VERMONT LEGAL AID

Office of the Health Care Advocate
264 North Winooski Ave., Burlington VT 05401
Toll Free Hotline: 800-917-7787
www.vtlawhelp.org/health ▪ Fax: 802-863-7152

April 16, 2024

Vermont Senate Committee on Health & Welfare
Senator Virginia Lyons, Chair
155 State Street
Montpelier, VT 05602

RE: Health Care Advocate Comments in Support of House Bill 233

Dear Chairwoman Lyons and Members of the Committee:

Thank you for inviting me to testify about this important bill. On behalf of the Office of the Health Care Advocate, I write to express our support for H.233, an act relating to licensure and regulation of pharmacy benefit managers. H.233 will strengthen Vermont's oversight of PBMs, shrink the proverbial black box, and help Vermonters struggling with high drug prices. We encourage you to pass H.233 with only one small change, which I will address.

I have been listening to your committee discussion throughout the session, so I know at least two things that are important to this committee: 1) a desire to do something now to address high drug prices; and 2) wanting to make good use of limited state resources. H.233 meets both of those aims.

H.233 addresses high drug prices in at least two ways.

First, H.233 bans copay accumulator adjustment programs. That is, the bill bans the harmful practice of *not* counting manufacturer copay assistance toward deductibles and out-of-pocket maximums.

I will concede that copay assistance does not bring down drug costs for the system; importantly, copay assistance also does not raise costs for the system.[1] However, copay assistance does lower drug costs for patients who use it, and it does so right now. When the patient leaves the pharmacy with their medication

[1] The AIDS Institute, *Comparison of Marketplace Average Benchmark Premiums Between States With and Without Copay Accumulator Adjustment Bans* (May 2023), https://aidsinstitute.net/documents/Copay-Assistance-Does-Not-Increase-Premiums-Final.pdf

having used copay assistance, they have more money in their pocket because of it—money to buy food, pay rent, or keep in savings.

Copay assistance is sometimes described as a bandage on a bleeding wound. The comparison is fair. When you are bleeding from high drug costs, though, if there is a bandage handy, you are going to put it on. Actually stopping the bleeding, that is a systemic issue that individual patients are not in a position to fix, unfortunately. Part of the problem is that we have a drug distribution system fueled by rebates. Those rebates, which PBMs aggressively negotiate for, drive up drug prices—that's a fact.[2] H.233 in its current form does not address the rebate issue. For the foreseeable future, we will continue to live in a world where everyone is clamoring for a rebate—which has the effect of keeping drug prices high. Therefore, patients need copay assistance, and they need it to count.

H.233 secures that lifeline for patients by requiring PBMs to count all payments made by or on behalf of a covered person. It also blunts the criticism that drug manufacturers use copay assistance to lure patients to expensive brand name drugs by including language that copay assistance does not have to count when there is a generic equivalent available. This compromise language was added, I believe, at the request of our Vermont insurers. It strikes a fair balance, and we hope you will support it.

H.233 also addresses high drug prices by banning spread pricing. Meaning, if enacted, pharmacy benefit managers would no longer be allowed to charge their health insurer clients more for prescription drugs than they reimburse pharmacies for those drugs.

Will banning spread pricing solve the problem of high drug prices? No, it would be a very modest step. However, it stands to reason that if insurers are no longer overpaying a few dollars per prescription, there will be *some* savings. PBMs, of course, will be compensated for their work in other ways, through fees. But what banning spread pricing does, more so than any modest savings, is to make the system more transparent. Spread pricing is one of the tools in the PBMs' black box. By definition, health insurers do not know the precise spread on a per transaction basis, and so neither do regulators and policymakers. H.233 takes spread pricing out of the black box and makes that black box just a little bit

[2] A study by the University of Southern California Schaeffer Center concluded that for every dollar of rebate, the list price of a drug goes up by $1.17. Neeraj Sood, PhD et al., Leonard D. Schaeffer Center for Health Policy & Economics, *The Association Between Drug Rebates and List Prices* 1 (Feb. 2020), https://healthpolicy.usc.edu/wp-content/uploads/2020/02/SchaefferCenter_RebatesListPrices_WhitePaper-1.pdf

smaller. The HCA supports the ban on spread pricing, as at least 12 states have already done.[3]

Clearly there is more that could be done to address high drug prices. H.233 as introduced had some of those good ideas—including requiring rebates to be passed through to beneficiaries and plan sponsors; also, requiring that PBMs reimburse pharmacies at their actual acquisition cost plus a professional fee. Those were ideas with merit. Nevertheless, H.233 is a major step forward.

H.233 makes careful use of limited state resources.

The major innovation in H.233 is to advance Vermont's regulation of PBMs from a registration model to a licensure model, with express provisions for DFR enforcement, including very importantly, funding for three new positions at DFR—full time staffers who will be responsible for ensuring PBM compliance with Vermont law. How is this fiscally responsible?

First, the licensure model is designed to raise the revenue to pay for itself. The licensure fees have been structured to pay for the new positions. In the ramp up period, the funding for these positions comes from money that DFR already generates by regulating banking and insurance in the state.

Next, as you heard from DFR, licensure gives their enforcement teeth. H.233 gives the commissioner of DFR authority to audit PBMs and to levy fines for failure to comply with Vermont law. What those three new staffers at DFR are likely to find is that PBMs are not faithfully adhering to Vermont law. And so there will be ample opportunities to levy fines. West Virginia, which also has a licensure model, for example, levied fines against PBMs of $270,000 in 2022[4] and $74,000 in 2023.[5]

Fining PBMs for failure to comply with the law should get them to come into compliance. While that would mean there are fewer fines, it would also mean that PBMs are complying with the law. Our laws are designed to save Vermonters money—to save independent pharmacies money, to save health insurers money,

---

[3] Nat'l Acad. for State Health Policy, *State Pharmacy Benefit Management Legislation*, https://nashp.org/state-tracker/state-pharmacy-benefit-manager-legislation/ (last updated Nov. 7, 2023).
[4] W.V. Ofcs. of the Ins. Comm'r, 2022 Annual Report at 27, https://www.wvinsurance.gov/Portals/0/pdf/reports/2022_OIC_Annual_Report.pdf?ver=2023-07-26-090913-770
[5] W.V. Ofcs. of the Ins. Comm'r, 2023 Annual Report at 26, https://www.wvinsurance.gov/Portals/0/pdf/reports/2023_OIC_Annual_Report.pdf?ver=2024-04-03-174239-027

to save consumers money. Getting PBMs to follow the law, which licensure and enforcement is intended to do, will equal savings for the state.

Two additional elements of H.233's enforcement language merit mentioning:

First, you heard from DFR that they oppose the provision in § 3616(b)(3) that would give the HCA the right to review "all materials" that a PBM provides to DFR in the course of an audit or investigation. Although we disagree that granting the HCA access to this information would, as DFR testified, impair their ability to conduct investigations, we have concluded that giving us access to "all materials" is too broad and has too many unknown, potentially legally fraught implications.

We propose significantly narrowing the scope of our access to just those materials that are generated at the conclusion of an investigation: specifically, DFR's initial examination report, any PBM response or rebuttal to the report, the final adopted report, and the Commissioner's order adopting the report. While we could likely obtain these materials by right as public records, obligating DFR to provide them to the HCA would be consistent with previous decisions of the legislature to involve the public advocate in health care oversight. Further, having this information will assist us with our statutory obligation to identify problems in the health care system and suggest solutions to regulators and policymakers.

The final element of H.233's enforcement language I want to mention briefly is the private right of action. This language would authorize any pharmacy, pharmacist, or other person injured by a PBM to file a lawsuit against the PBM in state court. Without this language, a person hurt by a PBM might have to rely solely on DFR to make them whole. This language makes it clear that injured parties can avail themselves of the civil courts to obtain relief. The HCA believes it is important to empower consumers of health care services to obtain justice in this manner.

For these reasons, the HCA encourages you to support H.233.

Thank you.

Sincerely,

/s/ Charles Becker
Staff Attorney
Office of the Health Care Advocate