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Chairwoman Lori Houghton
House Committee on Health Care
Via-email

Dear Chairwoman Houghton and members of the House Committee on Health Care,

Thank you for the opportunity for Cigna Healthcare to provide comments on H. 233 establishing standards and criteria for the licensure and regulation of pharmacy benefit managers providing claims processing services or other prescription drug or device services for health benefit plans. Cigna delivers choice, predictability, affordability and access to quality care through integrated capabilities and connected, personalized solutions that advance whole person health including Pharmacy Benefit Manager services through Express Scripts. Pharmacy Benefit Managers (PBMs) work to reduce prescription drug costs for health plans so that consumers can access necessary affordable prescription drugs. PBMs also provide many valuable services to their health plan clients and patients in ways such as improving prescription adherence, reducing medication errors, and managing overall drug cost spending.

This bill encompasses numerous provisions related to pharmacy benefit management, many of which are complex and require thoughtful consideration to avoid potential unintended consequences including a negative impact on the quality and affordability of prescription drug coverage available to Vermonters. We encourage the legislature to allow time for the impact of provisions in Act 131 of 2022 to be better understood before layering on additional PBM restrictions. It is important that the law not deprive employers, health insurers, and other entities providing prescription drug coverage of the freedom to make choices about how best to design their prescription drug benefit to meet their unique needs.

Language in section 1 says that a PBM cannot reimburse unaffiliated pharmacies less than they reimburse PBM affiliates for the same services and the reimbursement amount must be based on actual acquisition cost plus dispensing fee at least as much as in Medicaid. Mandating use of the same dispensing fees used in the Vermont Medicaid program, would cause an increase in the cost of health care. The bill would mandate that retail pharmacies receive a minimum dispensing fee of $11.13 which is significantly higher than the average dispensing fee paid today, estimated in one recent study to be $2. Using these numbers, prescription drug costs will increase $9.13 for every prescription filled at a retail pharmacy. Much of this additional cost will be shouldered by health benefit plans, such as the state employee plan, and the individuals they provide coverage for. Additionally, while we don’t oppose PBM licensure we’d recommend comparable processes used for other licensed entities. As mentioned by others, we also oppose the private right of action provision in this section.

The bill also requires that a PBM attribute any amount paid by or on behalf of a patient toward the deductible and out-of-pocket maximums. We recommend that at a minimum, this language be clarified so that drug manufacturers cannot use coupons to bypass a formulary. Copay coupons can undermine health insurers’ programs to incentivize use of generics and lower cost. The language should add exceptions to application of accumulator bans if there is a covered interchangeable bio-similar or there is a covered drug in the same therapeutic class that may be preferred under the plan’s formulary. Additionally, this requirement should not apply to an insured covered by a high deductible health plan if its application would render the insured ineligible for a health savings account or for any amount that the insured’s health benefit plan reduces or

eliminates cost sharing requirements when a manufacturer or other person makes payments on behalf of the insured for the qualified prescription drug.

Additionally, requirements should be added that any third party that pays any amount on behalf of an enrollee for a covered prescription drug must offer the assistance for the full plan year; must notify the enrollee prior to an open enrollment period if the financial assistance will be discontinued in a subsequent plan year; and may not condition the assistance on enrollment in a health plan or type of health plan, to the extent permitted under federal law.

Patients are vulnerable to financial exposure or disruptions in care if payments stop in the middle of treatment. Requiring assistance to be provided for the entire plan year and requiring notice when that assistance will be discontinued provides predictability, ensures patients can focus on their health, and allows patients to choose the right health plan for their needs.

And we would continue to note that spread pricing while not required, should be available as an option for clients. Additionally, Vermont law already mandates transparency with respect to spread pricing. Health benefit plans who enter into spread pricing arrangements with PBMs in Vermont choose to do so because they believe it is the best option for them. This is because spread pricing arrangements provide health benefit plans with cost predictability and shift financial risk from the plan to the PBM. It is not the right option for all plans, but many determine that it is the best option for them. This prohibition will deprive health benefit plans of the ability to make that choice.

Lastly, we'd request that and effective date for any changes allow sufficient time for plans to assess the ability to implement them.

Thank you for the opportunity to submit comments for your consideration. If you have any questions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cignahealthcare.com.

Sincerely,

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