Memorandum

To: Chairperson Lori Houghton and members of the House Committee on Health Care

From: Bobby-Jo Salls, VEHI Trust Administrator

RE: Written Testimony on Draft 1.2 of H.233

Date: February 28, 2024

Good afternoon.

For the record, my name is Bobby-Jo Salls. I'm a Trust Administrator for the Vermont Education Health Initiative — VEHI — a self-insured, public risk pool that offers health benefit plans to all public schools in Vermont, to several private schools, and to the Vermont State Teachers' Retirement System, representing about 35,000 lives.

My testimony is specific to amended section **(2)(A) of H.233** (Draft 1.2), on page 11, lines 1 – 16 and page 10. My comments are consistent with what Mark Hage testified to earlier. Mark, as you know, is also a Trust Administrator for VEHI, and we work together. He could not be here today.

The objective of the revised language in H.233, to provide retrospective financial relief to Vermonters being stung by high prescription costs, is admirable; unfortunately, it will be cumbersome and complex to enact, and it will absolutely increase our operational expenses.

And, for this reason, it will drive premiums upward for schools, school employees and their families, and for the Vermont State Teachers' Retirement System and the retirees we serve, and ultimately the taxpayers who bear the burden of the cost.

Moreover, and this is the most important point, H.233, as amended, will return the value of rebates only to a small number of our subscribers, but, in doing so, it will put VEHI in the position of needing to increase premiums most years for all members.

For these reasons, though VEHI would very much like to see lower Rx costs for those enrolled in our benefit plans – and for all Vermonters – we cannot support the amended language, and we request to be exempted from it.

All things being equal, the loss of rebates will mean higher premiums for school districts, school employees, and VSTRS

Here is the language at issue:

"(2)(A) At least annually, a health benefit plan shall determine for each covered person the total amount of all rebates the plan or its pharmacy benefit manager received in connection with the dispensing or administration of a drug to the person and shall pass along that amount to the covered person whose use of the drug or drugs generated the rebates.

If VEHI is not exempt from this provision, it will have to set premium rates each year based on the assumption that it will lose a large amount of rebate money – in the millions potentially – even though we will not know if our assumptions are accurate until months after we've submitted rates to DFR. This is

because, typically, the majority of rebate amounts are paid out by PBMs 90 to 120 days after the close of the quarter and then reconciled annually at the close of the calendar year. However, adjustments to these rebates can trickle in for years, as it takes time to submit files to the manufacturer for payment, reconcile those payments, and then remit those payments to each individual client. VEHI received a rebate in January of 2024 which included adjustments to rebates back to the fall of 2021. There were 8 quarters worth of adjustments and half of them were positive adjustments, in other words the PBM taking back rebates they had previously given. If 100% of all rebates received would need to go back to the patients, it would result in a significant administrative burden and additional cost to the plan to try and reconcile this back to each patient retrospectively and it could take months to complete.

We do know, however, when setting rates, the rebate amounts we received in past years, and they are substantial sums. And this will heavily influence how we think about prospective rebate losses with respect to the rates we file with DFR.

For example, if our rebate loss estimates should prove to be too high after the fully reconciled rebates are announced by our PBM, premiums for the next fiscal year, which DFR would already have approved, would be higher than they should have been, and school budgets will have "baked in" that error.

Should our loss estimates prove too low, however, our premiums could be insufficient to cover actual expenses and that may have a negative impact on our financial stability and reserves.

Once again, we fully understand and appreciate that you are trying to do right by Vermonters. But it is critical to bear in mind that most rebate money is tied to high-cost medications taken by a small number of patients. Mark Hage spoke about this in his testimony on H.233.

On the other hand, **approximately 85% of VEHI's Rx claims are for generics**. The overwhelming majority of VEHI subscribers, therefore, will not be eligible for a retroactive payment under H.233; but they and their school districts will suffer financially if premiums rise because of the changes proposed in the amended bill.

More administrative complexity means higher premiums

As I alluded to earlier, the annual "pass-along" mandate of 100% of all rebates/monies received from Manufacturers to the patient in H.233 will be administratively burdensome to enact annually and inflate VEHI's administrative expenses.

This, in turn, will also put unwelcome pressure on premiums.

The retroactive payment requirement of 100% of all rebates received, as we see it, will necessitate a complicated and time-consuming adjudication process by PBMs, which must arrive at a precise amount owed to each patient for each claim covered by a rebate. The cost of these PBM services will be passed on to us, and eventually borne by schools, school employees and VSTRS in the form of higher premiums.

Increased cost with dispensing fees

VEHI and Blue Cross of VT have a competitive dispensing fee, paired with an AWP (Average Wholesale Price) plus Dispensing fee agreement, which is a different pricing agreement than the NADAC pricing in the bill. This could result in differences in the ingredient costs of medications, but a detailed analysis would

need to be conducted to determine the cost/benefit of this type of change. The Medicaid dispensing fee would increase our per-script cost by $10-15 dollars per script. At 300,000 prescriptions, this could easily increase our costs by $3 million, which would be another percentage point added to our rates.

Important points to take away from this testimony:

Around 30,000 of VEHI members are on our Gold CDHP, so the next few points below will be reflective of that plan design.

- Under the statewide bargaining agreement, all public-school employees have a Health Reimbursement Arrangement **that covers their entire Gold CDHP deductible and a portion of their coinsurance**.
- The maximum out-of-pocket exposure under the statewide bargaining agreement for all public-school employees ranges from $300 - $1,000 and that is **after** their $1,900 - $4,400 HRAs are exhausted.
- Because of the HRA administration on these plans, only those who have exhausted their HRAs would be eligible for any rebate within that $300 - $1000 window, which would be incredibly difficult to identify. (see example in addendum)
- VT has statewide caps on prescriptions of $1,600/$3,200 which in many cases would be paid with their HRA dollars. (see example in addendum)
- VEHI is non-profit. We have no shareholders. VSBIT and VT-NEA, the administrators of the pool, do not receive bonuses or incentives from rebates.
- ALL rebates received by VEHI directly offset our claims costs. Pharmacy rebates come through on a quarterly basis as a reduction on our weekly claims expense from our carrier, Blue Cross of VT. This reduces our expenses to benefit **ALL VEHI members**.
- Our FY 25 rates, which were filed with an average increase of 16.4%, had rebates assumed in the calculation, which is equivalent to 6% savings in premium. So, if the VEHI plan did not receive any of these rebates, the premium increase would have been 6% higher. We understand that some rebates would continue to come back to the plan (for example, once a patient has hit their out-of-pocket maximum and VEHI is paying 100% of the cost of the medication), but we do believe some level of premium increase would result in the loss of all rebates to the plan.

Members on a Silver CDHP plan (about 3,000 lives) with an HSA have an additional list of complications with this proposed retroactive benefit that we can address if needed.

Thank you again for trying to find ways to help Vermonters, but unfortunately the amended language in H.233 is inevitably going to drive costs for the great majority of school employees and their employers.

VEHI is acutely aware of the rising prescriptions costs, and we partner with Remedy Analytics to find cost savings and audit our PBM agreement. Our Board of Directors unanimously endorsed S.98 to expand the authority of the Green Mountain Care Board to set upper limits on high-cost medications.

Thank you again for your time, and we ask that you exclude VEHI from this bill.

Addendum

The examples below highlight the complexity of identifying the members responsibility (in yellow) and this is three out of thousands of scenarios based on plan design, employee segment, and the order of claims received.

Example: Licensed Teacher, Single Plan, Gold CDHP, $50,000 specialty drug - First claim of the year											
Specialty Drug $50,000	0 - $1,800	$1,801-$5,300	$10k	$15k	$20k	$25k	$30k	$35k	$40k	$45k	$50k
	Deductible	**Coinsurance**									
Plan Design	$1,800	80/20% of costs $1,900 - $3,500 up to $700 for member									
Member Cost w/out HRA*	$1,600	$0									
HRA paid by District	$1,600	$0									
Patient Pays	$0	$0									
VEHI Pays 80% coinsurance	$0	$0									
VEHI Pays 100% after 80/20%	$48,400										
*Rx has a $1,600 annual cap in VT											

Example: Licensed Teacher, Single Plan, Gold CDHP, $50,000 specialty drug - after some medical claims (ie: $1,000)											
In this example, the member would have already used $1,000 of the $1,900 HRA											
Specialty Drug $50,000	0 - $1,800	$1,801-$5,300	$10k	$15k	$20k	$25k	$30k	$35k	$40k	$45k	$50k
	Deductible	**Coinsurance**									
Plan Design	$800 remaining	80/20% of costs $1,900 - $3,500 up to $700 for member									
Member Cost w/out HRA*	$800	$700									
HRA paid by District	$800	$100									
Patient Pays	$0	$600									
VEHI Pays 80% coinsurance	$0	$2,800									
VEHI Pays 100% after 80/20%	$0	$0	$45,700								
*Rx has a $1,600 annual cap in VT											

Example: Non-Licensed Paraeducator, Single, Gold CDHP, $50,000 specialty drug - after some medical claims (ie: $1,000)											
In this example, the member would have already used $1,000 of the $2,200 HRA											
Specialty Drug $50,000	0 - $1,800	$1,801-$5,300	$10k	$15k	$20k	$25k	$30k	$35k	$40k	$45k	$50k
	Deductible	**Coinsurance**									
Plan Design	$800	80/20% of costs $1,900 - $3,500 up to $700 for member									
Member Cost w/out HRA*	$800	$700									
HRA paid by District	$800	$400									
Patient Pays	$0	$300									
VEHI Pays 80% coinsurance	$0	$100									
VEHI Pays 100% after 80/20%	$0	$0	$48,400								
*Rx has a $1,600 annual cap in VT											