COMMUNITY ACCESS NATIONAL NETWORK

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Maryland Prescription Drug Affordability Board
16900 Science Drive, Suite 112-114
Bowie, MD 20715

RE: Ongoing Review Concerns

Dear Honorable Members of the Maryland Prescription Drug Affordability Board,

The Community Access National Network (CANN) is a 501(c)(3) national nonprofit organization focusing on public policy issues relating to HIV/AIDS and viral hepatitis. CANN's mission is to define, promote, and improve access to healthcare services and support for people living with HIV/AIDS and/or viral hepatitis through advocacy, education, and networking.

While CANN is primarily focused on policy matters affecting access to care for people living with and affected by HIV, we stand in firm support of all people living with chronic and rare diseases and recognize the very reality of those living with multiple health conditions and the necessity of timely, personalized care for every one of those health conditions. State Prescription Drug Affordability Boards are of profound importance to our community.

Implementation of Program Protections Remains Unclear

To date, it is unclear how 340B, VA, or other federal program claims will be operationalized to ensure a UPL would not be imposed on them. The statute requires inquiry that has not yet been met. Specifically, it states that:

BEFORE ESTABLISHING AN UPPER PAYMENT LIMIT THAT APPLIES TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM, THE BOARD SHALL CONFER WITH THE MARYLAND MEDICAL ASSISTANCE PROGRAM TO APPROVE THE APPLICATION OF THE UPPER PAYMENT LIMIT BY ASSESSING WHETHER THE PROPOSED UPPER PAYMENT LIMIT WILL:
(I) CONFLICT WITH THE MEDICAID DRUG REBATES PROGRAM, THE COVERED OUTPATIENT DRUG RULE (CMS–2345–FC), OR ANY OTHER FEDERAL REQUIREMENTS AS APPLICABLE; AND
(II) REQUIRE ADDITIONAL FUNDING TO BE ALLOCATED TO THE MARYLAND MEDICAL ASSISTANCE PROGRAM BUDGET.

Additionally, there has not been evidence of energies being directed towards developing guardrails to protect any potential drug to which a UPL has been applied from removal from drug formularies. It is also necessary to address the potential for UPL-designated drugs to be subjected to increased utilization management or higher-tier plan assignment.

Designations Remain Questionable

The preliminary designation that certain drugs have caused "affordability challenges" is based on percentages of WAC increases over time, percentages of specific drug spend relative to overall state drug spend, and an acknowledgement that patient cost share in relation to net plan spend is higher in certain markets. It is unclear why a specific WAC increase trend is being utilized to define "unaffordability", how any increase is related to net state program spend, or how such an increase in WAC is affecting patient cost sharing or adverse benefit design. Moreover, the way pricing has been discussed has inappropriately separated the price of drugs from their therapeutic value. When drugs are effective, more doctors prescribe them because of improved health outcomes, and more patients use them, as long as they have access. Thus, stating that exceeding 1% of gross prescription drug spend for state and local governments, as in the case of Farxiga, is an "affordability challenge", without delineating the definition of "affordable" spend percentage based on specific factors, including qualitative and quantitative patient health outcomes, is problematic.

Ongoing analysis also needs to address the issue that the cost review study process to date has not contained enough informed data specific to Maryland. Board members have even acknowledged that the data concerning drug spending has a heavy focus on the increase in drug spending nationally, but a paucity of data on how it affects Marylanders specifically, along with their spending trends and the factors that may be affecting such. Thus, it is unclear why staff felt exercising MFP domestic reference pricing as potential upper payment limits is in the best interest of patients and the state.

Anticipation of Non-UPL Solutions is High

Staff have expressed plans to devote more energy to non-UPL affordability solutions in ongoing endeavors. This has been anticipated by many stakeholders. Notably, Oregon recently decided not to recommend upper payment limits to the legislature as a policy suggestion because it deemed them ineffective. They are focused on pursuing non-UPL solutions to affordability.

In addition to patient out-of-pocket caps, a potential solution worth inquiry is PBM pass-through requirements in the same nature as existing West Virginia legislation. Maryland currently prohibits spread pricing in the Medicaid program. However, West Virginia's active legislation goes further to mandate PBMs to pass through 100% of manufacturer rebates, discounts, and other remuneration to the health plan/consumer, rather than retaining them as profit. The update to the West Virginia Pharmacy Audit Integrity Act mandates that "a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums." Any rebates in excess of a

patient's defined cost-sharing cannot be retained by a PBM as profit but must be passed on by the health plan to lower premiums. This is especially relevant given the Board's future endeavor to implement affordability measures statewide for commercial markets as well. A recent West Virginia insurance bulletin delineates evidence-based data showing real-world savings.

As the affordability discourse continues to develop, we hope to see a thorough analysis of stakeholder concerns, including those of Board members. There seems to be a high-level understanding of weaknesses in ongoing processes. However, a proverbial "digging into the weeds" is what needs to be done to reassure the public that direct patient benefit is the current trajectory.

Respectfully submitted,

Ranier Simons
Director of State Policy, PDABs
Community Access National Network (CANN)

On behalf of
Jen Laws
President & CEO
Community Access National Network

WEST VIRGINIA INSURANCE BULLETIN
No. 26-01

Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► Prescription Drug Rebate Impact to Commercial Health Insurance Plans◄

In 2021, the Legislature passed House Bill 2263 amending West Virginia's Pharmacy Audit Integrity Act (PAIA) located in Chapter 33, Article 51 of the West Virginia Code. The 2021 updates to the PAIA generally went into effect on January 1, 2022. One of the more substantive updates to the law was regarding prescription drug rebates. The West Virginia Offices of the Insurance Commissioner (OIC) is issuing this Insurance Bulletin to publicly provide frequently requested information regarding the effects of the prescription drug rebate law on health insurance rates as reported by commercial health insurers to the OIC.

W.Va. Code §33-51-9(k) provides "a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums."[1] This provision of the PAIA is oftentimes referred to as the "point-of-sale" or "pass-through rebate" provision. Any rebate calculated by a pharmacy benefit manager (PBM) to be over and above a covered individual's defined cost sharing may not be retained by the PBM but must be passed on to the health benefit plan and must be used by the health benefit plan to reduce the cost of premiums. *See* W.Va. Code St. R. §114-99-5.14.3.

Beginning in 2023, the OIC asked health insurers who file rates with the OIC to calculate the total amount of rebates received on prescription drugs and to assess the impact thereof on health insurance rates. Health insurers have been asked to separate the rate effect due to West Virginia's prescription drug rebate law from the health insurer's otherwise filed rate request without the effect of the prescription drug rebate law. Health insurers have complied and provided the OIC with the percentage that their annual rate request was reduced due to receipt of prescription drug rebates. Data submitted to the OIC by the health insurers is subsequently reviewed by OIC contracted actuaries.[2] Health insurers who have submitted this information in their annual filings are Aetna Health Insurance Company, CareSource West Virginia Company, Highmark Blue Cross Blue Shield, The Health Plan of West Virginia, THP Insurance Company, UnitedHealthcare Insurance Company, and Optimum Choice, Inc.

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[1] W.Va. Code §33-51-3 defines "defined cost sharing" as "a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan." [2] The OIC does not currently possess specific data on how rebates affected the rate filings of specific insurers prior to 2022. Prior to the implementation of the point-of-sale or pass-through rebate law, PBMs and health insurers were able to negotiate rebate contract terms. Some insurers may have required 100% of rebates to be passed through to the insurer, while other insurers may have allowed their PBM to retain rebates, or portions thereof, as part of the PBM's compensation.

2023 Filings (2024 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	17.10%	-5.50%	11.60%
Company A	Large Group	16.20%	-5.50%	10.70%
Company B	Individual	6.10%	-3.10%	3.00%
Company C	Individual	10.40%	-8.30%	2.10%
Company C	Small Group	13.50%	-7.10%	6.40%
Company C	Large Group	9.60%	-1.80%	7.80%
Company D	Individual	6.57%	-6.72%	-0.15%
Company D	Small Group	16.18%	-6.28%	9.90%
Company E	Small Group	6.41%	-5.55%	0.86%
Company F	Small Group	29.60%	-14.00%	15.60%
Company G	Small Group	29.40%	-14.00%	15.40%

2024 Filings (2025 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	18.80%	-6.20%	12.60%
Company A	Large Group	18.70%	-6.20%	12.50%
Company B	Individual	15.097%	-2.75%	12.347%
Company C	Individual	12.30%	-9.60%	2.70%
Company C	Small Group	17.60%	-9.67%	7.93%
Company C	Large Group	17.30%	-0.70%	16.60%
Company C	Transitional	18.90%	-10.30%	8.60%
Company D	Individual	7.72%	-7.45%	0.27%
Company D	Small Group	17.80%	-7.07%	10.73%
Company E	Small Group	11.89%	-7.60%	4.29%
Company F	Small Group	21.80%	-11.70%	10.10%
Company F	Large Group	5.21%	0.00%	5.21%
Company G	Small Group	21.900%	-11.70%	10.200%

2025 Filings (2026 Plan Year)

Company	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	24.70%	-8.00%	16.70%
Company A	Large Group	26.00%	-8.00%	18.00%
Company B	Individual	9.300%	-2.20%	7.100%
Company C	Large Group	21.10%	-7.70%	13.40%
Company C	Individual	20.20%	-6.30%	13.90%
Company C	Small Group	25.11%	-8.91%	16.20%
Company D	Individual	15.81%	-7.93%	7.88%
Company D	Small Group	24.38%	-7.56%	16.82%
Company D	Large Group	15.82%	-8.42%	7.40%
Company E	Small Group	28.67%	-7.50%	21.17%
Company E	Large Group	5.09%	-8.00%	-2.91%
Company F	Small Group	12.57%	-2.62%	9.95%
Company F	Large Group	22.60%	-13.00%	9.60%
Company G	Large Group	22.60%	-13.00%	9.60%
Company G	Small Group	10.10%	-1.30%	8.80%

Please e-mail any questions concerning this Insurance Bulletin to OICBulletins@wv.gov.

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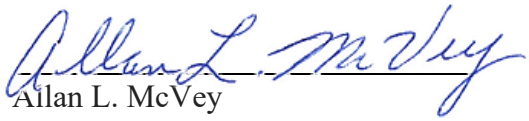

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