**Testimony in Opposition to**

**LD 1783 An Act To Require Health Insurance Carriers and Pharmacy Benefits Managers To Appropriately Account for Cost-sharing Amounts Paid on Behalf of Insureds**

Submitted by Kimberly Cook
January 19, 2022

As Maine's only nonprofit CO-OP health insurance company, we exist for the benefit of our Members and our mission is to provide affordable, high quality benefits that promote health and wellbeing.

Requiring carriers to apply payments made by drug manufacturers to a Member's deductible and out of pocket maximum fails to address the issue of high priced drugs, and instead introduces yet another driver to the rising costs of coverage. This proposal would further facilitate pharmaceutical manufacturers' manipulation of the market wherein they provide coupons up to a plan's maximum out of pocket cost sharing (MOOP) and subsequently rely on 100% coverage by the insurer.

At Community Health Options, we would prefer to see lower costs of prescription drugs rather than manufacturer-based gimmicks that only result in greater enrichment of the manufacturers. However, until the root cause of high prescription drug prices is addressed, we will work to advantage our Members within the realities and constraints that exist. To that end, we actively seek out ways to help our Members with their cost sharing, including the application of coupons. However, we cannot support a policy whereby pharmaceutical manufacturers write off the initial costs by covering a drug's initial expense on behalf of a consumer, to then profit immensely across all premium payers as the patient continues to fill the prescription throughout the year.

Annually, LD 1783 would eliminate the cost sharing responsibilities of approximately 1% of our Members. That 1% of enrollees account for nearly 60% of prescription drug costs. The cost of this reduction would come at the expense of the vast majority of our Membership. LD 1783 does not reduce the price of costly prescription drugs. As a non-profit health plan, the surging expense of specialty medications is ultimately borne by our Members in the form of higher monthly premiums.

We are also concerned that, as currently written, this legislation is likely to further dampen interest in fully insured small group plans. As small groups with less expensive risk profiles exit the community-rated market for self-insured, experience-rated products not subject to the requirements of LD 1783, they leave behind a more costly pool that in turn drives up the per person costs of the community-rated pool. Also, assuming Maine moves forward with a merged market, the move to self-insured group products will increase premiums not only for fully insured small groups but for individuals as well.


In addition to burdening Members with higher premiums, LD 1783 is inherently inequitable. Favoring individuals who happen to receive drug company coupons by eliminating their out of pocket responsibilities, while expecting Mainers who encounter high medical bills for procedures and hospital care to pay full freight appears arbitrary and unfair. What if a private equity group opens an integrated physical therapy and specialty surgery center for back surgeries and joint replacements (only serving commercially insured/more lucrative patients, of course), and offers a coupon to pay a patient's out of pocket costs if they undergo the surgery within 6 months? Patient results would not be better, the overall cost of the care would increase, but the individual patient would receive a financial benefit from this incentive scheme while the true cost is born by the premium dollars of the full pool of insureds. As more patients take advantage of this incentive, total costs increase, and hence premiums would reflect the increased costs.

Recently-enacted law already provides guidelines for rebates, discounts, credits, or other compensation remitted by or on behalf of a pharmaceutical manufacturer. (See 24-A §4350-A (1).) This compensation must be either: remitted directly to the covered person at the point of sale to reduce the out-of-pocket cost to the covered person; or retained by the carrier and applied in future plan years to offset the premium for covered persons. This statutory requirement already provides a sufficient manner of applying compensation provided by pharmaceutical manufacturers. Going further, as LD 1783 does, and mandating that these inducements be used to wipe away cost sharing will create an imbalance in the richness of the plan with the premiums set to accommodate expected utilization. LD 1783 will effectively result in creating plans with higher actuarial values and thus higher monthly premiums for Mainers.

We appreciate the opportunity to share these comments. We agree that high prescription drug costs merit attention. We encourage this Committee to address the issue in a more direct manner rather than adopting an approach that shifts costs and burdens Mainers with higher monthly premiums.