"Co-pay assistance is extremely helpful for people like me, especially now that I am out of a job. Assuming that I keep my current health insurance through COBRA – which will cost roughly $2,000/month – the copay assistance I receive for my disease-modifying therapy, Ocrevus, is going to be even more important in stretching our medical benefits. Having that assistance count towards my copay makes everything else that much more affordable. My benefits expire at the end of February, and I hope to have a new job by then, but if not, I will pay for COBRA as Ocrevus would otherwise be unaffordable."

The Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to escalating price increases, barriers to care and a system too complex to navigate. It is reasonable to question the role of copay assistance programs and the potential role they inadvertently play in raising costs or impeding access—but this should not be the first change that happens. Until we find real solutions to the challenges in our healthcare system that prevent people from affordably accessing the care and treatments they need, we cannot rip away the band-aids people have come to rely on—like copay assistance programs. Mechanisms like copay accumulators primarily impact people who are seeking whatever avenue they can find to be able to take their needed medication.

The Society supports solutions that help safeguard access for people who need life-changing medications, without getting them caught in the middle of struggles between other stakeholders.
We respectfully request the Committee favorably report SB 290.

Sincerely,

Shannon Wood
Senior Manager, Advocacy
National Multiple Sclerosis Society
4200 Innslake Drive, Suite 301
Glen Allen, VA 23060

Dr Angus Worthing - SB290 Copay Accumulator Testim

Uploaded by: Worthing, Angus

Position: FAV

Date: Wednesday, January 20, 2021

Bill: SB0290 - Health Insurance – Out–of–Pocket Maximums and Cost–Sharing Requirements – Calculation

Committee: Senate Finance
The Honorable Delores Kelley, Chair

POSITION: Support

Submitted by: Angus Worthing, M.D.
Arthritis & Rheumatism Associates PC
Chevy Chase, MD

Good afternoon Chair and members of the Committee. My name is Dr. Angus Worthing, and I am grateful for the opportunity to testify on behalf of my medical group and my patients in favor of SB0290, entitled Health Insurance Out of Pocket Maximums and Cost-Sharing Requirements Calculation.

I have been practicing medicine in Maryland since 2008. In addition to my full-time rheumatology practice, I serve on the executive committee of my medical group, Arthritis & Rheumatism Associates, which has offices in Maryland, Virginia, and the District of Columbia, I am a Clinical Assistant Professor of Medicine at Georgetown University Medical School, and I serve on the Board of Directors of the American College of Rheumatology. Briefly, my background in this topic includes treating patients who have autoimmune and musculoskeletal diseases like rheumatoid arthritis, osteoporosis, lupus, gout, and many others using various prescription medications that can either be dispensed in our office as infusions, or dispensed by pharmacists for patients to take as pills or self-injections. These drugs can be life-changing for people – they relieve previously disabling joint pain, prevent damage to joints and other organ systems, prevent permanent disability, and extend a person's life expectancy. It's really gratifying to take care of people who experience this life-changing effect. They've often experienced pain for months or years while getting diagnosed and while trying 1 or more less-costly medications which failed them, and are now doing well, back to work because of the medications they are currently taking. But many of these medicines can be challenging for patients to obtain due to high out of pocket costs.

As written, this legislation sets up an effective process to protect Marylanders against a new tactic by insurance companies that makes these drugs unaffordable, and also disrupts the doctor-patient relationship. My colleagues and I strongly support the bill and we commend Delegate Young and Senator Benson for introducing it.

Currently, when patients face a high copayments for prescription drugs, copay assistance funds can help defray their out of pocket costs and allow them to start taking medication and continue medications that are keeping their illnesses controlled. These assistance programs can typically pay up to $10,000 to $20,000 per year for a patient's medication. Unfortunately, some insurance carriers have stopped allowing copay assistance funds to be applied to patients' out of pocket costs. These patients are forced to make payments that are often unaffordable in order to obtain their medicines. It's heartbreaking to see the look of fear and anxiety on my patients' faces when they can't afford the medications that rescued them from the disabling pain they had for months or years until they started drugs that worked for them. When autoimmune diseases flare, patients often must use medicine to suppress the immune system or even be hospitalized. The COVID-19 pandemic is arguably the worst possible time to put people on immune-suppressing drugs or hospitalized them.

Also, insurers implement these tactics by requiring me to report my patients' copay assistance data before reimbursing my office for the cost of their intravenous medications, for the purpose of preventing us from applying copay funds towards patients' copayments. This places me in conflict with the welfare of my patients and disrupts our relationship. The American Medical Association commented – in its November 2020 policy supporting legislation like HB 167 and SB 290 – that doctors who report this patient data would be violating the AMA Code of Medical Ethics.

The nation's largest insurance company announced in the fall that it would implement this disruptive tactic on January 1, 2021. While implementation was paused in response to our concerns, my patients are at risk of this and other insurance company programs. I encourage the General Assembly to pass this legislation urgently, so that our patients insured in Maryland can have the same protections that our Virginia patients enjoy.

As a physician, it is a privilege to be here today and be able to advocate on behalf of my patients and the thousands of individuals likewise situated. I look forward to your questions. Thank you.

FOR ADDITIONAL INFORMATION CONTACT BARBARA BROCATO AND DAN SHATTUCK AT
BARBARA@BMBASSOC.COM

Dr. Angus Worthing - Support - SB290 Copay Accumul

Uploaded by: Worthing, Angus

Position: FAV

Date: Wednesday, February 10, 2021

Bill: SB0290 - Health Insurance – Out–of–Pocket Maximums and Cost–Sharing Requirements – Calculation

Committee: Senate Finance
The Honorable Delores Kelley, Chair

POSITION: Support

Submitted by: Angus Worthing, M.D.
Arthritis & Rheumatism Associates PC
Chevy Chase, MD

Good afternoon Chair and members of the Committee. My name is Dr. Angus Worthing, and I am grateful for the opportunity to testify on behalf of my medical group and my patients in favor of SB0290, entitled Health Insurance Out of Pocket Maximums and Cost-Sharing Requirements Calculation.

I have been practicing medicine in Maryland since 2008. In addition to my full-time rheumatology practice, I serve on the executive committee of my medical group, Arthritis & Rheumatism Associates, which has offices in Maryland, Virginia, and the District of Columbia, I am a Clinical Assistant Professor of Medicine at Georgetown University Medical School, and I serve on the Board of Directors of the American College of Rheumatology. Briefly, my background in this topic includes treating patients who have autoimmune and musculoskeletal diseases like rheumatoid arthritis, osteoporosis, lupus, gout, and many others using various prescription medications that can either be dispensed in our office as infusions, or dispensed by pharmacists for patients to take as pills or self-injections. These drugs can be life-changing for people – they relieve previously disabling joint pain, prevent damage to joints and other organ systems, prevent permanent disability, and extend a person's life expectancy. It's really gratifying to take care of people who experience this life-changing effect. They've often experienced pain for months or years while getting diagnosed and while trying 1 or more less-costly medications which failed them, and are now doing well, back to work because of the medications they are currently taking. But many of these medicines can be challenging for patients to obtain due to high out of pocket costs.

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Unfortunately, some insurance carriers have stopped allowing copay assistance funds to be applied to patients' out of pocket costs. These patients are forced to make payments that are often unaffordable in order to obtain their medicines. It's heartbreaking to see the look of fear and anxiety on my patients' faces when they can't afford the medications that rescued them from the disabling pain they had for months or years until they started drugs that worked for them. When autoimmune diseases flare, patients often must use medicine to suppress the immune system or even be hospitalized. The COVID-19 pandemic is arguably the worst possible time to put people on immune-suppressing drugs or hospitalize them.

Also, insurers implement these tactics by requiring me to report my patients' copay assistance data before reimbursing my office for the cost of their intravenous medications, for the purpose of preventing us from applying copay funds towards patients' copayments. This places me in conflict with the welfare of my patients and disrupts our relationship. The American Medical Association commented – in its November 2020 policy supporting legislation like HB 167 and SB 290 – that doctors who report this patient data would be violating the AMA Code of Medical Ethics.

The insurance industry opposed this legislation in 2020 on the basis that it would promote the use of high-cost brand-name drugs over equally effective lower cost drugs and that "These dynamics are well understood by the federal government," which prohibits copay programs. This is an unfortunate distortion of reality – my patients use high-cost drugs only after being failed by the less-costly ones. And beneficiaries of federal Medicare insurance generally don't need copay assistance for drugs given in doctors' offices because over 80% have secondary insurance to offset what Medicare doesn't cover. Finally, when Maryland doctors try to order the the less-expensive version of the only off-patent specialty drug in rheumatology – the so-called biosimilar – Maryland's largest insurer currently refuses to cover it and forces us to use higher cost brand-name drug, likely because of secretive rebates it and its pharmacy benefits manager garner from the manufacturer. These rebates are a key driver of high US drug prices, according to the US Department of Health and Human Services. About 2% of Americans are taking specialty drugs, so likely over 100,000 Marylanders risk losing access to their life-changing medication if this bill is not enacted.

The nation's largest insurance company announced in the fall that it would implement this disruptive tactic on January 1, 2021. While implementation was paused in response to our concerns, my patients are at risk of this and other insurance company programs. I encourage the General Assembly to pass this legislation urgently, so that our patients insured in Maryland can have the same protections that our Virginia patients enjoy.

As a physician, it is a privilege to be here today and be able to advocate on behalf of my patients and the thousands of individuals likewise situated. I look forward to your questions. Thank you.

FINAL Letter in Support of MD SB290 Copay Accumula

Uploaded by: Worthy, Stacey

Position: FAV

AIMED ALLIANCE

February 1, 2020

Via Electronic Communication

Delores G. Kelley Chair, Finance Committee Chair, Health and Long-Term Care Sub-Committee Maryland Senate delores.kelley@senate.state.md.us	Brian J. Feldman Vice-Chair, Finance Committee Maryland Senate brian.feldman@senate.state.md.us

Re: Letter in Support of SB290

Dear Senator Kelley and Senator Feldman:

Aimed Alliance is a 501(c)(3) non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. We are writing in support of SB290, and we ask that you approve the bill for a full vote before the legislature.

Historically, privately insured individuals who cannot afford their copayments or coinsurance have been able to obtain aid from copayment assistance programs—programs in which a pharmaceutical manufacturer may offer cost-sharing assistance, typically in the form of a coupon card, to an individual to ease the burden of high out-of-pocket costs. Traditionally, the coupon card has contributed also toward the patient's deductible and maximum out-of-pocket limit. These programs have been especially helpful for individuals enrolled in high deductible health plans (HDHPs) in which the patient is responsible for high out-of-pocket costs until the deductible is reached. Increasingly, HDHPs are the only option for many Americans; many employers and marketplace exchanges only offer HDHPs.[1]

Health plans are increasingly implementing copay accumulator programs, which prevent the value of a drug manufacturer's coupon from counting toward a patient's deductible and maximum out-of-pocket limit.[2] Under such programs, once copayment assistance runs out, the plan enrollee is again faced with an inability to afford his or her medication. In some instances, there are no generic alternatives, and patients may be forced to ration their medications or abandon treatment altogether.[3] As a result, they can experience disease progression, relapse, and other adverse events, thereby increasing health care utilization.[4]

SB290 seeks to rectify this issue by requiring payers to include any payments made by the insured or a person on behalf of the insured when calculating the cost-sharing requirement and maximum out-of-pocket limit. Effectually, this bill would prohibit health insurers from adopting

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[1] https://www.goodrx.com/blog/the-pros-and-cons-of-high-deductible-health-plans

[2] https://www.npr.org/sections/health-shots/2018/05/30/615156632/why-some-patients-getting-drugmakers-help-are-paying-more

[3] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/

[4] https://www.healthaffairs.org/do/10.1377/hblog20180824.55133/full/

copay accumulator programs, ensuring that Maryland patients would not be unreasonably penalized for relying on financial assistance from third parties.

Millions of American across the country rely on cost-sharing assistance to afford their medications. Such assistance is only helpful if it can be counted toward patients' deductibles and maximum out-out-pockets limits. Copay accumulator programs are especially problematic during the COVID-19 pandemic when unemployment rates are dramatically increasing every week, and individuals are struggling more than ever to afford their medications. In November 2020, Maryland's unemployment rate was at 6.8 percent, twice as high as the previous year.[5] In Baltimore City, the unemployment rate was 8.5 percent, which is also two times as high as the previous year.[6] Many of these individuals may now rely on marketplace exchange plans with high out-of-pocket costs. They need additional protections, such as the ones laid out in SB290. As such, we ask that you support SB290 and urge your fellow legislators to pass the bill. Thank you for considering our position on SB290.

Sincerely,

Stacey L. Worthy
Counsel

CC:

Malcolm L. Augustine
Pamela G. Beidle
Joanne C. Benson
Antonio L. Hayes
Stephen S. Hershey, Jr.
J. B. Jennings
Katherine A. Klausmeier
Benjamin F. Kramer
Justin D. Ready

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[5] https://www.bls.gov/eag/eag.md.htm.

[6] http://www.dllr.maryland.gov/lmi/laus/.

SB0290, HEAU Amendments_2.10.21.pdf

Uploaded by: Cammarata, Kimberly

Position: FWA

Office of the Attorney General's Health Education and Advocacy Unit
Submitted to the Finance Committee on 2/10/21

Senate Bill 290 (Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation)

First Reader, Proposed Amendments

On page 2, line 17, after "(D)" add "(1) SUBJECT PARAGRAPH (2) OF THIS SUBSECTION"

On page 2, line 21, substitute (a) for (1)

On page 2, line 22, substitute (b) for (2)

On page 2, at the end of line 23 add "(2) SUBJECT TO PARAGRAPHS (3) AND (4) OF THIS SUBSECTION, SUBSECTION D(1) SHALL NOT APPLY TO ANY PRESCRIPTION DRUG THAT HAS AN AB RATED GENERIC EQUIVALENT AS DETERMINED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION. (3) EACH ENTITY SUBJECT TO THIS SECTION SHALL ESTABLISH AND IMPLEMENT A PROCEDURE BY WHICH AN ENROLLEE MAY RECEIVE THE BENEFITS OF SUBSECTION (D)(1) IF, IN THE JUDGMENT OF THE AUTHORIZED PRESCRIBER, (A) THE AB RATED GENERIC HAS BEEN INEFFECTIVE IN TREATING THE DISEASE OR CONDITION OF THE ENROLLEE; (B) THE AB RATED GENERIC HAS CAUSED OR IS LIKELY TO CAUSE AN ADVERSE REACTION OR OTHER HARM TO THE ENROLLEE; OR, (C) THE BRAND NAME DRUG IS MEDICALLY NECESSARY FOR THE ENROLLEE TO ADHERE TO THE APPROPRIATE USE OF THE MEDICATION. (4) *ADVERSE DECISION* – A DECISION BY AN ENTITY SUBJECT TO THIS SECTION NOT TO PROVIDE THE BENEFITS OF SUBSECTION (D)(1) IN ACCORDANCE WITH SUBSECTION (D)(3) CONSTITUTES AN ADVERSE DECISION AS DEFINED UNDER SUBTITLE 10A OF THIS TITLE.

SB0290_FWA_HEAU_2.10.21.pdf

Uploaded by: Cammarata, Kimberly

Position: FWA

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

Writer's Direct Fax No.
(410) 576-6571

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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 10, 2021

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

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

Re: Senate Bill 290 (Health Insurance - Out-of-Pocket Maximums and Cost-Sharing Requirements - Calculation): Support with Amendment

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports Senate Bill 290 which would require carriers to apply the value of manufacturer drug coupons or other direct support to a deductible; other cost-sharing requirements; and out-of-pocket (OOP) maximums ("cost-sharing credits"). Federal laws that have been in flux are now settled: states may legislate consumer protections requiring carriers to apply cost-sharing credits, which carriers may reject absent a state law.[1]

'Copay accumulator programs' that prohibit such credits have been implemented by some Maryland carriers in recent years to the detriment of consumers, resulting in HEAU complaints from consumers dependent on brand drugs to treat AIDS, HIV and other chronic conditions. Without cost-sharing credits, these consumers face the choice of doing without life-sustaining drugs or taking on crippling medical debt.

Last session, this bill's opponents contended that cost-sharing credits would unjustifiably increase the health care system's spend on prescription drugs based on national data. We respectfully submit the contentions are not supported by a comprehensive analysis of Maryland data, including likely savings in this market due to reduced utilization of hospital and other services, because that analysis has not yet been done.

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[1] 85 Fed. Reg. 29164, 29261; https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf

200 Saint Paul Place ♦ Baltimore, Maryland, 21202-2021
Main Office (410) 576-6300 ♦ Main Office Toll Free (888) 743-0023
Consumer Complaints and Inquiries (410) 528-8662 ♦ Health Advocacy Unit/Billing Complaints (410) 528-1840
Health Advocacy Unit Toll Free (877) 261-8807 ♦ Home Builders Division Toll Free (877) 259-4525 ♦ Telephone for Deaf (410) 576-6372

Faced with similar arguments, the Massachusetts Health Policy Commission examined the use and impact of prescription drug coupons in Massachusetts. The Commission's July 2020 report[2] offers useful guidance on these complex issues.

Since 2012, Massachusetts has authorized cost-sharing credits except for brand drugs with an "AB rated" generic equivalent as determined by the Food and Drug Administration (FDA).[3] The AB rating means the generic has been proven to be the therapeutic equivalent of the brand drug.[4] The Commission conducted a comprehensive analysis of its market data on cost-sharing credits for brand drugs with non-AB generic equivalents, described as brand drugs with generic close therapeutic substitutes and brand drugs with no close therapeutic substitute.[5] The closing summary stated in part:

> Policy questions regarding drug coupons reflect a tension between goals of preventing excess spending and supporting patient access. [Our] research concludes that drug coupons increase utilization and spending for a number of drugs with lower cost generic alternatives that would be clinically appropriate for many patients, with implications for higher premiums. However, there are also cases where patients with commercial insurance cannot afford clinically necessary medication due to high drug prices and the cost-sharing design of their plans. In these cases, drug coupons provide financial relief and likely improve adherence, leading to better clinical outcomes.
>
> Continued growth in high deductible plan enrollment, coupled with increasing drug prices, suggests that patient affordability challenges will only increase. **The problem of drug affordability is worse now than it was before 2012. Eliminating the availability of coupons at this time – without substantial protections for patient affordability – would likely create serious challenges for many patients in the Commonwealth.**

(Emphasis added).[6]

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[2] https://www.mass.gov/doc/prescription-drugcoupon-study/download

[3] *Id*., page 1

[4] https://www.fda.gov/drugs/development-approval-process-drugs/orange-book-preface#:~:text=These%20are%20designated%20AB.&text=drug%20products%20for%20which%20actual,than%20with%20the%20active%20ingredients.

[5] *Id*., page 2-3

[6] *Id*., page 25

We support the bill as drafted, which would apply cost-sharing credits without exception. However, we also recognize the merit, for cost containment purposes, of excepting brand drugs with AB rated generic equivalents as Massachusetts has done since 2012, followed by California in 2017,[7] with consumers afforded procedures and relief modeled on Md. Code Ann., Ins. § 15-831(d) if the authorized prescriber's judgment is that the AB rated generic equivalent has been ineffective in treating the disease or condition of the consumer or has caused or is likely to cause an adverse reaction or other harm to the member. The proposed amendment is enclosed for the committee's consideration.

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

cc: Sponsor

---

[7] *Id*, page 25

SB290_OOP Maximums Calculation_Oppose.pdf

Uploaded by: Lininger, Brett

Position: UNF

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

January 20, 2021

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

RE: SB 290 – Oppose

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente respectfully opposes SB 290, "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 775,000 members. In Maryland, we deliver care to over 450,000 members.

This bill 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.

While this legislation may appear to provide a means to lower health care costs for consumers, it creates unintended consequences that maintain high costs of prescription drugs and increases health insurance premiums. Drug companies use coupons and other mechanisms to pay a consumer's out-of-pocket costs while, at the same time, charging the health plan the full price of increasingly higher priced drugs. The inflation in costs are reflected to consumers in the form of premium increases. This legislation would exacerbate that dynamic by requiring plans to count those payments toward out-of-pocket maximums or cost-sharing requirements.

Additionally, broadly mandating coupon acceptance interferes with benefit structures designed to promote use of generic medications with low costs. The availability of a coupon may cause physicians and beneficiaries to choose an expensive brand-name drug when a less expensive and equally effective generic or other equally efficacious but lower-priced alternative is available. In some cases, increased use of coupons may increase overall drug costs without demonstrating any

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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.

improvements on patients’ outcomes. When consumers are relieved of financial obligations, manufacturers are relieved of a market constraint on drug prices, which can distort the market and the true costs of drugs. Such coupons can add significant long-term costs to the health care system that may outweigh the short-term benefits of allowing the coupons, and counter-balance issuers’ efforts to point enrollees to more cost-effective drugs. Should a patient be unnecessarily started on a brand-name drug, given a suitable generic or other clinically appropriate and economical alternative is available, the patient may be left to bear the cost of the more expensive medication once the coupon is no longer offered.

The General Assembly has taken other innovative steps to address the high cost of prescription drugs – most notably by establishing the nation’s first Prescription Drug Affordability Board – and will consider legislation this session to fully fund that Board. Kaiser Permanente presented to the Board this fall about prescription drug pricing and will continue to work closely with them as requested. Further, there are pending mandates from federal regulatory authorities that require carriers to take a similar approach when utilizing coupons that are nearing their implementation date.

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Wayne D. Wilson

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

SB 290 - CareFirst Written Testimony.PDF

Uploaded by: Rivkin, Deborah
Position: UNF

Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
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SB 290 – Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation

Position: Oppose

Thank you for the opportunity to provide written comments regarding Senate Bill 290. Senate Bill 290 requires health plans to count prescription drug coupons towards an insured's cost sharing obligation. **While well intentioned, passing this bill would further drive up the costs of health care coverage by limiting the ability of health insurers to manage the costs of expensive brand drugs.**

- Drug manufacturers provide patients with discount coupons to help offset the patients' out-of-pocket costs for medication. While these discounts help individual patients, unfortunately they also promote the use of higher-cost drugs instead of equally effective and less expensive drugs – raising health care costs for all.
    - For example, one recent study estimates[1] that coupon use increased the percentage of prescriptions filled with brand-name formulations by more than 60 percent. The study estimated that national spending on drugs, on average, grew by $30 million to $120 million for each co-payment coupon over a 5-year period following the entry of generic competitor drugs.
- Pharmacy costs are the largest portion of CareFirst's health care dollar, and these costs continue to rise each year, driven by the increases in prices of brand and specialty drugs.
- The use of coupons masks the price of expensive brand name drugs to consumers and undermines the design of health insurance products, and the cost of these drugs is then ultimately borne by consumers and employers in the form of higher premiums.
- These dynamics are well understood by the federal government, and pharmacy coupons are prohibited for use by beneficiaries enrolled in Medicare, Medicaid, and other federal healthcare programs.

While CareFirst strongly supports the policy goal of reducing prescription drug costs for consumers, this bill has a number of unintended consequences that in fact contribute to rising prescription drug costs. For these reasons, CareFirst respectfully opposes SB 290.

We urge an unfavorable report.

CareFirst stands ready to work with policymakers on efforts that actually reduce the costs of prescription drugs, improving affordability and outcomes for our members and communities.

About CareFirst BlueCross BlueShield

In its 83rd year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and employers in Maryland, the District of Columbia and Northern Virginia. In 2019, CareFirst invested $43 million to improve overall health, and increase the accessibility, affordability, safety and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn or Instagram.

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[1] The New England Journal of Medicine. "Undermining Value-Based Purchasing — Lessons from the Pharmaceutical Industry". Nov. 2016. Web. http://www.nejm.org/doi/full/10.1056/NEJMp1607378?query=featured_home&

SB290_OOP Maximums Calculation_Oppose.pdf

Uploaded by: Taylor, Allison

Position: UNF

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 10, 2021

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

RE: SB 290 – Oppose

Dear Chair Kelley and Members of the Committee:

Kaiser Permanente respectfully opposes SB 290, "Health Insurance – Out-of-Pocket Maximums and Cost-Sharing Requirements – Calculation."

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While this legislation may appear to provide a means to lower health care costs for consumers, it creates unintended consequences that maintain high costs of prescription drugs and increases health insurance premiums. Drug companies use coupons and other mechanisms to pay a consumer's out-of-pocket costs while, at the same time, charging the health plan the full price of increasingly higher priced drugs. The inflation in costs are reflected to consumers in the form of premium increases. This legislation would exacerbate that dynamic by requiring plans to count those payments toward out-of-pocket maximums or cost-sharing requirements.

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Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

allison Taylor

Allison Taylor
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

SB 290 LOI MIA.pdf

Uploaded by: Paddy, Michael

Position: INFO

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

JAY COON
Deputy Commissioner

Maryland
INSURANCE ADMINISTRATION

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TESTIMONY OF
THE
MARYLAND INSURANCE ADMINISTRATION
BEFORE THE
SENATE FINANCE COMMITTEE

FEBRUARY 10, 2021

SENATE BILL 290 – HEALTH INSURANCE - OUT-OF-POCKET MAXIMUMS AND COST-SHARING REQUIREMENTS - CALCULATION

POSITION: LETTER OF INFORMATION

Thank you for the opportunity to provide written comments regarding Senate Bill 290. Senate Bill 290 amends § 15-118 of the Insurance Article and requires certain payments to be applied to a member's cost-sharing or out of pocket maximum "to the extent authorized by federal law" in new subsection (d). The MIA offers the following technical comments regarding the impact of this language on the scope of enforcement.

The words "to the extent authorized by federal law" can be read to limit the application of the law to circumstances in which the federal law has expressly addressed and authorized the consideration of third-party payments. The circumstances in with the federal law expressly addresses and authorizes the application of a third-party payment to a member's cost sharing obligation are limited. Currently, 45 CFR §156.1250, specifically requires or "authorizes" certain third-party payments to be accepted by carriers for ACA plans. The regulation reads as follows:

> *Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments for the QHPs from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):*
>
> *(a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;*

> *(b) An Indian tribe, tribal organization, or urban Indian organization; and*
>
> *(c) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.*

Additionally, 45 CFR § 156.130 provides:

> *(h) Use of direct support offered by drug manufacturers. Notwithstanding any other provision of this section, and to the extent consistent with State law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers for specific prescription drugs may be, but are not required to be, counted toward the annual limitation on cost sharing, as defined in paragraph (a) of this section.*

The above-referenced federal regulations are the only sections of federal law or regulation that expressly allow or "authorize" third party payments to be applied to a member's cost sharing. In all other circumstances for which the federal regulations are silent, carriers are currently permitted to determine on their own whether or not to apply third party payments toward a member's cost-sharing or out of pocket maximums.

While the Maryland Insurance Administration does not have a policy position on Senate Bill 290, we write to advise the Committee that if the Committee's intent is to more broadly require carriers to apply third-party payments to a member's cost-sharing or out of pocket maximum, unless *prohibited* by federal law, the current language does not clearly state that and creates the basis for push back in enforcement. If the Committee's intent is indeed broader, the Committee may wish to consider whether "to the extent not prohibited by federal law" is more appropriate wording than "to the extent authorized by federal law."

SB 290 LOI MIA.pdf
Uploaded by: Paddy, Michael
Position: INFO

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor

KATHLEEN A. BIRRANE
Commissioner

JAY COON
Deputy Commissioner

Maryland
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TESTIMONY OF
THE
MARYLAND INSURANCE ADMINISTRATION
BEFORE THE
SENATE FINANCE COMMITTEE

JANUARY 20, 2021

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