Testimony of Erika Satterwhite, Head of Global Policy, Viatris Inc.

Regarding LD 1706

Presented on May 20, 2021

Good morning Senator Sanborn, Representative Tepler and members of the Health Coverage, Insurance, and Financial Services Committee. My name is Erika Satterwhite and I am Head of Global Policy at Viatris Inc. Prior to the 2020 combination of Mylan and Upjohn, I held various positions at Mylan with a focus on both International Pharmaceutical Policy and Biosimilar Policy. I am here to express my support for LD 1706.

Viatris is a new kind of healthcare company. We aim to deliver increased access to affordable, quality medicines for patients here in the US and around the world, regardless of geography or circumstance. Viatris' global product portfolio includes a unique blend of generic medicines, biosimilars, off-patent brand medicines, and consumer products, across a wide range of therapeutic areas.

LD 1706 will help Mainers pay less for prescription drugs. It's that simple.

Generic medicines save Mainers $70 million[1] each year, but many patients are still paying for expensive brand-name drugs when lower-cost, equivalent generic drugs are available. Why are Mainers overpaying when generic medicines are now 90% of the prescriptions filled in the United States, yet represent only 20% of all drug spending?[2]

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[1] MylanBetterHealth.com

[2] https://accessiblemeds.org/sites/default/files/2020-09/AAM-2020-Generic-Drug-Biosimilars-Savings-US-Fact-Sheet.pdf

Insurance companies compile lists of drugs they will cover each plan year that are called formularies. Drugs on the formulary are assigned to different tiers, which then correspond to the out-of-pocket portion patients are responsible for paying. Tiering was originally designed to incentivize patients to choose lower priced generics or brands, which can be 'preferred' by the plan by placing them on a lower tier with lower patient out-of-pocket costs than other medicines in the therapeutic class.

Unfortunately, this access to lower priced generics is happening less and less. And the reason is one word: rebates. Pharmaceutical manufacturers offer rebates to pharmacy-benefit managers (PBMs) or insurance plan administrators in exchange for "favorable" placement on the formulary (a lower tier relative to other drugs in the therapeutic class). While this is commonplace for brand drugs, which are listed on formularies as individual products, the generic market is structured differently and does not typically rely on rebates because generics are not generally listed on formularies as individual products.

The generic and biosimilar industry is the only actor in the health care system that consistently saves money for patients. Health care data firm IQVIA reports that over the past five years, changes in prices on brand drugs have generated an estimated additional $21 billion in manufacturer net revenue while generic drug price changes have resulted in a reduction of $7 billion over the same time period.[3]

But that competition can't happen if patients don't get formulary access to competitors. Insurance companies are now choosing to not cover generics, or are placing them on the same, or higher tiers than their brand equivalent so they can continue to receive the rebates offered by the brand manufacturer after generics come to market. Patients end up spending needlessly on more expensive brand medicines because, when this happens, patients pay the higher out-of-pocket costs associated with the brand tier.

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[3] IQVIA Institute for Human Data Science. (August 2020). Medicine Spending and Affordability in the United States. Available at https:// www.iqvia.com/-/media/iqvia/pdfs/institute-reports/medicine-spending-and-affordability-in-the-united-states.pdf?_=1611863416480.

There's no need to over-complicate this. It's really just common sense. Generics should always be made available to patients when they come to market, and they should be placed on a lower tier with lower cost sharing than their brand equivalent to drive savings at the pharmacy counter for those same patients.

In the materials I submitted you will find real world examples of Maine health plans where patients are not receiving the full benefit of a generic drug being placed on a lower formulary tier. Over the course of a year, too many Mainers miss out on hundreds of dollars of out-of-pocket savings at the pharmacy counter.

LD 1706 will ensure patients stop overpaying at the pharmacy counter. The opponents of this bill will tell you this is only happening with a small subset of drugs that consist of mostly high-cost specialty drugs. We agree the problem is mostly focused on generic competition for higher priced brand drugs, including specialty drugs. But that makes this even more important, specialty drugs may represent a small subset of drugs by volume, but they're the ones with the outsized cost to patients. Brand specialty medicines account for roughly 2% of all prescriptions, but nearly 50% of all drug spending in the United States.[4] Two percent of the prescriptions, but half the spending.

Generics, including specialty generics, should not be subject to the same high cost sharing as brand products. Plans can create a "specialty generics" tier to account for the relatively higher cost of specialty generics compared to commodity generics while also providing a lower cost share for the patient at the pharmacy counter compared to the brand drug.

Opponents will also claim modifying formularies to move all generics and biosimilars to lower tiers will just raise premiums for all patients and cost-sharing for all tiers. Studies suggest that

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[4] Express Scripts (2019). 2019 Drug Trend Report. Available at https://www.express-scripts.com/corporate/drug-trend-report#2019-bythe-numbers.

implementing LD 1706 would not have a large effect on premiums. Avalere Health concluded in an independent study that a similar proposal requiring generic drugs be placed on generic tiers in Medicare Part D would only be associated with a 4.5% increase in plan liabilities.[5] While plans would not necessarily need to reflect any such increase in premiums, even if the full change was passed to plan holders this would be less than $10 for the average Mainers' premium of around $200 after subsidies.[6] This small potential increase in premiums would ultimately result in a fairer distribution of costs by limiting the high out-of-pocket costs on patients at the pharmacy counter that can lead to abandonment of prescriptions and worsening health outcomes.

LD 1706 will help Maine consumers and allow them to fill their prescriptions without overpaying at the pharmacy counter. Maine patients are currently being deprived of out-of-pocket savings because brand rebates are increasingly incentivizing plans to steer patients away from lower cost generics and biosimilars. I would like to thank President Jackson for presenting this bill and for his leadership to ensure Mainers have access to affordable medicine. LD 1706 is an effective solution to deliver savings directly to Maine patients at the pharmacy counter and I would encourage the Committee to vote ought pass. Thank you for the opportunity to address the Committee today and I'm happy to answer any questions you may have.

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[5] Avalere - Medicare Part D Generic Drug Tiering Request for Comment: Implications for Patient Out-of-Pocket Spending and Part D Plan Costs

[6] Kaiser Family Foundation, Marketplace Average Benchmark Premiums data for Maine, 2021; Maine Bureau of Insurance press release "Maine Bureau of Insurance Announces 13.1 Percent Overall Average Decrease in Individual Health Insurance Rates for 2021" Aug 26 2020; eHealth Affordable Care Act Resources "How much does health insurance cost without a subsidy" Nov 23 2020

How Mainers can stop overpaying for prescriptions drugs

Generic medicines save patients in Maine $70 million[1] every year, but many consumers are still paying for expensive brand-name drugs when a cheaper, equivalent generic is available.

Patients are being left behind.

Insurance companies' lists of which drugs they cover are called **formularies**. On these formularies, drugs are assigned to different **tiers**, which represent the portion a patient will have to pay out of pocket for those drugs. Tiers were originally designed to drive spending toward generics, lower priced therapies, and preferred brands by placing them on lower tiers.

However, insurance companies are increasingly choosing not to cover generics, or are placing them on the same, or higher tiers than their brand-name equivalent in exchange for "rebates" from brand-name pharmaceutical manufacturers. The result is needless spending on expensive, brand-name medicines, which leads to **higher out-of-pocket costs** for patients, **higher overall drug prices**, and contributes to the **unnecessarily high cost of healthcare.**

Generics should always be made available, and placed on a lower tier with lower cost sharing than their brand equivalent to drive savings for patients.

ADVAIR DISKUS®

Advair is one of the most commonly used **asthma** medications, with over 60,000 prescriptions filled in Maine every year. Generic versions exist, but many insurance companies don't cover them, or place them on the same tier as the brand-name version. The result is that **9 times out of 10**, pharmacies dispense the more expensive brand-name version.

Antonio has insurance from Harvard Pilgrim. He needs an Advair inhaler every month, and each prescription costs him $25. His plan only charges a $10 copay for generic drugs, but since Harvard Pilgrim doesn't cover generic Advair, Antonio is stuck buying the brand-name version. Over the course of a year, he pays an extra $180.

Zytiga® abiraterone acetate

The generic version of the **cancer** treatment Zytiga has been around for over 2 years, offering a huge discount compared to the brand-name version. Yet pharmacies in Maine continue to dispense the more expensive drug **4 times out of 10.** Many insurance plans place the generic and the brand-name versions on the same tier.

Debbie is a cancer patient and has a health insurance plan from Anthem. She has been prescribed Zytiga, which would cost her $4,000 for a one-month supply. Anthem covers the generic, but they place it on the same, high tier as the brand-name version even though the generic price is 96% lower, well below the price threshold for "specialty drugs."

With insurance from Aetna, generics for **5** of the top **25** drugs are **NOT COVERED**, forcing patients to pay a premium for brand-name products.

With insurance from Community Health Options, generics for **10** of the top **25** drugs Are on **HIGH FORMULARY TIERS**, meaning generic savings are often not passed on to patients.*

Generics should always be made available and placed on a lower tier with lower cost sharing than their brand equivalent to lower costs for patients.

[1] MylanBetterHealth.com

* Includes generics for products that have engaged in 'product hopping', when brand products make modest reformulations that offer little or no therapeutic advantages to extend exclusivity.

VIATRIS™

How Mainers can stop overpaying for prescriptions drugs

CIPRODEX®
(ciprofloxacin 0.3% and dexamethasone 0.1%)
STERILE OTIC SUSPENSION

Ciprodex is a drug used to treat **ear infections**. There are lower-priced generic versions available, but insurance formularies often block patients from accessing them. The result is that patients end up with the brand-name version **4 times out of 10**.

Amy has Aetna insurance through her employer. She needs to pick up a Ciprodex prescription for her daughter's ear infection. Since Aetna doesn't cover the generic, Amy has to buy the brand-name version and pay a $30 copay. Amy's copay would only be $10 if she could get the generic.

AFINITOR®
(everolimus) Tablets

The **cancer** treatment Afinitor can prove extremely expensive for patients. The generic, priced at thousands less, should help alleviate that burden, but the brand-name version is still used **8 times out of 10.** Maine's insurers often don't cover the generic, or place it on the same, high tier as the brand-name version.

Bruce gets health coverage through Anthem. Afinitor is on the Anthem's "specialty drugs" tier, which mean Bruce must pay a large portion of the bill. His out of pocket cost for a one-month supply of brand-name Afinitor is an astonishing $7,500. Anthem covers generic Afinitor, but they place it on the same "specialty drugs" tier as the brand-name version.

COPAXONE®
(glatiramer acetate injection)

The **multiple sclerosis** treatment Copaxone is an expensive "specialty drug." The generic version has been out for over 5 years and is priced thousands of dollars lower. Nonetheless, since Maine's top insurers put it on the same tier as the brand-name version, Mainers get the brand-name drug **7 times out of 10.**

Cindy has insurance from Harvard Pilgrim. Her prescription for Copaxone could cost over $3,000 for a one-month supply. Harvard Pilgrim covers the generic, but they place it on the same tier as brand-name Copaxone. Since the insurance plan doesn't differentiate between the generic and the brand-name versions when it comes to tier placement, Cindy misses out on hundreds of dollars of potential savings.

Generics should always be made available and placed on a lower tier with lower cost sharing than their brand equivalent to lower costs for patients.

Copay and cost sharing amounts based on a wholesale acquisition cost and the following plans: Harvard Pilgrim HMO Gold 1500, Community Health Options Community Value HMO, Anthem Gold HMO 1600, Aetna Choice POS II. Prescription coverage based on plan formularies as of 9/2020.

Prescription volume and WAC data source: IQVIA, IQVIA SMART US Regional Edition, 9/2020.

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