



**Chronic Care
Policy Alliance**

State Advocates
Working Together
to Bridge the Gaps
in Chronic Care

Testimony RE SB 290 (Benson): Health Insurance - Out-of-Pocket Maximum and Cost-Sharing Requirements – Calculation

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Position: FAVORABLE

The Chronic Care Policy Alliance (CCPA) is a network of state and regional advocacy organizations advancing public policy that improves the lives of those living with chronic conditions and diseases.

CCPA is dedicated to ensuring people living with chronic diseases can have a better quality of life. We accomplish this by focusing on four key principles:

- [Prevention](#)
- [Affordability](#)
- [Access to Care](#)
- [Quality Health Care](#)

The CCPA urges you to support and pass SB 290 (Benson) to ensure that patients with chronic and/or rare diseases can afford pharmaceutical drug treatments to manage one or more of their medical conditions. In the last few years health insurers and Pharmacy Benefit Managers have developed Accumulator Adjustment Programs that have placed further financial burdens on patients.

Some medicines are expensive and needed by patients over long periods of time and over the course of their lifetime. Many patients cannot afford the high costs of their drug treatment. In those cases, patients have depended upon the help of financial assistance from drug manufacturers, family, friends, Go Fund Me, private charities, religious organizations, and others to help pay for their medicines and have those payments apply toward their out-of-pocket costs and deductible.

The Accumulator Adjustment programs will take the money from patients and third-party sources but will not count those funds towards deductibles or out-of-pocket costs. Thus, a patient and her/his family will never be able to meet their cost sharing obligations and will always be beholden to the health insurer – much like the old “company store” where workers were never able to get out of debt to the company store.

Insurers and PBMs benefit handsomely. The costs that they pass on to patients and their families are not based upon the significant discounts and rebates that drug companies give to Insurers and PBMs. Rather patient costs are based upon the “list or retail” price. As a result, patients are being gouged and insurers and PBMs are paying minimum costs and sharing profits with stockholders at the expense of patients.

These programs were invented by PBMs as part of the “war” between health insurers and pharmaceutical companies concerning the high cost of drugs. Insurers believe that payments from third parties on behalf of patients keep drug prices high and their drug spend high. They further believe that these types of programs will reduce costs and their drug spend. There is no evidence that these programs will reduce costs. Regarding insurers’ drug spend, there **will** be an impact because patients will not be able to afford their medicines and won’t get the drug therapies they need. There is no doubt that patients who cannot obtain their drug therapeutic treatments as a result of these accumulator programs will unfortunately be using and increasing their medical benefits instead. In this war, patients are pawns and collateral damage.

Health insurers and PBMs operate on the premise that if a person needs more health care services, they should pay more. In other words, sick people should be financially penalized for being sick. Government policy should be directed to helping those people who have limited means and chronic and/or rare diseases. Payors and PBMs should not be allowed to continue practices such as accumulator adjustment programs. Instead, government should end or prevent such predatory and discriminatory practices.

We urge your support of SB 290. Feel free to reach out to me at the contact information below.

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