BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

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Representative Houghton, Chair
Representative McFaun, Vice Chair
Representative Black, Ranking Member
Representative Berbeco
Representative Carpenter
Representative Cina
Representative Cordes
Representative Demar
Representative Farlice-Rubio
Representative Goldman
Representative Peterson

Dear Chair Houghton and Members of the House Health Care Committee,

Blue Cross VT appreciates the revisions to the Pharmacy Benefit Management bill, **H.233** (version 1.2), which addresses multiple concerns expressed by stakeholders.

There are several proposals in the new draft that have concerning impacts and will add to the financial pressure of high prescription drugs costs for our members.

Individual Payment at Point of Sale § 3612. (e)(1)(D) page 10

The bill now adds to the list of calculations of the amount a person filling a script at a pharmacy many not "pay an amount greater than the lesser of" the National Average Drug Acquisition Cost (NADAC) plus a reasonable dispensing fee. The inclusion of this criteria does not line up with any other methodology for paying pharmacies. **Adding a new pricing methodology (NADAC + dispensing fee) may create situations where an individual benefits, but there is also an offsetting cost to implement the new calculation.**

Manufacturer Rebate Refund § 3612. (e)(2)(A) & (B) page 11

The new proposal to pass through manufacturer drug rebates to individuals annually (instead of at the point of sale) **creates a different set of administrative challenges and costs; will result in inequities among patients with similar situations; and will benefit individuals to the detriment to all people contributing through premiums to pay for prescription drugs in their risk pool.**

Practical concerns:

- The proposal to have health plans “pass along” rebates to the covered person annually seems to require payments to members for their out-of-pocket expenses related to prescriptions when rebates are paid. This will require developing a new program to track individual patients, out-of-pocket expenses tied to drug manufacturer rebates, and potentially issue checks post-plan year. This will come with significant administrative and IT costs that will put further pressure on premiums.
- While the data on the rebate amounts will be more accurate with a once-a-year accounting that falls at least a quarter after the end of the plan year, it will still be incomplete in some instances as rebate collections can occur many months after a claim pays.
- The qualified health plans sold on the Exchange must meet federal actuarial value “AV” requirements – the measure of how much of the benefit is paid by the plan and how much by the insured. (For example, an 80% AV value plan on average must have 20% of the costs paid for out-of-pocket, with 80% covered by the health plan.) Requiring the health plan to “pass along” rebates recalibrates this balance, and therefore the cost-sharing requirements for other services will need to be increased to offset the shift in rebates from premiums to out-of-pocket costs.

Equity concerns:

- Two patients, taking the exact same medication with identical health plan benefits and the same out-of-pocket costs, will not both receive the rebate benefit if one filled their prescription through a 340b pharmacy, or there was another manufacturer denied a rebate payment. 340b pharmacies are not required to, and do not, pass along discounts to commercial plan members.
- Patients with high-cost drugs for which no rebates are available will receive no benefit and have higher premiums due to the shift of the monetary value of rebates from the group to individuals.
- Many drugs which qualify for manufacturer rebates are very high-cost and the premiums and out-of-pocket expenses paid by the individual member do not begin to cover the price of the drug. Individuals will receive benefits in greater proportion to their financial contribution, than other individuals who collectively cover the total cost of prescription medications.

Manufacturer Payment, Coupon, Discount or Financial Assistance applied to the Deductible and Out-of-Pocket Maximum § 3612. (e)(3)(A) page 11 and Sec. 3. 8 V.S.A. § 4089j (d)(2)(F) on page 26

Blue Cross VT applies the manufacturer coupon to the member's deductible and OOP drug maximum and does not utilize co-pay accumulators. Because manufacturer coupons are used to offset out-of-pocket cost share as a means of incentivizing patients to choose certain drugs often with a higher overall cost,[1] **Blue Cross VT requests consideration of a prohibition on the use of drug manufacturer coupons if there is a generic equivalent drug available.** This provision has been in Massachusetts statute (section (2)) since 2012 and is NCOIL model language (National Council of Insurance Legislators page 10 and 11). The addition of the NCOIL model language on HDHPs (§ 3612. (e)(3)(B) page 12) is appreciated.

Prohibition on Spread Pricing between the PBM and the Pharmacy § 3612. (f) page 12

This proposes to eliminate spread pricing for PBMs. **Blue Cross VT opposes a prohibition on spread pricing because this will increase the cost of PBM services/drugs for members, but appreciates the changes to allow sufficient lead time to implement these provisions.**

Blue Cross VT is concerned about legislation that will increase the financial pressure of high prescription drugs costs for members.

[1] "Also, some studies[7,8] found that **coupon use can induce demand for brand-name drugs by 60% or more by reducing the sales of generic drugs**." Patterns of Manufacturer Coupon Use for Prescription Drugs in the US, 2017 – 2019 JAMA Network, May 16, 2023.