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Testimony on H.233 An Act Relating to Pharmacy Benefit Management

Thank you for inviting me here today to speak about this important issue.

I do not have an academic health policy background, but I do have a background as a consumer of health care services. Specifically, my experience is as a person with high annual pharmacy claims — someone locked into the expensive, brand drug space. For me, pharmaceuticals have literally been a lifesaver. But the cost is high. More than I can afford. When you need an expensive medication, you really become acutely aware of just how dependent you are on the health care system. There's a certain amount of stress you carry with you. What if I somehow lose access to this treatment? Passage of the ACA was a huge relief — and gave me the courage to leave a stable job and to go to law school.

Lately, however, things seem to have taken a turn for the worse. Quickly, I want to share with you a story of a time when my access to medication was jeopardized. And it happened recently, with "good" health coverage that I have through my partner's employer.

For the 2022 plan year, I was required to use the specialty drug mail order pharmacy operated by my health plan's PBM. It was not a good experience. A few weeks before the plan year started, I received a letter informing me that drug manufacturer coupons would no longer count toward my deductible and out of pocket maximums. Since the coupion would not count, I told the pharmacy not to use it. But despite me telling to remove the copay assistance card from my account, they went ahead and used it anyway. At the same time, they took payments from me totaling my full maximum out of pocket for the year. Except I kept noticing balances on my account. By June, the PBM pharmacy insisted I owed them a couple thousand dollars.

I requested an accounting, which showed that they had collected the manufacturer copay assistance and were now insisting I pay them back for it. Again, despite me telling them not to use the coupon, and despite me having paying my out-of-pocket max in full. I spent many hours on the phone with them trying to get them to fix the problem. Eventually, in August of that year, they refused to send me my medication. Literally, if I would not pay them the money that I did not owe, they would not send me my medication. What did I do? I paid cash at a local pharmacy that month. But I also told my partner that he had to get his employer involved. And who wants to do that? Go to your employer to discuss something so personal. Luckily my partner has a good employer. And they did fix the problem.

[START SLIDES]

I tell that story not to be dramatic. But to emphasize that **regulation of PBMs is a consumer protection issue**. This isn't just a matter of saving our community pharmacies. PBM regulation is a consumer protection issue, too. When I was going through that ordeal with the PBM pharmacy, I spent a lot of time in online consumer forums, trying to gauge, am I the only one going through is? It was very little comfort to learn that no, I was not alone. There are many thousands of people out there being harmed by PBMs — maybe not with intent, but harmed nonetheless.

Act 131 was a major step forward. I think there is a tendency to think that Act 131 was mostly about PBM relations with pharmacies and health plans. But there were significant consumer protection provisions in Act 131 too:

- **Eliminated specialty pharmacy networks** by requiring that PBMs allow retail pharmacies to fill "all prescription drugs" regardless of whether the drug is considered by the PBM to be a specialty drug (Act 131, Sec. 4(b); 8 VSA 4089j(b))
- **Prohibited mandatory mail order and other PBM patient steering mechanisms**, including mail order solicitation and mail order incentivizing (Act 131, Sec. 4(d); 8 VSA 4089j(d))
- **Restricted mid-year formulary changes** (Act 131, Sec. 2; 18 VSA 9472(e))

- **Instituted consumer cost protections** by limiting the amount a PBM can require a covered person to pay for a drug to no more than cost sharing, MAC, or cash price, whichever is less (Act 131, Sec. 2; 18 VSA 9472(f))
- **Impliedly banned copay accumulator adjustment programs** (Act 131, Sec. 2; 18 VSA 9472(f)(2) & Act 131, Sec. 4, 8 VSA 4089j(d)(2))

All of these provisions are great consumer protections. Except Act 131 lacked an enforcement mechanism. There are limited levers DFR can pull to ensure compliance with the law.

Which is why the HCA is eager for you to take the PBM regulation issue up again with H.233. [NEXT] H.233 builds upon the progress made by Act 131. Incorporates all of Act 131's consumer protection provisions plus:

- Requires PBM licensure (for a fee) and provides for DFR enforcement, including fines of 25-50 k per violation;
- allows a private right of action for pharmacies, pharmacists, or "other persons" aggrieved by PBMs;
- allows HCA access to PBM data collected during DFR enforcement proceedings, providing for consumer-focused oversight outside of government.

The HCA supports these provisions of the bill. In addition, we are supportive of other provisions of the bill that merit further discussion. [NEXT]

The first provision I will discuss in detail is reimbursement of pharmacies at actual acquisition cost + a professional fee. In *principal*, the HCA supports reimbursing pharmacies at actual acquisition cost + a fee. Doing so just makes sense. If one goal of H.233 is to make the system more transparent, then reimbursing pharmacies at actual acquisition cost + a fee is a step in the right direction. [NEXT]

Last summer, I came across this report, *Unraveling the Drug Pricing Blame Game*, by trusted experts 3Axis Advisors.[1] If you have not read the report, it is well worth the time. Even just the executive summary is quite informative. Here's a snippet. "Our study found that the great harm from our system's current approach to drug pricing appears to be on patients."[2] They then go

[1] https://www.3axisadvisors.com/s/Unravelling_the_Drug_Pricing_Blame_Game_3AA_APCI_0923.pdf
[2] Unravelling the Drug Pricing Blame Game, page 3.

on to describe a system in which PBMs control reimbursement to pharmacies and where it is not uncommon for a pharmacy to reimbursed many different prices, for the same drug, on the same day. Sometimes higher than pharmacies' costs, often times lower. They go on to say … "While these disparate pricing experiences can have a significant impact on pharmacy providers and health plan sponsors, the most obvious and important impact is felt by the patient…"[3]

Reimbursing pharmacies at their actual acquisition cost + a professional fee would make drug pricing more rational and transparent. In practice though, we will need to have clarity on what the AAC is. Already we have a benchmark called NADAC — which is the "National Average Drug Acquisition Cost" — and NADAC is a reliable indicator of pharmacies' actual acquisition costs.[4] The state of West Virginia already requires that pharmacies be reimbursed at NADAC plus a dispensing fee.[5]

Further an analysis cited in *Unraveling the Drug Pricing Blame Game* shows NADAC prices are lower than the Wholesale Acquisition Cost by 4 to 5% on brands and by close to 50% on generics.[6] This should mean that patients, particularly during the deductible phase, will see lower costs. In summary, while the HCA is generally supportive of this provision — because we thinks it is less complex and more transparent — if we move forward, it will be important that consumers benefit from it through lower prices, or that they at least be held harmless.

To ensure that patients benefit, we propose adding language to § 3612(e) of H.233 (top of page 11). This is the provision from Act 131 that says that PBMs cannot require consumers to pay more than their cost sharing under the plan, the maximum allowable cost, or the cash price — whichever is less. We propose adding to that list the pharmacy's actual acquisition cost + dispensing fee. Patients should not be paying more for their medications than PBMs are reimbursing pharmacies. [NEXT]

Another provision I would like to discuss is rebate pass-through. H.233 contains language at 3612(e)(2) (page 11) — that a patient's cost sharing shall be calculated at point of sale based on a price that has been reduced

[3] Unravelling the Drug Pricing Blame Game, page 4.
[4] Unravelling the Drug Pricing Blame Game, pages 17-18.
[5] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/IB_22-03_PBM_Pharmacy_Reimbursement.pdf
[6] Unravelling the Drug Pricing Blame Game, page 18.

to an amount equal to 100 percent of all rebates received, or to be received, and that any remaining rebate in excess of the covered person's cost-sharing be passed on to the health plan to reduce premiums. Said simply, this provision would require all state-regulated plans in Vermont to be rebate pass through plans — with an important distinction, that first the rebate be applied to the patient's cost share

We support this language, because frankly, patients who are generating rebates for health plans should directly benefit from the rebate. Right now that is not the case. Currently, when a person is prescribed a medication by their doctor — imagine an expensive brand name medication for which the PBM is negotiating a rebate on behalf of the plan — in the deductible phase of the year, when the person has no coverage, that person will go to the pharmacy counter and pay the full list price for the drug, or close to it. So that's potentially a high out-of-pocket cost for the consumer, and an out-of-pocket cost that is inflated because of the rebate that the PBM negotiated. [NEXT]

DFR showed you an illustration of how rebating increases the cost to the system of brand name drugs. The example comes from a USC Schaeffer Center letter to the FTC, as cited in DFR's report.[7] It illustrates how, for a $100 drug with a $20 rebate, the system ends up paying $107.14 — for a drug that the manufacturer is willing to accept $80 for. First, we agree with the premise that rebating leads to higher list prices. A report from the same USC Schaeffer Center concluded that for every dollar of rebate, the list price of the drug goes up by $1.17.[8] The practice of rebating is driving up drug prices.

But there are a few problems with the Schaeffer Center's example — at least with respect to how patients experience rebates, particularly during the deductible phase of the year. The problem with the example is that in the person's deductible phase, unless this was a drug for which deductible was waived, then patient wouldn't pay $20 for the medication. They'd pay <u>at least</u> $100 for it – the full list price. And they'd likely pay more. [NEXT]

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[7] https://healthpolicy.usc.edu/wpcontent/uploads/2022/06/Van-Nuys-et-al.-Public-Comments-to-FTC-on-PBMs.pdf

[8] https://healthpolicy.usc.edu/wp-content/uploads/2020/02/SchaefferCenter_RebatesListPrices_WhitePaper-1.pdf

First, the drug's list price is stated to be $100. And as you heard DFR testify, the list price is the WAC — wholesale acquisition cost. But there are actually two list prices: WAC and AWP – average wholesale price.[9] You can think of AWP as more like the sticker price on a new car and the WAC as close to what the dealership actually paid for the car. But not quite. Because we have NADAC, we know that pharmacies actually acquire brand name drugs at WAC minus 4%.[10] Therefore, this $100 drug cost the pharmacy $96 to acquire.

Next, we know that PBMs typically negotiate contracts with pharmacies and health plans based AWP.[11] So the health plan might agree to reimburse the PBM for brand drug pharmacy claims at a discount off of AWP. In this example, the health plan negotiated a 15% discount off AWP — which the patients does get the benefit of at the pharmacy counter when they go to pick up their drug. You can see they paid $102, which is the AWP of $120 minus 15%. But even with that discount, the patient pays $2 more than the WAC. In fact, the patient pays more than anyone else for this drug. Indeed, the patient is the only one paying for the drug in this example.

Remember we also heard that Vermont has a low pharmacy out of pocket max of $1,600. And that is accurate, with the important caveat that there are bronze plans without the separate Rx limit, where Rx out-of-pocket costs can exceed $9,000 for an individual.[12] But for the most part, there is this $1,600 out of pocket max. And in many cases, the prescription deductible is equal to the prescription out-of-pocket max. Back to the example of a $100 drug — depending on the plan — this person could go the entire year without getting any coverage for the drug, paying that full $102 every month and still not reaching their deductible. Meanwhile, the plan retains an $18 rebate every month.

Also keep in mind, the patient is paying premiums every month for the benefit of having *essentially* no coverage. Premiums are listed in the original example at $87.14, but not many people are paying so little each month. Even the cheapest bronze plans are roughly $750 a month. I listed $500 as a realistic amount a person might pay each month in premiums — maybe for a marketplace plan with a subsidy or with an employer

[9] Unravelling the Drug Pricing Blame Game, pages 14-17.
[10] Unravelling the Drug Pricing Blame Game, page 18.
[11] Unravelling the Drug Pricing Blame Game, pages 19-22.
[12] https://info.healthconnect.vermont.gov/sites/vhc/files/documents/2024_PlanDesigns_FinalRates.pdf

contribution. Back to the example, if this person needed this medication every month — it's a chronic condition — they would be paying out $500 a month in premiums — or $6,000, get 12 fills of this drug in a year — never getting coverage for it. In sum, paying an additional $1,224 for the medication that the manufacturer only nets $960 for and that the PBM and the plan share a $20 rebate each month totaling $240.

That is why the HCA supports the concept of rebate pass through at point of sale to consumers that is contained in H.233, and believe, if a patient is generating a rebate for a health plan, they should benefit from it.

I anticipate that you are going to hear testimony later in the week to the effect that rebate pass through at point of sale would drive up premiums for everyone else. Here is why I think that argument is overstated. Remember that the rebate only passes through to the patient to the extent the patient has a cost sharing obligation. In our oversimplified example above, the patient has cost sharing every month, and so the $20 would pass through to the patient. But a more realistic example, when we are talking about high-cost brand name drugs —as you heard DFR say, that patient is likely to hit their deductible and out-of-pocket max early in the year. Therefore, the max of any rebate pass through to the patient for the year would be $1,600. Consider that $1,600 is really a small amount of money in the world of high-cost brand name drugs — for drugs that are $10,000 a year, $50,000 a year, $100,000 a year, the health plan will still retain the vast majority of any rebate earned in those circumstances.

The final provision I will address are copay accumulator adjustment programs. [NEXT] H.233 would affirmatively ban copay accumulator adjustment programs in Vermont, and we support making this change.

First, what is a copay accumulator adjustment program? A copay accumulator adjustment program is when a health plan decides <u>not</u> to allow manufacturer copay assistance to count toward a patient's deductible and out of pocket max. Why is it called an adjustment? Because at first the copay assistance appears to count — it shows up in your accumulators — but then the PBM subtracts it out. [NEXT] Erasing any benefit to the patient. But notably, reducing the insurer's costs. [NEXT]

What is the status of copay accumulators under current Vermont law? We are not one of the 19 states to have an affirmative ban on the books. What

we have is the language from Act 131 that says any amounts paid by a covered person must count toward any deductible and out of pocket maximum. In their Act 131 report, DFR said, "read in a light most favorable to patients, the statutory language *suggests* that Vermont health plans must apply copayment assistance to patient deductibles."[13] To me that sounds like an implied ban. [NEXT] But since "in the light most favorable to patients" isn't a legal standard — from a patient perspective, it would be far better to make the statutory language clear that any amounts paid by or on behalf of a covered person must be applied to any deductible and out of pocket max; and that includes any third party payments, financial assistance, discounts, coupons, etc… And that is exactly what H.233 says in two place: § 3612(e)(3) which amends 18 VSA 9472(f)(2) and an amendment to 8 VSA § 4089j.

The HCA strongly supports this language that would *affirmatively* ban copay accumulator adjustment programs in Vermont. And let me explain why. [NEXT]

First to the point, that for patients — these things (drug manufacturer copay assistance cards) are great, because you get access to an expensive brand name drug — and because Vermont has a low prescription out of pocket max — before you know it, the patient has hit the limit, and they don't have to worry anymore. To that, I would say yes, that is exactly the point: copay assistance enables patients to access expensive, but in many cases lifesaving or at least life improving, medications — so they don't have to worry about it anymore, or at least until next January. And when you have a chronic illness, that's huge, to not have to worry. Therefore, that's one reason we support a copay accumulator ban.

Another point raised in previous testimony, from the health plan / PBM's perspective — with the coupon, the patient is going to take an expensive brand name, when they could just be taking a generic. But that's not really the case. Data shows that manufacturer copay assistance greater than 85% of the time is utilized when there is no generic equivalent.[14]

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[13] Vermont Department of Financial Regulation, Act No. 131 (2022) Report: Pharmacy Benefit Management (Jan. 15, 2023) at 35, *available at* https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Reports%20and%20Resources/W~Department%20of%20Financial%20Regulation~Act%20131%20(2022)%20Report-%20Pharmacy%20Benefit%20Management~1-16-2023.pdf

[14] https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

Furthermore, when generics do enter the market, that copay assistance tapers off.

You heard additional testimony, again from the health plan/PBM point of view, that issuing coupons is what manufacturers do if they don't get the placement they want on a PBMs formulary, and that by giving people coupons the drug manufacturers can circumvent or undermine the PBMs formulary. But that's not right either. First, brand name drugs tend to have copay assistance available — particularly where there are multiple brands competing in a therapeutic class and with little to no generic competition. It is just as likely that a drug with "preferred placement" has copay assistance available, as it is that a non-preferred brand has copay assistance available. Also, preferred or not preferred, the drug is on the formulary. If it's not on the formulary, then the person doesn't have coverage for the drug, and they can't use the coupon. They can only use the coupon if the drug is on the PBM's formulary. Further, any utilization management the PBM has in place — step therapy or prior authorization — all of that remains in place. Copay assistance does not circumvent utilization management or undermine formularies.

Remember, all that preferred or not preferred means is that one drug has offered the PBM a bigger rebate than the other. It does not mean the preferred drug is therapeutically better for the patient — which really should be a decision between doctor and patient anyway.

Lastly you heard that drug coupons drive up premiums. I also need to disagree with that. The experience of states that have enacted copay accumulator adjustment bans, meaning, where coupons must count, shows that after bans were enacted, there was no noticeable impact on premiums.[15] And here in Vermont — our two marketplace insurers have indicated in conversation that they already allow copay assistance to count. Meaning adopting the language in H.233 simply formalizes in law a situation that's already in practice on the ground. Therefore, there would be no change to premiums. But there would be peace of mind for patients – that their health plan could not simply decide to change that policy at any moment. [NEXT]

That concludes my testimony for today. Thank you for your time.

[15] https://aidsinstitute.net/documents/Copay-Assistance-Does-Not-Increase-Premiums-Final.pdf