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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.

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

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