Memorandum

To: Chairperson Lori Houghton and members of the House Committee on Health Care

From: Mark Hage, Director of Benefit Programs, Vermont-NEA

RE: Testimony on Select Provisions of H.233

Date: February 15, 2024

Good afternoon and thank you for the opportunity to testify.

For the record, my name is Mark Hage. I am the Director of Benefit Programs for Vermont-NEA. I am also a Trust Administrator for the Vermont Education Health Initiative — VEHI — a self-insured, public risk pool that offers health benefit plans to all public schools in Vermont, to several private schools, and to the Vermont State Teachers' Retirement System.

VEHI has been in existence since the mid-1990s. Since its genesis it has worked in collaboration with Blue Cross of Vermont. VEHI now serves approximately 35,000 employees, active and retired, and their dependents. Day to day, it is managed by myself and colleagues employed by the Vermont School Boards Insurance Trust (VSBIT). In essence, VEHI is a longstanding partnership between VT-NEA and VSBIT; its board of directors, however, is composed of representatives from Vermont-NEA and the Vermont School Boards Association (VSBA).

I am testifying on behalf of Vermont-NEA, not VEHI. But I will be drawing on my experience as a VEHI trust administrator, including on what I've learned from working closely with VEHI's independent pharmaceutical consultant, Remedy Analytics. If it would be of benefit to this committee, with respect to H.233 or other matters, to hear directly from VEHI, I and my colleague from VSBIT, Bobby-Jo Salls, would be happy to oblige.

To be clear, Vermont-NEA is well aware of the affordability and medical problems caused to all Vermonters by high pharmaceutical prices, and the union has been advocating for systemic reforms in this domain, and we will continue to do so. As the saying goes, medications don't work if you can't afford them.

Today, my testimony will be confined largely to two problematic sections of H.233, both of which have substantial and unwelcome financial implications for VEHI and, I imagine, for other large risk pools, public and private. For this reason, respectfully, Vermont-NEA cannot support them.

Rebates & Point-of-Sale Price

I'll begin with language on page 11, subsection (2), lines 7-13:

2) As used in subdivision (1)(A) of this subsection (e), the "cost sharing amount under the terms of the health benefit plan" shall be calculated at the point of sale based on a price that has been reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The pharmacy benefit manager shall pass on any remaining rebate amount in excess of the covered person's cost-sharing amount to the health benefit plan to reduce premiums.

Substantial PBM rebates, as you know, accrue to a large risk pool or insurance carrier. They are negotiated and monitored for VEHI by Remedy Analytics, with support from the Blue Cross pharmacy team. If those rebates were credited to patients at the point of sale to lower the cost of expensive drugs, a considerable portion of them would be lost to VEHI – and any other pool similarly situated.

These rebates are routinely deployed to lower future premium rates. Without them, VEHI would experience even greater upward pressure on premiums, and school districts and school employees would be negatively impacted.

Please do not interpret my words to mean that Vermont-NEA likes or values how PBMs are structured and function. Rebates are simply a present-day reality in the commercial market, and to protect the financial interests of VEHI, the pool cannot afford to lose large amounts of rebate revenue, especially now when prices for specialty medications are rising and making up an ever-greater percentage of total Rx costs.

It's important to know that roughly 85 to 87 percent of VEHI's Rx claims are generated by generic medications. The volume of subscribers who use brand-name medications, including specialty drugs, is dramatically lower: roughly 800 subscribers on specialty medications, in our pool of nearly 35,000, drive 55 percent of our Rx costs. This is because of the exorbitant cost of these prescriptions, and rebates, of course, are tied to expensive medications.

So, H.233's point-of-sale provision would indeed help some patients, but a demonstrably smaller number compared to the population of commercial insurance subscribers who do not generate rebates for pools like VEHI because they take generic or low-cost preferred medications. The latter population, however, would certainly experience what this provision would mean for their future premiums, along with their employers.

Let me add that I question how this provision could be implemented efficiently. It has the potential to be administratively complex. For example, prior to the start of a benefit year, the parties would need to reach an understanding with PBMs on good-faith estimates of what rebates are likely to be. Then, at some later point, those good-faith estimates would need to be reconciled with definitive rebate figures. I'm not asserting this is impossible to do, only that it warrants greater consideration on how it can be done to avoid adversely affecting pharmacists and driving up their administrative costs, and to minimize confusion and complications for patients.

Dispensing Fees

Let me turn now to page 22, subsection (e), which reads:

(e) A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in this State an amount less than the amount the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same pharmacist services. The reimbursement amount shall be calculated on a per-unit basis based on the pharmacy's actual acquisition cost and shall include a professional dispensing fee that shall be not less than the professional dispensing fee established for the Vermont Medicaid program by the 16 Department of Vermont Health Access in accordance with 42 C.F.R. Part 447.

An Rx dispensing fee for VEHI and the rest of the commercial insurance world is a proprietary matter embedded in contract language. So, I'm not at liberty to share the exact amount of VEHI's negotiated

dispensing fee, but I can assure you it is nowhere in the neighborhood of the $11.03 that, I believe, the Vermont Medicaid program requires for retail pharmacies.

Once again, strictly as a matter of fiduciary responsibility to public schools and their employees, and to VSTRS, VEHI could not absorb the dispensing fee proposed in H.233 for the retail pharmacy market. It would constitute a substantial new financial burden that would further inflate premiums.

With respect to both the provisions I spoke to today, therefore, I must request, if you move forward with them as written, that VEHI be exempted from them.

Wholesale Drug Distributor

Lastly, as it pertains to "Section 2011. Wholesale Drug Distributor Contract," specifically, subsection (b), on page 27 of H.233, Vermont-NEA would support a study to investigate the financial and administrative feasibility and benefits of contracting for and distributing medications via a wholesale drug distributor.

That distributor could conceivably be the State of Vermont, or it could be an entity chosen through a competitive bidding process as H.233 states. In either case, given the escalating cost pressures we are all experiencing with pharmaceuticals, in both the private and public sector, it would be wise to explore an alternative purchasing and distribution system that could lower prescription costs and bring more transparency to medication charges.

This proposal, in tandem with creating a Prescription Drug Affordability Board as proposed in S.98, would give us a fighting chance to tackle the structural and systemic problems that inevitably ensue with a for-profit PBM system.

This combined approach, I believe, is where will see in time the greatest reductions in Rx costs and without sacrificing access to high-quality pharmaceutical products and care.

Thank you.