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February 14, 2024

House Committee on Health Care
Vermont State House
115 State Street
Montpelier, VT 05633-5301

Re: H.233, An Act Relating to Pharmacy Management and Medicaid Wholesale Drug Distribution

Chair Houghton and Committee Members:

I write on behalf of MVP Health Care ("MVP") concerning H.233, An Act Relating to Pharmacy Benefit Management and Medicaid Wholesale Drug Distribution. Notably, MVP does not own or operate a Pharmacy Benefit Manager (PBM), but does contract with a third-party for services such as negotiating lower drug prices with manufacturers, network management, drug utilization review, and claims processing. MVP retains management of its formulary and clinical management programs. As such, MVP's comments focus on sections that impact purchasers of these services, and any downstream effects on our members and ratepayers.

Spread Pricing Prohibition - Neutral
Section 1 (p.12, lines 1-2)

MVP does not utilize spread pricing arrangements in its PBM contract.

Co-Pay Accumulator Program Bans – Neutral
Section 1 (p.11, lines 14-21)

MVP does not utilize any co-pay accumulator programs in its Vermont fully insured commercial lines of business.

Definition of "Cost-Sharing Amounts" – Oppose
Section 1 (p. 11, lines 1-13)

The bill would limit what consumers pay out-of-pocket for covered prescription drugs by establishing a cap based on a "lesser of" standard based on patient cost-share, the maximum allowable cost for the drugs, or the cash-price cost of the drug. The definition of "cost-sharing" amount, however, would require pharmacy rebates to be calculated and applied at the pharmacy point-of-sale (POS):

…

(2) As used in subdivision (1)(A) of this subsection (e), the "cost-sharing amount under the terms of the health benefit plan" shall be calculated at the point of sale based on a price that has been reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The pharmacy benefit manager shall pass on any remaining rebate amount in excess of the covered person's cost-sharing amount to the health benefit plan to reduce premiums.

…

While well intentioned, POS rebate reductions will require wholesale changes to pharmacy claims adjudication systems and practices, and will result in significant complexity, confusion, and abrasion for consumers. Today, MVP's PBM partner negotiates rebate amounts directly with drug manufacturers. Those rebates are based on various factors, such as total drug volume and utilization, and serve to reduce the net cost of spending on a particular drug. Cumulative rebates received are reconciled at least annually, and MVP uses those funds to reduce health care costs, which is passed on to consumers via lower premiums.

The proposed definition would require that an individual member's out-of-pocket costs be lowered for each individual pharmacy transaction. Neither MVP nor the PBM knows what total rebates will be at POS because these amounts are reconciled and based on total, rather than individual drug unit, spending. Most concerning, POS rebates would put the members in the middle of very complicated transactions. For example, consumers might owe a repayment of excess rebates on their POS transactions if rebate reconciliations don't match estimated amounts applied at POS. This would be a terrible member experience that MVP cannot support. In reality, the net effect of this change would be an increase in overall drug spend that is then passed on to customers in higher premiums.

Federal policymakers have been looking at a similar POS requirement in Medicare, but face these very same operational issues. The Congressional Budget Office (CBO) has also estimated that these proposals would increase total federal health care spending by $177 billion, and that individual consumer impacts would be mixed—with some paying less for a drug at POS, with others paying more. Congress has delayed implementation of the Medicare rules until at least 2032, and we urge the House Health Care Committee to reject this change.

340B Claim Tracking Prohibition – Neutral, but With Comments
Section 1(p.23, lines 17 through 20)

The bill would prohibit PBMs from attempting to identify when 340B drugs are dispensed to commercial health insurance enrollees:

…

(i) A pharmacy benefit manager shall not:

(1) Require a claim for a drug to include a modifier or supplemental transmission, or both, to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by Medicaid; or

…

MVP understands that this prohibition exists in current law. We also appreciate the important role of the federal 340B program as a critical resource for our community safety net providers. That said, we offer two observations for your consideration:

- 340B drugs are not rebate eligible under federal rules. So, this prohibition prevents a PBM or health plan from knowing when a 340B drug is used. Under the proposal discussed in the prior section, there would be no way to know whether a particular drug is 340B and therefore eligible for a rebate at POS.

- As a matter of public policy, this prohibition also limits our collective ability to understand how the federal 340B program affects total health care spending. It's noteworthy that the prohibition does not apply to Medicaid, where government payers want to understand this information—not

only for rebate eligibility purposes, but overall program costs. Commercial payers and public policymakers could benefit from the same transparency.

Applicability of Fines – Need Clarification
Section 1 (p. 13, lines 4-7)

The bill would establish new penalties on PBMs and health plans for violations:

…

(d) The Commissioner may impose a penalty on a pharmacy benefit manager or the health insurer with which it is contracted, or both, for a violation of this chapter. The penalty shall be not less than $25,000.00 nor more than $50,000.00 for each violation of this chapter.

…

MVP seeks clarification on intent and applicability of these proposed fines. In what instance would a fine be levied on both parties, or on a health plan for a PBM violation? Further, how is "violation" defined in the context of the bill's many new requirements? For example, could MVP (or the PBM) owe a minimum $25,000 fine for any comparatively minor violations on a per-member basis?

Pharmacy Participation Requirement Restrictions – Oppose & Request Clarification
Section 1 (p.22, lines 17-21)

The bill would prohibit a health plan or its PBM from withholding reimbursement for services on the basis of non-compliance with participation requirements:

…

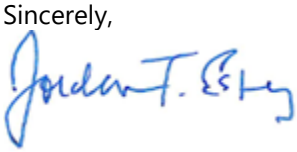
(f) A pharmacy benefit manager shall not restrict, limit, or impose requirements on a licensed pharmacy in excess of those set forth by the Vermont Board of Pharmacy or by other State or federal law, nor shall it withhold reimbursement for services on the basis of noncompliance with participation requirements.

…

MVP seeks additional clarification on the intent of the last portion of this provision, starting with "nor shall it." What is meant by "participation requirements?" This is an important question as it relates to a contract between a health plan and/or PBM and a pharmacy. While the intent of prohibiting requirements on a licensed pharmacy in excess of those set by the Vermont Board of Pharmacy seems clear, to our knowledge, that body has no jurisdiction over "participation requirements" in private contracts. MVP would oppose, for example, having to reimburse for services that it has not contracted with a pharmacy to perform.

Questions?
Thank you for the opportunity to provide comments on H.233. Please contact me with any questions.

Sincerely,



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