HEALTHCARE
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Testimony of Trevor Putnoky
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In Opposition to

LD 1053, An Act to Ensure That Rebates from Prescription Drug Manufacturers Are Passed on to Patients at Pharmacies

March 27, 2025

Good afternoon, Senator Bailey, Representative Gramlich, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

My name is Trevor Putnoky and I'm the President and CEO of the Healthcare Purchaser Alliance of Maine. The HPA is a nonprofit that represents the purchasers of health care in Maine. Our mission is to advance and support access to high-quality, affordable care. We have over 60 members, including some of the largest public and private employers and health trusts in Maine. Collectively, our members spend over a billion dollars annually providing health care for nearly one quarter of the commercially insured population in the state. Over one-quarter of that total—or more than $225 million annually—is spent on prescription medications.

I'm here today to testify in strong opposition to LD 1053. We agree with Representative Cloutier that rebates from pharmacy manufacturers should be used to defray plan member costs, and current Maine statute accomplishes that by mandating rebates be applied either at the point of sale or to reduce overall plan premium costs. Our members typically use manufacturer rebates to lower overall premium costs, which defrays costs for all their employees and dependents.

LD 1053 would mandate that rebates be applied directly to the plan member who is prescribed the drug at the point of sale. But the rebate associated with a drug often exceeds a patient's cost sharing amount, particularly once a patient hits their out-of-pocket maximum and no longer has to contribute a copay or coinsurance. As currently drafted, LD 1165 does not appear to revert any of those excess rebates back to the plan to help reduce members' premium costs.

So, while LD 1053 would lower out-of-pocket costs for the small portion of plan members who are prescribed rebated drugs, it would increase premiums for the vast majority of plan members, as those rebate dollars would no longer be available to reduce premiums across the board. Specifically, if LD 1053 were enacted and plans could no longer use rebates to lower plan costs, premiums would increase by approximately 7–8 percent.[1] That translates into approximately $1,500 per employee per year—or for a Maine business with 100 employees, over $150,000 annually.

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[1] Letter to the Committee on Health Coverage, Insurance and Financial Services on LD 1165, An Act to Enhance Cost Savings to Consumers of Prescription Drugs from the Maine Education Association Benefits Trust, January 4, 2024 and letter to the Letter to the Committee on Health Coverage, Insurance and Financial Services on LD 1165, An Act to Enhance Cost Savings to Consumers of Prescription Drugs from the Maine Municipal Employees Health Trust, January 4, 2024.

During the 131st Legislature, the committee considered amending a similar bill, LD 1165, to require that any excess rebates revert back to the plan to reduce total plan/premium costs. While this amendment was an improvement on the original bill, it still would have increased premiums by 1–2 percent—or more than $300 per employee per year. Maine employers are already struggling to provide affordable health coverage to their employees and dependents in the face of steadily rising costs. Whether the impact is 7–8 percent or 1–2 percent, it is too high and would force employers to make tough choices about how to cover those costs, including through higher employee premium contributions, higher deductibles, additional employee cost sharing, or stagnating wages.

Bill supporters will argue that West Virginia saw no increase in premiums when that state enacted similar legislation in 2021 that required rebates to be applied at the point of sale, with any excess rebates passed onto the plan to reduce premiums. But a key difference between West Virginia and Maine is that, prior to enacting that legislation, West Virginia did not have in place a law like Maine's, which requires carriers and pharmacy benefit managers (PBMs) to use rebates to defray premiums costs.[2] Hence, when West Virginia required that rebates be applied at the point of sale, that law change did not divert rebates that were previously being used to lower plan costs, which would explain why the policy did not increase premiums.

In addition to the immediate impact on premiums, perhaps the most distressing outcome of LD 1053 is the powerful incentive that it creates for patients and providers to choose high-cost, rebateable brand drugs over more affordable, equally effective generics and biosimilars. Plans often use cost sharing to disincentivize members from choosing expensive brand drugs when less costly generics and biosimilars are available, but if rebates eliminate a member's cost sharing responsibility—as LD 1053 would do—patients and providers would choose them. Rebates exist in large part to encourage PBMs and insurers to include higher cost drugs on formulary when more affordable competitor drugs exist. If those higher cost drugs become free to members as a result of LD 1053, we expect utilization to increase significantly. And since the entire cost of the drug—less members' cost share—is paid by the employer, this would lead to a dramatic increase in overall spending.

Humira, which is a top 3 drug by spend for our purchaser members, provides a great example of how this could play out. Brand Humira costs $8,304 per patient per month in our book of business, while Adalimumab-abdm, which has no rebate, can cost as little as $1,315.[3] Under LD 1053, a plan member with a $100 specialty copay could opt to get brand Humira for free, with the Humira rebate covering their $100 copay and their employer picking up the remaining $7,304, or they could pay a $100 specialty copay for Adalimumab-abdm and save their employer nearly $7,000. While we would love it if the member chose to pay more for the less costly biosimilar, no one expects that this will happen. Consumers will opt for the drug that mitigates their own out of pocket spending.

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[2] 3/17/25 correspondence from West Virginia Offices of the Insurance Commissioner.

[3] Adam Fein, "Humira Biosimilar Price War Update: Should We Be Glad that CVS Health and Express Scripts Are Using Private Label Products to Pop the Gross-to-Net Bubble?" *Drug Channels*, September 4, 2024. Available at: Humira Bio https://www.drugchannels.net/2024/09/humira-biosimilar-price-war-update.html#:~:text=The%20Express%20Scripts%20pricing%20seems,We%20apologize%20for%20the%20errors.

While Maine law generally requires pharmacists to substitute generics for brand drugs when available, patients can still access brand drugs as long as their prescriber indicates that the drug should be dispensed as written. We fully expect that prescribers, who want to shield their patients from costs, will do this.

Thank you for the opportunity to share the HPA's feedback on LD 1053. I'd be happy to answer any questions and will be available for the work session.