STATEMENT

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In Support of LD 1580 (Nutting)

April 29, 2025

Position: The Pharmaceutical Research and Manufacturers of America (PhRMA) supports LD 1580, which would curb pharmacy benefit manager (PBM) practices that lead to higher costs for patients, health plans, employers, and the state of Maine.

PBMs are operating in ways that enrich themselves to the detriment of those who rely on their negotiating power and expertise—creating and profiting from misaligned incentives and raising clear conflicts of interest. This has raised the attention of states, Congress, and the Federal Trade Commission. The proposed reforms in LD 1580 would hold PBMs accountable and benefit patients by stemming PBM practices that drive up health care costs. Specifically, this legislation would:

- delink PBM compensation from the price of a medicine, eliminating incentives for PBMs to favor higher-priced medicines over lower cost alternatives that save patients money; and
- prohibit the PBM practice of "spread pricing" by prohibiting PBMs and insurer contracts that enable PBMs to profit from the difference between charges to insurers and pharmacy reimbursement.

Due to their large market share, PBMs exercise an enormous amount of influence in the prescription drug market.

PBMs administer prescription drug benefits for more than 275 million publicly and privately insured Americans.[i] Just three PBMs control nearly 80% of the entire United States PBM market.[ii] This market concentration allows PBMs to exercise enormous influence over patients' access to medicines.

Health insurance companies use PBMs to negotiate prescription drug prices and develop formularies that determine what medicines people can get and how much they must pay. PBMs are supposed to help lower costs for medicines, but they often enrich themselves over the interests of patients and their health plan clients. For example, the three largest PBMs also operate mail-order, specialty and retail pharmacies and often require patients to use a pharmacy that the PBM owns or in which the PBM has a financial stake.

In recent years, these PBMs have each created separate "rebate contracting entities" – which they refer to as group purchasing organizations, or PBM GPOs – that negotiate rebates for their commercial market clients. PBM GPOs are an additional non-transparent middleman in the supply chain, and experts have raised concerns that they are likely to increase costs without providing any direct benefits for patients.[iii] Further, there are no requirements that PBMs share negotiated rebates and discounts with the clients they claim to serve: health insurance companies, employers, state agencies, or patients.

LD 1580 would help make medicines more affordable for patients by breaking the link between a PBM's compensation and the price of medicines.

Specifically, LD 1580 would prohibit provisions in PBM and insurer contracts that permit PBMs to charge fees tied to the price of the drug, rebates, premiums, or cost-sharing. Since rebates and administrative fees paid to PBMs are typically calculated as a percentage of a medicine's list price, government agencies, economists, and other experts have noted that PBMs may favor medicines with high list prices and larger rebates to maximize their revenue. [iv,v,vi,vii] According to Nephron Research, the share of PBM profits from fees, which are tied to the list price of a medicine, has quadrupled in the last 10 years.[viii] And, according to a Senate Finance Committee report, "PBMs have an incentive for manufacturers to keep list prices high, since the rebates, discounts, and fees PBMs negotiate are based on a percentage of a drug's list price—and PBMs may retain at least a portion of what they negotiate."[ix] The current PBM compensation model is causing patients to face a higher financial burden for their prescription drugs because PBMs can exclude drugs with lower list prices and base cost sharing on higher list prices.[x]

For example, in 2022, two of the three largest PBMs excluded one or more lower list price authorized insulins in favor of a higher list price alternative.[xi] Further, the manufacturer of the first interchangeable biosimilar insulin simultaneously introduced two identical versions (a branded version with a higher list price and rebates and an unbranded version with a lower list price), giving payers the option of which to cover, but not one of the three largest PBMs included the lower list price version as a preferred option on their 2023 standard commercial formulary.[xii,xiii] In fact, one of the three preferred the higher list price version and excluded coverage of the lower list price version altogether, even though coverage of the latter could lower out-of-pocket costs for insulin for many patients with deductibles and coinsurance.[xiv]

In addition, the Health and Human Services (HHS) Office of Inspector General (OIG) has also indicated that PBMs may have incentives to penalize manufacturers for reducing list prices, including removing medicines from the formulary or placing them on a less-preferred cost sharing tier, both of which may result in higher costs for patients.[xv] Ending price-based PBM compensation in favor of flat fees is expected to reduce PBM incentives to prefer higher price medicines, thereby generating savings for employers and plan sponsors.[xvi] Patients with deductibles and coinsurance could also benefit from expanded coverage of lower price medicines in the form of lower out-of-pocket costs.

To the extent that PBMs provide valuable services to their clients, they should be entitled to compensation based on that value. However, PBM compensation should not be permitted to be tied to the price of a medicine.

LD 1580 would also prohibit the PBM practice of "spread pricing," which enables PBMs to profit from the difference between the amount they reimburse pharmacies for a medicine and the amount charged to their clients.

Using a tactic called "spread pricing," PBMs often bill more than what they pay to the pharmacy for medicines and keep the difference, enriching themselves, typically unbeknownst to their own clients and patients. This business practice adds opacity to a supply chain that needs transparency to best serve the needs of patients. At least 23 states have now banned spread pricing in Medicaid and/or the commercial market, and the Center for Medicare and Medicaid Services has also taken action to limit

spread pricing.[xvii] For example, the state of Ohio was overcharged nearly $225 million in a single year due to PBM spread pricing, and the Congressional Budget Office found that prohibiting the use of spread pricing in Medicaid would save taxpayers more than $900 million over 10 years. [xviii,xix]

Insurers and PBMs have been steadily negotiating bigger rebates while at the same time passing more costs on to patients. Prohibiting spread pricing could help Maine ensure that the amount paid by the health plan for a prescription drug is more closely aligned with the amount of reimbursement to the pharmacy.

For the above-stated reasons, we ask Maine legislators to support LD 1580.

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The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research companies, which are laser focused on developing innovative medicines that transform lives and create a healthier world. Together, we are fighting for solutions to ensure patients can access and afford medicines that prevent, treat and cure disease. Over the last decade, PhRMA member companies have invested more than $800 billion in the search for new treatments and cures, and they support nearly five million jobs in the United States.

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[i] Pharmaceutical Care Management Association (PCMA). About PCMA. Accessed: February 24, 2025. https://www.pcmanet.org/about/.

[ii] Federal Trade Commission. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, at 1. July 2024. https://www.ftc.gov/reports/pharmacy-benefit-managers-report.

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[iv] Senate Finance Committee. "Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug," 2021. https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL%201).pdf.

[v] 84 Fed. Reg. at 2341.

[vi] Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy. Chapter 13: The Medicare Prescription Drug Program (Part D): Status Report." March 2021. https://www.medpac.gov/document/chapter-13-the-medicare-prescription-drug-program-part-d-status-report-march-2021-report/.

[vii] Sood N, Ribero R, Van Nuys K. The Association Between Drug Rebates and List Prices. USC Schaeffer White Paper. February 11, 2020. https://healthpolicy.usc.edu/research/the-association-between-drug-rebates-and-list-prices/.

[viii] Nephron Research PBM Gross Profit Model, August 2023.

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[xiii] Drug Channels. The Big Three PBMs' 2023 Formulary Exclusions: Observations on Insulin, Humira, and Biosimilars. January 10, 2023. https://www.drugchannels.net/2023/01/the-big-three-pbms-2023-formulary.html.

[xiv] *Id.*

[xv] Health and Human Services Office of Inspector General. Removal of Safe Harbor Protection for Rebates Involving Prescription Pharmaceuticals and Creation of New Safe Harbor Protection for Certain Point-of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees. 84 Fed. Reg. 2340 (November 20, 2020). https://www.federalregister.gov/documents/2020/11/30/2020-25841/fraud-and-abuse-removal-of-safe-harbor-protection-forrebates-involving-prescription-pharmaceuticals.

[xvi] 3 Axis Advisors. Evaluation of Federal Drug Pricing Proposals. Part I: Delinking PBM Compensation from Drug List Prices. July 25, 2023. https://www.3axisadvisors.com/s/3AA-Delinking-PBMA-Analysis-Part-1-0723.pdf.

[xvii] CMS issues new guidance addressing spread pricing in Medicaid, ensures pharmacy benefit managers are not up-charging taxpayers. May 15, 2019. https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not.

[xviii] Ohio's Medicaid Managed Care Pharmacy Services, Auditor of State Report. August 2018. https://audits.ohioauditor.gov/Reports/AuditReports/2018/Medicaid_Pharmacy_Services_2018_Franklin.pdf

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Maine LD 1580 Will Cost the State $64 Million In Increased Premiums

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 prohibit employers and other plan sponsors from compensating their PBMs based on a drug's list price (so called "delinking"). Although some of the provisions are subject to interpretation, enacting just the bill provisions discussed below could cost the state of Maine $64 million annually in increased premiums.

LD 1580 would delink PBM compensation from a drug's list price.

- Prohibiting employers and other health plan sponsors from choosing to compensate PBMs based on a drug's list price or utilization, "delinking," would essentially force PBMs to delink their business arrangements from the value of their services. The current pay-for-PBM-performance model has effectively delivered prescription drug savings to employers and plan sponsors for years. Banning this compensation model would be a major cost to employers and patients.
- Delinking in the commercial market would cause an increase in health insurance premiums of up to $26.6 billion.[1] This estimate does not include the increased nondrug health costs and the cost of reduced innovation that would likely also occur. A state that implements this type of legislation could increase health insurance premiums by up to $149 per commercially insured patient in that state.[2]

Projected 1-Year Increases in Premiums In Maine, (millions)

Issue	Commercial Market Total
Implement Delinking	**$64**

Methodology: The methodology used to create these cost projections was from PCMA's "Commercial Delinking Would Cause Premiums to Soar in the States." Maine has a law requiring PBMs to pass all rebates to plan sponsors or patients at the pharmacy counter. This estimate reflects the non-rebates portion of the delinking estimate.

[1] Matrix Global Advisors. "The Economics of "Delinking" PBM Compensation." 2023.

[2] PCMA. "Commercial Delinking Would Cause Premiums to Soar in the States." 2024.

PCMA

resulting in a $3.2 million loss with an anticipated recurring annual increase of 8 percent. Rebates and point of sale rebates could be impaired, creating a $49.7 million loss in rebates with an anticipated recurring annual increase of 8.5 percent. The total anticipated impact for NMPSIA is a $60 million loss in FY26, with estimated recurring losses of 25.5 percent in subsequent years.

Preliminary Projected Cost Impact to NMPSIA Plan

	FY25	FY26	FY27
MAF and PBM Fees	$179,000	$7,120,000	$7,760,000
PrudentRx Elimination	$82,000	$3,216,000	$3,473,000
Total Projected Plan Impact	*$1,516,000*	*$60,064,000*	*$65,188,000*

Preliminary Projected Cost Impact to NMPSIA Members

	FY25	FY26	FY27
Rebate Elimination (POS)	$115,000	$4,521,000	$4,905,000
PrudentRx Elimination	$9,000	$328,000	$354,000
Total Projected Member Impact	*$124,000*	*$4,849,000*	*$5,259,000*

Retiree Health Care Authority (RHCA) Fiscal Implications

RHCA reports its rebate estimates were projected based on calendar year 2024 rebates. The cost implications noted below were determined only for the RHCA commercial members (pre-Medicare retirees), given that employer group waiver plans and Medicare plans are governed by federal rules under the Centers for Medicare and Medicaid Services. In addition to the total plan costs to RHCA, the agency also notes the potential cost implications to plan members with the elimination of the SaveOnRx and Smart90 programs, along with possible fiscal impacts to RHCA's Narrow Network and Mail Parity programs

Projected Cost Impact to NMRHCA

	FY25	FY26	FY27
SaveOnRx Program Elimination	$47,000	$1,841,000	$1,988,000
Smart90/Narrow Network/Mail Parity	$32,000	$1,248,000	$1,348,000
MAF Fees	$33,000	$1,307,000	$1,425,000
Administration Fees	$21,000	$790,000	$822,000
Rebate Elimination	$410,000	$16,239,000	$17,619,000
Total Projected Plan Impact	$543,000	$21,425,000	$23,202,000

Projected Cost Impact on NMRHCA Members

	FY25	FY26	FY27
SaveOnRx Program Elimination	$3,000	$95,000	$103,000
Smart90/Narrow Network/Mail Parity	$5,000	$169,000	$182,000
Total Projected Member Impact	$8,000	$264,000	$285,000

Health Care Authority State Health Benefits Program Fiscal Implications

HCA reports the bill could affect fundamental changes to PBMs in New Mexico. These changes could be temporarily disruptive to state health benefit plan members regarding new formularies, mail order providers, prior authorization requirements, and other factors. The member cost impact is indeterminate dependent on how OSI would implement the provisions of the bill.