MAINE ASSOCIATION OF HEALTH PLANS

Testimony of Katherine Pelletreau
to the Joint Standing Committee on Health Coverage, Insurance and Financial Services

In Opposition To

LD 1706 An Act to Require Appropriate Coverage of and Cost-sharing for Generic Drugs and Biosimilars

May 20, 2020

Good Morning Senator Sanborn, Representative Tepler, Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services:

My name is Katherine Pelletreau and I am the Executive Director of the Maine Association of Health Plans (MeAHP). MeAHP has five members including Aetna, Anthem Blue Cross and Blue Shield, Cigna, Community Health Options and Harvard Pilgrim Health Care. Collectively, MeAHP's members provide or administer health insurance coverage to over 600,000 Maine people. The organization's mission is to improve the health of Maine people by promoting affordable, safe and coordinated healthcare.

This bill is similar, although not identical, to LD 2095 from the 129th Legislature. At that time the Committee decided it did not merit passage and it was unanimously voted ONTP.

LD 1706 seeks to force carriers to incentivize the use of generics and biosimilars even if they are more costly than negotiated prices for brand versions of medications. It is true that typically generics are less costly and plan designs reflect that. That is why the generic dispensing rate in most commercial insurances is so high, 85-90% according to one member Plan. **This bill deals with the small number of generics and biologics that are more expensive than brand name prescriptions.**

In a competitive market with rebates, **the lowest net cost is the critical metric**, whatever the type of drug and regardless of whether it is a brand, generic, or biosimilar.

There is no alternative to volume-based discounts other than rebates and current law already dictates that rebates are used to benefit consumers. Passage of this bill as proposed ignores P.L. 2019, c. 469 (LD 1504) which requires accounting for the value of rebates to benefit members either by remittance to the covered person at the point of sale or application by the carrier in its plan design and in future plan years to offset premiums. The law requires that beginning March 1, 2021 and annually thereafter, carriers file with the Superintendent a report demonstrating how the carrier has complied with this requirement. We suggest that the Committee give this new law time to work.

Drug marketplaces are complex. It is commonly thought that generics act to drive down cost but with specialty drugs that is not always the case. For example, generics did not have much cost-lowering power for specialty medicines designed to treat multiple sclerosis (MS).[1]

What drives down costs is competition and that includes competition in generics. Like brand drugs, there is also the issue of generics launching at a higher price for a 180 day "generic exclusivity period" that runs from FDA approval. Per the FDA, "The first generic drug applicant to submit a substantially complete generic application that includes a challenge to the brand-name drug's patents and that meets certain regulatory and legal requirements may be eligible for a 180-day exclusivity."[2]

For a generic, often during the 180-day exclusivity period, the brand provides the lower net cost because of rebates. Biosimilars are minimally lower in cost and do not always offer rebates like a preferred biologic reference price might.

There is further complexity around biosimilars. Biosimilars are not generics – a generic is interchangeable, while a biosimilar may have the same action but is not identically formulated. This bill gives advantage to biosimilars rather than brands that are already in the market. In the biosimilars market, there is a level of exclusivity. These manufacturers do not have incentives to offer rebates because they are protected by patents. Generics are often manufactured for simpler, often single compound drugs, but less common for more complex specialty and biosimilar drugs. There is a movement towards the manufacture of biosimilars; while few have been approved, there are many more in the pipeline. It is unclear what impact these drugs will have on costs.

Given the complex dynamics around drugs such as those I have described, the key metric is the ***lowest net price*** that the health plan can negotiate, not whether the drug is generic, biosimilar or brand.

Thank you for the opportunity to offer these comments.

[1] https://www.npr.org/sections/health-shots/2020/01/20/797477657/patients-still-struggle-to-balance-high-costs-of-ms-treatment-despite-generic?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top
[2] https://www.fda.gov/files/drugs/published/Exclusivity-and-Generic-Drugs--What-Does-It-Mean-.pdf