March 27th, 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 1053 An Act to Ensure That Rebates from Prescription Drug Manufacturers Are Passed on to Patients at Pharmacies; Opposed

Chair Bailey, Chair Perry and Members of the Committee,

My name is Sam Hallemeier, Director of State Affairs, and I am writing on behalf of the Pharmaceutical Care Management Association (PCMA). PCMA is the national association representing America's pharmacy benefit managers (PBMs). PBMs administer prescription drug plans and operate mail-order and specialty pharmacies for more than 275 million Americans with health coverage through large employers, health insurers, labor unions, and federal and state-sponsored health programs.

PCMA opposes LD 1053, which requires that rebates negotiated by PBMs on behalf of health plan sponsors be applied to a patient's cost-sharing at the point of sale. While we appreciate the legislature's concern with the rising cost of prescription drugs, **LD 1053 is a one-size-fits-all mandate that will do little to address the increasing price of drugs and will only serve as a windfall to drug manufacturers.**

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. One fundamental way PBMs help consumers obtain lower prices for prescription drugs is by negotiating rebates (discounts) with drug manufacturers. Negotiations between PBMs and manufacturers are the only tool to leverage competition and drive lower drug costs. Rebates are typically used to keep costs down across the board as employers and other plan sponsors use the savings from rebates to lower premiums for everyone. While point-of-sale rebates are possible under specific plan designs, the decision to apply rebates at the point-of-sale or as a hedge against rising premiums is and should be determined by the plan sponsor.

When considering mandatory POS rebates, it is crucial to keep in mind that:

1. **Rebates have consistently been shown to save consumers money**: Recently, the Centers for Medicare & Medicaid Services (CMS) found that a federal proposal for POS rebates in Medicare Part D would **increase** premiums by up to **25%** and **increase** drug spending by **$196 billion**.[1]

[1] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

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2. Under the federal proposal, CMS actuaries predicted **manufacturers would keep at least 15%** of what they would have offered in rebates and also found that **drug spending would increase by $137 billion as they would have little incentive to lower their list prices.**[2]
3. **Mandatory POS rebates under the federal proposal would provide drug manufacturers a $40-$100 billion windfall.** [3] The fact that drug manufacturers applauded a federal proposal to restructure rebates should reinforce that manufacturers, not consumers, taxpayers, and employers, would be the real winners.

Additionally, mandatory POS rebates would require releasing confidential information that inadvertently discloses actual rebate amounts. Eliminating this type of confidentiality of rebate levels and undermining the negotiating power held by payers, including employers, would inhibit a PBMs' ability to negotiate a better price for consumers. **As CMS noted in their assessment of a federal proposal, rebates would be reduced by 15%[4], meaning consumers pay more.** Finally, the FTC has long stated that "if manufacturers learn the exact amount of the rebates offered by their competitors...the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[5]

By disrupting competition in the prescription drug market, mandatory rebates, whether at 100% of rebates or less, ultimately will increase the premiums that all pay for health care and prescription drugs. PCMA opposes LD 1053 and we urge the committee to vote ought not to pass.

Please let me know if you have any questions or would like more information. Sincerely,

Sam Hallemeier

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[2] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases

[3] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

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[5] FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts

PBM-Negotiated Rebates Reduce Costs for Plan Sponsors

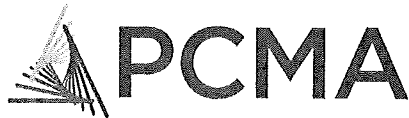
Price concessions, in the form of rebates, negotiated by pharmacy benefit managers (PBMs) significantly lower the cost of drugs. According to researchers, PBMs, who are hired by plan sponsors to maximize the value of prescription drug benefits, help patients and payers save $941 per enrollee per year in prescription drug costs,[i] equaling $654 billion over the next 10 years.[ii] Plan sponsors use these savings to benefit patients by lowering premiums, deductibles, and cost sharing.

Drug Manufacturers Set Drug Prices; PBMs Work to Achieve the Lowest Net Cost for Drugs: It is always the drug manufacturer who decides what the price of a given drug will be. PBMs do not set drug prices—rather, PBMs evolved as a means to lower the cost of drug benefits by negotiating price concessions with manufacturers and pharmacies on behalf of plan sponsors, such as large employers, government programs, and insurers. In addition, PBMs lower costs by encouraging use of generics, offering specialty pharmacy services, and helping patients with drug adherence. PBMs would not serve 266 million[iii] enrollees through all kinds of health plans if they did not bring down costs.

Negotiated Drug Rebates Are the Only Practical Method to Apply Pricing Concessions: Drug manufacturers facing competition for their products are usually willing to negotiate on the price they initially set if a large purchaser can demonstrate that its enrollees account for a given market share. Because PBMs recommend and administer formularies that encourage enrollees to prefer some medications over others, PBMs, rather than insurers, negotiate with manufacturers. As benefit administrators, PBMs never take physical possession of a drug and thus a simple volume discount, which the manufacturer may give a wholesaler, say, is not possible. The only way a PBM can prove that its enrollees used a given drug -- its sales volume -- is through a tally of paid claims at the end of a period, which typically is quarterly. Based on the market share tally, the manufacturer pays the contractually agreed rebate.

Rebates Drive Competition among Brand Drug Manufacturers: PBMs and health plan sponsors create formularies to give patients an incentive to take the most clinically appropriate and cost-effective medication. The formulary drugs are recommended by independent scientific experts who consider the latest clinical evidence. Ultimately, the PBM client determines which drugs will be in its formulary and how they are covered. When therapies are judged equivalent, PBMs can negotiate rebates from manufacturers for favorable positions on formularies.

Plan Sponsors Decide the Portion of Rebates They Receive: PBMs are transparent to clients with respect to rebates, in accordance with contractual requirements. Nearly half of employer plan sponsors negotiating to receive manufacturer rebates elect to receive 100% of the rebate amounts[iv] and pay administrative fees to the PBM. Other payers negotiate for their PBMs to receive a portion of the rebates. Payers may also negotiate to put drug inflation risk on the PBM by locking in a specific rate for their drugs. Plan sponsors may negotiate any combination of these payment methods and other provisions, and always have the right to audit their PBMs' performance under their contracts. On average, PBMs pass back 90% of negotiated rebates from drug manufacturers, which payers use to lower enrollees' and their own health spending.[v]



PBM-Negotiated Rebates Are Like a Sealed-Bid Contracting Process: A number of policy makers and other observers have called for revealing drug prices negotiated between PBMs and manufacturers, in the mistaken belief that this so-called transparency would lower costs. In fact the opposite is true. If rebates were made public, the companies giving the biggest rebates would likely stop giving them and costs would rise. Drug price negotiations operate more like sealed-bid auctions where bidders offer the lowest price they can in hopes of winning business.

Revealing or Interfering in Confidential Negotiations Undermines Competition, Raising Costs for Consumers and Plan Sponsors: Respected government bodies and universities have established that confidential negotiations result in more competition and lower costs for patients and plan sponsors:

- The Federal Trade Commission has stated that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors ... then tacit collusion among manufacturers is more feasible ... Whenever competitors know the actual prices charged by other firms, tacit collusion — and thus higher prices — may be more likely."[vi]
- The FTC has also warned several states that legislation requiring PBM disclosure of negotiated terms could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[vii]
- Additionally, the Department of Justice and the FTC issued a report noting that "states should consider the potential costs and benefits of regulating pharmacy benefit transparency" while pointing out that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[viii]
- Researchers at the University of Pennsylvania find that, "[t]ransparency requirements that attempt to set actual reimbursement for drugs at the pharmacy's or PBM's actual cost or acquisition price may have unintended consequences, leading to higher real costs and/or manipulated prices."[ix]

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[i] Visante, Inc. "The Return on Investment (ROI) on PBM Services," Prepared by Visante on behalf of PCMA, November 2016. https://www.pcmanet.org/wp-content/uploads/2016/11/ROI-on-PBM-Services-FINAL.pdf
[ii] Visante Inc., "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Prepared for PCMA, February 2016. https://www.pcmanet.org/wp-content/uploads/2016/08/visante-pbm-savings-feb-2016.pdf
[iii] PR Newswire, "PBMs Provide Policy Solutions to Increase Competition, Reduce Rx Costs," Feb 04, 2016.
[iv] Pharmacy Benefit Management Institute, "PBMI Research Report: Trends in Drug Benefit Design," 2016.
[v] Written Testimony of Joanna Shepherd, Ph.D, Emory University for the ERISA Advisory Council Hearing on PBM Compensation and Fee Disclosure, June 19, 2014, Citing J. P. Morgan, "Pharmacy Benefit Management, Takeaways from Our Proprietary PBM Survey," May 21, 2014.
[vi] U.S. Federal Trade Commission and the U.S. Department of Justice, Improving Health Care: A Dose of Competition (July 2004)
[vii] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).
[viii] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004.
[ix] Danzon, P. "Pharmacy Benefit Management: Are Reporting Requirements Pro or AntiCompetitive?" https://bepp.wharton.upenn.edu/files/?whdmsaction=public:main.file&fileID=9696

DEPARTMENT OF
Professional &
Financial Regulation
STATE OF MAINE

- OFFICE OF SECURITIES
- BUREAU OF INSURANCE
- CONSUMER CREDIT PROTECTION
- BUREAU OF FINANCIAL INSTITUTIONS
- OFFICE OF PROF. AND OCC. REGULATION

2023 Annual Report on Prescription Drug Compensation for Benefit of Covered Persons

Prepared by the Maine Bureau of Insurance

December 2024

Janet T. Mills
Governor

Joan F. Cohen
Acting Commissioner

Robert Carey
Superintendent

Introduction

Under 24-A M.R.S., § 4350-A, carriers must file an annual report with the Superintendent, demonstrating how they used compensation from a pharmaceutical manufacturer, developer or labeler to benefit their members during the previous calendar year. This report is for calendar year 2023.

For 2023, the Bureau of Insurance added several new questions to the annual survey sent to carriers, as displayed below. These additional questions were developed in response to the Health Coverage, Insurance, and Financial Services Committee of the 131st Legislature's request for more specific information about claims and the costs of prescription drug coverage.

The Bureau received responses from Aetna Life Insurance Company, Aetna Health, Inc., Cigna Health and Life Insurance Company, Anthem of Maine, Community Health Options, Harvard Pilgrim Health Care and HPHC Insurance Company (combined), Taro Health, United Healthcare of New England, United Health Care Insurance Company, and Wellfleet Insurance Company (which provides student health plans in Maine). To protect the confidentiality of company information, we have assigned each carrier a random letter as indicated in the charts below.

Statutorily Required Questions and Carrier Answers

1) The total amount in Rx rebates the company, as a carrier[1], or a pharmacy benefits manager (PBM) that the carrier contracts with, received directly or indirectly from any pharmaceutical manufacturer, developer or labeler:

Carrier A	$65,542,877
Carrier B	$450,170
Carrier C	$3,126,832
Carrier D	$49,858,027
Carrier E	$17,732,439
Carrier F	$6,765,915
Carrier G	$109,564
Carrier H	$325,634
Carrier I	$4,750,587
Carrier J	$74,154

[1]Carrier is defined by 24-A M.R.S. § 4347 as follows:

Carrier. "Carrier" has the same meaning as in section 4301-A, subsection 3, except that "carrier" does not include a multiple-employer welfare arrangement, as defined in section 6601, subsection 5, if the multiple-employer welfare arrangement contracts with a 3rd-party administrator to manage and administer health benefits, including benefits for prescription drugs. "Carrier" also includes the MaineCare program pursuant to Title 22, chapter 855 and the group health plan provided to state employees and other eligible persons pursuant to Title 5, section 285.

2) The percentage of each above amount that was remitted directly to a covered person at the point of sale and an explanation of the methods by which the company is providing this amount directly to covered persons:

Carrier A	2.2%	For claims where a rebate is generated, the allowed amount is reduced by the rebate prior to cost share determination. The cost share is applied to the reduced amount, therefore deductible claims get the full rebate, coinsurance claims get a share of the rebate, and copay claims may experience savings if the allowed amount is less than the copay.
Carrier B	6.5%	At the point of sale, a calculation is done to see if the member's liability per the members' benefit is greater than the cost of the drug less an estimated rebate amount. If it is less, the member pays the cost of the drug less an estimated rebate in place of the normal member liability.
Carrier C	5.8%	At the point of sale, a calculation is done to see if the member's liability per the member's benefit is greater than the cost of the drug less an estimated rebate amount. If it is, the member pays the cost of the drug less an estimated rebate in place of the normal member liability.
Carrier D	0.00%	RX Rebates are not applied directly to covered persons at the point of sale.
Carrier E	0.00%	N/A
Carrier F	0.00%	N/A
Carrier G	0.00%	Rebates are not applied at point of sale/ provided directly to covered persons. Rebates are retained by the plan to offset future premiums.
Carrier H	1.00%	At point of sale, rebates are applied to reduce the total cost of the drug before member cost share is calculated.
Carrier I	4.00%	At point of sale, rebates are applied to reduce the total cost of the drug before member cost share is calculated.
Carrier J	0.0%	N/A

3) The percentage of the amount that was applied to its plan design to offset premium in future years and an explanation of how the company is applying these funds to offset premium in future years:

Carrier A	97.8%	Assumed prescription drug rebates are included in the rate development process for the Individual, Small Group and Large Group segments and factored in as a reduction to claims (for the individual and small group markets) or a reduction in administrative expense (in the large group market) in developing premium rates. Both approaches result in a reduction of premium.
Carrier B	93.5%	Rebates retained by the health plan are used as an input in determining what the premiums in the future years will be.
Carrier C	94.2%	Rebates retained by the health plan are used as an input in determining what the premiums in the future years will be.
Carrier D	100%	100% of Rx rebates are applied to plan design to offset the premium in future years. For the small group and individual markets, Rx rebates are credited as an offset to pharmacy claims directly in the rate development process thereby reducing premiums to all covered members. In our large group market, Rx rebates are reflected in the premium through the underwriting process. Note that when setting premiums, we project pharmacy rebates based on future expectations. This may not exactly match the pharmacy rebates received during the year. There is also uncertainty inherent in estimating pharmacy rebates in a given year.
Carrier E	100%	100% of manufacturer compensation received by us and our PBM for individual and small group business is applied to offset future premiums. Premiums in the pricing period are based on the claims experience in the experience period adjusted forward to the pricing period for trend, benefit and cost-sharing differences, changes in network contract terms, changes in membership demographics, retention, etc. For example, premiums in the pricing period 1/1/2023-12/31/2023 were based on claims experience from 1/1/2021-12/31/2021 with adjustments as previously mentioned. The claims experience in the experience period is net of pharmacy rebates received for the pharmacy claims incurred in that period.

Carrier F	100%	The rebate funds will continue to be used at 100% to reduce premiums through the pricing and underwriting premium development.
Carrier G	100%	Rebates are applied back to the plan to reduce claim costs.
Carrier H	99.00%	In calculation of premium, the value of rebates is considered in the administrative component of the calculation.
Carrier I	96.00%	In calculation of premium, the value of rebates is considered in the administrative component of the calculation.
Carrier J	100%	The amount in Question 1 will be factored into the premium rate calculations for Plan Year 2025. These funds will be used to offset administrative costs. Our hope is that lower administrative costs will lead to lower premiums in future years.

New Questions and Responses for 2023

4) The total amount paid for prescription drug claims involving drugs for which your company received compensation directly or indirectly from any pharmaceutical manufacturer, developer or labeler:

Carrier A	$206,304,011
Carrier B	$562,660
Carrier C	$6,334,177
Carrier D	$96,669,438
Carrier E	$63,974,406
Carrier F	$34,039,665
Carrier G	$745,539
Carrier H	$1,075,447
Carrier I	$12,343,532
Carrier J	$149,262

5) The total amount paid for all claims other than those involving prescription drugs for which your company received compensation directly or indirectly from any pharmaceutical manufacturer, developer or labeler:

Carrier A	$669,097,932
Carrier B	$1,533,326
Carrier C	$32,480,927
Carrier D	$375,591,802

Carrier E	$203,460,589
Carrier F	$85,492,641
Carrier G	$1,538,648
Carrier H	$2,983,510
Carrier I	$36,728,836
Carrier J	$1,522,599

6) The average percentage of premium devoted to prescription drugs coverage involving your company's fully-insured plans:

Carrier A	23.3%
Carrier B	26.8%
Carrier C	16.3%
Carrier D	19.2%
Carrier E	5.3%
Carrier F	16.6%
Carrier G	23%
Carrier H	21.5%
Carrier I	21.5%
Carrier J	20%

7) The amount of average premium increase for fully-insured plans if the compensation identified in Question 1 were passed along to the consumer at the point of sale:

Carrier A	$45.73 PMPM. The estimated premium impact for directly applying all pharmacy rebates at Point of Sale (POS) is around 7%. We reallocated the Rx rebate traditionally used to lower overall premiums towards direct relief of individual members' drug costs, and account for the potential for altered member purchasing behaviors influenced by immediate savings on drug cost. It is important to note that the entire amount identified in response to Question 1 cannot be passed through at the POS because no rebates would be paid in instances where the rebate exceeded the applicable cost share or the member has met their out-of pocket maximum. In such cases, the excess rebate amount will not be refunded to the member nor will it be used to lower the future premiums cost as we do today.
Carrier B	$ 99.32 PMPM. We determined the projected increase in premium by determining the 2023 PBM savings on a PMPM basis and then applying the appropriate retention costs on top of these savings. We have not applied trend so these estimates are for 2023 only.
Carrier C	$42.97 PMPM. We determined the projected increase in premium by determining the 2023 PBM savings on a PMPM basis and then applying the appropriate retention costs on top of these savings. We have not applied trend so these estimates are for 2023 only.

Carrier D	The impact of point of sale Rx rebates depends on how the program is administered, the type and level of member cost sharing and the extent to which Rx rebates are used to offset member cost sharing in practice. The Rx rebates passed through to consumers at point of sale would result in commensurately higher premium in the market.
Carrier E	The claims utilized in pricing is currently net of rebates identified in Question 1. If the rebates were to the consumer at the point of sale, the starting claims experience would be higher and therefore, would ultimately increase the average premium for most insured plans.
Carrier F	0.8% PMPY. This could have a wide range of impact depending on the plan design. For example, a plan that uses copays only on pharmacy is going to have a negligible impact because lowering the cost at the point of sale doesn't change the member's copay, while a member with a large deductible could get the full amount of the rebate until their deductible is satisfied. Our average estimated impact is an increase of 0.8% on a PMPY basis to premium.
Carrier G	$80.00 PMPY. Claim costs would be increased by about 4%-which would cause premiums to increase by about 4%-which would be about $80 per year.
Carrier H	$46.70 PMPM. The premium would increase by the compensation amount reported in Question 1 if the amount was passed through to the consumer at the point of sale.
Carrier I	$58.48 PMPM. The premium would increase by the compensation amount reported in Question 1 if the amount was passed through to the consumer at the point of sale.
Carrier J	$134.82 PMPY. This amount is PMPY based on the 2023 total rebates divided by total members as of 12/31/2023. This assumed amount passed along to consumers would be commensurate to the 2023 experience on a per member basis.

Rebates calculated as a percentage of Rx expenditures.

Carrier A	32%
Carrier B	80%
Carrier C	49%
Carrier D	51%
Carrier E	28%
Carrier F	20%
Carrier G	50%
Carrier H	30%
Carrier I	38%
Carrier J	50%

Summary

Four carriers reported that they applied 100% of the amount received directly or indirectly from any pharmaceutical manufacturer, developer or labeler to its plan design to offset future premiums. Five carriers reported that less than 100% of the amount is applied to offset future premiums, but these amounts were small. In each of those cases, the remaining amounts were applied to lower the cost of the drug prior to the sale to the consumer.

The new questions reveal a significant amount spent on prescription drugs as opposed to other claims. Most carriers reported that approximately one quarter of their premium was devoted to prescription drug claims. All carriers confirmed that their premiums would increase if their respective rebate amounts were applied exclusively to consumers at the point of sale.