HEALTHCARE PURCHASER ALLIANCE OF MAINE

Testimony of Trevor Putnoky

to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In Support of

LD 1580, An Act to Prohibit Pharmacy Benefits Managers from Imposing Certain Fees and Pricing

April 29, 2025

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

My name is Trevor Putnoky. I'm the President and CEO of the Healthcare Purchaser Alliance of Maine and 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 $250 million annually—is spent on prescription medications.

I'm here today to testify in support of LD 1580.

As this committee is well aware, rising prescription drug costs are a major contributor to the high cost of health care for Maine consumers and employers. Indeed, HPA members spend more than twice as much on medications as they do on inpatient hospital care. And between October 2020 and October 2024, prescription drug costs grew 44 percent—more than double the trend for medical spend over the same time period. Not surprisingly, you've been asked to consider several bills this year that aim to reduce costs for the many Maine employers and families struggling to afford the rapidly rising prices of prescription drugs.

During deliberations on those bills, many have expressed frustration that the only meaningful way to reduce costs is to somehow lower manufacturer prices. While efforts to reduce manufacturer prices are important, a substantial portion of the money that consumers and employers spend on medications does

not go to drug manufacturers; it goes to middlemen like PBMs.[1] While we certainly believe that PBMs should be fairly compensated for the services they provide, LD 1580 promotes a PBM model that would limit their compensation to reasonable service fees and prohibit some of the other practices that PBMs utilize to generate revenue at the expense of Maine employers and consumers. By limiting the dollars flowing to these middlemen, this bill could meaningfully reduce the cost of prescription drugs in Maine, without negatively impacting patient access to medications.

In 2019, Maine enacted legislation that requires PBMs to pass 100 percent of manufacturer rebates on to plans to lower premiums. As you heard earlier this session, pass-through of these rebates reduces plan costs for Maine employers and employees by more than 10 percent. But rebates represent only one source of PBM income. PBMs may still receive—and retain—other forms of manufacturer compensation. LD 1580 would expand upon the important protections established in the 2019 legislation by prohibiting PBMs from retaining any revenue generated by an employer's pharmacy plan, other than a reasonable service fee, thus ensuring that all revenue generated by a plan accrues to plan members, not to the PBM. PBMs will contend that revenue retained from other sources is used to offset administrative costs. But because PBM contracts are often opaque, it's difficult for employers to determine whether the amount of revenue that PBMs retain exceeds the reasonable cost of administering a plan.

Limiting PBM revenue to reasonable service fees also removes misaligned incentives that can be created when a PBM retains some of these revenue streams, incentives that can lead to even higher costs for employers and consumers. Specifically, if PBMs generate revenue from including certain drugs on formulary, or on a preferred formulary tier, that can create incentives for the PBM to promote those drugs on formulary, even if more affordable options may be available.

LD 1580 would also prohibit spread pricing, which is the practice of a PBM billing an employer more for a drug than they pay the pharmacy. Under spread pricing, for example, a PBM may pay a pharmacy $10 for a drug that the pharmacy dispenses to a member of an employer's plan. The PBM then charges the plan a higher price—say $15—for that drug, and pockets the $5 difference—that's the spread. This might not sound like a lot, but over hundreds and thousands of prescriptions, that spread adds up and can substantially increase employers' and consumers' pharmacy costs.

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[1] Karen Van Nuys, Rocio Ribero, Martha Ryan, et al., "Estimation of the Share of Net Expenditures on Insulin Captured by US Manufacturers, Wholesalers, Pharmacy Benefit Managers, Pharmacies, and Health Plans From 2014 to 2018," *JAMA Health Forum*, November 5, 2021. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2785932#:~:text=Net%20expenditures%20per%20100%20units,(from%20%2413.82%20to%20%2410.40).

It's hard to know the magnitude of spread pricing in the commercial market, because PBM contracts are notoriously opaque, but some states have investigated spread pricing in their Medicaid programs and found substantial spread. For example, a 2018 auditor's report of Ohio's Medicaid program found spread of more than 31 percent for generic drugs.[2] And a 2019 review of Kentucky's Medicaid program found that spread accounted for nearly 13 percent of Medicaid managed care revenue paid to PBMs.[3]

We often hear that PBMs' value proposition derives from their market power, which enables them to negotiate lower prices for their clients. But while large PBMs may indeed have the market clout to negotiate better pricing, if they're building in spread and not passing those lower prices onto their clients, it's the PBMs, not their clients, who benefit from that market power. Moreover, this practice can also hurt pharmacies, particularly independent pharmacies, who may end up getting paid substantially less for a prescription than the plan pays the PBM for that script, with the PBM, not the pharmacy, benefitting from the inflated price.

Opponents of this bill will argue that Maine employers are already free to contract with PBMs that use administrative fee payment models and don't utilize spread pricing. This is not the case for most small employers, who make up the vast majority of businesses in Maine and have been particularly hard hit by the rising costs of health care. Small employers are typically fully insured, and their only options in the Maine market are plans that combine medical and pharmacy in one integrated product, with the pharmacy plan typically based on a traditional model. Even if those employers want to use a plan based on an administrative fee payment model and no spread pricing, that option is not available to them through the fully insured market.

While we strongly support the PBM model in LD 1580, we also understand the need to preserve choice in the market. To that end, if the committee is interested in promoting this model, we suggest that you consider requiring that plans offer a no-spread PBM option in their fully insured products.

Thank you for the opportunity to provide HPA's feedback on LD 1580. I'd be happy to answer any questions.

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[2] "Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period," *Ohio Auditor of State*, August 16, 2018. Available at: https://ohioauditor.gov/news/pressreleases/details/5042.

[3] "Medicaid Pharmacy Pricing: Opening the Black Box," Kentucky Cabinet for Health and Family Services, Office of Health Data Analytics, Department for Medicaid Services, February 19, 2019. Available at: https://drive.google.com/file/d/1f0eZyVg5e-lmUOS4VQhQLQHfsVld_XEL/view.