The Maryland All Copays Count Coalition

February 27, 2024

House Health and Government Operations Committee

HB 879 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements and Prohibitions

Position: SUPPORT

Dear Chair Pena-Melnyk, Vice Chair Cullison and Honorable Committee Members,

The Maryland All Copays Count Coalition which includes the undersigned organizations write to you in support of HB 879. **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

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

ensure copay assistance counts towards insurance deductibles and out-of-pocket maximums. We respectfully request your support for HB 879 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

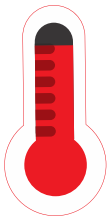
Supporting Patients with Rising Out-of-Pocket Costs

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

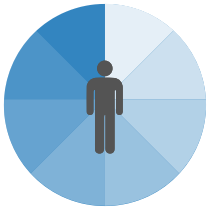
Insurers are getting paid twice; once from copay assistance programs and then a second time from the patient's pocket. This eliminates any long-term patient benefit from copay assistance programs.

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.

HFM Hemophilia Foundation of Maryland

National Bleeding Disorders Foundation Formerly NHF

Spondylitis Association of America Serving the Spondyloarthritis Community

The AIDS Institute

Susan G. Komen

Immune Deficiency Foundation

Arthritis Foundation

Cancer Action Network American Cancer Society fightcancer.org

HFA Hemophilia Federation of America

Crohn's & Colitis Foundation

National Psoriasis Foundation

MedChi The Maryland State Medical Society

For more information contact Matt Prentice with the Immune Deficiency Foundation at mprentice@primaryimmune.org

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.

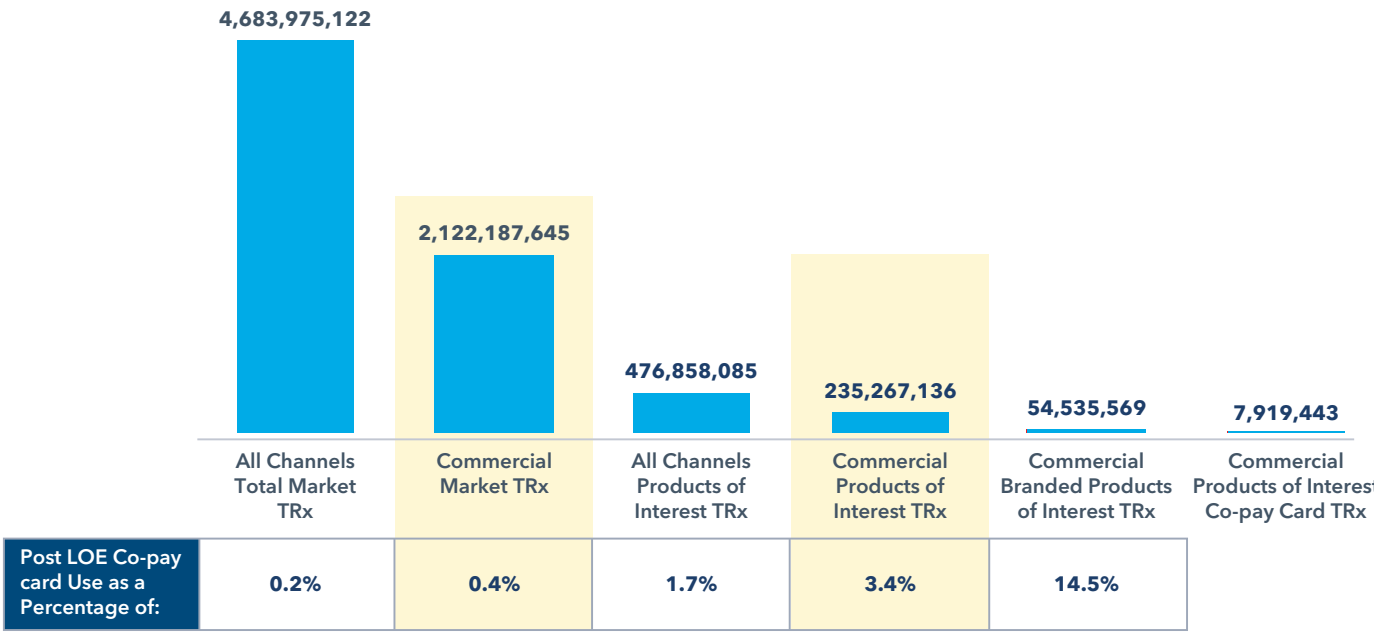
Figure 1: Market Cohort Definitions

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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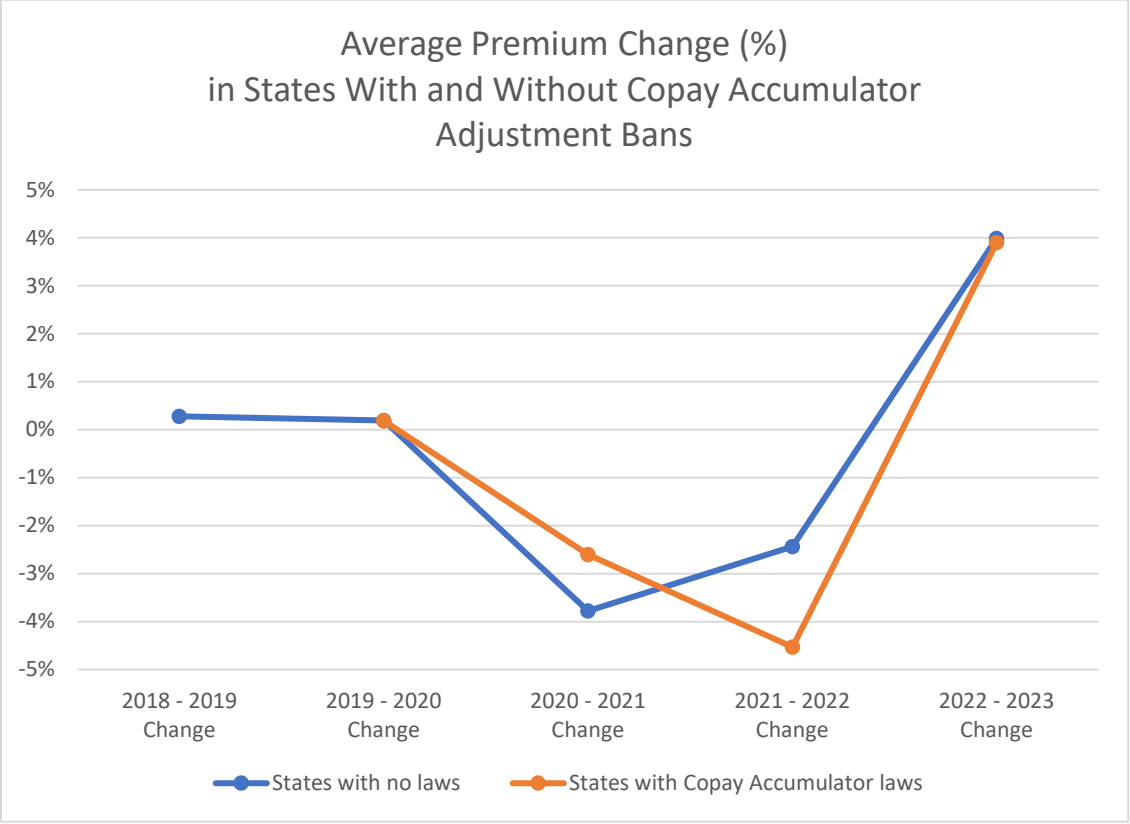
May 2023

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