**Consumers for Affordable Health Care**

Advocating the right to quality, affordable health care for all Mainers.

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**Testimony in Support of:**
**LD 1580, An Act to Prohibit Pharmacy Benefits Managers from Imposing Certain Fees and Pricing**

**April 29, 2025**

Senator Bailey, Representative Mathieson, and esteemed members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services. Thank you for the opportunity to provide this testimony in support of LD 1580, An Act to Prohibit Pharmacy Benefits Managers from Imposing Certain Fees and Pricing.

My name is Kate Ende, and I am the Policy Director at Consumers for Affordable Health Care (CAHC), a nonpartisan, nonprofit organization that advocates the right to quality, affordable health care for every person in Maine. As designated by Maine's Attorney General, CAHC serves as Maine's Health Insurance Consumer Assistance Program (CAP), which operates a toll-free HelpLine. Our HelpLine fielded nearly 7,300 calls and emails last year from people across Maine who needed help obtaining, keeping, using, or fixing problems with private health insurance or with accessing or affording health care services. CAHC also serves as the Ombudsman program for Maine's Medicaid program, MaineCare, and helps people apply for and navigate the enrollment process for MaineCare. It is with that background that we provide these comments.

Recent polling found that more than half of Mainers are concerned about being able to afford prescription drugs. Furthermore, one in three Mainers report they have not taken medication as prescribed, due to high drug costs, including cutting pills in half, skipping doses of medication, postponing refilling prescriptions, and skipping filling prescriptions altogether. Survey results also reveal that nearly 9 out of ten Mainers support implementing policies to address rising prescription drug costs.[1]

Several states have passed PBM legislation in response to the current business model, which has been criticized as anti-consumer and anti-competitive.[2] The industry's practices have been documented for years and include but are not limited to:

- **Formulary design that increases PBM revenue at the expense of consumers.** A formulary is an insurance plan's list of covered prescription drugs that usually includes multiple tiers with varying copays. PBMs design formularies and can determine which drugs will be covered, and at what tier. PBMs negotiate with drug manufacturers for rebates and kickbacks that are dependent on which tier a drug is placed on and are sometimes contingent on prioritizing more expensive brand name drugs over lower cost alternatives. This creates financial incentives for PBMs to steer consumers to higher cost drugs.
- **Penalizing consumers by charging them more** for shopping at pharmacies in which PBMs do not have an ownership stake.
- **Engaging in "spread pricing,"** which is when PBMs charge a carrier more for a covered prescription drug than the amount they reimburse the pharmacy for that drug. The difference between what the carrier pays and what the pharmacy is reimbursed is the "spread," which is kept by the PMB.

[1] https://drive.google.com/file/d/1of-aZWztHbCJDGZODeqoWEVvYcokHw41/view
[2] https://nashp.org/new-nashp-model-legislation-helps-states-bring-transparency-to-pharmacy-benefit-managers/

- **Not sharing or distributing rebates they receive from drug manufacturers** that could create savings for purchasers and consumers.

There is a long history of PBM self-dealing that redounds to the detriment of consumers, taxpayers, and pharmacists. Multiple investigations by U.S. Attorneys and state Attorneys General resulted in billions of dollars in settlements over the years. While these investigations and lawsuits stretch back to before 2003, PBMs' anti-competitive and anti-consumer behavior continues around the country, in part because PBMs are not generally regulated by the federal government.[3]

In 2014, testimony before the *Employee Benefits Security Administration Advisory Council on Employee Welfare and Pension Benefit Plans - U.S. Department of Labor*, antitrust lawyer and former FTC attorney, David Balto stated that PBMs no longer serve as "honest brokers" and engage in a wide range of anticompetitive conduct:

> *"Although PBMs offer a great deal of promise in terms of the potential to control pharmaceutical costs, there is a pattern of conflicts of interest, self-dealing and anticompetitive conduct, all of which ultimately means that consumers pay far more for drugs than necessary."*[4]

PBMs have been the subject of major federal or multidistrict lawsuits over allegations of fraud; misrepresentation to plan sponsors, patients, and providers; unjust enrichment through secret kickback schemes; and failure to meet ethical and safety standards. Balto's testimony describes more than $371.9 million in damages to states, plans, and patients:[5]

- **United States v. Merck & Co., Inc., et al.** – $184.1 million in damages for government fraud, secret rebates, drug switching, and failure to meet state quality of care standards.
- **United States v. AdvancePCS** (now part of CVS/Caremark) – $137.5 million in damages for kickbacks, submission of false claims, and other rebate issues.
- **State Attorneys General v. Caremark, Inc**. – $41 million in damages for deceptive trade practices, drug switching, and repacking.
- **State Attorneys General v. Express Scripts** – $9.5 million for drug switching and illegally retaining rebates and spread profits and discounts from plans.

In addition, a recent FTC report found that, over the course of five years, the three largest PBMs are estimated to have generated $1.4 billion in income from spread pricing for just 51 generic specialty drugs.[6]

Maine policymakers previously took action to require PBMs to pass on rebates from drug manufactures to carriers and employers, which are then used to lower premium costs. However, rebates are not the only revenue stream for PBMs. LD 1580 would bring much needed transparency to PBMs in Maine and would help to reduce conflicts of interests. Several years ago, Montana's state employee plan switched to a transparent PBM that did not take any spread and passed along all rebates in full. Montana's requirement of PBM transparency and limitations on self-dealing resulted in millions of dollars in savings and additional revenues for the plan.[7]

Given today's high health care costs, it is crucial we ensure PMBs are operating in the best interests of consumers, not inflating costs for their own bottom line, which is why we urge you to support this bill.

Thank you.

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[3] https://www.maine.gov/legis/housedems/news/ld1116treat.htm
[4] https://www.dol.gov/sites/default/files/ebsa/about-ebsa/about-us/erisa-advisory-council/ACBalto061914.pdf
[5] Ibid
[6] https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf
[7] https://www.propublica.org/article/in-montana-a-tough-negotiator-proved-employers-do-not-have-to-pay-so-much-for-health-care