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February 27, 2024

The Honorable Joseline A. Pena-Melnyk
Chair, House Health and Government Operations Committee
241 Taylor House Office Building
6 Bladen Street
Annapolis, MD 21401

Re: AHIP Opposes HB 879 (Calculation of Cost Sharing Contribution), HB 876 and HB 1368 (Clinician Administered Drugs), and HB 1270 (Rebates and Calculation of Cost Sharing Requirements)

Dear Chair Pena-Melnyk:

On behalf of AHIP and our members, I appreciate the opportunity to provide comments to the House Health and Government Operations Committee on the following legislation before the committee this week: HB 879 (calculation of cost sharing contribution) HB 876 and HB 1368 (clinician administered drugs), and HB 1270 (rebates and calculation of cost sharing requirements). AHIP opposes these bills because they do nothing to address the rising cost of prescription drugs.

The following outlines our concerns with each of these bills:

HB 879 (Calculation of Cost Sharing Contribution)

HB 879 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 HB 879 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. HB 879 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

[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

simply lower their prices, they offer copay coupons, vouchers, discounts, or payments to offset cost-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 HB 879.

HB 876 and HB 1368 (Clinician Administered Drugs)

HB 876 and HB 1368 impact 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 these bills create an anti-competitive, high-cost clinician-administered drug market in Maryland. If passed, these bills 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 HB 876 and HB 1368 forward. These bills would restrict patient options for choosing convenient, safe, and cost-saving pathways of specialty pharmacy and mail order delivery of their medications.

HB 1270 (Rebates and Calculation of Cost Sharing Requirements)

AHIP opposes HB 1270 because it does nothing to help uninsured patients afford the drugs they need. Drug prices continue to rise with no end in sight, and hardworking families feel the consequences every day. The original list price of a drug, determined solely by the drug manufacturer, drives the entire pricing process. The problem is the price: If the original list price is high, then the final cost patients pay will be high. This bill will increase health insurance premiums by requiring carriers to forfeit the savings achieved through manufacturer rebates, and instead provide point-of-sale (POS) rebates to a select group of enrollees. If pharmaceutical manufacturers wish to make drugs more affordable for patients, then the solution is easy: they should lower the price of their drugs.

POS rebates only benefit a small number of consumers. Rebates are generally offered by manufacturers only when there are two or more competing drugs within the same therapeutic class. To help lower costs, carriers and PBMs leverage these competing drugs when negotiating with manufacturers. The savings from rebates are passed on to all enrollees through improvements to benefit packages, reductions in premiums, and/or lower out-of-pocket costs. HB 1270 eliminates the shared benefit all consumers receive when carriers and PBMs negotiate rebates on costly drugs. POS rebates won't help most patients who take generic drugs, which account for more than 90% of the market.[9] This bill will also not help patients who take brand name drugs that do not have competition in their therapeutic class, since

[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

[9] NCSL. https://www.ncsl.org/research/health/generic-retail-drug-pricing-and-states.aspx

rebates are generally not offered for those drugs. The California Health Benefits Review Program (CHBRP) estimates that a similar bill would only impact 3.48% of all prescriptions.[10]

POS rebates will raise the cost of health insurance for Marylanders. The focus on how savings are distributed is a deliberate tactic by pharmaceutical manufacturers to avoid addressing the more serious issues surrounding the lack of competition, transparency, and accountability in the pricing of prescription drugs. POS rebate proposals have repeatedly been found to have a high price tag and AHIP has strong concerns about the impact these requirements will have on insurance costs in Maryland.

When a similar mandate was adopted in the Medicare Part D program, CMS's own actuaries estimated that ***it would increase premiums by 25%, cost taxpayers between $200 and $400 billion, and lead to a $137 billion windfall for pharmaceutical manufacturers.***[11] The California bill mentioned earlier was estimated to ***increase health insurance premiums by $200 million annually.***[12] The California Senate Appropriations Committee refused to advance that bill due to the increased premium cost; similarly, Congress has continually disallowed the federal "rebate rule" to take effect.

A mandate to provide POS rebates is incredibly difficult to operationalize. In addition to the cost of these programs, requiring rebates to be passed on to consumers at the point of sale represents an enormous administrative challenge because rebates are not paid by pharmaceutical manufacturers in real time. Rebates are paid retrospectively to carriers and PBMs based on several factors, including the volume of prescriptions utilized by the plan's members. Manufacturers have no requirement to pay rebates within a defined time, and they are often not paid until long after the plan year ends. At the end of the plan year, carriers and PBMs will need to account for any gaps between rebates anticipated and the amount of rebates actually received; this would likely have to be done through higher premiums or increased cost sharing.

Given these concerns, AHIP urges you to not move HB 1270 forward.

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
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[10] Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing. California Health Benefits Review Program. www.chbrp.org/sites/default/files/bill-documents/AB933/AB%20933%20Abbreviated%20Report%2001042022%20FINAL.pdf.
[11] Rebate Rule a Big Pharma Bailout Paid For on The Backs Of American Seniors And Taxpayers. CSRxP. https://www.csrxp.org/rebate-rule-a-big-pharma-bailout-paid-for-on-the-backs-of-american-seniors-and-taxpayers/
[12] Abbreviated Analysis of California Assembly Bill 933 Prescription Drug Cost Sharing. California Health Benefits Review Program. www.chbrp.org/sites/default/files/bill-documents/AB933/AB%20933%20Abbreviated%20Report%2001042022%20FINAL.pdf.

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.