CFF MD SB 595 Letter of Support.pdf
Uploaded by: Amanda Attiya
Position: FAV

CYSTIC FIBROSIS FOUNDATION®

February 27, 2024

Finance Committee
Maryland State Senate
East Miller Senate Building
11 Bladen Street
Annapolis, MD 21411

Dear Honorable Members of the Maryland State Senate Finance Committee:

On behalf of the people living with cystic fibrosis (CF) in Maryland, we write to express our support for SB 595, which would require insurers to apply third-party assistance to out-of-pocket maximums and other patient cost-sharing requirements and prohibit some alternative funding programs (AFP). We recognize that copay assistance is problematic; it allows pharmaceutical companies to charge payers high prices, while shielding many individual patients from the costs. It is reasonable that payers would push back against this tactic, as drug costs continue to increase. Nevertheless, patients with chronic diseases like CF often struggle to afford their care and rely on copay assistance to access vital medications. SB 595 would help ensure patients' health and financial wellbeing are not sacrificed in the ongoing, systemic debate between payers and pharmaceutical companies about prescription drug pricing.

About Cystic Fibrosis
Cystic fibrosis is a progressive, genetic disease that affects the lungs, pancreas, and other organs. There are close to 40,000 children and adults living with cystic fibrosis in the United States, including approximatley 570 living in Maryland, and CF can affect people of every racial and ethnic group. 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 care for many people with the disease.

Accumulator Programs Jeopardize Access to Care
Accumulator programs prevent third-party payments from counting towards deductibles and out-of-pocket limits and therefore increase out-of-pocket costs for patients—which can cause people with CF to forgo needed care and lead to adverse health outcomes. According to a survey conducted by George Washington University of over 1,800 people living with CF and their families, nearly half reported skipping medication doses, taking less medicine than prescribed, delaying filling a prescription, or skipping a treatment altogether due to cost concerns.[i] Because CF is a progressive disease, patients who delay or forgo treatment—even for as little as a few days—face increased risk of lung exacerbations, costly hospitalizations and potentially irreversible lung damage.[ii]

Accumulator programs also place additional financial strain on people with CF who are already struggling to afford their care. More than 70 percent of survey respondents indicated that paying for health care has caused financial problems such as being contacted by a collection agency, filing for bankruptcy, experiencing difficulty paying for basic living expenses like rent and utilities, or taking a second job to make ends meet. And while three quarters of people received some form of financial assistance in 2019 to pay for their health care, nearly half still reported problems paying for at least one CF medication or service in that same year.

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 further burden patients are unacceptable. Accumulators are especially challenging for a disease like CF, which has no generic options for many of the condition's vital therapies. The situation has become even more

dire as a company that manufactures CF therapies recently reduced the amount of copay assistance available for people enrolled in accumulator programs.

Alternative Funding Programs Cause Confusion and Delays in Accessing Care
Pharmacy benefit managers (PBMs) and health plans have recently developed new tactics to capitalize on pharmaceutical companies' financial assistance programs by contracting with third-party vendors to manage their specialty medication benefits through AFPs. The PBM or health plan denies coverage of the specialty medication—either by eliminating the drug from its formulary or denying the prior authorization request—and therefore forces the consumer to enroll in the AFP to get his or her drugs. AFPs then work to get the consumer enrolled in a manufacturer assistance program in order to shift drug costs from the payer to the pharmaceutical company.

The lack of transparency and coercive nature of these programs leave people with CF facing unnecessary, confusing, and time-consuming administrative barriers, financial harms, and treatment gaps. Often, people with CF are not aware that these third-party programs are a part of their benefit design, so they are confused about this entity and their role in their health benefits. When they are contacted by the AFP at the start of the benefit plan year, people with CF are told that their essential medications are not covered by their plan and their option is to either pay the full or very significant proportion of the therapy's cost or work with the AFP, which will then assist with obtaining their medication at no- or low-cost. The AFPs then follow-up repeatedly if patients choose not to enroll. This creates a significant amount of stress and confusion for people with CF and in the meantime, there are often delays in getting needed care. For instance, in 2023, 48 percent of the CF Foundation's case management cases related to AFPs have resulted in a therapy gap.

As more plans have begun using AFPs, we appreciate that SB 595 would prohibit use of AFPs by some plans. A recent survey reveals that up to forty percent of commercial plans use or are considering using AFP practices.[iii] This legislation would take an important step in protecting access to care for people with CF by banning some of these practices.

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The Cystic Fibrosis Foundation, along with the undersigned directors of CF care programs in Maryland, urge you to support SB 595 and help ensure continued access to quality, specialty care for people with CF. We appreciate 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
Cystic Fibrosis Foundation

Noah Lechtzin, MD; MHS
Director, Adult CF Program
Associate Professor, Dept of Medicine
Johns Hopkins University School of Medicine

Peter J. Mogayzel, Jr., M.D., Ph.D.
Director, Eudowood Division of Pediatric Respiratory Sciences
Professor of Pediatrics
Director, Cystic Fibrosis Center
Johns Hopkins University School of Medicine

[i] https://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1056&context=sphhs_policy_briefs
[ii] Trimble AT, Donaldson SH. Ivacaftor withdrawal syndrome in cystic fibrosis patients with the G551D mutation. J Cyst Fibros. 2018 Mar;17(2): e13-e16. doi: 10.1016/j.jcf.2017.09.006. Epub 2017 Oct 24. PMID: 29079142.
[iii] Adam Fein. The Shady business of Specialty Carve-Outs, a.k.a. Alternative Funding Programs. Drug Channels (Aug. 2, 2022), https://www.drugchannels.net/2022/08/the-shady-business-of-specialty-carve.html

SB0595_FAV_MDCSCO, ASCO_Health Benefit Plans - Cal
Uploaded by: Danna Kauffman
Position: FAV

February 28, 2024

Senator Pamela Beidle
Senate Finance Committee
Room 3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

Dear Chair Pamela Beidle and Members of the Senate Finance Committee,

The Maryland/District of Columbia Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are pleased to support SB 595, which would prohibit health carriers in the state from utilizing co-pay accumulator programs and save patients with cancer on their out-of-pocket costs.

MDCSCO is 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 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

MDCSCO and ASCO are committed to supporting policies that reduce cost, while preserving the quality of cancer care; however, it is critical that such policies be developed and implemented in a way that does not undermine patient access. Co-pay accumulator programs target specialty drugs for which manufacturers often provide co-pay 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 policy means 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.

Co-pay accumulator programs lack transparency and are often implemented without a patient's knowledge or full understanding of their new "benefit." Far from being beneficial, co-pay accumulator programs increase the financial burden for patients, many of whom are facing life-threatening illness. The impact is especially hard on low-income populations. Increasing patient cost can contribute to medical bankruptcy and cause patients to discontinue care, seek non-medical alternatives—or forego treatment altogether. The result is poorer health outcomes and greater cost to the system.

MDCSCO and ASCO are encouraged by the steps SB 595 takes toward eliminating co-pay accumulator programs in Maryland and we strongly urge the Senate Finance Committee to pass it. 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 on behalf of MDCSCO at dkauffman@smwpa.com or Aaron Segel at ASCO aaron.segel@asco.org if you have any questions or if we can be of assistance.

Sincerely,

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

Everett Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

SB0595_FAV_MedChi_Health Benefit Plans - Calculati
Uploaded by: Danna Kauffman
Position: FAV

MedChi

The Maryland State Medical Society

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TO: The Honorable Pam Beidle, Chair
Members, Senate Finance Committee
The Honorable Steven S. Hershey, Jr.

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

DATE: February 28, 2024

RE: **SUPPORT** – Senate Bill 595 – *Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 595. Senate Bill 595 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 595 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 595 is a consumer protection bill that protects patients from unfair practices where the carrier reaps the benefits of the copay assistance program AND the full cost-sharing requirement of the patient before having to pay for the full drug coverage of the patient. We urge a favorable vote.

SB0595_FAV_MTC_Health Benefit Plans - Calculation

Uploaded by: Drew Vetter

Position: FAV

MARYLAND TECH COUNCIL

TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
The Honorable Stephen S. Hershey, Jr.

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

DATE: February 28, 2024

RE: **SUPPORT** – Senate Bill 595 – *Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions*

The Maryland Tech Council (MTC) writes in **support** of *Senate Bill 595: Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions*. We are a community of nearly 800 Maryland member companies that span the full range of the technology sector. Our vision is to propel Maryland to become the number one innovation economy for life sciences and technology in the nation. We bring our members together and build Maryland's innovation economy through advocacy, networking, and education.

This bill would require insurance carriers and pharmacy benefit managers to include cost sharing amounts paid by third parties when calculating a patient's co-pay or coinsurance. There are existing programs under which charities, non-profits, and drug manufacturers will provide copay assistance to offset the out-of-pocket medication costs for qualified patients. Many such patients are low income and rely on this assistance to afford critical medication. These types of programs are commonly used for patients with rare diseases or other chronic disorders, such as primary immunodeficiencies. The amount of co-pay assistance is intended to be counted toward a patient's deductible, co-insurance, or out-of-pocket maximum, decreasing the amount a patient must pay out-of-pocket.

Unfortunately, there has been a rise in insurance copay accumulator programs, which do not allow copay assistance to count toward deductibles or out-of-pocket maximums. With passage of this bill, Maryland would join the 19 other states that have banned co-pay accumulators. Passage of this bill would have an immediate impact on the out-of-pocket costs patients face for the cost of prescription drugs. Prescription drug affordability has been a major focus of the Maryland General Assembly, and separate legislation is being considered to expand the authority of the Prescription Drug Affordability Board. As MTC testified during the hearing on that legislation, we do not believe such an expansion will have the intended effect of lowering costs for patients. We believe that the solution offered in Senate Bill 595 would provide immediate relief to patients. For these reasons, we urge a favorable report.

Hello Senators.pdf
Uploaded by: Emma Miller
Position: FAV

Hello Senators

I am asking you to Please vote Yes on HB595

Patients often believe they've reached their out -of-pocket maximun when they order their medication using patient assistance programs. However, when they attempt to refill their prescriptions the following month, the pharmacy informs them that they must pay thousands of dollars before receiving their next shipment. This discrepancy arises from the insurance company's implementation of a Copay Accumulator adjustment program (CAAP), which accepts assistance money but fails to apply it to deductibles. Consequently, patents are required to pay the entire deductible before their shipment cab be released, with no option for making partial payments. This practice results in the health plan receiving twice or more the maximum out-of-pocket amount stipulated in the policy; once or more from the assistance program and once from the patient

As someone working with the bleeding disorder community, ensuring access to affordable medications is not just a matter of convenience, but a necessity for maintaining health and quality of life. Your willingness to listen to our concerns regarding copay accumulators speaks volumes about your dedication to serving your constituents.

SB595 are more than just pieces of legislation; they represent hope for individuals who rely on medications to manage their conditions. By supporting these bills and ensuring that #AllCopaysCount in Maryland, you have the opportunity to make a tangible difference in the lives of many.

I sincerely urge you to cast your vote in favor of SB595 Your advocacy on this issue will positively impact countless individuals within our community.

Once again, thank you for your time, your empathy, and your commitment to championing the needs of those living with bleeding disorders and other chronic conditions.

With appreciation,

Emma Miller-Clark
Hemophilia Foundation of Maryland
13 Class Court
Parkville, Maryland 21234
410-661-2307

ACSCAN_FAV_SB595.pdf
Uploaded by: Lance Kilpatrick
Position: FAV

Memorandum In Support of SB 595– Senator Hershey

Senate Finance Committee

February 28, 2024

American Cancer Society Cancer Action Network is the nonprofit nonpartisan advocacy affiliate of the American Cancer Society. ACS CAN empowers cancer patients, survivors, their families and other experts on the disease, amplifying their voices and public policy matters that are relevant to the cancer community at all levels of government. We support evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. On behalf of our constituents, many of whom have been personally affected by cancer, we stand in strong support of SB 595.

Copay accumulators are an insurance benefit structure that does not "count" drug copays from third parties (known as copay assistance) toward a person's insurance deductible or out-of-pocket maximum. These programs target those who rely on assistance from charities or manufacturers to afford their medications and essentially allow insurance companies and pharmacy benefit managers to collect deductibles or out-of-pocket maximums twice.

The cost of buying cancer-fighting medications can be very expensive, often running in the thousands of dollars. For those with high deductible health insurance policies, the out-of-pocket costs for these medications can be incredibly burdensome and prohibitive. In our 2022 ACS CAN Survivor Views Survey, over 70% of respondents were worried about affording care. Half of cancer patients and survivors reported incurring cancer-related medical debt. Women and African Americans in particular were most likely to experience cancer-related medical debt.

Many patients seek out copay assistance from charities or manufacturers to mitigate the high costs of the medications they are taking. With copay assistance, a certain amount of money is put towards the cost of the medication. However, health insurance companies and pharmacy benefit managers have responded by creating copay accumulator programs. These insurance benefit structures do not count drug copays from third parties toward a person's insurance deductible or out of pocket maximum. These programs target those who rely on assistance from charities or manufacturers to afford their medications and essentially allow insurance companies to collect deductibles or out-of-pocket maximums twice.

Legislation by Senator Stephen Hershey would ensure all copays count. This legislation would eliminate barriers to treatment for patients by clarifying that ALL payments made by the patient, or on behalf of the patient, count toward the patient's deductible and out-of-pocket costs.

Insurers and pharmacy benefit managers shouldn't be able to get paid twice for the same medications. 19 states, Puerto Rico, and the District of Columbia have enacted legislation requiring insurers to count third-party payments toward payment cost-sharing limits. We're asking you to support legislation that will add Maryland to this list, and end this discriminatory practice of copay accumulator programs by ensuring All Copays Count.

ACS CAN thanks the Chair and committee for the opportunity to testify and urges a favorable report of SB 595.

Lance Kilpatrick, Government Relations Dir. | lance.kilpatrick@cancer.org | fightcancer.org | 410-547-2143

MD_SB 595.pdf
Uploaded by: Lindsay Gill
Position: FAV

February 27, 2024

Senate Finance Committee

SB 595 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

Position: SUPPORT

Dear Chair Beidle, Vice Chair Klausmeier and Honorable Committee Members,

On behalf of all ALS patients, I respectfully request your support for SB 595, which will significantly help reduce the out-of-pocket healthcare costs for our community.

Amyotrophic lateral sclerosis (ALS) is a fatal progressive neurodegenerative disease that slowly robs a person's ability to walk, talk, eat, and eventually breathe. The cost of care for someone living with ALS is astronomical, with annual out-of-pocket expenses reaching upwards of $250,000 per year. As with many people living with complex medical conditions, those with ALS must take various drugs to maintain their health. The copays associated with acquiring them significantly add to this crushing financial burden.

One way that patients afford their care is through copay assistance programs, where cards or coupons from nonprofit organizations or drug manufacturers help reduce the cost of drugs. However, insurers and pharmacy benefit managers increasingly use copay accumulator adjustment programs to prevent such assistance from counting towards patient cost-sharing, such as their deductible or annual out-of-pocket maximum.

Copay accumulator adjustment programs do not just harm patients' pocketbooks; they undermine their access to life-saving prescription drugs, making it even more difficult for people living with ALS and other complex medical conditions to adhere to a treatment plan. With lower copays, consumers are less likely to skip taking their medications.

We strongly support the prohibition of copay accumulator adjustment programs. We believe that *all patients* should be able to afford necessary treatments by ensuring *all payments* – made by or on behalf of the patients – are counted towards a patients' deductible and out-of-pocket maximums.

Thank you for your time and your consideration of this critical legislation. For all these reasons, we respectfully request your support for SB 595

Sincerely,

Lindsay Gill
Managing Director, Advocacy
The ALS Association

Megan Waranch Testimony SB0595.pdf
Uploaded by: Megan Waranch
Position: FAV

Dear Honorable Committee Chair and Committee Members,

Good afternoon. I am Megan Waranch, and I reside in Owings Mills, MD, just outside of Baltimore, with my husband and two children. My youngest child, Cassius, was diagnosed with severe hemophilia at the tender age of 20 months. Today, I stand before you as an advocate for the hemophilia community, voicing my support for SB 595 – Out of Pocket Maximums and Cost-Sharing Requirements – Calculation.

Hemophilia is a rare genetic bleeding disorder that can cause internal and joint bleeding, sometimes due to trauma, but often from everyday activities. We have no family history of hemophilia, so Cassius's diagnosis of a lifelong, severe chronic condition was both surprising and traumatic. I recall being pregnant with Cassius and expressing to my mother that "something just didn't feel right". Today, I sit before you with a similar feeling regarding our current situation.

Fortunately, advancements in treatment have enabled Cassius to lead a somewhat normal life. While there is no cure for hemophilia, medications now exist that can prevent or stop bleeding. Following Cassius's diagnosis, his hematologists recommended a treatment called Emicuzimab, also known as Hemlibra in the marketplace. Hemlibra, a prescription medicine administered as a subcutaneous shot, is used for routine prophylaxis. It helps to prevent or reduce the frequency of bleeding episodes in those living with hemophilia A. However, Cassius also requires a backup prophylaxis, a treatment containing clotting factor that would prevent ongoing bleeds should he experience a bleed on Hemlibra. The annual costs for his treatments are around $x, excluding any ER or hospital visits.

There are no generic or low-cost options for hemophilia treatment. Copay assistance has been our only means of affording these life-saving treatments for Cassius, which have protected him from joint damage and other complications. Since his diagnosis, I have become well-versed in the intricacies of insurance. I had to be, as insurance companies make it extremely difficult to understand what treatments are covered and whether your insurance plan has a copay accumulator. In fact, when Cassius was diagnosed, I was employed by CareFirst BlueCross BlueShield. I assumed we would be in the best of hands, but I quickly discovered that even benefits specialists working at insurance companies often lack knowledge of the coverage details for people with hemophilia, including the issue of copay accumulators.

When I left CareFirst and joined my new employer in the summer of 2022, I encountered the same experience. I asked questions about coverage for Hemlibra and backup prophylaxis to ensure they would be covered. I was assured by the corporate benefits team that the insurance accepted copay assistance and that Cassius's medications were fully covered. Due to the high costs of Cassius's treatment regimen, both our deductible and out-of-pocket maximum are reached during his first prescription fill of the year.

Regrettably, on February 1, 2024, we were notified by our specialty pharmacy, CVS Specialty Pharmacy, where we receive Cassius's monthly Hemlibra shipment, that we had a balance on

our account. After numerous exhausting conversations with our specialty pharmacy, our PBM, and our insurance carrier, we learned the insurance company, United Healthcare, had implemented an accumulator adjustment policy and accepted the assistance money, but did not apply it to our deductible and out-of-pocket maximum. We were advised we would be required to pay the entire deductible and out-of-pocket maximum before the next shipment could be released. There was no option for making payments. In this matter, our health plan now receives twice or more, the maximum out of pocket written for the policy, once by the assistance program, and once by me, the patient's mother.

Another analogy would be if a student received a college tuition scholarship from our organization, and the college accepted the scholarship but billed the student in full, stating they still owed the full amount because they did not pay it themselves. This would be hard to understand how the university could do that.

Please understand how frustrating it is when treatments are available, yet unattainable. Treatments are only as effective as they are accessible. I am deeply concerned about our current situation and how we will afford our deductible of $6,000 and our out-of-pocket max of an additional $9,000.

I was never notified by my employer or insurance company of a change to our plan regarding how copay assistance is managed and applied. We had no time to plan how we would come up with or save the $15,000 or any additional ongoing costs related to Cassius's medications. It is also extremely troubling to know that our copay assistance is being held by our insurance company without being applied to our costs. Even more troubling is how our PBM and United Health Care are able to "double dip" by accepting copay assistance of $15,000 and then billing me an additional $15,000 on top of what they have accepted.

My husband and I both work, and we are faced with a current financial situation that we are unable to afford, while the insurance company has only increased their profit by an extra $15,000. This is a significant amount of money to us, while it is a drop in the bucket for insurance companies.

You may have heard that premiums will go up if this practice is banned in Maryland. Several recent studies have been conducted that indicate little impact on insurance costs and show that allowing copay assistance to count towards a patient's deductible does not increase premiums, but in many cases, it lowers the costs as patients remain compliant and prevent disease progression and other complications. Without assistance, patients have no choice but to go to the ER for their treatment care which is expensive for our health care system.

Ensuring all copays count is about fair business practices. SB 595 will address these unfair practices, protecting patients by ensuring any payments made on their behalf count towards their out-of-pocket costs. I ask you to be a hero to my son, your constituents, and the rare and chronic disease community of Maryland. Nineteen other states, the territory of Puerto Rico, and the District of Columbia have passed similar legislation including our neighboring states,

Tennessee, Kentucky, Georgia, North Carolina, West Virginia, and Virginia. Please support SB 595 and pass it out of committee today!

Thank you.

Sincerely,
Megan Waranch

COMMITTEE PRESENTATION v4 for distribution.pdf
Uploaded by: Mellisa Hurtt
Position: FAV

MARYLAND LEGISLATION
February 28, 29 2024

Good afternoon, my name is Melissa Hurtt, and I am here today on behalf of the Bleeding Disorders community. My son, Jay, was born with severe hemophilia 29 years ago and I too, have moderate hemophilia. We live in Lothian; MD and I appreciate the opportunity to witness to you today on the urgency and impact of ……

- Maryland Senate Bill SB595 – I would especially like to thank Senator Hershey for your sponsorship of this bill.
    - Finance Committee
- House Bill HB 879 - I would especially like to thank Delegates S. Johnson and A. Johnson for your sponsorship of this bill.
    - Health & Government Operations

I AM HERE TODAY TO ASK YOU TO VOTE "YES" TO THESE POLICIES AND HERE'S WHY….

Hemophilia is a rare genetic disorder where the patient is missing a critical clotting protein necessary in the clotting cascade. Bleeding episodes can occur spontaneously in the brain and other organs, joints and muscles and are excruciatingly painful and can be life-threatening and at the minimum crippling and disabling. Bleeding episodes are managed by intravenous infusions of clotting factor replacement. The medication is extremely expensive and no "generics" are available.

In 2019, I suffered a spontaneous knee bleed that required 90 days of IV infusions totaling more than $225,000, 6 months of physical therapy and I was on disability for more than 9 months. Unfortunately, I still walk with a limp at times.

As a result, of managing my and my son's hemophilia; I am pretty savvy about health insurance and specifically shop to ensure manageable deductibles, affordable maximum out of pocket expenses and look for "co-pays" for our medication vs. "co-insurance" because clotting factor is so expensive. I also review formularies to ensure our products are available.

This past November, I retired and shopped "The Maryland Health Connection." I worked with a broker, explained my unique needs and we found a manageable, affordable plan. We rely on co-pay assistance from the manufacturer to offset our out-of-pocket expenses, so I was quite shocked to learn last week, that the insurance carrier I selected on the Maryland Exchange will soon be coming after my co-pay assistance pocketing the $10K provided by the manufacturer for my benefit. I read my 195-page policy and nowhere is this information disclosed. So, I would say that my insurer has done quite the "bait and switch" an unfair business practice in and of itself. The Maryland Health Exchange is a state program, and consumer needs to be protected.

My story is benign compared to my son's story….

By the time Jay was 18 years old – he had received more than 4000 intravenous infusions in his elbows or antecubital veins and hands. Repeated sticking of these veins leaves a mark or "track mark" … The cost of the *medication alone* by the tender age of 18 was more than $16million dollars…. I never really thought much of his track marks because they represented successful infusions of a lifesaving medication to stop bleeding episodes. What I did not consider is how a stranger or future employer might see those track marks. Jay had gone for an interview to be a lifeguard and so wore lifeguard attire including a short-sleeved t-shirt. When Jay got home from the interview, I asked how it went? He said great – the guy loved me, but then I put my hands on the table, and I saw him look at my hands and arms and the interview just ended, and I think he thought I was a drug addict?"

Hemophilia stole his innocence and a normal childhood and now insurance companies are stealing money given for his care and life-saving medication. 3rd party co-pay assistance was meant for Jay's care and NOT INTENDED for the profits of insurance companies…

Ladies and gentlemen – you alone TODAY have within your ability to course correct this unfair business practice and I am asking you to vote YES on this policy for 3 reasons:

1. This is a consumer protection bill, and it is in the best interest of Maryland residents/constituents to have affordable access to life-saving medications…
    a. Healthy hemophiliacs are a lot less expensive than disabled ones.
    b. The healthcare system is already overloaded why add to it by making life-saving medications unaffordable.
    c. Disabled citizens become unemployed citizens increasing further the burdens on unemployment and Medicaid…
2. 19 Other states to date plus DC and PR are ahead of Maryland in recognizing the need to ban co-pay accumulators.
3. This is a Bi-partisan policy and in the states where the bans have been passed; the bills have passed unanimously.

Thank you for your time and attention and I look forward to seeing the outcome of our efforts today.

Maryland Copay Accumulator Testimony_The AIDS Inst
Uploaded by: Naomi Gaspard
Position: FAV

February 27, 2024

Senate Finance Committee

SB 595 – Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements and Prohibitions

Dear Chair Beidle, Vice Chair Klausmeier and Honorable Committee Members:

The AIDS Institute, a non-partisan, nonprofit organization dedicated to improving healthcare access for people living with HIV, hepatitis and other chronic health conditions, is writing in **support of SB595.** This bill would directly help vulnerable patients who are struggling to afford their specialty prescription medications.

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

SB595 will address the negative effects of a policy that many insurers and pharmacy benefit managers are instituting that limits patients' ability to afford and access medications. Through copay accumulators and other copay diversion policies, insurers and PBMs divert copay assistance funds intended for the patient to their own bottom lines. Like underwriting tactics before the passage of the Affordable Care Act, these policies undermine coverage for the most serious conditions (HIV, hepatitis, multiple sclerosis, hemophilia, cancer, and lupus to name a few). By restricting access to these life-saving prescriptions, insurers and PBMs are costing the healthcare system more when patients seek care in emergency settings and their conditions have worsened to require more intensive interventions.

Opponents of the bill claim that copay assistance steers patients to higher costs drugs. However, a study from IQVIA found that only **0.4% of copay assistance use in the commercial market was for brand name drugs that have a generic equivalent.**[2] These patients do not have cheaper or other alternatives. Additionally, insurers and PBMs have utilization management protocols a

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

[2] IQVIA. "Evaluation of Co-Pay Card Utilization." Available online at: https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization.

patient must pass, such as step therapy and prior authorization before a patient is granted access to a medication. The proposed legislation will protect patient access to critical medications and lower healthcare costs as patients remain adherent to their treatment regimens.

To date, nineteen other states (including neighboring Virginia, West Virginia, and Delaware), the District of Columbia, and Puerto Rico have passed similar legislation to ensure copay assistance counts towards insurance deductibles and out-of-pocket maximums.

We strongly urge you to pass SB595 to protect Marylanders' access to life saving medications.

Sincerely,

Naomi Gaspard, Policy Manager
The AIDS Institute

National Policy Office
1705 DeSales St NW, Suite 700 Washington, DC 20036 | Ph: 202-835-8373
Program, Policy, and Administrative offices
17 Davis Blvd, Suite 403, Tampa, FL 33606 | Tallahassee, FL | 813-258-5929
theaidsinstitute.org

SB595 Testimony Scan.pdf
Uploaded by: Steve Hershey
Position: FAV

STEPHEN S. HERSHEY, JR.
Legislative District 36
Caroline, Cecil, Kent, and
Queen Anne's Counties

MINORITY LEADER

Finance Committee
Executive Nominations Committee
Rules Committee

Joint Committee on Legislative Ethics
Legislative Policy Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 423
Annapolis, Maryland 21401
410-841-3639 · 301-858-3639
800-492-7122 *Ext.* 3639
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Steve.Hershey@senate.state.md.us

Honorable Pamela Beidle
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: Senate Bill 595 Health Benefit Plans- Calculation of Cost Sharing Contribution – Requirements and Prohibitions

Dear Chair and Members of the Committee,

Senate Bill 595 ensures that copay assistance, a vital source of financial assistance for Maryland patients to afford medication, will count towards their deductibles and out-of-pocket maximums.

To offset high out-of-pocket costs, patients often apply for and receive copay assistance. Most of the copay assistance is provided by drug manufacturers to patients taking one of their products and in some cases the assistance comes from non-profits or charities.

In Senate Bill 595, when calculating an individual's cost sharing requirement, insurance carriers and pharmacy benefit managers must include amounts paid by the individual or by another person on behalf of the individual.

There are nineteen other states that have passed similar legislation, including our neighboring states of Virginia, West Virginia and Delaware and the District of Columbia.

I ask for a favorable vote on Senate Bill 595.

The AIDS Institute Scan.pdf
Uploaded by: Steve Hershey
Position: FAV

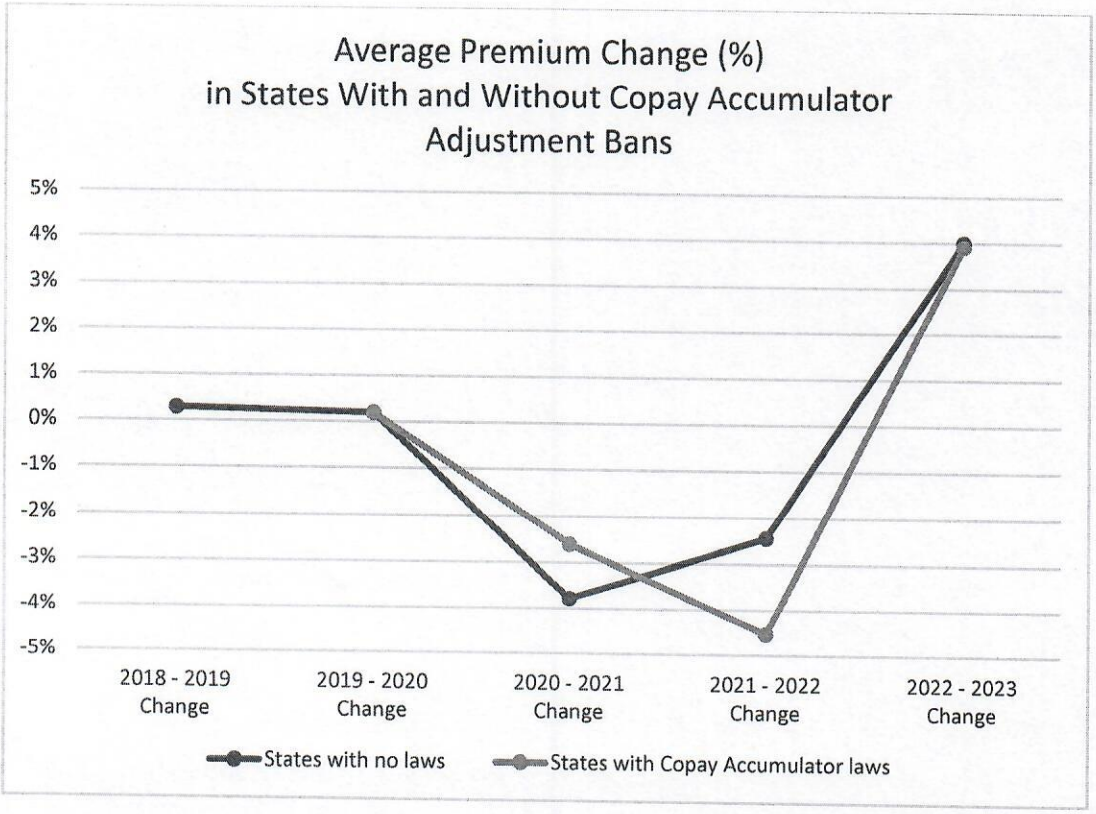
THE AIDS INSTITUTE

May 2023

Comparison of Marketplace Average Benchmark Premiums Between States With and Without Copay Accumulator Adjustment Bans

Between 2019 and 2022, 16 states enacted laws banning insurers and pharmacy benefit managers (PBMs) from diverting copay assistance funds intended to help patients living with serious, complex chronic illness afford the expensive medications on which they rely. Patients and providers first noticed this practice (called "copay accumulator adjustments") in 2017.[1]

The AIDS Institute analyzed annual premium changes in states with copay accumulator adjustment bans and those without. **We found no evidence that enacting a copay accumulator adjustment ban has a meaningful impact on average premiums.**



Source: Marketplace Average Benchmark Premiums, Kaiser Family Foundation. Assumes that impact of copay accumulator adjustment bans would begin on Jan 1 of the year following enactment of the state law.

[1] For more information about copay accumulator adjustment policies and their impact on patients, see: The AIDS Institute, *Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness: Copay Accumulator Adjustment Policies in 2023*, February 2023.

Marketplace Average Benchmark Premiums by State Copay Assistance Accumulator Bans in Place by 2023

States	2018	2019	2020	2021	2022	2023
Arizona	$516	$471	$442	$436	$390	$410
Illinois	$486	$478	$451	$423	$418	$453
Virginia	$535	$555	$521	$479	$450	$371
West Virginia	$545	$596	$628	$654	$752	$824
Georgia	$483	$487	$463	$456	$394	$413
Arkansas	$364	$378	$365	$394	$387	$416
Connecticut	$545	$475	$570	$580	$581	$627
Kentucky	$422	$460	$471	$476	$387	$422
Louisiana	$474	$454	$500	$545	$541	$565
North Carolina	$627	$618	$558	$516	$504	$512
Oklahoma	$659	$696	$601	$554	$498	$510
Tennessee	$743	$548	$511	$466	$445	$473
Delaware	$589	$684	$548	$540	$548	$549
Maine	$588	$544	$513	$440	$427	$457
New York	$506	$569	$610	$597	$592	$627
Washington	$336	$406	$391	$388	$396	$395
Alabama	$558	$546	$553	$590	$597	$567
Alaska	$726	$702	$724	$675	$712	$762
California	$430	$439	$430	$426	$417	$432
Colorado	$470	$488	$358	$351	$358	$380
District of Columbia	$324	$393	$414	$415	$387	$428
Florida	$466	$477	$468	$457	$456	$471
Hawaii	$438	$493	$474	$478	$484	$469
Idaho	$478	$498	$520	$495	$461	$425
Indiana	$339	$339	$387	$421	$398	$397
Iowa	$713	$762	$742	$523	$502	$484
Kansas	$518	$552	$502	$491	$450	$471
Maryland	$487	$419	$397	$347	$328	$336
Massachusetts	$316	$332	$343	$363	$389	$417
Michigan	$381	$383	$360	$347	$340	$362
Minnesota	$385	$326	$309	$307	$327	$335
Mississippi	$519	$521	$487	$459	$448	$461
Missouri	$529	$499	$483	$479	$442	$473
Montana	$525	$561	$483	$471	$483	$477
Nebraska	$767	$838	$711	$699	$595	$550
Nevada	$432	$410	$374	$393	$383	$386
New Hampshire	$475	$402	$405	$357	$309	$323
New Jersey	$413	$352	$392	$405	$424	$441
New Mexico	$414	$365	$345	$339	$389	$445
North Dakota	$377	$457	$383	$493	$497	$475
Ohio	$371	$380	$375	$375	$375	$413
Oregon	$414	$443	$446	$437	$444	$462
Pennsylvania	$575	$484	$459	$455	$390	$433
Rhode Island	$311	$336	$332	$349	$361	$379
South Carolina	$520	$552	$509	$476	$444	$496
South Dakota	$521	$557	$593	$618	$601	$626
Texas	$434	$444	$432	$436	$424	$461
Utah	$550	$542	$486	$472	$456	$471
Vermont	$505	$622	$662	$669	$749	$841
Wisconsin	$569	$537	$491	$457	$429	$456
Wyoming	$865	$865	$881	$791	$762	$802

Source: Kaiser Family Foundation, Marketplace Average Benchmark Premiums. Assumes law impacted premiums the year after it was passed. Key: Blue cells = States with copay accumulator adjustment bans passed between 2019 and 2022; Orange font = Year law impacted premiums

The Maryland All Copays Count Coalition Scan.pdf
Uploaded by: Steve Hershey
Position: FAV

The Maryland All Copays Count Coalition

February 27, 2024

Senate Finance Committee

SB 595 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

Position: SUPPORT

Dear Chair Beidle, Vice Chair Klausmeier and Honorable Committee Members,

The Maryland All Copays Count Coalition which includes the undersigned organizations write to you in support of SB 595. **This legislation would ensure that copay assistance programs, a vital source of assistance for Maryland patients to afford their medication, will count towards deductibles and out-of-pocket maximums.**

Our Coalition represents Marylanders living with chronic and rare conditions who rely on high-cost specialty drugs. The high-cost specialty medications required to manage these complex conditions are consistently placed on the highest cost-sharing tier of health plan formularies resulting in high out-of-pocket costs. To offset high out-of-pocket costs, patients will apply for and receive copay assistance.

In recent years, health insurers and pharmacy benefit managers (PBMs) have begun implementing new programs that prevent any copay assistance funds from counting toward patients' deductibles and out-of-pocket maximums. These programs are often referred to as copay accumulators or copay maximizers. These programs eliminate any benefit from copay assistance and result in a significant financial barrier to accessing treatment. When facing high out-of-pocket costs, patients do not use their medications appropriately, skipping doses to save money or abandoning treatment altogether.

Health insurers and PBMs will say that these programs help reduce health care costs by making patients try cheaper alternatives; however, data shows that for all commercial market claims for specialty medications where copay assistance was used, only 3.4% of those claims were for a product that may have a generic alternative available.[1] Furthermore, instead of refusing to accept copay assistance, insurers and PBMs pocket the assistance funds, and then "double dip" by again collecting the full out-of-pocket costs from the patient.

To date, nineteen other states (including neighbors Virginia, West Virginia, and Delaware), the District of Columbia, and Puerto Rico have passed similar legislation to

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ensure copay assistance counts towards insurance deductibles and out-of-pocket maximums. We respectfully request your support for SB 595 to ensure Marylanders can fully access the lifeline that copay assistance provides.

Sincerely,

American Cancer Society Cancer Action Network
Arthritis Foundation
Crohn's & Colitis Foundation
Hemophilia Foundation of Maryland
Hemophilia Federation of America
Immune Deficiency Foundation
MedChi, The Maryland State Medical Society
National Bleeding Disorders Foundation
National Psoriasis Foundation
Spondylitis Association of America
Susan G. Komen
The AIDS Institute

ALL COPAYS COUNT COALITION

Supporting Patients with Rising Out-of-Pocket Costs

Copay accumulators are a barrier to effective, affordable treatments in Maryland

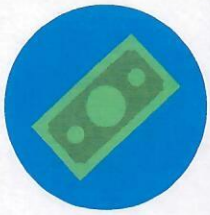
Senate Bill 595 / House Bill 879 would require all payments made by patients—directly or on their behalf—be counted toward their deductibles and out-of-pocket maximums. Requiring health insurance carriers to count all payments will protect Marylanders from surprise bills and treatment delays as well as allowing individuals to utilize the full benefit of copay assistance programs. Urge Maryland Lawmakers to join 19 other states, D.C., and Puerto Rico to ensure all copays count.

MARYLANDERS CAN'T AFFORD TO WAIT

The COVID-19 pandemic has only exacerbated the financial strain that high-cost treatments put on patients and their families. Marylanders should not be punished for using copay assistance to help afford their treatments.

INSURANCE BILLS SHOULDN'T HAVE TO BE PAID TWICE

Insurers are getting paid twice; once from copay assistance programs and then a second time from the patient's pocket. This eliminates any long-term patient benefit from copay assistance programs.

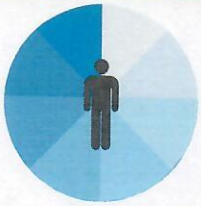


CONTINUITY OF TREATMENT & PATIENT WELL BEING SUFFERS

Many individuals are unaware of these programs until it's too late, leaving their treatment held hostage without additional payment. If copay assistance is not counted, otherwise stable patients might have no other option except discontinuing a lifesaving therapy.

THOSE ON HIGH DEDUCTIBLE HEALTH PLANS (HDHP) ARE MOST AT RISK

Patients will experience increased out-of-pocket costs and take longer to reach required deductibles.



WHAT ARE COPAY ACCUMULATORS?

To temper high prescription costs, many individuals living with rare or chronic conditions receive copay assistance.

These individuals rely on copay assistance programs offered by charities or drug manufacturers to cover the cost of their copays, which can be as high as 20-50% of their medication's cost.

Insurers are increasingly implementing copay accumulator programs. These programs are a health insurance benefit design that stipulate that payment from copay assistance programs may not be counted toward an individual's deductible or out-of-pocket maximum.

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SB595_MD Copays Count_FAV.pdf
Uploaded by: Therese Hessler
Position: FAV

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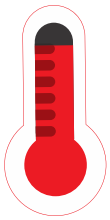

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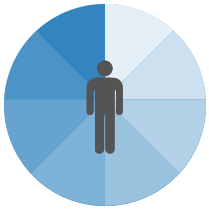

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ALL COPAYS COUNT COALITION

Correcting the Record on Copay Assistance and Accumulator Adjustment Policies

MYTH

Copay assistance provided by pharmaceutical manufacturers keeps drug prices high, by incentivizing the use of high-cost treatments instead of lower cost generic equivalents.

FACT

Copay accumulator adjustment policies (CAAPs) largely target specialty medications for which there are generally no generic equivalents available. In fact, data shows that for all commercial market claims for specialty medications where copay assistance was used, only 3.4% of those claims were for a product that may have a generic alternative available.[1] If copay assistance programs were intended to drive patients away from generic alternatives, then this share would be significantly higher.

The truth is that copay assistance is a critical lifeline that helps ensure the most vulnerable patients can access their needed medications. When barriers prevent patients from accessing these medications, it ends up costing the health system more money due to complications and worsening health outcomes. Research has found that the cost of patients not receiving optimal medication therapy is over $528 billion each year in the United States.[2]

MYTH

Copay assistance enables patients to circumvent plan design and go right to the highest-cost drugs.

FACT

Patients taking specialty medications must first go through utilization management (UM) protocols imposed by their health plan, such as prior authorization and step therapy, before being granted access to the medication their doctor has prescribed. It is only *after* receiving approval for his/her medication from the health plan that patients can request copay assistance.

MYTH

If patients don't like accumulator policies, they should be better health care consumers and choose a health plan that works better for them.

FACT

When it comes to choosing a health plan, most patients do not have a choice. Plans with copay accumulators are either all that is offered, or all they can afford. For many Americans, it all comes down to the cost of the premium, and sadly, the lowest premium plans come with the highest out-of-pocket cost burden. In fact, many employers only offer high deductible health plans (HDHPs) which can require a deductible of up to $8,700 – which many patients cannot afford without assistance.

With more than 80% of commercially insured plans having copay accumulator policies, millions of Americans are insured, but left unable to exercise their health plan benefits to get the medications they need.[3]

Correcting the Record on Copay Assistance and Accumulator Adjustment Policies

MYTH

When patients are allowed to use copay assistance, they have less "skin in the game."

FACT

Patients living with chronic illnesses don't have the luxury of forgoing certain health care treatments and services. Copay assistance helps shoulder the increasingly high burden of out-of-pocket costs for needed medicines.

In recent years, **patients are being forced to pay more out of pocket than ever before.** More than half of all Americans are now in HDHPs, and the average deductible has increased 90% since 2015.[4,5] While 56% of Americans report being unable to cover an unexpected expense of over $1,000, Affordable Care Act (ACA)-compliant plans are allowed to charge $8,700 out of pocket for an individual and $17,400 for a family in 2022.[6,7] **This is not a matter of choosing smarter – it is an impossible financial situation.**

MYTH

Internal Revenue Service (IRS) guidance stands in the way of the Centers for Medicare & Medicaid Services (CMS) disallowing copay accumulator adjustor policies.

FACT

This is a misreading of the IRS guidance. **Although critics often point to 2004 IRS informal guidance as preventing CAAP bans, the guidance does no such thing.**

The IRS informal guidance itself does not address copay assistance at all. What's more, the 2004 informal guidance predated patient cost-sharing protections that were set in the ACA, prior to the emergence of accumulator adjustor policies.

The IRS has since clarified its position on the use of copay cards for enrollees on a HDHP paired with a health savings account (HSA) that wish to contribute to their HSA, stating that the enrollee is only required to meet the minimum deductible to be considered to have met their financial responsibility. **Claiming IRS rules block copay help from counting towards a patient's deductible is simply untrue and harms America's most vulnerable patients.**

To set the record straight, **CMS should require that insurers and pharmacy benefit managers (PBMs) *count all copayments made by or on behalf of an enrollee* toward that enrollee's annual deductible and out-of-pocket limit.** CMS can do this in their annual updated guidance, known as the Notice of Benefit and Payment Parameters (NBPP), which informs health insurance plan design and implementation.

REFERENCES

1 https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

2 https://www.sciencedaily.com/releases/2018/04/180402160613.htm?utm_source=H2Rminutes

3 https://www.ajmc.com/view/contributor-providers-and-patients-push-back-payers-push-forward-co-pay-mitigation-programs

4 https://www.hemophilia.org/sites/default/files/document/files/NHF - National Patients and Caregivers Survey on Copay Assistance %28Key Findings%29.pdf

5 https://aidsinstitute.net/documents/2021_TAI_Double-Dipping_Final-031621.pdf

6 https://www.cnbc.com/2022/01/19/56percent-of-americans-cant-cover-a-1000-emergency-expense-with-savings.html

7 https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

AN EVALUATION OF CO-PAY CARD UTILIZATION IN BRANDS AFTER GENERIC COMPETITOR LAUNCH

Introduction

Patient savings programs, in particular co-pay card programs, continue to bear scrutiny across the industry. Co-pay card programs are patient-based programs designed by manufacturers to assist commercially insured and cash paying patients in affording their medications. Industry stakeholders are especially critical of these programs, claiming they incentivize the use of high-cost therapies – including the purchase of branded drugs over their less expensive, generic equivalents. In an effort to quantify the use of patient savings programs among brands that have lost exclusivity on their patents (LOE) and have generic equivalents in the market, IQVIA identified post-LOE brands in pharmacy claims data and measured co-pay card use within them.

Approach

IQVIA analyzed retail, pharmaceutical, patient claims-level data from 2013 through 2017 to quantify the use of co-pay card programs in brands that have lost exclusivity. Brands with at least one generic equivalent were identified as "post-LOE" in the analysis. IQVIA further categorized the post-LOE brands by those with a manufacturer co-pay offset program (i.e, brands that demonstrated at least 1% of volume adjudicated with a co-pay card while a generic was available). Claims volumes were aggregated and compared across these different market cohorts (summarized in Figure 1).

Co-pay card use is captured in the IQVIA data at a claim level using the secondary payer information present on the claim. Among commercial claims, secondary payers predominantly are attributed to co-pay card programs provided by manufacturers.

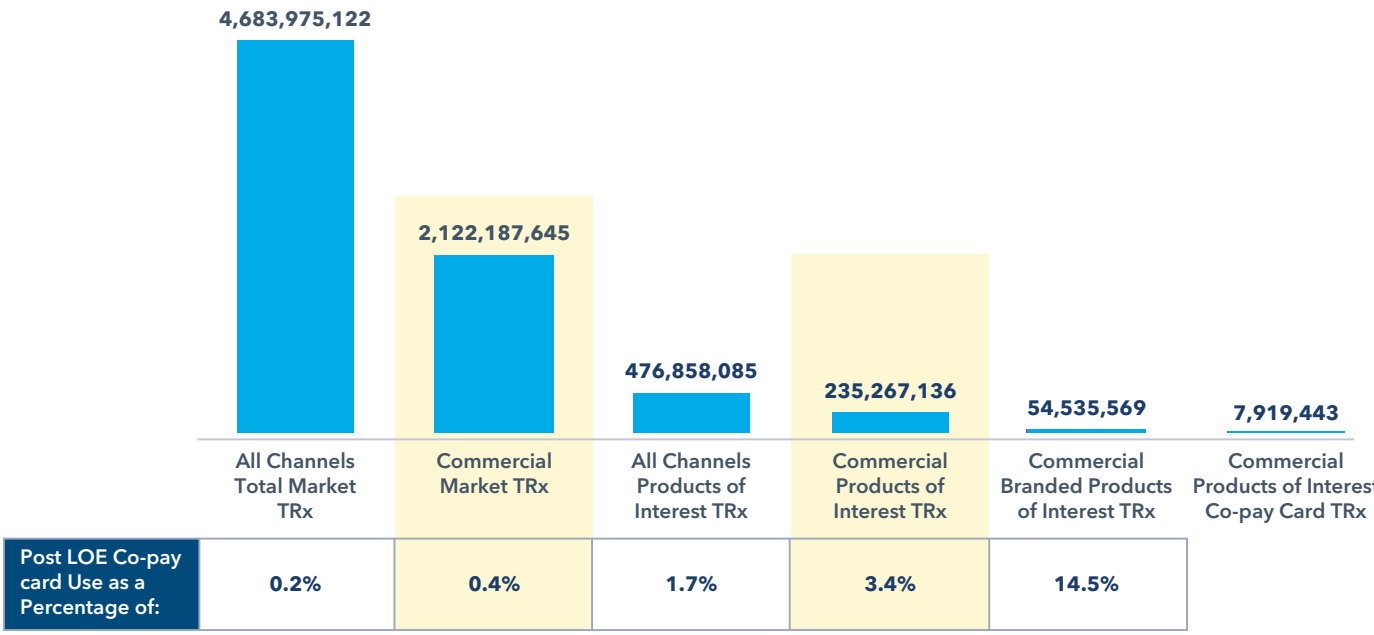
Figure 1: Market Cohort Definitions

MARKET COHORT	DESCRIPTION	B AND/OR G
All Channels Total Market TRx	Encompasses all volume across payer channels.	Brand & Generic
Commercial Market TRx	Limits to commercial volume only.	Brand & Generic
All Channels Products of Interest TRx	Flags brands with at least one generic entry and further refines by limiting to brands that had at least 1% of their volume adjudicated with a co-pay card post-LOE. The generic volume associated with these brands is also included to reflect the molecule's volume across payer channels.	Brand & Generic
Commercial Products of Interest TRx	Limits to the commercial volume for Products of Interest.	Brand & Generic
Commercial Branded Products of Interest TRx	Reflects the branded commercial volume for the products of interest.	Brand Only
Commercial Products of Interest Co-pay Card TRx	Represents the branded products of interest that were filled with a co-pay card.	Brand Only

Results:

Despite continued public attention, patient co-pay assistance program claims only make up a small proportion of commercial, prescription volume for post-LOE products with co-pay card programs. As demonstrated in Figure 2, a small subset of commercial volume is represented by post-LOE brands with evidence of a manufacturer-sponsored co-pay card programs. While co-pay cards are still being utilized by patients on brand scripts after LOE, the use is limited and only makes up 0.4% of the total commercial market volume. The total commercial volume for post-LOE products with a co-pay card program available (the brands and their generic counterparts) represent 11.1% of commercial volume. For prescriptions filled with a post-LOE brand that sponsors a patient support program, 14.5% of claims are associated with these programs.

Figure 2: Claims Volume by Market Cohort (2017)



Source: IQVIA NSP, NPA, and FIA data sets; IQVIA Analysis

Implications:

While some manufacturers may implement strategies to retain brand volume after the loss of exclusivity, manufacturer co-pay assistance programs appear to have limited use and represent only part of a brand's potential retention strategy. Formulary exclusions and automatic generic substitution at the pharmacy are effective tools for promoting generic uptake, thereby curtailing co-pay card use among post-LOE brands. Additionally, co-pay card use on branded scripts post-LOE represents a sliver of the total commercial market, making up only 0.4% of volume across all products. When narrowing in on the total commercial volume for products where manufacturer co-pay assistance is available, only 3.4% of total volume is attributable to prescriptions using these programs. If patient savings programs were having a substantial impact on generic product uptake after loss of exclusivity, one would expect to see higher utilization in the market.

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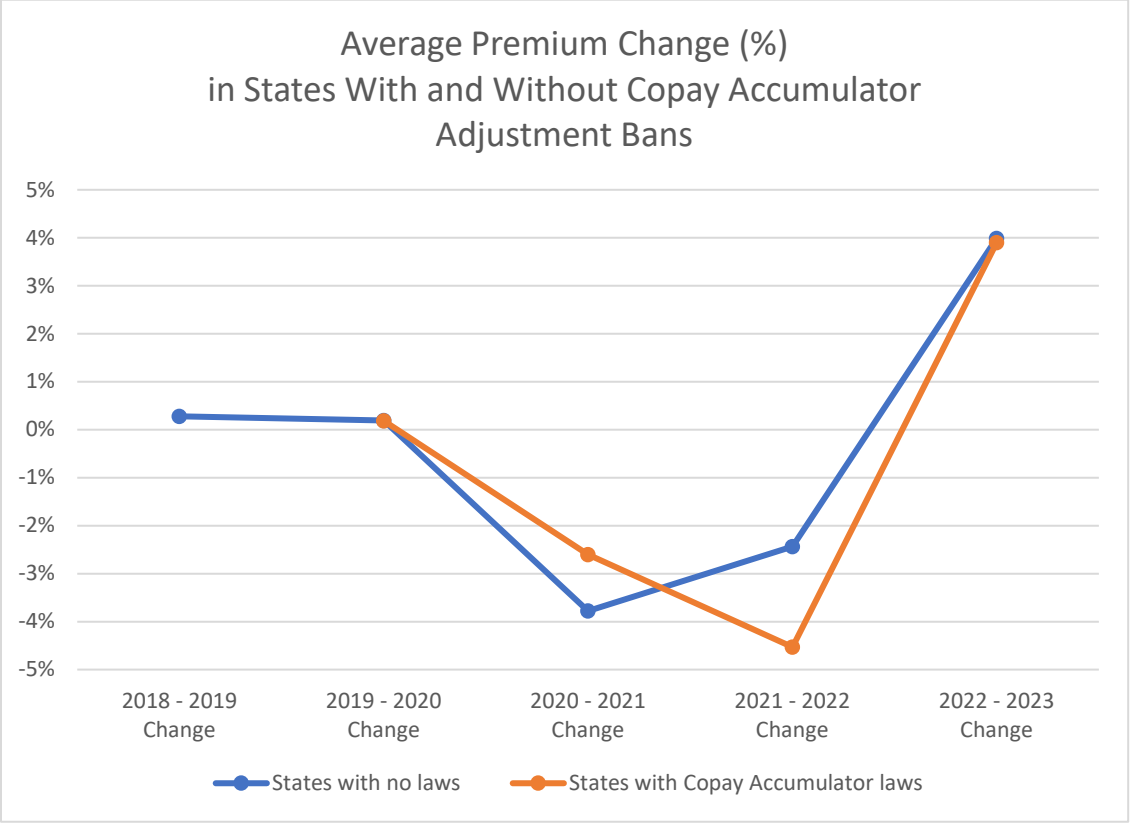
May 2023

Comparison of Marketplace Average Benchmark Premiums Between States With and Without Copay Accumulator Adjustment Bans

Between 2019 and 2022, 16 states enacted laws banning insurers and pharmacy benefit managers (PBMs) from diverting copay assistance funds intended to help patients living with serious, complex chronic illness afford the expensive medications on which they rely. Patients and providers first noticed this practice (called "copay accumulator adjustments") in 2017.[1]

The AIDS Institute analyzed annual premium changes in states with copay accumulator adjustment bans and those without. **We found no evidence that enacting a copay accumulator adjustment ban has a meaningful impact on average premiums.**



Source: Marketplace Average Benchmark Premiums, Kaiser Family Foundation. Assumes that impact of copay accumulator adjustment bans would begin on Jan 1 of the year following enactment of the state law.

[1] For more information about copay accumulator adjustment policies and their impact on patients, see: The AIDS Institute, *Discriminatory Copay Policies Undermine Coverage for People with Chronic Illness: Copay Accumulator Adjustment Policies in 2023*, February 2023.

Marketplace Average Benchmark Premiums by State Copay Assistance Accumulator Bans in Place by 2023

States	2018	2019	2020	2021	2022	2023
Arizona	$516	$471	$442	$436	$390	$410
Illinois	$486	$478	$451	$423	$418	$453
Virginia	$535	$555	$521	$479	$450	$371
West Virginia	$545	$596	$628	$654	$752	$824
Georgia	$483	$487	$463	$456	$394	$413
Arkansas	$364	$378	$365	$394	$387	$416
Connecticut	$545	$475	$570	$580	$581	$627
Kentucky	$422	$460	$471	$476	$387	$422
Louisiana	$474	$454	$500	$545	$541	$565
North Carolina	$627	$618	$558	$516	$504	$512
Oklahoma	$659	$696	$601	$554	$498	$510
Tennessee	$743	$548	$511	$466	$445	$473
Delaware	$589	$684	$548	$540	$548	$549
Maine	$588	$544	$513	$440	$427	$457
New York	$506	$569	$610	$597	$592	$627
Washington	$336	$406	$391	$388	$396	$395
Alabama	$558	$546	$553	$590	$597	$567
Alaska	$726	$702	$724	$675	$712	$762
California	$430	$439	$430	$426	$417	$432
Colorado	$470	$488	$358	$351	$358	$380
District of Columbia	$324	$393	$414	$415	$387	$428
Florida	$466	$477	$468	$457	$456	$471
Hawaii	$438	$493	$474	$478	$484	$469
Idaho	$478	$498	$520	$495	$461	$425
Indiana	$339	$339	$387	$421	$398	$397
Iowa	$713	$762	$742	$523	$502	$484
Kansas	$518	$552	$502	$491	$450	$471
Maryland	$487	$419	$397	$347	$328	$336
Massachusetts	$316	$332	$343	$363	$389	$417
Michigan	$381	$383	$360	$347	$340	$362
Minnesota	$385	$326	$309	$307	$327	$335
Mississippi	$519	$521	$487	$459	$448	$461
Missouri	$529	$499	$483	$479	$442	$473
Montana	$525	$561	$483	$471	$483	$477
Nebraska	$767	$838	$711	$699	$595	$550
Nevada	$432	$410	$374	$393	$383	$386
New Hampshire	$475	$402	$405	$357	$309	$323
New Jersey	$413	$352	$392	$405	$424	$441
New Mexico	$414	$365	$345	$339	$389	$445
North Dakota	$377	$457	$383	$493	$497	$475
Ohio	$371	$380	$375	$375	$375	$413
Oregon	$414	$443	$446	$437	$444	$462
Pennsylvania	$575	$484	$459	$455	$390	$433
Rhode Island	$311	$336	$332	$349	$361	$379
South Carolina	$520	$552	$509	$476	$444	$496
South Dakota	$521	$557	$593	$618	$601	$626
Texas	$434	$444	$432	$436	$424	$461
Utah	$550	$542	$486	$472	$456	$471
Vermont	$505	$622	$662	$669	$749	$841
Wisconsin	$569	$537	$491	$457	$429	$456
Wyoming	$865	$865	$881	$791	$762	$802

Source: Kaiser Family Foundation, Marketplace Average Benchmark Premiums. Assumes law impacted premiums the year after it was passed. Key: Blue cells = States with copay accumulator adjustment bans passed between 2019 and 2022; Orange font = Year law impacted premiums

Immune Deficiency Foundation Testimony - Maryland

Uploaded by: Tyahna Arnold

Position: FAV

Immune Deficiency Foundation

Fostering a community empowered by advocacy, education, and research

February 27, 2024

Senate Finance Committee

SB 595 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

Position: SUPPORT

Dear Chair Beidle, Vice Chair Klausmeier and Honorable Committee Members,

The Immune Deficiency Foundation (IDF) strongly supports SB 595. **This legislation would ensure that copay assistance programs, a vital source of assistance for Maryland patients to afford their medication, will count towards deductibles and out-of-pocket maximums.**

IDF is dedicated to improving the diagnosis, treatment, and quality of life of people affected by primary immunodeficiency (PI) through fostering a community empowered by advocacy, education, and research.

Individuals with PI have one of the over 450 rare disorders in which a person's immune system fails to function properly because of genetic or intrinsic defects. They are highly susceptible to recurrent, persistent, and severe infections, which, without treatment, can lead to organ damage and often require significant interventions and hospitalization. Fortunately, most people with PI can live healthy, productive lives if they receive lifelong immunoglobulin replacement therapy, an innovative and lifesaving therapy derived from donated plasma. However, immunoglobulin costs, on average, $7,500 to $10,000 per month, and there is no generic form of this lifesaving treatment.

To help temper high out-of-pocket costs, many individuals living with PI receive copay assistance for their specialty medication. Many of those receiving assistance enroll in the copay assistance programs offered by the manufacturer that produces their medication. This assistance is vital to those who would be required to pay their entire annual deductible or out-of-pocket maximum at the beginning of their plan year. The amount covered by these programs is intended to be counted toward the individual's deductible or out-of-pocket maximum, decreasing the amount of money one must spend before their benefits are activated for the year.

In recent years, health insurers and pharmacy benefit managers (PBMs) have begun implementing new programs that prevent any copay assistance funds from counting toward patients' deductibles and out-of-pocket maximums. These programs are often referred to as copay accumulators or copay maximizers. These programs eliminate any benefit from copay assistance and result in a significant financial barrier to accessing treatment. When facing high out-of-pocket costs, patients do not use their medications appropriately, skipping doses to save money or abandoning treatment altogether.

Health insurers and PBMs will say that these programs help reduce health care costs by making patients try cheaper alternatives; however, data shows that for all commercial market claims for specialty medications where copay assistance was used, only 3.4% of those claims were for a

product that may have a generic alternative available.[1] Furthermore, instead of refusing to accept copay assistance, insurers and PBMs pocket the assistance funds, and then "double dip" by again collecting the full out-of-pocket costs from the patient.

To date, nineteen other states (including neighbors Virginia, West Virginia, and Delaware), the District of Columbia, and Puerto Rico have passed similar legislation to ensure copay assistance counts towards insurance deductibles and out-of-pocket maximums. We respectfully request your support for SB 595 to ensure Marylanders can fully access the lifeline that copay assistance provides.

Sincerely,

Matthew Prentice
Director of State Policy
Immune Deficiency Foundation
(443) 901-4579

[1] https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

CareFirst Testimony - Calculation of Cost Sharing

Uploaded by: Tricia Swanson

Position: FWA

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Senate Bill 595/House Bill 879 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

Position: Favorable with amendments

Thank you for the opportunity to provide comments on this legislation. As part of its mission, CareFirst is committed to driving transformation of the healthcare experience with and for our members and communities. Ensuring equitable access to quality, affordable services across the healthcare continuum is essential to advancing holistic care and improving health outcomes. Fundamental to holistic care is an informed strategy to address the prescription drug and other therapeutic needs of our members and the communities we serve.

Prescription Drug "Copay Coupons" Drive Up Health Care Costs and Insurance Premiums

Drug manufacturers often provide patients with discounts or other cost-sharing assistance, known as copay coupons, to offset the patient's out-of-pocket costs for a prescription drug. While these discounts help individual patients, they also promote the use of higher-cost brand name drugs when equally effective, lower cost generic drugs are available. These additional costs are passed on to all consumers in the form of higher premiums. Several studies have confirmed these impacts:

- National Bureau of Economic Research (NBER): NBER estimates in the absence of copay coupons, on average, health care costs will decrease by ~$385 per member per month, which is nearly 8% of total costs. NBER research also shows the price for brand name drugs with copay coupons increased by 12% compared to an average of 7.5% annually for brand name drugs that didn't have an associated copay coupon.[i] While the absence of copay coupons might increase certain individual out of pocket expenses, this will be offset by an overall reduction in health care costs due to lower premiums and lower list prices from drug manufacturers.
- University of Southern California Schaeffer Center for Health Policy and Economics (USC): USC notes it is unclear if the use of coupons on drugs without a generic equivalent increases cost, but there is evidence the use of coupons on drugs with an available generic seems "very likely to raise costs without any obvious benefit".[ii]
- New England Journal of Medicine (NEJM): NEJM states cost-sharing assistance programs "discourage patients from using generic drugs and other less costly alternatives to new, patent-protected therapies" and may result in higher drug prices because of the relationship between patient demand and costs. Furthermore, these programs "accomplish nothing more than cost shifting if [they] shield patients from costs."[iii]

Drug Manufacturers Often Only Offer Copay Coupons for Limited Periods of Time

Drug manufacturers often do not provide copay coupons for the entire duration of a patient's use of a drug. They often discontinue copay coupons after a patient has reached their deductible. Doing so causes confusion, while also exposing other patients to higher premiums due to increased costs. A more effective way to ensure predictability in the use of copay coupons and protect patients is to require any cost-sharing assistance to be provided to all patients prescribed the drug for the entire plan year.

This Bill runs counter to the District of Columbia, California, and Massachusetts, as well as the Federal Government

The phenomenon noted above was recognized by Massachusetts and California, who have banned the use of copay coupons for brand name drugs with generic versions available. The Federal government has also banned use of copay

coupons for all Federal health programs, including Medicare and Medicaid, as they violate the anti-kickback statute. Additionally, in response to concerns regarding how copay coupons encourage the use of branded drugs, the District of Columbia recently enacted a bill that includes a limited ban on copay accumulator programs with special consideration for generic drugs. Under this law, carriers are not permitted to use copay accumulators for drugs without a generic equivalent or interchangeable biologic on a preferred formulary or for generic equivalents or interchangeable biologics that the member gained access to through some type of exceptions process. As drafted, this bill would make Maryland an outlier.

CareFirst's proposed amendments will incentivize drug manufacturers to lower their high prices, while protecting consumers from high costs

Copay coupons are used by drug manufacturers to avoid lowering prescription drug list prices and increase their profits. CareFirst recommends the following amendment for your consideration to reform copay coupons and reduce health care costs for Maryland residents.

1. **Limit the accumulator ban to covered drugs that have no lower-cost alternative.**
   - This amendment would not allow Pharma to circumvent formulary management and give patients the ability to go "off formulary" for the same price.
   - The language limits the manipulation of Pharma where there are less expensive options available – either as a generic, another brand that the insurer has placed on a lower formulary tier or when the drug is available in an alternative form.

2. **Require patient assistance to be provided to all enrollees for the entire plan year and require advanced notice of discontinuation.**
   - This amendment is entirely for patient protection. This would ensure there is no discriminatory behavior allowed depending on what type of insurance a person may or may not have, and protect patients who rely on medications for long periods and have their assistance halted suddenly.

3. **Provide an HSA exemption.**
   - According to IRS Guidance[i] (Letter 2021-0014), the IRS does not allow the value of a drug coupon to be counted towards a consumer's deductible. Banning accumulators and requiring health plans to count coupons towards a consumer's deductible, could impact a consumer's ability to contribute to their HSAs.

For the aforementioned reasons, CareFirst supports the bill with the inclusion of the amendments listed above.

About CareFirst BlueCross BlueShield

As the largest not-for-profit healthcare plan in the Mid-Atlantic region, CareFirst provides health insurance products and administrative services to 3.6 million individuals and employers in Maryland, the District of Columbia, and Northern Virginia. Through its affiliates and subsidiaries, CareFirst offers a comprehensive portfolio of health insurance products and administrative services, participating in the individual, small group, and large employer markets and Medicare and Medicaid. CareFirst's mission aligns with our commitment to improve overall health and increase the accessibility, affordability, safety, and quality of healthcare throughout our service areas.

To learn more about CareFirst, visit www.carefirst.com. For insights on how CareFirst is working to transform healthcare visit www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn, or Instagram.

[i] Dafny, L., Ho, K., & Kong, E. (2022, February 14). *How do copayment coupons affect branded drug prices and quantities purchased?* NBER. Available at: https://www.nber.org/papers/w29735

[ii] Van Nuys, K., Joyce, G., Ribero, R., & Goldman, D. (2018, February 20). *A perspective on prescription drug copayment coupons.* USC Schaeffer. Available at: https://healthpolicy.usc.edu/wp-content/uploads/2018/02/2018.02_Prescription20Copay20Coupons20White20Paper_Final-2.pdf

[iii] Howard, D. (2014, July 10). *Drug companies' patient-assistance programs — helping patients or profits?* NEJM. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp1401658

20224.02.28 MD SB 595 Copay Accum Coupon.pdf
Uploaded by: Heather Cascone
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February 28, 2024

Chairwoman Pamela Beidle
Vice Chair Katherine Klausmeier
Senate Finance Committee Members
Miller Senate Office Building, 3 East
Annapolis, Maryland 21401

SB 595 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

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

On behalf of the Pharmaceutical Care Management Association (PCMA), I appreciate the opportunity to provide comments on a bill requiring pharmacy benefits managers to include certain cost-sharing amounts paid by or on behalf of an enrollee or a beneficiary when calculating the enrollee's or beneficiary's contribution to a cost-sharing requirement. I respectfully request an unfavorable report on the bill.

PCMA is the national trade association representing America's Pharmacy Benefit Managers (PBMs), which administer outpatient prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 large and small employers, labor unions and government programs. PBMs are projected to save payers over $34.7 billion through the next decade -- $962 per patient per year – as a result of tools such as negotiating price discounts with drug manufacturers, establishing and managing pharmacy networks, in addition to disease management and adherence programs for patients.

I want to emphasize at the outset of my testimony that **PCMA does *not* oppose true means-tested patient assistance programs that help individuals afford their prescription drugs.** There is an important difference between means-tested patient assistance programs and copay coupons targeted to individuals with health insurance.

The unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays and deductibles. While health plans pay the vast amount of their members' prescription drug costs, drug manufacturers' price increases have forced health plans to create new benefit designs that keep monthly premiums as low as possible—but require some members to shoulder more of the cost before their deductible is met.

Drug manufacturers encourage patients to disregard formularies and lower-cost alternatives by offering "coupons" to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternatives and towards more expensive brand drugs (with higher cost-sharing obligations), completely undermining the formulary a plan sponsor offers.

Here are the facts when it comes to manufacturer coupons:

- The prices for drugs with manufacturer coupons **increase faster (12-13% per year)** compared to non-couponed drugs (7-8% per year).[1]
- If Medicare's ban on coupons were not enforced, costs to the program would **increase $48 billion** over the next ten years.[2]
- Coupons were responsible for a **$32 billion increase** in spending on prescription drugs for commercial plans.[3]
- For every $1 million in manufacturer coupons for brand drugs, **manufacturers reap more than $20 million in profits (20:1 return).**[4]

By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still permitted in the commercial market.

Supporters of coupons say that they decrease costs for patients. While they can decrease an individual patient's cost at the pharmacy counter, they do not reduce ***actual*** costs. **Coupons are temporary—the individual patient likely pays more when the coupon goes away, instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.**

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to increase copay assistance rather than just making their medications more affordable. The simplest, most effective way to reduce patient cost on drugs is for manufacturers to drop the price of the drug.

I appreciate the opportunity to voice our concerns and am happy to answer any questions you may have.

Sincerely,

Heather R. Cascone

[1] Leemore Dafny, Christopher Ody, and Matt Schmitt. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. The National Bureau of Economic Research. October 2016.
[2] Visante. Drug Manufacturer Coupons Raise Costs in Medicare Part D, Hurting Vulnerable Beneficiaries. May 2020.
[3] Visante. How Copay Coupons Could Raise Prescription Drug Costs By $32 Billion Over the Next Decade. November 2011.
[4] Dafny et al. October 2016

AHIP Comments_MD SB 595 copay accumulators, SB 754
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February 27, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
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Annapolis, MD 21401

Re: AHIP Opposes SB 595 (Calculation of Cost Sharing Contribution) and SB 754 (Clinician Administered Drugs)

Dear Chair Beidle:

On behalf of AHIP and our members, I appreciate the opportunity to provide comments to the Senate Finance Committee on the following legislation before the committee this week: SB 595 (calculation of cost sharing contribution) and SB 754 (clinician administered drugs). AHIP opposes these bills because they do nothing to address the rising cost of prescription drugs and we urge you not to move them forward.

The following outlines our concerns with each of these bills.

SB 595 (Calculation of Cost Sharing Contribution)

SB 595 requires health insurance providers and PBMs to include certain cost-sharing amounts paid *on behalf* of an enrollee or beneficiary when calculating the beneficiary's/enrollee's cost-sharing requirement, including high-deductible health plans (HDHPs) and would impede the programs health insurance providers and PBMs use to help reign in pharmaceutical costs.

AHIP shares the widespread concern that drug prices are excessive, unreasonable, and out-of-control. We believe everyone should be able to get the medications they need at a cost they can afford. However, AHIP is concerned that the provisions in SB 595 would do nothing to address the fundamental issue with high-cost pharmaceuticals. On the contrary, it continues to allow drug manufacturers to continue their questionable business practices. Pharmaceutical companies continue to raise their prices year after year – even several times a year – which makes health care more expensive for everyone. As a result, more than 22 cents of every health care dollar spent on health insurance premiums goes to pay for prescription drugs[1] – more than any other individual spending category.

Health insurance providers and pharmacy benefit managers (PBMs) negotiate with drug manufacturers to reduce the impact of out-of-control drug prices. However, the problem with prescription drugs is the price, which manufacturers alone set and control, without any parameters or oversight.

Data Proves that Drug Coupons Are Used by Drug Manufacturers to Keep Drug Prices High, Raising Costs for Everyone. SB 595 endorses practices drug manufacturers employ that are explicitly forbidden in federal health programs, like Medicare and Medicaid, because they have been deemed as illegal kickbacks.[2] Manufacturers acknowledge their drugs are unaffordable for patients. But rather than simply lower their prices, they offer copay coupons, vouchers, discounts, or payments to offset cost-

[1] Where Does Your Health Care Dollar Go? America's Health Insurance Plans. September 6, 2022. https://www.ahip.org/resources/where-does-your-health-care-dollar-go

[2] See 42 U.S.C § 1320a-7b; Special Advisory Bulletin: Pharmaceutical Manufacturer Copayment Coupons. Department of Health and Human Services, Office of the Inspector General. September 2014. Available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/2014/SAB_Copayment_Coupons.pdf

sharing expenses (collectively, "copay coupons") to hide their exorbitant prices. Drug manufacturers strategically offer these promotions to a narrow set of patients, for a narrow selection of drugs, and often only for a limited period.

There are multiple academic studies by Harvard,[3] the Congressional Research Service,[4] the National Bureau of Economic Research,[5] and others, that find that drug manufacturers use patient assistance programs as a sales tool – focusing on their rates of return, encouraging patients to stay on branded drugs after a generic is introduced, and subsidizing third-party foundations to drive sales and attract patients who otherwise might not have used the high-priced drug.

Accumulator Programs Hold Drug Manufacturers Accountable for High-Priced Drugs. Employers and health insurance providers have worked hard to develop programs that hold drug manufacturers accountable for uncontrolled prices. Accumulator programs aim to better reflect patients' actual out-of-pocket spending on drugs and to shed light on pharmaceutical manufacturer pricing schemes.[6] These programs help to restore the balance in the system by allowing the patient to benefit from the use of manufacturer coupons at the pharmacy counter, but not counting the coupon towards the deductible – since the drug manufacturer is paying the amount of the coupon. The cost savings achieved by these programs are then utilized to lower costs for everyone.

A case study conducted by economists at Harvard, Northwestern, and UCLA, on the effect of copay coupons in Massachusetts (where coupons are banned) and your neighboring state New Hampshire (which allowed coupons) finds:

- Prices for brand name drugs with copay coupons rose 12-13% per year compared to price increases of 7% to 8% per year on brand name drugs that did not offer coupons. And after a generic alternative entered the market, coupons increased spending on branded drugs by $30-$120 million per drug over five years.
- After reviewing a sample of 23 medications, coupons increased total spending by $700 million in the five years after generic entry.[7]

For these reasons, AHIP urges you not to advance SB 595.

SB 754 (Clinician Administered Drugs)

SB 754 impacts the ability of health insurance providers to structure benefits and requirements for costly clinician-administered drugs that provide substantial cost savings for Marylanders without sacrificing product safety or the quality of care.

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[3] Dafny, et. al. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. American Economic Journal: Economic Policy 9, no. 2 (May 2017): 91–123. https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf

[4] Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs). Congressional Research Service. June 15, 2017. https://crsreports.congress.gov/product/pdf/R/R44264/5.

[5] Dafny, et.al. How do copayment coupons affect branded drug prices and quantities purchased? National Bureau of Economic Research. February 2022. https://www.nber.org/system/files/working_papers/w29735/w29735.pdf.

[6] Humer, Caroline and Michael Erman. Walmart, Home Depot adopt health insurer tactic in drug copay battle. Reuters. November 13, 2018. Available at https://www.reuters.com/article/us-usa-healthcare-employers/walmart-home-depot-adopt-health-insurer-tactic-in-drug-copay-battle-idUSKCN1NI1F1.

[7] Dafny, et. al. When Discounts Raise Costs: The Effect of Copay Coupons on Generic Utilization. American Economic Journal: Economic Policy, no. 2 (May 2017): 91– 123. Available at https://www.hbs.edu/ris/Publication%20Files/DafnyOdySchmitt_CopayCoupons_32601e45-849b-4280-9992-2c3e03bc8cc4.pdf.

Specialty and clinician-administered drugs generally are high priced medications that treat complex, chronic, or rare conditions and can have special handling and/or administration requirements and many of them are administered by a clinician intravenously, intramuscularly, under the skin, or via injection at a variety of sites of care including hospitals and infusion centers. Both the number and the price of these drugs have rapidly increased in recent years, and, as a result, they are a leading contributor of drug spending growth.

Patients, families, and employers are exposed to not only the high price of specialty drugs, but they are subjected to significant facility markups and fees. Studies have shown that hospitals charge patients and their health insurance more than double their acquisition costs for medicine, with markups between 200-400% on average.[8] Health insurance providers are utilizing specialty pharmacies to safely deliver critical medications for patient use, bypassing hospital markups. In an AHIP survey (attached), it was found:

- Costs per single treatment for drugs administered in hospitals were an average of **$8,200 more** than those purchased through specialty pharmacies.

The proposed provisions of the bill create an anti-competitive, high-cost clinician-administered drug market in Maryland. If passed, this bill would effectively remove any competitive incentives for providers to offer lower prices and higher quality care as health plans would not be able to employ tailored benefit designs to reward patients for seeking out care at high-quality, lower-cost sites.

Given these concerns, AHIP urges you to not move SB 754 forward. It would restrict patient options for choosing convenient, safe, and cost-saving pathways of specialty pharmacy and mail order delivery of their medications.

AHIP's member plans are eager to continue to work to fight for more affordable medications for all Maryland patients, families, and employers. Unfortunately, these bills are not the answer.

Thank you for your consideration of our comments on these important issues.

Sincerely,

Keith Lake
Regional Director, State Affairs
klake@ahip.org / 220-212-8008

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

[8] Hospital Charges and Reimbursement for Medicines: Analysis of Cost-to- Charge Ratios. September 2018. http://www.themorancompany.com/wp-content/uploads/2018/09/Hospital-Charges-Reimbursement-for-Medicines-August-2018.pdf