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Chairwoman Ginny Lyons
Senate Committee on Health & Welfare
Via-email

Dear Chairwoman Lyons and members of the Senate Health & Welfare Committee,

Thank you for the opportunity for Cigna Healthcare to provide comments on H. 233. Cigna weighed in throughout the House Committee process for this bill and still has some remaining concerns and would request consideration of the following:

Definitional Concerns:
The definition of "Health plan benefit" should be limited to health insurers in Vermont. We recommend adding "in this state" after "health insurer" to that definition. Additionally, the bill should be limited to only fully insured plans. We request you end the definition of health benefit plan after the phrase "to State government" deleting the reference to section 9402 and (A), (B) and (C). ERISA plans operating across multiple states rely on a single set of federal rules so that they may offer a uniform benefit. Introducing state by state complexities undermines the purpose of ERISA by creating additional cost and complexity for ERISA plan sponsors, ultimately resulting in reduced benefits and increased premiums. At a minimum, employers should have a choice of whether to implement or offer the provisions in this legislation as part of their benefit designs.

Spread Pricing:
While not required, spread pricing should be available as an option for plan sponsors. Vermont law already mandates transparency with respect to spread pricing. Health benefit plans who enter into spread pricing arrangements with PBMs in Vermont choose to do so because, after examining all their options in a fiercely competitive market, they conclude that it is the best option for the members they serve. This is because spread pricing arrangements provide health benefit plans with cost predictability and shift financial risk from the plan to the PBM. It is not the right option for all plans, but many determine that it is the best option for them. This prohibition will deprive health benefit plans of the ability to make that choice.

Instead of prohibiting spread pricing we would suggest language that says a PBM shall make available to health benefit plans the option of charging such health benefit plans the same price for a prescription drug as it pays a pharmacy for the prescription drug.

Copay Accumulator:
The bill requires that a PBM attribute any amount paid by or on behalf of a patient toward the deductible and out-of-pocket maximums. Copay accumulators and efforts by PBMs to utilize available manufacturer coupons, vouchers and other financial assistance save our plans up to $96 per member per year. These programs allow greater cost sharing for medications across employees, increase awareness of the implications of high-priced drug alternatives and maintain the integrity of plan formularies. We appreciate that the House added suggested language to protect a high deductible health plan from this provision, however, the bill still requires that a PBM attribute any amount paid by or on behalf of a patient toward the deductible and out-of-pocket maximums. While language was added to include exceptions to application of accumulator bans where there is a covered interchangeable bio-similar or there is a covered drug in the same therapeutic class that may

be preferred under the plan's formulary, if the language moves forward we would also suggest adding requirements that any third party that pays any amount on behalf of an enrollee for a covered prescription drug must offer the assistance for the full plan year, must notify the enrollee prior to an open enrollment period if the financial assistance will be discontinued in a subsequent plan year, and may not condition the assistance on enrollment in a health plan or type of health plan, to the extent permitted under federal law. Patients are vulnerable to financial exposure or disruptions in care if payments stop in the middle of treatment. Requiring assistance to be provided for the entire plan year and requiring notice when that assistance will be discontinued provides predictability, ensures patients can focus on their health, and allows patients to choose the right health plan for their needs.

Private Right of Action:
It is not necessary to codify a private right of action for pharmacy/pharmacist/members since these entities may already bring legal action against PBMs. There are numerous legal mechanisms currently in place that a party may pursue for recourse when it believes it has been injured by a PBM's conduct. As written, this provision introduces uncertainty & confusion into the process and has the potential to create unintended consequences of unwarranted, baseless and costly litigation. We therefore respectfully request its removal.

Fees and Advertising Materials:
For your information, the revised licensure-related fees included in the last version of the bill in the House appear to be significantly higher than elsewhere nationally. Additionally, on the requirement that advertising materials be filed and approved by DFR, we are concerned that potentially subjective opinions of what is appropriate could delay communication with members. Could there perhaps there could be a template communication approved in advance and then only come back to DFR if there are substantial changes, so as not to unnecessarily tie up communication with members. We'd appreciate if you could add some flexibility to this section alllowing DFR to manage as appropriate.

Thank you again for the opportunity to submit these comments and suggestions to improve the bill. If you have any questions, or would like to discuss potential language to implement some of our suggestions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cignahealthcare.com or reach out to Cigna's external government relations consultant, Becky Lewandoski at Rlewandoski@drm.com.

Sincerely,

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