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,

This contains information and concerns regarding **H.233 Pharmacy Benefit Management** legislation under consideration.

Blue Cross VT is a small, local, not-for-profit health plan that is not vertically integrated with any pharmacy benefit manager (PBM) or pharmacy chain. Currently, a vendor contract with a PBM (Optum Rx) supports the provision of pharmacy benefits for our members and customers. Through the affiliation with Blue Cross Blue Shield of Michigan, also a single-state nonprofit health plan which also engages the same PBM, Blue Cross VT expects to achieve efficiencies and economies of scale by collaborating over time.

There are several proposals in this legislation that have concerning and/or significant cost impacts for our members whose premiums pay for the costs of health care services, including prescription drugs. These are our major areas of concern:

DFR Regulation of PBMs § 3603, § 3604, § 3611

Blue Cross VT is neutral on moving from a system of state registration to state licensing of pharmacy benefit managers.

Manufacturer Rebate at the Point of Sale § 3612. (e)(2) page 11

Blue Cross VT opposes passing through the manufacturer drug rebate at the point of sale for practical reasons. Rebates are not paid to the health plan at the time of the prescription is filled at the pharmacy. The health plan receives the rebates quarterly

from the PBM, based on the claims submitted during the previous quarter. **The exact amount of the rebate, or if a rebate will be paid, is not known at the point of sale.**

Furthermore, rebates are not paid for a specific drug in all situations that cannot be determined at the point of sale. In one example: manufacturers do not pay rebates for prescriptions filled through the 340b program. The Vermont Legislature has added a prohibition in statute of identifying to the PBM if the prescription drug is for a drug being filled using the 340b drug program 18 V.S.A. § 9473(g), unless the claim is for VT Medicaid. Therefore, it cannot be known if a rebate will be paid for the prescription. There are additional situations where rebates are not paid that cannot be determined at the point of sale.

Manufacturer Payment, Coupon, Discount or Financial Assistance applied to the Deductible and Out-of-Pocket Maximum § 3612. (e)(3) page 11; language also on page 26 (F)

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] These consumer choices collectively drive up pharmaceutical costs. Mandating that these amounts be attributed to the deductible and state out-of-pocket (OOP) maximum, is an additional inducement for patients to choose higher cost prescriptions with a false sense of savings. **In practice, Blue Cross VT applies the manufacturer coupon to the member's deductible and OOP drug maximum and does not utilize co-pay accumulators.**

There has been important research on the impact of drug manufacturer coupons and the impact on health system costs. Notably:

> "This study builds on existing literature showing that coupons are provided to serve manufacturers' commercial interests. Manufacturers' decisions to provide coupons can have distinct but interrelated impacts on patient, payers, and health systems. For price-sensitive patients, coupons can lower their out-of-pocket expenses in the short run and enable them to fill their prescriptions. However, for payers, these coupons can increase demand for high-cost drugs and place a greater financial burden on prescription drug spending. Furthermore, manufacturers may be disinclined to offer universal rebates for the drug to payers if they can generate revenue by targeting individual patients with coupons. If it is the

[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.

> case, manufacturers may have less incentive to reduce prices, resulting in a greater financial burden on health systems."
>
> Patterns of Manufacturer Coupon Use for Prescription Drugs in the US, 2017 – 2019 JAMA Network, May 16, 2023.

Several states, including Massachusetts and California, have passed legislation to improve the benefits of coupons for patients and reduce inefficiencies in the pharmaceutical marketplace. Vermont should consider these policies.

It is illegal for drug manufacturers to offer coupons for people covered by Medicare and Medicaid. The anti-kickback statute prohibits the knowing and willful offer of payment or remuneration to a person to induce the purchase of any item or service for which payment may be made by a federal health care program. It is ironic that this legislation considers requiring in statute for prescription drugs covered through commercial health plans what is prohibited and illegal in federally-funded health plans.

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

PBMs generate revenue on the difference between the price they pay pharmacies for drugs and the amount health plans pay the PBM for our member's drugs. Similarly, pharmacies generate revenue on the amount of money they pay wholesalers for the drugs, and the amount that PBMs pay pharmacies. These are two examples of "spread pricing" in the drug supply chain.

This bill proposes to eliminate the first example as a means of revenue for PBMs, while continuing to allow pharmacies to generate revenue from their spread pricing. **Blue Cross VT opposes a prohibition on spread pricing because of our concern about increasing the cost of PBM services for our members.**

In addition, a ban on spread pricing will create significant disruption, as the financing system for prescription drugs between the health plan and the PBM will need to be renegotiated. Implementing these changes on a short time frame, in the middle of an existing PBM contract, and mid-way through a plan year, all raise serious concerns about the impact. This provision should only be effective upon the execution of a new contract, and at the start of a calendar year, with sufficient lead time to incorporate the financial impact of these changes into health plan rates and self-funded employers to budget for these changes.

PBM Denies an Appeal then Pharmacy May Direct Bill the Health Insurer § 3631 (d) page 22

Blue Cross VT opposes allowing a pharmacy to avoid the outcome of a denied appeal by charging the health plan and mandating payment. There are no other instances where a legal process may be overridden by mandating payment from a third party. Pharmacies should be required to follow the same legal process as all other aggrieved entities. **This will increase costs for members.**

PBM Pay Pharmacy Actual Acquisition Cost + VT Medicaid Dispensing Fee § 3631 (e) page 22

Blue Cross VT opposes mandating the price the PBM must pay a pharmacy and mandating the VT Medicaid dispensing fee ($11.13 for generic and brand traditional drugs and $17.03 for specialty drugs). Furthermore, DVHA's pricing methodology includes the lower of many benchmarks, only one of which is Actual Acquisition Cost (AAC).

- We do not know the impact of the pricing proposal could have on overall reimbursement to pharmacies. This will increase claims payments to pharmacies and the financial impacts to QHP, teachers and State of Vermont employees should be carefully studied before passing mandated cost increases.
- This provision benefits all pharmacies and is not targeted toward the remaining 18 independent local pharmacies. Chain pharmacies, PBM-affiliated pharmacies, and pharmacies out-of-state would all benefit from the increase in revenue from the mandated pricing and dispensing fees.
- A change of this magnitude requires modeling and analysis of the impact on costs to self-funded employer groups and impact on premiums.
- **Matching VT Medicaid's dispensing fees alone would increase prices for Blue Cross VT members by over $10 million per year.**

Patient Consent 8 VSA § 4089j. (e) page 27

Blue Cross VT supports patient consent before changing a drug order and pharmacy location, but have two concerns:

- Please ensure that this does not undermine the generic or biosimilar substitution laws, and;
- Prevent a practice or facility from requiring that patient prescriptions be filled at an in-house retail pharmacy.

In conclusion

Drug costs for Blue Cross VT members grew by an astounding 24.9% last year (2022 to 2023). Higher drug costs are paid for by patients through higher premiums and higher out-of-pocket expenses. A portion of the last year's eye-popping increase is from drug manufacturer price increases, but a portion of the cost growth is also attributable to the policies included in Act 131, relating to pharmacy benefit management, passed in 2022.

Blue Cross VT opposes adding to the financial pressure of high prescription drugs costs for our members by adding policies which result in higher costs.