Maine LD 180 Will Cost the State $340 Million In Increased Prescription Drug Costs

The core mission of pharmacy benefit managers (PBMs) is to reduce prescription drug costs for health plan sponsors so that consumers have affordable access to needed prescription drugs. PBMs offer a variety of services to their health plan sponsor clients and patients that improve prescription adherence, reduce medication errors, and manage drug costs.

The proposed Maine legislation will seriously undermine the ability of PBMs to control drug costs and as a result, drug spending in Maine will soar. The proposed legislation includes a provision to implement a mandatory dispensing fee. Although some of the provisions are subject to interpretation, enacting just the bill provision discussed below could cost the state of Maine almost **$34 million in excess drug spending** in the first year alone and **$340 million** over the next 10 years.

LD 180 would implement prescription drug reimbursement mandates.

- Requiring PBMs to reimburse pharmacies at mandated levels of the National Average Drug Acquisition Cost (NADAC) plus a $11.89 dispensing fee will cause spending on prescription drugs to soar. Research also shows that mandating reimbursement at NADAC levels will cause drug spending to go up,[1] adding to the hundreds of millions of dollars in extra costs.

Projected 10-Year Increases in Prescription Drug Spending in Maine, 2025–2034 (millions)

	Fully Insured Group Market	Individual Direct Purchase Market	Total
Implement a Mandatory Dispensing Fee	$259	$81	$340

Methodology: The methodology used to create these cost projections for adopting AWP was that used by Visante in the January 2023 paper "Increased Costs Associated With Proposed State Legislation Impacting PBM Tools." The dispensing fee methodology: A $2 dispensing fee was assumed as a baseline for all prescription fills.[2] .Projected increases in costs for dispensing fees are the difference between all prescriptions filled with a $2 dispensing fee and all prescriptions filled with $11.89 dispensing fee. Count of prescription fills in each state was held constant at 2023 levels, the most recent year for which fill data is available. Given the increasing trajectory of prescription drug fills, this is likely an undercount of the number of drug fills and, therefore, an underestimation of the costs associated with dispensing fee mandates. The upper dispensing fee limit of $11.89 is used because the bill mandates a dispensing rate similar to the state's Medicaid FFS rate. The commercial market includes prescriptions covered by commercial payers (group fully insured, group self-insured, and individual direct purchase) as well as some government programs, such as the Children's Health Insurance Program, Veterans Administration, and Indian Health Service. The number of commercial prescriptions is divided into each insurance market segment proportional to their population. The methodology is derived from PCMA's "Dispensing Fee Mandates Increase Prescription Drug Spending" report.

[1] The Commonwealth Fund. "Competition, Consolidation, and Evolution in the Pharmacy Market." 2021.
[2] The Menges Group. "Pennsylvania Medicaid MCO Prescription Drug Repricing: Cost Impacts of Using NADAC Payment Structure." 2019.

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April 16th, 2025

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

RE: LD 180 An Act Regarding Reimbursements by Pharmacy Benefits Managers to Pharmacies; Opposed

Chair Bailey, Chair Mathieson and Members of the Committee,

On behalf of the Pharmaceutical Care Management Association (PCMA), we wish to share opposition related to LD 180. 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.

Plan sponsors hire PBMs to manage prescription drug benefits and contain costs for the plan. To that end, PBMs harness competition in the pharmacy market to ensure plans and patients get the best prices for prescription drugs. Eliminating business-to-business reimbursement negotiations and instead setting minimum rates—typically at the National Average Drug Acquisition Cost (NADAC) and a minimum dispensing fee—for pharmacies dispensing drugs to patients covered by private health coverage would add to the ever-growing list of costs.

What is the NADAC survey, and why is it an inappropriate reimbursement benchmark?

The NADAC survey is collected monthly, administered by the federal government, from a random sample of pharmacies in the United States. The survey collects drug invoice price data from pharmacies. The survey suffers from a few big flaws:

1. It is voluntary, so no one knows whether it is a representative sample of pharmacies.
2. It does not collect information on discounts or rebates that are not on a pharmacy's invoice—discounts that can be a significant amount of money. Thus, no one knows how

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representative of a pharmacy's true cost it is, resulting in a potentially significantly inflated number.

3. It does not consistently include drugs dispensed by mail-service pharmacies, specialty drugs, or drugs purchased through the federal 340B program, so no one knows if the rate is representative of average costs for individual drugs.

4. The data on pharmacy cost is self-reported and not verified or audited for accuracy.

How would payments to pharmacies be determined by the government?

When the government sets rates, it eliminates the ability to negotiate reimbursement contracts and instead picks a single pricing benchmark as minimum ingredient cost reimbursement, usually NADAC. The government may also set a mandatory minimum dispensing fee. These rates become the new reimbursement floor, regardless of whether a pharmacy wanted to accept more competitive rates in exchange for higher volume or if the pharmacy's costs were much lower than the government mandate.

Recently, the Louisiana State Legislature analyzed the costs of a proposed rate-setting policy for its government-sponsored health programs that would have eliminated competitive dispensing fees and ingredient costs. For the roughly 200,000 members enrolled in the state's group plan, the increase in dispensing fee would have cost the state—as payer— at least $48 million more per year,[1] with no added value to patients. In 2022, West Virginia began requiring pharmacy benefit managers (PBMs), who work on behalf of plan sponsors, to reimburse pharmacies using the National Average Drug Acquisition Cost survey plus a $10.49 dispensing fee.[2] Using prescription drug data from one PBM's experience in West Virginia and applying that to all commercial market prescriptions filled in the state, this law could have increased West Virginia drug spending by over $113 million ($140 per commercially insured person) in just one year.[3] That's a 13% increase in commercial retail drug spending.

In the interest of Maine patients and payers, it is for these problematic provisions noted above that we must respectfully oppose LD 180. Now is not the time to increase the cost of providing reliable and affordable access to prescription drugs.

Sam Hallemeier
Pharmaceutical Care Management Association
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[1] LA HB 529 (2023) and supporting materials, including Legislative Fiscal Office's Fiscal Notes on HB 529 (2023). May 3, 2023. Available at Louisiana Legislature.
[2] West Virginia Code 33-51-9.
[3] PCMA. "Dispensing Fee Mandates Increase Prescription Drug Spending." 2025.

Government Rate-Setting Mandates Force Patients, Employers, and Unions to Pay More

When employers and individuals are footing the bill in commercial health programs, the free market should determine pharmacy reimbursements, not the government. Some states are considering requiring private sector health plans to pay minimum dispensing fees and reimbursement rates based on an imprecise survey of pharmacy costs (the National Average Drug Acquisition Cost survey, or "NADAC"). These policies financially benefit pharmacies at the expense of the employers, unions, taxpayers, and patients paying for health coverage.

NADAC is an imprecise tool to determine pharmacy costs and should not be used alone to set rates.

» NADAC is a *voluntary, unaudited* survey that leaves out important data points, including off-invoice discounts and rebates[1] that reduce pharmacies' net costs. Figure 1 illustrates how off-invoice discounts can affect NADAC.

Figure 1: How Off-Invoice Discounts Skew NADAC

Pharmacy	Drug A Invoice Cost	Wholesaler Discount 15% (not on invoice)	Pharmacy's Net Cost to Buy Drug A	Amount Reported on NADAC Survey	NADAC Rate (average invoice cost)	Amount NADAC Is *Over* Pharmacy's Net Cost (windfall to pharmacy)
1	$50.00	$7.50	$42.50	$50.00	$55.00	$12.50 (29% profit)
2	$60.00	$9.00	$51.00	$60.00	$55.00	$4.00 (7.8% profit)

» NADAC also does not include drugs purchased under the federal 340B program, many drugs dispensed by mail service pharmacies, and many specialty drugs. Without these data points, NADAC, on its own, is not a reliable source on how much a pharmacy pays for a drug.

Requiring PBMs to reimburse pharmacies at mandated rates will cause spending on prescription drugs to soar and does nothing to improve value for patients.

» Legislation requiring minimum pharmacy reimbursement is designed to subsidize independent pharmacies through inflated reimbursements, pure and simple.

» Setting reimbursements at no less than NADAC with a minimum dispensing fee is an immediate budget-buster. Dispensing fees in the commercial market average less than $2. If all states adopted minimum dispensing fees of $10.50 (the average dispensing fee in many state Medicaid programs) on every commercial prescription filled, as many have proposed, prescription drug spending nationwide would increase by over $16 billion in one year.[2]

» States that have proposed NADAC and minimum dispensing fees have projected significant cost increases because of the policy.[3]

Pharmacies are essential for providing access to prescription drugs, but they do not need government-mandated bailouts.

» Pharmacies remain the most accessible health care providers. Eighty-nine percent of Americans live within 5 miles of a retail pharmacy,[4] and most have access to home delivery and specialty pharmacies that further increase their access to prescription drugs.

» Despite cries to the contrary, the independent pharmacy market continues to grow. Since 2014, the number of independent retail pharmacies nationwide increased by 5.8%.[5] The independent pharmacy market remains an important and accessible segment of the pharmacy market. There is no crisis of access in pharmacy services.

» Making patients, employers, unions, and others funding health care cover what amounts in some states to be a very large increase in dispensing fees and a requirement to base drug reimbursements on imprecise data is unfair and will result in a windfall for pharmacies both large and small.

Patients deserve to benefit from free market price competition.
Oppose government rate-setting policies in pharmacy benefits.

1 Retail Price Survey and NADAC Methodology. Centers for Medicare and Medicaid Services. 2023.

2 Mandating Pharmacy Reimbursement Will Increase Prescription Drug Spending. PCMA.

3 Louisiana HB 529 (2023), projected costs were $48 million in the first year for the state plan; West Virginia SB 435 (2024), estimating a $5.9 million cost for the state plan; see legislator vote statements explaining "no" votes on Oregon HB 3013 (2023), citing expected costs.

4 Pharmacy Practice & Safety. National Association of Boards of Pharmacies. 2024.

5 Based on NCPDP data. The State of the Pharmacy Market. PCMA. 2024.

ABOUT PCMA

PCMA is the national association representing America's pharmacy benefit companies. Pharmacy benefit companies are working every day to secure savings, enable better health outcomes, and support access to quality prescription drug coverage for more than 275 million patients. Learn more at www.pcmanet.org.

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What's Happening in West Virginia: What Do Increased Dispensing Fees Buy?

Spending on prescription drugs continues to increase annually as drug prices continue to rise. While we hope that more spending buys better health outcomes, that isn't always the case. Asking patients and employers to pay more money for the same prescription drugs threatens access and affordability.

West Virginia is one of the smaller states, with a **population of 1,713,600.**[1]

Despite lowering its uninsured rate from 13.5% in 2013 to only 5.9% in 2023,[2] **West Virginia may have the poorest health outcomes[3] in the country.**

Per capita, **West Virginia led the nation in deaths** caused by drug overdoses, diabetes, and kidney disease and ranked third in deaths caused by cancer.[4]

Along with poor health care outcomes, 36.2% of West Virginia residents are below the federal poverty level.[5] High health care costs can make it hard for residents to afford needed care.

West Virginia ranked **sixth highest in health care spending** per capita in 2020.[6]

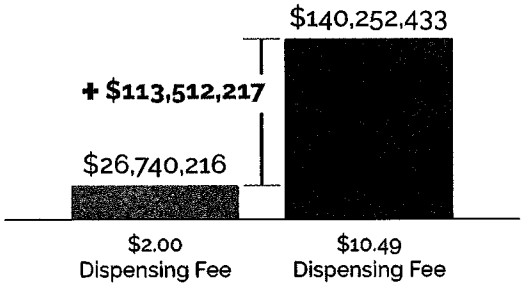
In 2020, West Virginia **spent $898 million[7] on retail prescription drugs** in the commercial market.

West Virginia employees pay, on average, **$1,753 annually in health insurance premiums** compared to the national average of $1,640.[8]

Many West Virginians depend on medications, so a state law that adds additional costs makes drugs less affordable and creates access issues for patients.

In 2022, West Virginia began requiring pharmacy benefit managers (PBMs), who work on behalf of plan sponsors, to **reimburse pharmacies using the National Average Drug Acquisition Cost survey plus a $10.49 dispensing fee.**[9] Using prescription drug data from one PBM's experience in West Virginia and applying that to all commercial market prescriptions filled in the state, **this law could have increased West Virginia drug spending by over $113 million ($140 per commercially insured person) in just one year.**[10] That's a 13% increase in commercial retail drug spending. **The burden of these increased costs will fall on patients and employers while going straight to pharmacists' bottom line.**

Estimated Increased Drug Spend in West Virginia Due to Mandated Dispensing Fee in 2022



1 KFF. "Total Number of Residents." 2023.
2 KFF. "Health Insurance Coverage of the Total Population." 2023.
3 MoneyGeek. "The Best and Worst States for Health Care." 2024.
4 CDC. "Stats of the States." 2022.
5 KFF. "Distribution of the Total Population by Federal Poverty Level (above and below 200% FPL)." 2023.
6 USA Facts. "Health in West Virginia." 2023.
7 PCMA acquired IQVIA data. The statements, findings, conclusions, views, and opinions contained and expressed in this report are based in part on data obtained under license from the following IQVIA Institute information service: IQVIA PayerTrak data for PCMA, 2022, IQVIA Inc. All Rights Reserved.
8 KFF. "Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance." 2023.
9 West Virginia Code 33-51-9.
10 PCMA. "Dispensing Fee Mandates Increase Prescription Drug Spending." 2025.

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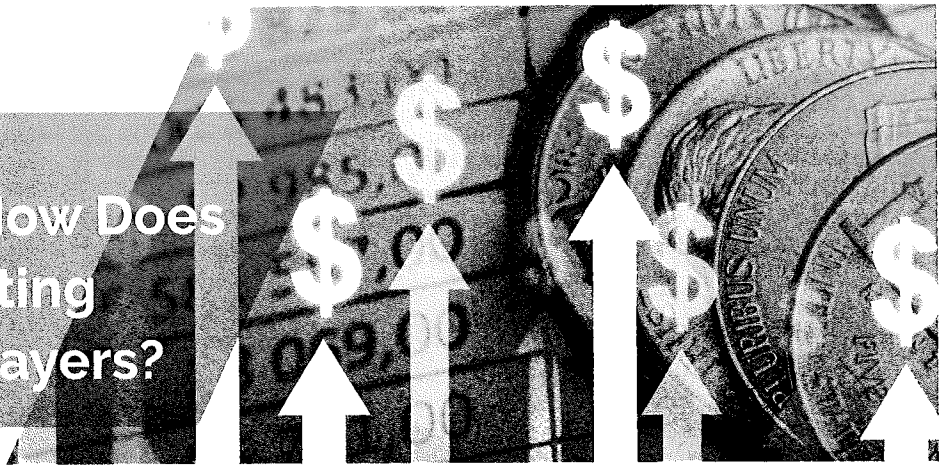
What Is NADAC, and How Does Government Rate-Setting Impact Patients and Payers?



Plan sponsors—employers, unions, governments, and private insurers—hire PBMs to manage prescription drug benefits and contain costs for the plan. To that end, PBMs harness competition in the pharmacy market to ensure plans and patients are getting the best prices for prescription drugs. Some state policymakers are considering eliminating private sector reimbursement negotiations and instead setting minimum rates—typically at the National Average Drug Acquisition Cost (NADAC) and a minimum dispensing fee—for pharmacies dispensing drugs to patients covered by private health coverage.

What is the NADAC survey, and why is it an inappropriate reimbursement benchmark?

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1. It is voluntary, so no one knows whether it is a *representative sample of pharmacies.*
2. It does not collect information on discounts or rebates that are not on a pharmacy's invoice—discounts that can be a significant amount of money. Thus, no one knows how *representative of a pharmacy's true cost* it is, resulting in a potentially significantly inflated number. (Add in a call-out to the table)
3. It does not consistently include drugs dispensed by mail-service pharmacies, specialty drugs, or drugs purchased through the federal 340B program, so no one knows if the rate is *representative of average costs for individual drugs.*
4. The data on pharmacy cost is self-reported and not verified or audited for *accuracy.*

How are pharmacy payments determined *without* government rate setting?

Payment terms are agreed to in a private contract between a PBM and a pharmacy or its representative (called a pharmacy services administrative organization, or PSAO) before the pharmacy dispenses any drugs to plan members. If a pharmacy uses a PSAO, the PSAO negotiates and agrees to reimbursement rates on the pharmacy's behalf. The largest PSAOs are owned by the drug wholesalers that control approximately 97% of the drug distribution in the U.S.[1]

How Off-Invoice Discounts Skew NADAC

Pharmacy	Drug A Invoice Cost	Wholesaler Discount 15% (not on invoice)	Pharmacy's Net Cost to Buy Drug A	Amount Reported on NADAC Survey	NADAC Rate (average invoice cost)	Amount NADAC Is *Over* Pharmacy's Net Cost (windfall to pharmacy)
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A PBM's payment to a pharmacy for dispensing a drug typically includes the ingredient cost (of the physical product) and a dispensing fee (for the pharmacy's overhead costs). PBMs do not know the pharmacy's true costs, and each pharmacy has different purchasing patterns and unique arrangements with pharmaceutical product suppliers (wholesalers). Some wholesalers and drug options are cheaper, and some are more expensive.

When picking a wholesaler, a pharmacy faces a choice: either shop for the lowest possible upfront prices or participate in a system where the wholesaler pays rebates when the pharmacy meets specific guarantees, such as purchasing a minimum volume of generic drugs (i.e., generic compliance ratio, or GCR). Pharmacies that choose the latter and participate in a system of rebates can end up paying higher costs on some drugs so they can meet minimum obligations and become eligible for those rebates. The pursuit of off-invoice rebates can be a double-edged sword—they can reduce net costs for some drugs but can cause pharmacies to overpay for others. Each pharmacy has its own business strategy for balancing these interests.

To ensure ingredient cost payments remain at market rates, PBMs use multiple price surveys and aggregators (e.g., MediSpan, First Data Bank, NADAC, etc.) to understand average pharmacy costs in the marketplace and arrive at a payment methodology. PBMs typically anticipate that pharmacies will be smart shoppers and look for the best wholesale prices. Dispensing fees are also agreed upon and may vary depending on each pharmacy's situation (rural, urban, etc.). Contracted reimbursement rates ensure an accessible pharmacy network while protecting the plan and patients from paying inflated, above-market prices.

How would payments to pharmacies be determined by the government?

When the government sets rates, it eliminates the ability to negotiate reimbursement contracts and instead picks a single pricing benchmark as minimum ingredient cost reimbursement, usually NADAC. The government may also set a mandatory minimum dispensing fee. These rates become the new reimbursement floor, regardless of whether a pharmacy wanted to accept more competitive rates in exchange for higher volume or if the pharmacy's costs were much lower than the government mandate.

How can we be sure that PBMs pay pharmacies enough?

Pharmacies continue to be the most accessible type of health care. According to the National Association of Boards of Pharmacy, 89% of Americans live within 5 miles of a pharmacy.[2] Since 2014, the number of independent retail pharmacies nationwide increased by 5.8%. While there have been small fluctuations year to year, there has been no dramatic shift in the number of independent pharmacies.[3]

How do mandated rates impact costs for patients, insurers, and pharmacies?

Recently, the Louisiana State Legislature analyzed the costs of a proposed rate-setting policy for its government-sponsored health programs that would have eliminated competitive dispensing fees and ingredient costs. For the roughly 200,000 members enrolled in the state's group plan, the increase in dispensing fee would have cost the state—as payer—at least $48 million more per year,[4] with no added value to patients.

In states that set minimum dispensing fees and rates, there is no incentive for pharmacies to negotiate on price. With no downward pressure on the price floor, that floor will continue to rise. Pharmacies are thus being subsidized by those who fund health care: patients, employers, unions, and taxpayers.

1 Drug "wholesalers combined share of the channel has grown... to 97% in 2022." 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers, p. 301. Drug Channels Institute. 2023.

2 Pharmacy Practice & Safety. National Association of Boards of Pharmacies. 2024.

3 Based on NCDPD data. The State of the Pharmacy Market. PCMA. 2024.

4 LA HB 529 (2023) and supporting materials, including Legislative Fiscal Office's Fiscal Notes on HB 529 (2023). May 3, 2023. Available at Louisiana Legislature.