NATIONAL
BLEEDING DISORDERS
FOUNDATION
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HFM
Hemophilia Foundation
of Maryland

February 24, 2025

Maryland Senate Finance Committee

RE: Patient Organization Support for SB 773 (Hershey)

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

On behalf of people living with inheritable bleeding disorders in the State of Maryland, we urge you to support Sen. Hershey's SB 773, which would require insurer and health care service contractors to count all payments made by or on behalf of patients toward their annual deductibles and out-of-pocket maximums. We pledge to work with you to ensure that this common-sense, bipartisan legislation becomes law. The National Bleeding Disorders Foundation (NBDF) is a national non-profit organization that represents individuals affected by bleeding disorders across the United States. Our mission is to ensure that individuals affected by hemophilia and other bleeding disorders have timely access to quality medical care, therapies and services, regardless of financial circumstances or place of residence.

The patients we represent often face multiple barriers to the therapies they need to treat their conditions, such as prior authorization and step therapy that limit or delay access to specialty medications. And once approved, patients often face enormous deductibles and cost-sharing requirements. With no other options to afford the medicine they need, many patients turn to charitable or manufacturer copay assistance to afford their drugs. Unfortunately, many insurers are taking this assistance intended for patients and not counting it towards a patient's deductible and out-of-pocket maximum. They call this a "copay accumulator adjustment policy." As a result, many patients who would otherwise hit their out-of-pocket limit never get the benefit of important financial protections promised by the Affordable Care Act. Instead, insurers continue to charge as if they have not been paid, even when they have received thousands of dollars in payments. Ultimately, this tactic results in higher profits for PBMs and insurance companies while patients go without necessary medication. This practice is so egregious that the Federal Employees Health Benefit Plan announced in 2023 that it would not accept any plan that employs it.[1]

Protecting patients from copay diversion schemes implemented by insurers and pharmacy benefit managers (PBMs) is more important than ever as out-of-pocket costs have climbed to new and staggering heights. For 2026, the annual limitation on cost-sharing for Affordable Care Act (ACA) plans will exceed $10,000 for an individual, an amount that most Americans simply do not have.[2] This unfeasible amount will have financial and medical repercussions for people with high health care needs.

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[1] U.S. Office of Personnel Management, Healthcare & Insurance, Letter Number: 2023-04 Federal Employees Health Benefits Program Call Letter, March 1, 2023. https://www.opm.gov/healthcare insurance/healthcare/carriers/2023/2023-04.pdf

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Consumer Information and Insurance Oversight, Final 2026 Actuarial Value Calculator Methodology, October 16, 2024. https://www.cms.gov/files/document/final2026-av-calculator-methodology.pdf.

Ensuring that copay assistance counts toward an enrollee's out-of-pocket costs is the only way many people living with chronic illness will be able to afford their life-saving prescription drugs.

PBMs and insurers often claim that prohibiting them from implementing copay diversion programs would undermine their ability to negotiate drug prices or to control access to high-cost medications. This is simply not true: PBMs and insurers tightly control access to high-cost medications by controlling formulary placement, cost-sharing tiers, and employing utilization management such as prior authorization and step therapy. By the time a person with a chronic illness is in a position to be using copay assistance to help them afford a high-cost medication, they have already exhausted other options and received approval from the PBM and/or insurer to fill their doctor's prescription.

Insurance carriers have said that by implementing programs that prevent the use of copay assistance programs counting to out-of-pocket costs helps reduce health care spending by encouraging patients to try cheaper alternatives; however, when patients do not have access to the medications they rely on, health care spending increases. Even more importantly, nearly all manufacturer copay assistance programs are for treatments that do not have a generic alternative. A study of claims data by IQVIA found that 99.6% of copay cards are used for branded drugs that do not have a generic alternative.[3]

To date, twenty-one (21) other states, the District of Columbia and Puerto Rico have passed similar legislation to ensure all copays count toward insurance deductibles and out-of-pocket maximums. We respectfully request that you make Maryland the next state to protect patients from unmanageable out-of-pocket costs through SB 773.

Respectfully,

Nathan M. Schaefer

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Senior Vice President

Public Policy and Access

National Bleeding Disorders Foundation

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