PCMA

March 20th, 2025

The Honorable Donna Bailey
The Honorable Lori Gramlich
Members, Committee on Health Coverage, Insurance and Financial Services
Cross Building, Room 220
100 State House Station
Augusta, ME 04333

RE: LD 627 An Act to Require Insurance Coverage for Glucagon-like Peptide-1 Receptor Agonist Medication; Opposed

Chair Bailey, Chair Gramlich and Members of the Committee,

On behalf of the Pharmaceutical Care Management Association (PCMA), we wish to share opposition related to LD 627. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state, and federal employee benefit plans, and government programs.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

PCMA opposes LD 627, which would require coverage of all FDA-approved Glucagon-like Peptide-1's (GLP-1's). I want to emphasize at the outset of my testimony that PCMA does not oppose covering drugs for certain health conditions such as obesity. Requiring that plans have an open formulary when it comes to certain health conditions removes a valuable tool for pharmacy benefit managers to create competition. If a patient is unable to take a medication on a plan's formulary, the doctor can trigger an appeals process to get the patient on the correct medication. These unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of how to handle these high costs. If drug companies are concerned about patients accessing medications, they should simply lower their prices. The Colorado legislature considered a similar policy proposal to require coverage of GLP-1's. For individual insurance they estimate a one year (2027) total premium increase of $10,800,000. For small group insurance they estimate a one year (2027) total premium increase of $11,864,000. For large group insurance they estimate a one year (2027) total premium increase of $32,019,000. The Health and Human Services Committee considered a similar bill for required coverage of GLP-1's in MaineCare. The Office of MaineCare Services in the Maine Department of Health and Human Services estimated that LD 480 would cost over $42 million in State Fiscal Year 2026.

LD 627 would cap a covered person's out-of-pocket copayment cost for GLP-1's at $35. Brand manufacturers are deflecting blame for skyrocketing drug costs by falsely claiming that high costs are a "coverage" problem that requires copay caps. By capping patient and out-of-pocket expenses, doctors and patients will inevitably choose more expense brand drugs over equally

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effective lower-cost generics. This will add to the growing problem of price increases.

Significant changes in benefit design like this can affect the overall cost of a health plan, which in turn affects consumers' premiums. Capping copays shifts costs from patients to health plans and does nothing to lower the high and rising price of drugs. This requires the plans to increase premiums to compensate for higher costs. Eventually, all members bear these higher costs through higher premium rates.

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable cap copays rather than just making their medications more affordable. The simplest, most effective way to reduce patient cost on drugs is for manufacturers to drop the price of the drug.

LD 627 impacts patient safety and increases cost by eliminating prior authorization. Prior authorization is designed to:

- ✓ Improve quality and promote evidence-based care.
- ✓ Protect patient safety.
- ✓ Address areas prone to misuse.
- ✓ Reduce unnecessary spending.

Prior authorization requirements are guided by *independent experts*. Physicians, pharmacists, and other medical professionals make up a Pharmacy and Therapeutics (P&T) committee, tasked with the development of clinically appropriate and evidence-based guidelines used to set a health plans formulary and drug management programs.

Patient safety is safeguarded with prior authorization requirements. Prior authorization is used for drugs that have potentially dangerous, even potentially fatal, interactions when used with other drugs. Prior authorization ensures that medications are safe, effective, and provide value for specific populations or subpopulations who may be affected differently by a medication (e.g., antipsychotic medications in children and adolescents).

Health plans use prior authorization tools to control the cost of drugs. Studies show prior authorization reduces drug spending by ensuring appropriate and cost-effective use of high-cost and high-risk drugs. Prior authorization can generate savings of up to 50% for targeted drugs or drug categories[1].

[1] "Specialty Utilization Management Proves Effective: Ampyra Prior Authorization Improves Safety and Saves Money," Prime Therapeutics, 2011."

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In the interest of Maine patients and payers, it is for these problematic provisions noted above that we must respectfully oppose LD 627. Given the unique environment Mainers and plan sponsors find themselves in, now is not the time to increase the cost of providing reliable and affordable access to prescription drugs.

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