February 27th, 2024

The Honorable Lori Houghton
Members, House Committee on Health Care
109 State Street
Montpelier, VT 05609

RE: H 233 - An act relating to pharmacy benefit management and Medicaid wholesale drug distribution; Opposed

Chair Houghton, and Members of the Committee,

On behalf of the Pharmaceutical Care Management Association (PCMA), we wish to share comments related to H 233. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state, and federal employee benefit plans, and government programs.

H 233 proposes several wide-ranging and costly changes to the pharmacy market in Vermont. Although the assumption is this assault on pharmacy benefit managers will lead to lower drug costs for the consumer, these changes do nothing to lower consumer drug costs. In fact, the passage of H 233 will place added costs onto Vermonters while subsidizing for-profit pharmacies. Specifically, the bill:

- Ban spread pricing contracts.
- Require rebates to be offered to patients at the point of sale.
- Require copay coupons be applied to a patient's deductible and out-of-pocket maximums
- Creating a private right of action

We believe that H 233 will have a detrimental impact on pharmacy benefit services in the State of Vermont.

Ban spread pricing contracts

PBMs offer payer clients a variety of contractual options to pay for PBM services, and they choose the one that is best for them based on the services they need and their plan membership. Each client evaluates and determines the financial arrangement that meets their specific needs for PBM services. One option for clients is to elect a pass-through pricing arrangement for pharmacy reimbursement. Under a pass-through contract, the reimbursement negotiated with the retail pharmacies is passed along to the client to pay, and the PBM collects

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

fees from the client to pay for the entirety of the services it performs for the client. In this case, there would be no difference between what the client pays the PBM and what the pharmacy is reimbursed by the PBM. This approach may involve more variation in cost along with drug price fluctuation due to drug shortages, patent expirations, and other market pressures.

Another option for clients is spread pricing. In spread pricing, clients choose a financial arrangement for pharmacy reimbursement where the price paid to the pharmacy by the PBM may not equal the price billed to them. In this case, the difference in the amount paid by the client to the PBM and the amount the PBM reimburses a pharmacy is how the PBM is paid for the services it provides to the client. Many clients choose a spread pricing arrangement because it achieves a pricing level guarantee to the client. It provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Employers and plan sponsors often want to maintain this option in the marketplace because they do not want to pay per member or per claim fees for the services provided by the PBM. Reducing contracting options will ultimately reduce employer and health plan flexibility to contract in the best way to meet their needs.

The Department of Medicaid in Ohio released an Executive Summary Assessing the Impact of Pass-Through Pricing. HealthPlan Data Solutions Inc. (HDS) released a report with data that shows the Ohio Medicaid switching to a pass-through model increased prescription drug spending in the State. “HDS found that the implementation of pass-through was associated with a 5.74% increase in amounts paid to pharmacies between Q4 2018 and Q1 2019. This is an increase of $38.4M in payment to pharmacies.”[1] In other words they are spending more money paying pharmacies, on top of now paying administrative fees. Also, the report notes that PBMs spend about $50 million per quarter administering the pharmacy benefit. Which means we are looking at over $238 million spend, which is more than the amount of spread we retained (about $225 million).

We request that you strike Section 3612 (f) for the reasons mentioned above and allow plans to continue to have the choice to select their contracts to pay for drugs.

Require rebates to be offered to patients at the point of sale

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. One fundamental way PBMs help consumers obtain lower prices for prescription drugs is by negotiating rebates (discounts) with drug manufacturers. Negotiations between PBMs and manufacturers are the only tool to leverage competition and drive lower drug costs. Rebates are typically used to keep costs down

[1] Corcoran, M. (2019, September). Executive Summary: Assessing the Impact of Pass-Through Pricing. https://owl.purdue.edu/owl/research_and_citation/mla_style/mla_formatting_and_style_guide/mla_works_cited_electronic_sources.html#:~:text=Cite%20web%20postings%20as%20you,author%20name%20is%20not%20known.

PCMA

across the board as employers and other plan sponsors use the savings from rebates to lower premiums for everyone. While point-of-sale rebates are possible under specific plan designs, the plan sponsor should determine the decision to apply rebates at the point-of-sale or as a hedge against rising premiums.

When considering mandatory POS rebates, it is crucial to keep in mind that:

1. Rebates have consistently been shown to save consumers money: Recently, the Centers for Medicare & Medicaid Services (CMS) found that a federal proposal for POS rebates in Medicare Part D would increase premiums by up to 25% and increase drug spending by $196 billion. [2]
2. Under the federal proposal, CMS actuaries predicted manufacturers would keep at least 15% of what they would have offered in rebates and also found that drug spending would increase by $137 billion as they would have little incentive to lower their list prices.[3]
3. Mandatory POS rebates under the federal proposal would provide drug manufacturers a $40-$100 billion windfall.[4] The fact that drug manufacturers applauded a federal proposal to restructure rebates should reinforce that manufacturers, not consumers, taxpayers, and employers, would be the real winners.

Additionally, mandatory POS rebates would require releasing confidential information that inadvertently discloses actual rebate amounts. Eliminating this type of confidentiality of rebate levels and undermining the negotiating power held by payers, including employers, would inhibit a PBMs' ability to negotiate a better price for consumers. As CMS noted in their assessment of a federal proposal, rebates would be reduced by 15%,[5] meaning consumers pay more. Finally, the FTC has long stated that "if manufacturers learn the exact amount of the rebates offered by their competitors…the required disclosures may lead to higher prices for PBM services and pharmaceuticals." [6]

Therefore, we request you strike Section 3612 (e)(2) as it will ultimately increase the prices that all pay for health care and prescription drugs.

---

[2] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

[3] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases

[4] CMS Office of the Actuary, "Proposed Safe Harbor Regulation" (August 30, 2018).

[5] A recent study, *Reconsidering Drug Prices, Rebates, and PBMs*, shows manufacturers alone set prices—independent of rebates. The study highlights top-selling Medicare Part D brand-name drugs (with steady price increases and no change in rebate levels) and Medicare Part B drugs, which have no negotiated rebates but extraordinary price increases.

[6] FTC, "Statement of the Federal Trade Commission Concerning the Proposed Acquisition of Medco Health Solutions by Express Scripts

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

Require copay coupons to be applied to a patient's deductible and out-of-pocket maximums

The unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays, and deductibles. While health plans pay the vast amount of their members' prescription drug costs, drug manufacturers' price increases have forced health plans to be selective in the drugs they will cover and create benefit designs that incent patient choice for the lowest-cost drug that treats the condition experienced. Copay coupons may come in the form of a coupon, debit card, or some other arrangement.

Drug manufacturers encourage patients to disregard formularies and lower-cost alternatives by offering "coupons" to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternative drugs such as generic drugs (with low copays) and toward more expensive brand drugs (with high copays) or more expensive brand name drugs, ignoring potentially equally or more effective and less expensive alternative medications. By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still allowed in the commercial market.

Copay accumulator programs are health plan programs designed to thwart drug manufacturers' efforts to force employers, unions, and public programs to pay for expensive, unnecessary brand medications through the use of copay coupons. Accumulators typically disallow the counting of the manufacturer's coupon towards the patient's out-of-pocket max and deductible because the patient hasn't actually incurred the cost. This ensures that the patient is incentivized to use the plan formulary and that the plan functions as designed.

Here are the facts when it comes to manufacturer coupons:

- The prices for drugs with manufacturer coupons increase faster (12-13% per year) compared to non-couponed drugs (7-8% per year).
- If Medicare's ban on coupons were not enforced, costs to the program would increase by $48 billion over the next ten years.
- For every $1 million in manufacturer coupons for brand drugs, manufacturers reap more than $20 million in profits (20:1 return).
- A 2020 study by the Commonwealth of Massachusetts Health Policy Commission, estimates that coupons increased premiums in the Group Insurance Commission program by $18 for a single premium and $52 for a family - increasing costs by over $44 million in excess spending.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

Supporters of coupons say that they decrease costs for patients. While they can decrease an individual patient's cost at the pharmacy counter, the patient and the plan ultimately pay more overall. Coupons are temporary—the individual patient likely pays more when the coupon goes away instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.

PCMA does not oppose true means-tested patient assistance programs that help individuals afford prescription drugs. There is an important difference between means-tested patient assistance programs and copay coupons, which are targeted to individuals with health insurance.

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to increase copay assistance rather than just making their medications more affordable. The simplest, most effective way to reduce patient costs on drugs is for manufacturers to drop the price of the drug. State legislation that seeks to disallow the use of accumulators eliminates an essential tool in the fight against rising pharmaceutical costs.

Therefore, we request you strike Section 3612 (e)(3)

Creating a private right of action

The language of Section 3613 of H 233 is both unclear and troublesome. On the one hand, the section appears to create a private right of action on behalf against PBMs. On the other hand, in its entirety, the language of this section is superfluous in that it appears redundant by restating the judicial process for a private entity to initiate a lawsuit. Such prescriptive language also raises concerns over the separation of powers. In such a scenario, the judicial process should be left to the purview of the judiciary.

Moreover, this section would encourage pharmacies (including those owned by large health systems) — who are market competitors of PBMs and health plans — to file frivolous lawsuits aimed at disrupting the business operations of payors and the normal contracting process between PBMs operating in Vermont. The state would be placing its finger on the scale and distorting relationships between competing private stakeholders. It would be favoring one discrete special interest group to the detriment of PBMs. Resulting in higher plan costs stemming from frequent and ruinous litigation. In turn, this state-imposed distortion would likely result in higher premiums or narrower benefits for beneficiaries in the state. It could also increase the cost of doing business for major employers in Vermont who seek to offer drug benefits.

Therefore, PCMA respectfully requests that the language of section 3613 be struck from the bill.

***

We stand ready to work with the committee to find ways to ensure access to affordable prescription drugs in Vermont, but not at the expense of Vermont citizens. We urge you to consider our suggestions above in H 233. Thank you for your consideration.

Sam Hallemeier

Senior Director, State Affairs
shallemeier@pcmanet.org
(202) 579-7647
Pharmaceutical Care Management Association