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July 29, 2026

Massachusetts House of Representatives
State House
Boston, MA 02108

Re: Support Rebate Pass-Through and Patient Copay Assistance Protections in S3141/H5618

Speaker Mariano and Members of the House of Representatives:

The Coalition of State Rheumatology Organizations (CSRO) **supports Sections 35 and 39 of the amended healthcare bill, S3141/H5618**. These provisions would require pharmacy benefit managers (PBMs) to pass prescription drug rebates directly to patients and require health plans and PBMs to apply all third-party payments and discounts made on a patient's behalf toward the patient's cost-sharing requirements. CSRO serves the practicing rheumatologist and is comprised of over 40 state and regional professional rheumatology societies nationwide whose mission is to advocate for excellence in the field of rheumatology, 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.

PBM Practices Harm Patients

Rheumatology patients were among the first to experience the harmful repercussions of pharmacy benefit manager (PBM) business practices because rheumatologic conditions regularly require complex, and often expensive, specialty medications. These PBM business practices were built on a system of perverse incentives, where the higher a drug's list price, the greater the income potential for the PBM. As a result, prescription drug formularies are designed to maximize PBM revenues. Time and time again, we've seen our patients switched between different medications when PBMs change their formularies to higher-priced drugs when they have more to gain from rebates and fees set at a percentage of the list price.

The three largest PBMs —Caremark Rx, Express Scripts (ESI), and OptumRx— control 80% of the prescriptions filled in the United States, according to the Federal Trade Commission.[i] This vertical integration allows the PBMs to control which medication patients can take (through formulary construction), when they can take these medications (through utilization management), where they can purchase their medications (through pharmacy networks), and how much they must pay for their drugs (through cost-sharing). Currently, all of these decision points are leveraged to maximize PBM profits rather than provide the patient with the best care at the greatest savings.

Formulary design decisions are disastrous for patients who pay coinsurance because their out-of-pocket cost is based on the list price of the medication – not what the PBM actually pays. An analysis by Drug Channels estimates that the spread between list and net price for insurers was over $200 billion in 2021.[ii] A 2021 report by the Texas Department of Insurance demonstrated that patients see marginal benefit from the supposed PBM "savings." Of $5,709,118,113 in rebates generated by PBMs for Texas insurers, only 21% made it back to patients in the form of direct savings.[iii]

Pass Manufacturer Rebates Directly onto Patients
CSRO supports Section 35 of the bill as it would require manufacturer rebates to bypass the PBM and **require 80% of the rebates to go directly to the patient**. PBMs claim to negotiate aggressive rebates and discounts that supposedly benefit employers and help keep premiums down. However, as demonstrated in the Texas report, those "savings" rarely trickle down to the patient. List prices appear to be fictional for everyone *except* the patient, whose cost-sharing is often based on the full price. It's time for rebates and other price concessions to benefit the patient – not the PBMs, especially as many patients are enrolled in health insurance plans that utilize high deductibles and/or significant cost sharing.

Given the immense vertical integration of PBMs and health insurance companies, policies that allow rebates to go directly to the health plan may have little impact in reducing patient expenses. Instead, rebates that go directly to the patient allow patients to see *immediate* savings at the point of sale. Not only will reducing patients' out-of-pocket costs improve adherence with better health outcomes, but it will also foster transparency and fairness in the healthcare system.

Copay Accumulator Adjustment Programs Put Patients at Serious Risk
CSRO also supports the patient assistance protections in Section 39 of the bill, which would **prohibit copay accumulator adjustment programs** used by health plans and PBMs to increase their profits at the expense of patients.

Copay assistance programs — offered by drug manufacturers, charitable foundations, and nonprofit organizations — exist specifically to help patients afford their medications. Through "copay cards" and financial assistance, these programs provide direct financial relief, helping patients meet their deductibles and out-of-pocket maximums so that cost does not impact their care.

Unfortunately, health plans and PBMs have recently found a way to capture this financial assistance for themselves – before it ever reaches the patient. Through their **own copay accumulator adjustment programs**, health plans collect the full dollar value of a patient's copay card — money provided by a third-party specifically for the patient's benefit – but deliberately refuse to credit any of it towards the patient's annual deductible or out-of-pocket maximum.

The result is a calculated deception. Patients believe they are making meaningful progress toward their annual cost-sharing limit, only to be blindsided when the copay card runs out and they discover they still owe their full deductible and out-of-pocket maximum, as if they had received no assistance at all. Health plans and PBMs try to justify these programs by calling drugs using copay cards "non-essential benefits" that include most pharmacy drugs used for cancer, inflammatory diseases, MS, and inflammatory bowel diseases, to name a few. In short, copay accumulator programs directly increase costs for patients with chronic diseases and particularly those with high deductibles.

The financial consequences are severe for some patients who 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.

On behalf of practicing rheumatologists throughout Massachusetts and the patients we serve, we request that you support Sections 35 and 39 in the amended version of **S3141/H5618.** We thank you for your consideration and are happy to further detail our comments upon request.

Respectfully,

Aaron Broadwell, MD, FACR
President
Board of Directors

Madelaine A. Feldman, MD, FACR
VP, Advocacy & Government Affairs
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[i] Federal Trade Commission. "FTC Sues Prescription Drug Middlemen for Artificially Inflating Insulin Drug Prices." September 2024.
[ii] Drug Channels. "Warped Incentives Update: The Gross-to-Net Bubble Exceeded $200 Billion in 2021 (rerun)." July 2022.
[iii] Texas Department of Insurance. "Prescription Drug Cost Transparency-Pharmacy Benefit Managers". 2021.