Maryland Senate Testimony_February 2025_FINAL.pdf

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Position: FAV

PAN Foundation

Improving access.
Transforming health.

Written Testimony Of
Amy Niles
Chief Mission Officer, Patient Access Network Foundation
1032 15th Street NW, Suite 413
Washington DC 20005

For the Maryland Senate Finance Committee Bill Hearing

Regarding Senate Bill 773, Health Benefit Plans - Calculation of Cost Sharing Contribution – Requirements

February 26, 2025

Chair Pena-Beidle, Vice Chair Hays, and members of the Senate Finance Committee, The Patient Access Network Foundation (PAN Foundation), appreciates the opportunity to submit testimony in **support** of ***Senate Bill 773, Health Benefit Plans - Calculation of Cost Sharing Contribution – Requirements.***

As a leading charitable foundation and healthcare advocacy organization, the PAN Foundation is dedicated to accelerating access to treatment for those who need it most and empowering patients on their healthcare journeys. We provide critical financial assistance for treatment costs, advocate for policy solutions that expand access to care, and deliver education on complex topics—all driven by our belief that everyone deserves access to affordable, equitable healthcare.

Since 2004, our financial assistance programs have helped more than 1.2 million people to start or stay on life-changing treatment. In addition, we’ve achieved major policy victories that increase access to care, mobilized patient advocates to call for change, and educated people nationwide on critical healthcare-related topics. We’re committed to working towards a future where equitable health outcomes are a reality for all.

Independent Charitable Patient Assistance Foundations

The PAN Foundation is one of nine national independent charitable foundations providing financial assistance to patients living with life-threatening, chronic, and rare diseases for their out-of-pocket prescription medication costs. Collectively the nine charitable organizations provide assistance through more than 200 disease funds.

All patient assistance programs are not the same. Independent charitable foundations are unique and operate differently from manufacturer patient assistance programs.

- Charitable patient assistance programs provide financial assistance to the underinsured, including people with federal insurance such as Medicare beneficiaries. For Medicare beneficiaries, foundations are a critical safety net, since people with federal insurance cannot seek financial assistance directly from pharmaceutical programs, due to the anti-kickback statute. This safety net is critical for Medicare beneficiaries who cannot afford the out-of-pocket costs associated with the prescription drugs and for whom programs, like those offered by the PAN Foundation, are a true lifeline to better health.

- Like other foundations, the PAN Foundation operates under guidance and an advisory opinion issued by the U.S. Department of Health and Human Services' (HHS) Office of Inspector General (OIG). The U.S. Department of Health and Humans Services Office of Inspector General (OIG) advisory opinions outline how independent charitable patient assistance foundations can operate while ensuring compliance with federal laws, regulations, and guidelines. In 2007, the PAN Foundation received its original OIG Advisory Opinion stating that we can provide cost-sharing assistance to Medicare Part D patients. PAN received an OIG Modification Letter in 2015 acknowledging our compliance with key disease fund requirements.

How does PAN provide assistance and provide notification to patients

The PAN Foundation's standardized application process makes sure every patient has the same experience. We process applications on a first-come, first-served basis to ensure eligible patients have an equal opportunity to receive assistance and prevent preferential treatment to any individual or groups of individuals using a specific drug or product. Our standardized application process also prevents referral sources or donor interests from influencing eligibility or enrollment. Patients—or their provider or pharmacy—can apply for a grant either online or over the phone.

To be eligible for a PAN Foundation grant, a patient must:

- Be getting treatment for the disease named in the disease fund.
- Have health insurance that covers their qualifying medication or product. *(Note: health insurance requirements vary by disease fund).*
- Be prescribed a medication listed as covered in the disease fund being applied for.
- Have an income that falls at or below a percentage of the federal poverty level specified by the disease fund.
- Reside and receive treatment in the United States or U.S. territories.The amount of assistance varies by disease fund, and at PAN, we offer assistance through more than 90 disease funds.

At PAN, it takes under 10 minutes to complete the application and, once submitted, patients find out immediately if they are approved. At that point, an official welcome letter and PAN Foundation identification card is sent to the patient via email or by mail within 10-14 business days after approval. This letter indicates the amount of assistance awarded, the eligibility period, what the grant can be used for, and the requirements that the patient must submit claims every 120 days through their eligibility period. If claims are not submitted within this timeframe, they may be disenrolled.

Copay Accumulators

Individuals living with serious, chronic health conditions often require ongoing and continuous access to treatment. And yet, these individuals 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. In recent years, many health insurers have shifted more financial responsibility onto patients with chronic illnesses by increasing deductibles, raising copayments, expanding drug formulary tiers, and increasing the patient's share of the cost of medications. For many disease states there are no lower-cost treatments or generic equivalent treatments available. As a result, copay assistance – whether from a charitable foundation or manufacturer - has become a necessity for many patients to be able to afford their lifesaving or life-extending medicines. Unfortunately, many insurers are taking this assistance intended for patients and not counting it towards a patient's deductible and out-of-pocket maximum. This it yet another barrier for patients and can result in unexpected bills that could reach into the thousands of dollars.

The PAN Foundation has long advocated for all copay assistance to count toward a person's deductible and out-of-pocket costs. Copay accumulator policies subvert the benefit of copay assistance, thereby discriminating against people living with chronic conditions.

When copay assistance is not counted toward a patient's deductible and out-of-pocket costs, the patient alone is left responsible for paying what is often an exorbitant amount in out-of-pocket costs that can inhibit access to a needed prescription medication. This means that the insurer is often accepting payments above and beyond the maximum cost sharing requirement, as the dollars from third-party payments are not counted towards the calculation of the patient's deductible or annual out-of-pocket maximum. Pharmacy Benefits Managers are potentially collecting the payments twice - once via copay assistance, and again when the patient requires other care, or when their copay assistance runs out and they need to get their prescriptions refilled assuming they can afford to do so.

Twenty-one states, DC and Puerto Rico have already acted to protect patients. These states have used their authority to block accumulator adjustor policies in state exchanges and certain private health insurance plans they regulate. Although not all patients are protected by these laws these state actions are helping millions of patients. The PAN Foundation urges you to add Maryland to this list of twenty-one states in adopting these patient protections.

Support for SB 773

SB 773 importantly requires health plans to count the value of copay assistance toward patient cost-sharing requirements. Adoption of the bill would bring much-needed relief to financially vulnerable individuals by ensuring that all payments—whether they come directly out of a patient's pocket or with the help of copay assistance—count towards their out-of-pocket costs.

The PAN Foundation urges the Committee to adopt SB 773 to allow copay assistance in its variety of forms to count toward patient cost-sharing requirements.

Thank you for the opportunity to submit this testimony; please don't hesitate to contact me at aniles@panfoundation.org if you would like further information on the issues raised.

SB773 Hershey Testimony Scan.pdf

Uploaded by: Daniel Granzow

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

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THE SENATE OF MARYLAND
Annapolis, Maryland 21401

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

RE: Senate Bill 773 – Health Benefit Plans – Calculation of Cost Sharing Contribution - Requirements

Dear Chairman and Members of the Committee,

Senate Bill 773 ensures that copay assistance, a vital source of financial assistance for Maryland patients to afford medication, will count toward their deductibles and out-of-pocket maximums. 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. Senate Bill 773 separates health plan design from the availability of patient assistance. This prevents other current, and future, health plan designs that are used to collect an individuals' copay assistance, but not count it towards their deductible and out-of-pocket costs.

This practice is occurring successfully in twenty-one other states, the District of Columbia and Puerto Rico.

I ask for a favorable vote for SB773

SB0773_FAV_MDCSCO_Health Benefit Plans - Calculati

Uploaded by: Danna Kauffman

Position: FAV

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA
SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

February 26, 2025

The Honorable Pam Beidle
Chair, Senate Committee on Finance
Room 3, East Wing, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SUPPORT: Senate Bill 773: *Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements*

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

The Maryland/DC Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are pleased to support **SB 773**, which would prohibit health carriers in the state from utilizing co-pay accumulator and co-pay maximizer programs and save patients with cancer on their out-of-pocket costs.

MDCSCO is a professional organization whose members are a community of physicians who specialize in cancer care. ASCO is an organization representing physicians who care for people with cancer. With over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care.

MDCSCO and ASCO are committed to supporting policies that reduce cost while preserving 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 and co-pay maximizer programs target specialty drugs for which manufacturers often provide co-pay assistance. With a co-pay accumulator or co-pay maximizer 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 deductibles and cost-sharing limits, co-pay accumulators and co-pay maximizers 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 and co-pay maximizer 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 and co-pay maximizer programs increase 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.

Additionally, SB 773 would ban alternative funding programs (AFPs), which are third-party programs that partially or fully exclude coverage for specialty drugs from a payer's prescription drug benefit due to the availability of charitable funding sources for patients. After carving out coverage for specialty drugs, AFPs coordinate with the patient to apply for charitable funds on their behalf. Access to these funds, however, is not guaranteed and could increase financial toxicity for cancer patients. AFPs create additional steps for patients seeking coverage for their medication, which can delay treatment and make adherence more challenging. According to the "Policy Brief on Alternative Funding Programs" released by our affiliate, the American Society of Clinical Oncology, these obstacles to obtaining cancer medications can produce delays, coverage gaps, and poorer health outcomes. While we believe a federal solution is necessary to fully address this issue, which mostly impacts self-funded health plans, MDCSCO and ASCO appreciate the Committee's efforts.

MDCSCO and ASCO are encouraged by the steps SB 773 takes toward eliminating co-pay accumulator and co-pay maximizer programs in Maryland and we strongly urge the Committee to pass it. For a more detailed understanding of our policy recommendations on co-pay accumulator and co-pay maximizer programs, we invite you to read the ASCO Policy Brief on Co-Pay Accumulators and Co-Pay Maximizers by our affiliate. We welcome the opportunity to be a resource for you. Please contact Nick Telesco at ASCO at Nicholas.Telesco@asco.org or Danna Kaufman, representing MDCSCO, at dkauffman@smwpa.com if you have any questions or if we can be of assistance.

Sincerely,

Mark Goldstein, MD President Maryland/DC Society of Clinical Oncology	Eric P. Winer, MD, FASCO Chair of the Board Association for Clinical Oncology

SB0773_FAV_MedChi_Health Benefit Plans - Calculati

Uploaded by: Danna Kauffman

Position: FAV

MedChi

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Senate Finance Committee
February 26, 2025
Senate Bill 773 – *Health Benefit Plans – Calculation of Cost Sharing Contributions – Requirements*
POSITION: SUPPORT

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, supports Senate Bill 773.

Senate Bill 773 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 co-pay assistance programs. Simply stated, Senate Bill 773 prohibits a carrier from excluding the amount paid by a co-pay 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.

Co-pay assistance programs help patients with the out-of-pocket costs of deductibles, coinsurances, and co-pays. For example, using a co-pay assistance program, if the out-of-pocket charge to fill a prescription for the patient is $50, the patient may pay $10, and a co-pay 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 co-pay assistance program.

As employers continue to utilize high-deductible plans, this concern becomes more pronounced. For patients with chronic conditions and high health care costs, the benefit of co-pay assistance programs is essential in receiving their medications. Senate Bill 773 is a consumer protection bill that protects patients from unfair practices where the carrier reaps the benefits of the co-pay 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.

For more information call:
Danna L. Kauffman
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

SB0773_FAV_MTC_Health Benefit Plans - Calculation

Uploaded by: Drew Vetter

Position: FAV

MARYLAND TECH COUNCIL
ADVANCING LIFE SCIENCES AND TECHNOLOGY

Senate Finance Committee
February 26, 2025
Senate Bill 773 – *Health Benefit Plans – Calculation of Cost-Sharing Contribution – Requirements*
POSITION: SUPPORT

The Maryland Tech Council (MTC), with over 800 members, is the State's largest association of technology companies. Our vision is to propel Maryland to be the country's number one innovation economy for life sciences and technology. MTC brings the State's life sciences and technology communities into a single, united organization that empowers members to achieve their goals through advocacy, networking, and education. On behalf of MTC, we submit this letter of support for Senate Bill 773.

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 co-insurance. There are existing programs under which charities, non-profits, and drug manufacturers will provide co-pay 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 co-pay accumulator programs, which do not allow co-pay assistance to count toward deductibles or out-of-pocket maximums. With the passage of this bill, Maryland would join the 21 other states requiring insurers to count co-pay assistance toward patient deductibles and out-of-pocket maximums. Passage of this bill would immediately impact 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 patient costs. The solution offered in Senate Bill 773 would provide immediate relief to patients. For these reasons, we urge a favorable report.

For more information call:
Andrew G. Vetter
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MD_SB773_EveryLife_Foundation_Letter.pdf

Uploaded by: Emily Stauffer

Position: FAV

EVERYLIFE
FOUNDATION
FOR RARE DISEASES

<u>SB 773 (FAV); EveryLife Foundation for Rare Diseases, 1012 14th St. NW, Suite 500, Washington, DC</u>

February 24, 2025

Maryland Senate
ATTN: Finance Committee
East Miller Senate Building, Room 3,
Annapolis, MD

Re: HB 1246 Regarding Calculation of Cost Sharing Contribution

On behalf of the EveryLife Foundation for Rare Diseases, we are pleased to submit testimony in support of SB 773. The EveryLife Foundation is a nonprofit, nonpartisan organization dedicated to empowering the rare disease patient community to advocate for impactful, science-driven legislation and policy that advances the equitable development of and access to lifesaving diagnoses, treatments, and cures.

It is estimated that over 30 million Americans live with one or more rare diseases that often result in burdensome medical, indirect, and non-medical expenses. Patients and families must navigate how to manage expenses from multiple inpatient and outpatient encounters, costs for prescription therapies and medical devices, and the support services that are critical for managing their health and well-being.

While 95% of rare diseases do not yet have an FDA-approved treatment, for those patients who do have an available therapy, cost-sharing assistance from drug manufacturers and patient assistance programs is an important factor in the ability to access life-alerting and life-saving treatments. Unfortunately, insurance companies are increasingly employing copay adjustment programs that prevent cost-sharing assistance from being applied to a patient's deductible or out-of-pocket maximum, removing the lifeline of cost-sharing assistance programs. SB 773 would prevent insurers from using these programs to take advantage of Maryland residents.

While copay adjustment programs can reduce costs for insurance companies, they leave patients with unexpected and unaffordable costs once their copay assistance is exhausted. In 2022, the EveryLife Foundation published The National Economic Burden of Rare Diseases in the United States, a study that examined the comprehensive economic impact of a subset of 379 rare diseases. The study found that the total economic impact of rare diseases in the US in 2019 was $997 billion; 60% of those costs were indirect and non-medical costs shouldered directly by families and society. Of the direct costs, inpatient care was the top driver of medical costs (~15%) while prescription medication was responsible for about 11% of medical costs.[1] With the proliferation of high deductible health plans, copay adjustment programs result in higher out-of-

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[1] EveryLife Foundation for Rare Diseases. April 2022. The National Economic Burden of Rare Disease in the United States in 2019.

pocket costs for the frequent expert outpatient care that rare disease patients require as it takes longer for patients to satisfy the deductible and out-of-pocket maximum requirements.

Copay adjustment programs eat into the already tight budget patients have, forcing some patients to take harmful actions, such as medicine rationing and prescription abandonment. An analysis by IQVIA showed that when patient costs reach $250, over 70% of new patients walk away from the pharmacy empty-handed, highlighting the direct connection between the rise in out-of-pocket costs and prescription abandonment.[2] Prescription abandonment is not an option for rare disease patients who are forced to incur considerable financial strain to maintain their prescription medicine costs.

Lowering the costs of health care is an important goal; however, insurance companies that use copay adjustment programs simply shift costs to patients while ultimately collecting up to double the amount of the patient's out-of-pocket requirements. Further exacerbating the tremendous out-of-pocket financial load families living with rare diseases are expected to bear.

Thank you again for the opportunity to testify in support of SB 773. We are excited at the prospect of Maryland joining the other states that have enacted similar legislation to protect patient access to treatments by preventing copay adjustment programs. We readily support the bill sponsor for taking a lead on this issue to ensure that all Maryland residents with a rare disease can maintain access to affordable, life-sustaining medical care.

Jamie Sullivan
Vice President of Policy
EveryLife Foundation for Rare Diseases

Emily Stauffer
Associate Director of State Policy
EveryLife Foundation for Rare Diseases

CC:

Michael Pearlmutter, Chief Executive Officer, EveryLife Foundation for Rare Diseases
Annie Kennedy, Chief of Policy, Advocacy and Patient Engagement, EveryLife Foundation for Rare Diseases
Vicki Seyfert-Margolis, Chair, Board of Directors, EveryLife Foundation for Rare Diseases

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[2] IQVIA. May 2019. Medicine Use and Spending in the US; A Review of 2018 outlook to 2023.

SB773_CSRO_FAV

Uploaded by: Jessica Frasco

Position: FAV

CSRO
Coalition of State Rheumatology Organizations

February 25, 2025

Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Re: Support SB 773 – Ban Copay Accumulator Adjustment Programs, Maximizer Programs and Alternative Funding Programs

Chair Beidle, Vice Chair Hayes and members of the Senate Finance Committee:

The Coalition of State Rheumatology Organizations (CSRO) supports SB 773, which would require health plans to count third-party discounts and payments made on behalf of patients towards the patient's copayments, coinsurance, deductibles, or other out-of-pocket costs. It would also ban the use of alternative funding programs and maximizer programs for prescription drugs. CSRO serves the practicing rheumatologist and is comprised of over 40 state rheumatology societies nationwide with a mission of advocating for excellence in the field of rheumatology and ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease.

Rheumatologic diseases, such as rheumatoid arthritis, psoriatic arthritis and lupus, are systemic and incurable, but innovations in medicine over the last several decades have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life.

Copay Accumulator Adjustment Programs

Many rheumatologic patients are prescribed specialty drugs for chronic conditions after trying and failing all available lower cost alternatives and are often prescribed multiple medications for several conditions. These specialty medications can be very expensive, and many patients would go without treatment if they did not have access to copay assistance. Copay assistance may be provided to the patient through "copay cards", furnished by manufacturers to help cover a patient's cost sharing as well as through non-profit foundations, which offer monetary assistance to patients.

Until recently, health plans would count the value of the card towards the patient's deductible. However, health insurers and pharmacy benefit managers now regularly use programs known as "copay accumulator adjustment programs." In Maryland, 50% of individual health plans reviewed in 2025 include a copay accumulator adjustment program.[i] These programs allow the patient to continue using their copay card but do ***not*** allow the copay assistance to count towards the patient's deductible or maximum out-of-pocket limit, driving great patient out-of-pocket costs. Unfortunately, these copay accumulator adjustment programs impact patients living with chronic conditions who require high-cost specialty medications, including rheumatic diseases, as well as patients who can only afford high deductible health plans.

Through these accumulator programs, insurers pocket the value of the copay assistance, in addition to demanding the full deductible value from the patient. Many copay cards hit an annual limit, at which point the patient is often responsible for the full copay for their medication if they have not met their plan's deductible or maximum out-of-pocket limit. Some patients may have cost sharing responsibilities of $5,000 a month or higher for their specialty medications or to cover multiple medications to treat their chronic conditions. When faced with these high out-of-pocket costs, many patients may abandon their treatment plan, forcing stable patients to discontinue their treatments. This can result in disease progression, flare ups, increased steroid use, and even loss of effectiveness of their original therapy if eventually restarted. Managing the results from non-adherence to their medication requires the use of substantially more resources than allowing for continuity of care from the start.[ii]

It is important to note that the Federal Employer Health Benefits prohibits the use of copay accumulator programs, according to a January 2024 letter. In this letter by the Federal Office of Personnel Management, the Office explicitly states that it will, "decline any arrangements which may manipulate the prescription drug benefit design or incorporate any programs such as copay maximizers, copay optimizers, or other similar programs as these types of benefit designs **are not in the best interest of enrollees or the Government**."[iii] We encourage the legislature to take a similar position on behalf of patients throughout Maryland.

Maximizers Increase Patient Out-of-Pocket Costs

This legislation would also ban the use of copay maximizer programs, which were developed for the health plan and PBM to "maximize" and capture the full value amount of the manufacturer copay card. These programs have become all too common, with 47% of covered lives across the country enrolled in plans with a maximizer.[iv] Through these programs, patients essentially surrender their copay cards to the maximizer program. The health plan or PBM then adjusts the patient's cost sharing to equal the card value. At times, the PBM may collect beyond the patient's original cost sharing responsibility if they are able to drain the full value of the card from the manufacturer through these maximizer programs. These programs are harmful to patients because the amounts collected by the maximizer do not count toward the patient's deductible or maximum out-of-pocket limit. Thus, they require patients to pay out-of-pocket longer and can make it difficult for patients to afford their medications.

Alternative Funding Programs

This legislation would also prohibit the use of alternative funding programs (AFPs), which are run by third-party vendors and utilized by health plans for *specialty* medications. Specialty medications are commonly more expensive as they are used to treat rare, complex and/or chronic conditions, including many rheumatologic diseases. They are usually placed in the highest tier of the prescription drug formulary. These programs profit off patient assistance programs and non-profit foundation funding that is intended as a safety net for truly uninsured patients, simultaneously delaying patient access to essential prescription medications.

The AFP works with the health plan to carve out specialty drugs from the plan's coverage and claims that specialty medications are non-essential health benefits (EHBs). This can allow the patient to appear uninsured, making the patient eligible to obtain their medication through an alternative source, including non-profit foundations, manufacturer patient assistance programs or international importation. If the AFP is unable to secure the medication from an alternative source, the health plan can choose to cover the medication as a normal pharmacy benefit, making the entire process for naught. In other cases, the health plan may still choose not to cover the medication, and the insured patient is required to pay out-of-pocket for the full cost of the drug.

AFPs Delay Patient Access to Essential Medications

Patients are often compelled to sign up for an AFP or else they are forced to pay the full price of the drug out-of-pocket. Once the patient enrolls in the AFP, there is often a significant delay in obtaining the medication as the AFP works to secure their medication from an alternative source. At times that alternative source may be a pharmacy outside of the United States, which means the drug is not subject to the same integrity standards as U.S. medications. It is important to note that in 2023, the FDA stated that it would take action against any AFPs that "import or offer [to] import illegal products." [v]

Patients that suffer from complex chronic conditions, such as rheumatoid arthritis and other rheumatologic diseases, require continuity of care to successfully manage their condition. Any disease progression caused by a delay or complete loss of access to an appropriate treatment can be irreversible, life threatening, and cause the patient's original treatment to lose effectiveness. AFPs work to game the system at the expense of the patient's health and maintenance of their health condition.

AFPs Exacerbate Patient Out-of-Pocket Costs

CSRO is particularly concerned about how AFPs impact patients with rheumatic conditions, such as rheumatoid arthritis, lupus and psoriatic arthritis, as well as other inflammatory conditions, such as multiple sclerosis and inflammatory bowel disease. These patients often require complex, and thus more expensive, medications. Since the medication is classified as a non-EHB, any outside assistance secured by the AFP does not count towards the patient's cost sharing responsibility. This exacerbates patient out-of-pocket costs, as the assistance does not count towards the patient's cost sharing.

Rheumatologists are entrusted with the safe care of patients with rheumatoid arthritis and other autoimmune diseases that require the careful choice of safe and effective medications and biological therapies. Copay accumulator adjustment programs, maximizer programs and alternative funding programs are all harmful to patients and drive patient out-of-pocket costs. As the legislature continues to consider opportunities to address the cost of medications for patients throughout Maryland, we encourage you protect patients and support SB 773. We thank you for your consideration and are happy to further detail our comments to the Committee upon request.

Respectfully,

Aaron Broadwell

Aaron Broadwell, MD, FACR
President
Board of Directors

Feldman

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
Board of Directors

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[i] The Aids Institute. "Our Loss, Their Gain: Copay Accumulator Adjustment Policies in 2025." February 2025.

[ii] Rheumatol Ther. "The Economic Benefit of Remission for Patients with Rheumatoid Arthritis." October 2022.

[iii] U.S. Office of Personnel Management Healthcare and Insurance. "Pharmacy Benefits Management (PBM) Transparency Standards." January 2024.

[iv] Drug Channels. "Why Plan Sponsors and PBMs Are Still Falling Hard for Copay Maximizers." February 2025.

[v] U.S. Food & Drug Administration. Letter to the Aimed Alliance. April 2023.

Senate Copay Testimony Final.pdf

Uploaded by: Kyle Rivers

Position: FAV

National
Multiple Sclerosis
Society

Maryland State Senate– Finance Committee
Public Hearing – February 26, 2025

Testimony of Kyle Rivers, FAV,
Senior Manager, Advocacy, National Multiple Sclerosis Society
One M Street S.E., Suite 510
Washington, DC 20003

Chairwoman Beidle, Vice-Chair Hayes, and members of the Senate Finance Committee, thank you for the opportunity to provide testimony on behalf of The National Multiple Sclerosis Society in support of SB0773, legislation that addresses copay accumulator programs which affect patients' access to health care.

Multiple sclerosis (MS) is an unpredictable disease of the central nervous system. Currently there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimize disability. Significant progress is being made to achieve a world free of MS.

MS is an expensive disease to live with and treat, impacting the healthcare system, health plans and, of course, families affected by MS. MS disease-modifying therapies (DMTs) are essential for many people with MS—but their prices have skyrocketed. As of July 2024, the median brand price of MS DMTs was over $107,000. Time on the market also does not guarantee a reduction in cost as 5 out of 7 of the DMTs that have been on the market for at least 13 years are priced over $100,000 annually and continue to see regular price increases. Although there are now more than twenty DMTs on the market with generics available for five of the brand DMTs, competition has not driven down their price, and the majority have increased in price several times each year. People with MS often face a high deductible and later co-insurance—meaning they are often responsible for thousands of dollars in out-of-pocket costs. This poses a significant challenge in accessing needed medications.

Copay accumulators (or accumulator adjustment programs) began from the belief that drug manufacturers' patient assistance programs are discouraging patients and their doctors from choosing generics or less-costly prescription drug alternatives. These programs are used to prohibit third party copay assistance from applying towards a patient's annual deductible or out-of-pocket maximum

In MS, copay accumulators make it more difficult for people to get the healthcare they need. As many as 70% of people living with MS rely on copay assistance programs to maintain access to their disease-modifying therapy. With the implementation of copay accumulator programs, people with MS are experiencing higher cost burdens as they struggle with unexpected expenses during their deductible period. It is well-known that people with chronic and high-cost conditions like MS face significant financial hardship each year until their deductible has been met and the full relief of their health insurance kicks in. This hardship is made worse by copay accumulator programs because preventing copay assistance from applying to a person's deductible means it takes them longer to reach the end of the deductible period. Because patients are responsible for 100% of their health care costs until the deductible is satisfied, prolonging the deductible period can put other medical needs—such as doctors' visits, rehab therapies, MRIs, or other medications—financially out-of-reach.

The National Multiple Sclerosis Society has called on all stakeholders in the prescription drug supply chain to come together and find real solutions to escalating price increases, barriers to care and a system too complex to navigate. It is reasonable to question the role of copay assistance programs and the potential role they inadvertently play in raising costs or impeding access—but this should not be the first change that happens. Until we find real solutions to the challenges in our healthcare system that prevent people from affordably accessing the care and treatments they need, we cannot rip away the band-aids people have come to rely on—like copay assistance programs. Mechanisms like copay accumulators primarily impact people who are seeking whatever avenue they can find to be able to take their needed medication.

The National MS Society supports solutions that help safeguard access for people who need life-changing medications, without getting them caught in the middle of struggles between other stakeholders.

On behalf of The National MS Society and Marylanders with MS, I respectfully ask for this bill's passage out of committee. Thank you again for the opportunity to offer testimony in support of this bill. Should you have any questions, please free to contact me at Kyle.Rivers@nmss.org

Memorandum In Support of SB 773– Senator Hershey

Senate Finance Committee

February 26, 2025

The 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 773.

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. 21 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 773.

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

Lindsay Jack_MD SB 773_Finance_Written Testimony_2

Uploaded by: Lindsay Jack
Position: FAV

February 26, 2025

Senator Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Chair Beidle, Vice Chair Hayes, and Members of the Senate Finance Committee:

RE: SB 773, Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements

Position: SUPPORT

On behalf of all ALS patients, I respectfully request your support for SB 773, 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 773.

Sincerely,

Lindsay Jack

Lindsay Jack
Managing Director, Advocacy
The ALS Association
Lindsay.Jack@als.org

SB773_BleedingDisordersTestimony_Maryland.pdf

Uploaded by: Matthew Delaney
Position: FAV

NATIONAL
BLEEDING DISORDERS
FOUNDATION
Innovate | Educate | Advocate

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

Nathan Schaefer, MSW

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

Immune Deficiency Foundation Testimony - Maryland

Uploaded by: Matthew Prentice
Position: FAV

Immune Deficiency Foundation

Fostering a community empowered by advocacy, education, and research

February 24, 2025

Senate Finance Committee

SB 773 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements

Position: SUPPORT

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

The Immune Deficiency Foundation (IDF) supports SB 773. **This legislation would ensure that copay assistance programs, a vital source of financial 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 550 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.

To help temper high out-of-pocket costs, many individuals living with PI receive copay assistance for their specialty medication. Individuals will enroll in the copay assistance programs offered by the manufacturer that produces their medication or apply to receive financial assistance from nonprofit organizations. 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 towards meeting their deductible.

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 referred to as copay accumulator adjustment programs, or simply copay accumulators. 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, less than 1% of those claims were for a product that may have a generic alternative available.[1]

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

To date, 21 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 773 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

MD All Copays Count Coalition - SB 773 Written Tes

Uploaded by: Matthew Prentice
Position: FAV

The Maryland All Copays Count Coalition

February 24, 2025

Senate Finance Committee

SB 773 – Health Benefit Plans - Calculation of Cost Sharing Contribution - Requirements

Position: SUPPORT

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

The Maryland All Copays Count Coalition, which includes the undersigned organizations, write to you in support of SB 773. **This legislation would ensure that copay assistance, a vital source of financial 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 specialty medications required to manage these complex conditions are often 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. Individuals will enroll in the copay assistance programs offered by the manufacturer that produces their medication or apply to receive financial assistance from non-profit entities.

In recent years, health insurers and pharmacy benefit managers (PBMs) have begun implementing new policies that prevent any copay assistance funds from counting toward patients' deductibles and out-of-pocket maximums. These programs are often referred to as copay accumulator adjustment programs, or simply "copay accumulators". These policies 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.

A 2025 annual report found that 50% of marketplace plans in Maryland have copay accumulator adjustment policies.[1] These plans include:

- CareFirst BlueChoice (HMO)
- CareFirst BlueCross BlueShield (PPO)
- Wellpoint

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[1] Available at https://aidsinstitute.net/documents/TAI-2025-Report.pdf

Health insurers say that copay accumulators *"...help nudge patients toward lower cost, higher value choices"*[2], however, a prior analysis showed that for all commercial market claims for specialty medications where copay assistance was used, less than 1% of those claims were for a product that may have a generic alternative available.[3] Simply put, patients don't choose a more costly drug.

Patients and providers work together to determine a treatment plan that works best for them. Copay assistance is only utilized *after* a patient, provider, and their health plan have approved their access to that medication. This process often involves patients going through prior authorization, step therapy, and other forms of utilization management to demonstrate that the medication identified by their provider is the best choice for them. Patients and families overcome these barriers only to encounter challenges with affording their out-of-pocket costs. Subsequently, the financial assistance they intend to use to help with out-of-pocket costs is not counted due to a copay accumulator policy. This is tragic and represents a financial barrier to care that is unacceptable.

To date, 21 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 773 to ensure Marylanders can fully access the lifeline that copay assistance provides.

Sincerely,

ALS Association
American Cancer Society Cancer Action Network
Arthritis Foundation
Chronic Care Policy Alliance
Crohn's & Colitis Foundation
EveryLife Foundation for Rare Diseases
Hemophilia Federation of America
Hemophilia Foundation of Maryland
HIV+Hepatitis Policy Institute
Immune Deficiency Foundation
Lupus and Allied Diseases Association
MedChi, The Maryland State Medical Society
National Bleeding Disorders Foundation
National Psoriasis Foundation
Spondylitis Association of America
Susan G. Komen
The AIDS Institute

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[2] AHIP statement available at https://www.ahip.org/news/press-releases/ahip-files-amicus-brief-in-support-of-copay-coupon-accumulators

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

TAI-Grade-Sheet_Maryland.pdf

Uploaded by: Matthew Prentice

Position: FAV

MARYLAND

C

50% of marketplace plans in MARYLAND have copay accumulator adjustment policies that harm patients.

Maryland gets a C because CareFirst BlueCross BlueShield (PPO), CareFirst BlueChoice (HMO), and Wellpoint have copay accumulator adjustment policies.

3 out of 6 marketplace plans in Maryland are **harming patients** by including these policies.

The Issue

Copay accumulator adjustment policies undermine important patient protections and make it more difficult for people trying to manage a chronic illness to afford medicines they need.

Health insurance companies and pharmacy benefit managers (PBMs) pocket copayments made for enrollees using third-party copay assistance but don't credit the payments to the enrollee's annual deductible or out-of-pocket limit.

The Solution

State regulators and policymakers need to ensure that patients are protected.

The insurers that still include copay diversion policies must end this practice immediately. And Maryland legislators can protect their constituents with chronic illnesses by joining other states by enacting legislation to protect residents from the harmful practices of copay accumulator and copay maximizer policies.

THE AIDS INSTITUTE

Such legislation would ensure all those living in Maryland with state-regulated insurance plans are protected.

In addition to Maryland's law, a federal rule requires all private health insurance plans, including marketplace and employer-sponsored health plans, to count copay assistance toward patient cost-sharing limits in most cases. The plans listed above have copay diversion policies contrary to this rule. Maryland insurance regulators can ensure health insurers and pharmacy benefit managers comply with federal rules.

The HELP Copays Act is a federal bill that would enact these same protections in federal law to protect people living with chronic illness with individual and employer health plans. Senators and Members of Congress from Maryland should support this patient-centered legislation and urge its enactment.

More About Copay Accumulator Adjustment Policies and Vulnerable Patients

Millions of Americans with serious and complex chronic illness endure long and expensive medical journeys to diagnose their condition and find the best medicine to treat it. But when those medicines are considered "specialty medications," their cost can be prohibitive, even with insurance. That's why many people turn to copay assistance programs to help afford their share of the cost.

Copay accumulator adjustment and copay maximizer policies allow insurers and pharmacy benefit managers (PBMs) to keep payments made on an enrollee's behalf without counting those payments toward the enrollee's annual deductible or out-of-pocket limit. These policies undermine access to lifesaving prescription drugs for people living with serious, complex, chronic illnesses.

Read the full report from The AIDS Institute here:
www.theaidsinstitute.org/copays/TAI-copay-report-2025.

Arthritis Foundation Written Testimony MD SB 773.p

Uploaded by: Melissa Horn

Position: FAV

Arthritis Foundation®

arthritis.org/advocacy

Senate Finance Committee

Re: Support for SB 773 - Make All Copays Count

February 24, 2025

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

On behalf of more than 1,036,000 Maryland residents with doctor-diagnosed arthritis, thank you for the opportunity to submit testimony in **support of SB 773,** legislation that addresses copay accumulator policies in Maryland to ensure that third-party patient copay assistance – a **payment** provided on behalf of eligible patients with chronic or terminal conditions to help them afford their prescribed medications – counts towards patients' annual out-of-pocket cost-sharing obligations.

Copay accumulator programs prevent any co-payment assistance that may be available for high-cost specialty drugs from counting towards a patient's deductible or maximum out-of-pocket expenses. Many pharmaceutical manufacturers offer co-pay cards that help cover a patient's portion of drug costs. Traditionally, pharmacy benefit managers have allowed these co-payment card payments to count toward the deductible required by a patient's health insurance plan. With an accumulator adjustment program, patients are still allowed to apply the co-payment card benefits to pay for their medications up to the full limit of the cards, but when that limit is met, the patient is required to pay their full deductible before cost-sharing protections kick in.

Currently, the state of Maryland does not have a law to ensure that health insurers count co-payment assistance towards a patient's cost-sharing requirements. Now more than ever, it will be important for the Maryland State Legislature to act given 3 out of 6 of marketplace insurers in the state have copay assistance diversion policies.[1]

Legislation is necessary on this issue as patients are often unaware they are enrolled in one of these programs until they go to the pharmacy counter and realize they must pay the full cost of their medication, which can lead them to abandon or delay filling their prescription. These programs can be called different names, and are often marketed as a positive benefit, and are disclosed many pages into plan materials, leading to a lack of awareness about them to patients.

In a recent Arthritis Foundation survey, 37% of patients reported they had trouble affording their out-of-pocket costs. Of those, 54% say they have incurred debt or

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[1] Institute, T. A. (2025). 2025 TAI Report: Copay Accumulator Adjustment Programs. National Policy Office. Washington, DC: The Aids Institute. Retrieved from https://www.theaidsinstitute.org/copays/TAI-copay-report-2025

suffered financial hardship because of it. The Arthritis Foundation also surveyed in 2017 asking patients about accumulator programs and found that if patients are faced with a large, unexpected charge for a prescription drug, the top three reactions would be: abandoning or delaying their prescription fill; lengthening the time between doses; and asking their provider to switch to another drug.

SB 773 resolves this issue by simply ensuring that when calculating a patient’s overall contribution to any out-of-pocket maximum or any cost-sharing requirement, a health plan must include any amounts paid by the patient or paid on behalf of the patient by another person or third party.

Currently, 21 states, DC and Puerto Rico have enacted laws that require insurers to count third party payments, including copay assistance, towards cost-sharing limits. Further, Minnesota and Nevada have also taken regulatory steps to issue guidance to plans to remove accumulator programs.

The Arthritis Foundation thanks the committee for their consideration of SB 773 to add Maryland to the list of states ensuring ALL copays count and urges all committee members to support this critical legislation.

Melissa Horn
Director of State Legislative Affairs
Arthritis Foundation
1615 L St. NW Suite 320
Washington, D.C. 20036
240.468.7464 | mhorn@arthritis.org

MD Health Benefit Plans SB773_The AIDS Institute W

Uploaded by: Naomi Gaspard

Position: FAV

THE AIDS INSTITUTE

Senator Pamela Beidle
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

February 24, 2025

Re: Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements

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

The AIDS Institute, a non-partisan, nonprofit organization dedicated to improving and protecting health care access for people living with HIV, hepatitis, and other chronic health conditions, is writing in **support of SB 773.** This bill will immediately and 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]

Senate Bill 17 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

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[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/

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. And most importantly, patients must be approved for a medication by the insurers and PBMs through utilization management protocols, such as step therapy and prior authorization, before they are granted access to a specialty medication. The proposed legislation will protect patient access to critical medications and lower healthcare costs as patients remain adherent to their treatment regimens.

Enrollees are currently shopping for health insurance plans for 2025. Insurers and PBMs keep information about copay accumulators unclear, leaving patients unsure what exactly their health plan covers. For example, in a review of 2025 marketplace plans, The AIDS Institute found that three of the six plans (CareFirst Blue Cross Blue Shield PPO, CareFirst Blue Choice HMO & Wellpoint) offered in Maryland include copay accumulator adjustment policies (otherwise known as CAAP) language. This puts the vast majority of patients across the state in a vulnerable position, unable to select a plan that will fit their health care needs and allow them to afford their prescriptions.

We strongly urge you to pass SB 773 to protect patient access to life saving medications.

Sincerely,

Naomi Gaspard,
Policy Manager
The AIDS Institute

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[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.

NICA and IAF Comments in Support of SB 773.pdf

Uploaded by: Sam Miller

Position: FAV

Infusion Access
Foundation

Maryland General Assembly
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

February 25th, 2025

Re: Support for SB 773

Dear Committee Members,

On behalf of the Infusion Access Foundation, I extend our gratitude for your service to the people of Maryland. We strongly encourage your support for SB 773, which will be heard during the upcoming Maryland Senate Finance Committee hearing on February 26th. This critical legislation addresses two important issues: ensuring that payments made by or on behalf of an enrollee count toward their cost-sharing obligations, and prohibiting insurers from altering coverage based on the availability or amount of financial assistance for drugs. These provisions are crucial in protecting access to care for Maryland patients, especially those relying on high-cost medications.

The Infusion Access Foundation is a nonprofit advocacy organization dedicated to protecting access to infusions and injections. We support patients across all disease states and advocate for expanding access to the therapies that help patients live their best, healthiest lives. In conjunction with our grassroots advocacy work, we advocate for individual patients who face significant barriers to care.

1. Ensuring Payments Count Toward Cost Sharing

Unfortunately, some insurers have implemented "copay accumulator" and "copay maximizer" programs, which prevent copay assistance from counting toward deductibles or out-of-pocket maximums. These policies create insurmountable financial barriers for patients, pushing their treatment out of reach and increasing the risk of disease progression, flare-ups, and complications. SB 773 will address this problem by ensuring that payments made by or on behalf of an enrollee, whether directly by the patient or through third-party assistance, count toward their insurance cost-sharing responsibilities. This provision will help ensure that patients can access the medications they need without being unfairly burdened by insurance practices that undermine financial assistance.

2. Prohibiting Insurers from Altering Coverage Based on Financial Assistance
Another critical issue addressed by SB 773 is the use of alternative funding programs (AFPs), or specialty drug carve-out programs, by insurers. These programs often exclude high-cost medications from standard coverage, directing patients to external vendors. This practice can result in delayed access to life-saving medications, increased out-of-pocket expenses, and significant administrative hurdles for both patients and healthcare providers, placing patients in a precarious position and exacerbating existing health disparities. SB 773 prohibits insurers from altering or conditioning the terms of a health benefit plan based on the availability or amount of financial assistance for medications. This provision ensures that patients can access necessary treatments without interference from insurer-imposed barriers. It promotes health equity, supports continuity of care, and reduces financial strain on patients and providers alike.

The passage of SB 773 represents a commitment to protecting the health and well-being of Maryland residents. We urge you to stand with patients and healthcare providers by supporting this critical legislation during the February 26th hearing.

Thank you for your leadership and dedication to improving access to care for the people of Maryland.

Sincerely,

Alicia Barron, LGSW
Executive Director
Infusion Access Foundation

NICA NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

Maryland General Assembly
Senate Finance Committee
3 E Miller Senate Office Building
Annapolis, MD 21401

February 25, 2025

Re: Support for SB 773

Dear Committee Members,

On behalf of the National Infusion Center Association (NICA), I would like to thank you for your service to the people of Maryland. We strongly urge your support for SB 773, which will be heard during the upcoming Maryland Senate Finance Committee hearing on February 26th. This critical legislation addresses two important issues: ensuring that payments made by or on behalf of a patient count toward their cost-sharing responsibilities and prohibiting insurers from altering coverage based on the availability or amount of financial assistance for medications. These provisions are vital not only to protecting patients but also to safeguarding the ability of healthcare providers to deliver high-quality care.

NICA is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of infused and injectable medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in high-quality, non-hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in quality of care and safety across care settings, and enable care delivery in the highest-quality, lowest-cost setting.

One of the most significant challenges we face as providers is the implementation of "copay accumulator" and "copay maximizer" programs by some insurance companies. These programs prevent copay assistance, whether paid directly by patients or through third-party assistance, from counting toward the patient's deductible or out-of-pocket maximum. As a result, patients are often unable to afford the treatments they need, or they delay seeking care until their financial situation becomes untenable. For providers, this creates a ripple effect of administrative burdens.

Healthcare professionals are forced to spend significant time and resources communicating with insurance companies, reprocessing claims, and attempting to secure approvals for treatments. This takes time away from providing care and drives up operational costs for healthcare facilities, particularly those in ambulatory infusion settings that already function as cost-effective alternatives to hospital care. SB 773 will help alleviate these pressures by ensuring that all payments made on behalf of patients count toward their cost-sharing obligations. This will allow providers to deliver care more efficiently and ensure patients can stay on their prescribed treatments without unnecessary financial obstacles.

Another troubling trend we are seeing is the rise of alternative funding programs (AFPs), also known as specialty drug carve-out programs. These programs exclude expensive medications from standard coverage and direct patients to external vendors, causing significant delays in the delivery of essential treatments. This is not just a problem for patients; it also creates major disruptions for healthcare providers.

Providers are often left managing the fallout of these carve-out programs, including having to find alternative treatment solutions and navigate the complicated processes these programs introduce. This diverts valuable time and resources from patient care, and for many infusion centers, it adds significant administrative burdens that are not reimbursed. AFPs also increase the financial burden on patients by creating additional layers of complexity in accessing their medications. When patients are delayed in receiving their treatments, it can lead to worsened health outcomes, including disease progression and complications that result in more intensive and costly interventions.

SB 773 will protect healthcare providers by prohibiting insurers from conditioning health plan coverage based on the availability or amount of financial assistance. This will prevent insurers from using financial assistance as a lever to alter coverage terms, thus protecting the integrity of the treatment process and reducing the administrative load placed on healthcare providers.

By ensuring that patients have uninterrupted access to necessary treatments, SB 773 will help healthcare providers focus on what matters most: providing the care their patients need.

The passage of SB 773 is a critical step toward reducing the administrative and financial burdens that these harmful practices place on healthcare providers, while ensuring that patients continue to have access to the life-saving treatments they rely on. We urge you to support this essential legislation during the upcoming Senate Finance Committee hearing. Thank you.

Sincerely,

Brian Nyquist

Brian Nyquist, MPH
President & CEO
National Infusion Center Association

MD HIV HEP Support Accumulator Ban.pdf

Uploaded by: Zach Lynkiewicz
Position: FAV

HIV+HEP
POLICY INSTITUTE

February 24, 2025

Senator Pamela G. Beidle, Chair
Senate Finance Committee
Maryland Senate
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401

Re: Written Testimony in Support of SB0773 – Ensure All Copays Count

Members of the Senate Finance Committee:

The **HIV+Hepatitis Policy Institute**, a leading organization advocating for equitable and affordable healthcare for individuals living with or at risk of HIV, hepatitis, and other chronic health conditions, strongly supports **Senate Bill 773.** This vital legislation ensures that health insurers accept and count payments made on behalf of patients toward their deductibles and out-of-pocket maximums.

The Harmful Impact of Copay Accumulators

Copay accumulators are harmful policies increasingly implemented by insurers, employers, and pharmacy benefit managers (PBMs). Under these policies, copay assistance provided by drug manufacturers does not count toward patients' cost-sharing obligations, such as deductibles and out-of-pocket maximums. While patients can initially use the assistance to afford their medications, they often face unexpected and substantial costs later in the year when the assistance runs out, leaving them unable to pay for their prescriptions.

According to the AIDS Institute, in Maryland, 3 out of 6 health plans offered in the individual marketplace for 2025 explicitly state in their plan documents that copay assistance may not be counted toward patients' cost-sharing obligations. This practice leaves patients in a precarious situation: insurers collect the manufacturer's copay assistance, but the patient receives no credit toward their deductible or out-of-pocket maximum. Later, when patients return to refill their medications, they are often hit with unaffordable copays—sometimes thousands of dollars—effectively forcing them to pay twice. This "double-dipping" practice unfairly burdens patients and jeopardizes their ability to adhere to life-sustaining treatments.

Why Senate Bill 773 Is Essential

By passing Senate Bill 773, Maryland will join 21 other states, the District of Columbia, and Puerto Rico in protecting consumers purchasing insurance on the private market. This legislation ensures that copay assistance counts toward cost-sharing obligations, preventing patients from facing insurmountable financial barriers to their medications.

For people with HIV, hepatitis, and other chronic conditions, reliable access to medication is critical. Individuals with HIV and hepatitis B require lifelong drug regimens, while those with hepatitis C can be cured in as little as 8 to 12 weeks. Yet high deductibles and cost-sharing requirements often make these treatments unaffordable, even for insured patients. Copay assistance is a lifeline, particularly in today's challenging economic climate, where inflation and rising costs are straining household budgets.

When patients are forced to forego their medications due to high costs, the consequences are severe—not just for individual health outcomes, but also for public health and healthcare system costs. Policies that limit access to copay assistance exacerbate these challenges, disproportionately affecting those who are already vulnerable. Senate Bill 773 represents an essential safeguard against harmful insurer practices, ensuring equitable access to life-saving treatments for Maryland residents.

If you have any questions or need any additional information, please do not hesitate to reach out to our Government Affairs Manager, Zach Lynkiewicz, at zlynkiewicz@hivhep.org.

Thank you for your consideration and leadership on this critical issue.

Sincerely,

Carl E. Schmid II
Executive Director

cc: Sen. Stephen S. Hershey, Jr.
Senate Finance Committee

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Uploaded by: Matthew Celentano
Position: FWA

The League of Life
and Health Insurers
of Maryland

15 School Street, Suite 200
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February 26, 2025

The Honorable Pam Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

Senate Bill 773 – Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. respectfully requests a favorable with amendments report on *Senate Bill 773 – Health Benefit Plans – Calculation of Cost Sharing Contribution – Requirements.*

As the committee is aware, carriers and advocates spent a lot of time on the basis of this legislation during the 2024 Maryland General Assembly Session. House Bill 879 passed that chamber and was in possession of the Senate Finance Committee at the end of Session.

That bill would have, when calculating an insured's or enrollee's contribution to the insured's or enrollee's coinsurance, copayment, deductible, or out-of-pocket maximum, required a carrier to include any discount, financial assistant payment, product voucher, or other out-of-pocket expense made by or on behalf of the insured or enrollee for a prescription drug that: (1) is covered under the insured's or enrollee's health benefit plan: and (2) does not have an AB-rated generic equivalent or an interchangeable biological product preferred under the health benefit plan's formulary or, if there is such an alternative, the insured or enrollee has obtained access to a brand drug through a prior authorization, step therapy protocol, or exception or appeal process of the carrier. This bill from last Session has been reintroduced as House Bill 1246.

We suggest moving forward with Senate Bill 773, but amending the initiative to mirror House Bill 1246 as introduced For these reasons, the League urges the committee to give Senate Bill 773 a favorable with amendments report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

AHIP Comments_MD SB 773 Copay Accumulator_2.24.25.

Uploaded by: Keith Lake

Position: UNF

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February 24, 2025

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

Re: SB 773, Copay Coupon Accumulator Ban

Dear Chair Beidle:

On behalf of AHIP, we offer the following comments in opposition Senate Bill 773, which restricts health plans' ability to hold down drug costs. This bill does nothing to control the soaring prices of prescription drugs set by pharmaceutical manufacturers, but instead rewards drug makers for steering patients towards more expensive brand-name drugs. SB 773 would encourage the use of more expensive drugs, increase premiums, and reduce wages for Maryland residents.

Drug manufacturers intentionally use copay coupons to keep drug prices high. Everyone should be able to get the medications they need at a cost they can afford. But drug prices are out of control, and Maryland families feel the consequences every day. Pharmacy costs now represent over 24 cents out of every dollar of premium spent on health care.[1]

Drug manufacturers acknowledge their drugs are unaffordable for patients, but rather than addressing this by lowering their prices, they instead offer copay coupons[2] to hide the actual cost of those drugs. Coupons intentionally offset short term cost sharing for a few patients, while increasing the cost of pharmacy care for everyone and benefiting drug manufacturers.

Copay coupons encourage the use of high-priced branded prescription drugs when more affordable generic alternatives are available. The federal government considers copay coupons to be an illegal kickback if used by an enrollee in Medicare or Medicaid because they induce a patient to use a specific drug.[3] In the commercial market, coupons are often offered by the drugmaker only for a limited time – once the patient hits their deductible, the drugmaker discontinues the patient's assistance.

The Centers for Medicare and Medicaid Services (CMS) has concluded that coupons can distort the market and hide the true cost of drugs. "Such coupons can add significant long-term costs to the health care system that may outweigh the short-term benefits of allowing the coupons, and counter-balance issuers' efforts to point enrollees to more cost-effective drugs."[4]

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[1] Where Does Your Health Care Dollar Go? AHIP. October2024.
[2] Here, the term "copay coupons" is used to represent all payments provided by a third party towards a patient's cost sharing (copay, coinsurance, deductible). This includes coupons directly from drug manufacturers, but also third-party payments and discount programs from patient assistance programs.
[3] *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.
[4] *Notice of Benefit and Payment Parameters for 2020*. Final Rule. April 25, 2019.

Health plans use guardrails to hold drug manufacturers accountable for pricing schemes such as copay coupons. It is critical to have guardrails in place against this kickback system to ensure transparency and affordability in drug pricing. Employers and health plans have worked hard to develop guardrails that reflect patients' actual out-of-pocket spending on drugs and shed light on drug manufacturer pricing schemes.[5] These employer and health plan guardrails do not result in higher costs for patients. Instead, they maximize the value of coupons to benefit the patient, taxpayers, and plan sponsors, and reduce the ability of drug manufacturers to avoid fair negotiation on prices.

This bill will have negative consequences for all patients. This bill would significantly hamper health insurance providers' ability to develop programs to hold manufacturers accountable for problematic pricing schemes. To assist policymakers considering whether to require health plans to accrue third-party payments towards patient cost-sharing, AHIP commissioned the actuarial firm Wakely to analyze the impact of such policy. Wakley found that legislation like SB 773 would:

- **Increase premiums**, with the largest increases in the individual marketplace
- **Result in adverse selection** into lower premium plans, such as Bronze plans, resulting in **higher premiums and consumers dropping their coverage.**
- **Reduce wages** for workers who receive coverage at work, due to **higher employer costs.**
- **Encourage use of more expensive drugs** over cheaper alternatives.[6]

Restricting the use of health plans' guardrails will reduce incentives for drug companies to offer lower prices because those drug companies can continue to replace real price reductions with coupons. As a result, drug companies will make more money, while consumers and businesses continue to foot the bill through lower wages and higher premiums and out-of-pocket expenses.

The broad scope of this bill will have an even greater impact on patients' costs. As discussed, we have concerns with curtailing insurers' programs to address the market manipulation from copay coupons for prescription drugs. However, this bill reaches further by applying these requirements to all "health care services" leading to even greater detrimental impacts for patients as it opens the door to allow any provider to steer patients towards their practice with the promise of paying a portion of their cost sharing amount. For example, an out-of-network provider with rates twice as high as in-network providers could agree to subsidize a patient's cost-sharing and leave the insurer on the hook for twice the amount they would pay an in-network provider. This will effectively nullify insurers' ability to design cost-effective networks and place an enormous financial strain on employers paying health care costs.

Wakely's analysis found that broader bills like this will increase health care spending and undermine cost-saving networks by allowing providers to direct patients to higher cost out-of-network facilities.[7]

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[5] Humer, Caroline and Michael Erman. *Walmart, Home Depot adopt health insurer tactic in drug copay battle*. Reuters. November 13, 2018.
[6] *Implications of Third-Party Payments on Commercial Market*. Wakely. July 15, 2024.
[7] *Id.*

Furthermore, this bill is not limited to covered health care services, which means that patients receive the benefit of covered services (using their cost sharing payments to reach their deductible or out-of-pocket maximum) for all services, whether covered by their health plan or not.

The legislature should focus on solutions that forbid market manipulation. Instead of taking away the few tools that health plans and employers use to address ever increasing drug prices, the legislature should focus on fixing the market distortion caused by drug manufacturer pricing schemes, including copay coupons. We support a ban on copay coupons, especially in cases where less expensive generic alternatives are available, as California and Massachusetts have done.[8] This has been proposed by a group of prestigious health care scholars looking at ways to offer evidence-based steps for reforming health care spending in the US.[9]

If you wish to allow the use of drug manufacturer coupons to continue, we urge you to consider reforms that require a fair and equitable distribution of such coupons with sufficient oversight and transparency. This includes requiring that coupons be given to all patients prescribed a drug, assistance be provided for the entire plan year, and manufacturers inform health plans when they are providing a coupon or other type of financial assistance to an enrollee of that health plan.

AHIP Recommendation. AHIP opposes SB 773 as it eliminates valuable tools used in the effort to hold drug manufacturers accountable for their exorbitant prices.

AHIP stands ready to work together with state policymakers to ensure every patient has access to the high quality, affordable drugs that they need.

Sincerely,

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

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

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[8] *CA Health and Safety Code § 132000- 132008.; Mass. Gen. Laws Ann. ch. 175H, § 3*.
[9] *Eliminating Prescription Drug Copay Coupons*.