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TO: Members of the House Committee on Health Care

FROM: Charles Storrow, Leonine Public Affairs on behalf of MVP Healthcare

SUBJECT: H.353 (*An Act Relating to Pharmacy Benefit Management*)

DATE: March 19, 2022

Thank you for the opportunity to testify on H.353 on behalf of our client MVP Health Care. MVP Health Care provides health coverage to more than 40,000 Vermonters through the fully insured individual, small group and large group markets. MVP does not oppose Pharmacy Benefit Manager (PBM) licensure and oversight but is concerned by some of the proposed H.353 requirements, as follows (page and line numbers refer to draft 1.2):

1. **Prohibition of Spread Pricing Contractual Arrangements**

   Proposed §3612(f) (p.6, line 5) would prohibit PBMs from entering into contracts with health insurers that utilize "spread pricing" in the state of Vermont. These types of contracts are often desirable to health insurers because they lock in drug prices over a multiple-year period. As a result, the PBM essentially shoulders both upside and downside risk. Not every "spread" is positive to the PBM, and a PBM can lose money if the amount they must reimburse pharmacies for dispensing a given drug exceeds the price the health insurer has contractually agreed to pay to the PBM. Notably, there is no administrative fee paid by insurers to the PBM under these arrangements. Absent the ability to negotiate spread pricing contracts insurers will instead be charged an administrative fee by the PBM for the claims processing and other services provided by the PBM. Finally, it is important to understand that prohibiting spread pricing arrangements will not result in lower drug prices for consumers or higher reimbursement amounts for pharmacies.

2. **Deductible Application of Cash Payments and Third-Party Cost-Share Assistance**

   Proposed §3612(e)(2) (p. 6 line 20) would require any amount paid by a health insurance enrollee to be attributed toward a plan's deductible. While MVP appreciates the intent, it is concerned about its ability to operationalize this requirement when a member pays cash or utilizes third-party financial assistance such as copay coupons at the pharmacy point of sale and

that information is unknown to the PBM or insurer.

3. Maximum Allowable Cost (MAC) Pricing Appeals Process

Existing law requires PBMs to have an appeal process whereby a pharmacy can contest a PBM's maximum allowable cost (MAC) listing for a drug. *See* subsection (f) on page 11 at line 4 and subdivision (3) on page 11, line 17. However, the new subsection (i) on page 13, line 17 provides that if a pharmacist *loses* such an appeal it can nonetheless balance bill the patient's insurer for the difference between the PBM's MAC amount and the pharmacy's "reasonable cost" (which is undefined) in acquiring the drug. On its face, this provision seemingly undermines the need for an appeal process and will result in increased prescription drug costs for MVP's Vermont members.

4. Any Willing Pharmacy Requirements

Bill section 3 on page 17 would amend 8 V.S.A. § 4089j. That statute already guarantees that retail pharmacists can fill prescriptions in the same manner and at the same level of reimbursement as a mail order pharmacy. In other words, a health insurer and its PBM cannot require an insurer's beneficiary to use a mail order pharmacy if that beneficiary wants to use a retail pharmacy that can at least match the level of reimbursement paid to a mail order pharmacy. Notably, MVP does not charge differential cost-sharing requirements based on the type of pharmacy utilized to fill a prescription.

On page 17 at lines 17 draft 1.2 of H.353 would amend section 4089j by adding a new subdivision (d)(1) to that statute. The proposed subdivision would allow an insurer's beneficiary to have a prescription filled at any pharmacy, regardless of whether the pharmacy is the insurer's/PBM's network. As a result, it essentially eliminates pharmacy contractual agreements that are in place that help with affordability and important patient protections. Currently, all in-network pharmacies must be credentialed and meet certain standards to participate in plan networks. They must also agree to terms and conditions on price as well as quality requirements such as capability to provide patient prescription drug education, assessment, adherence monitoring services, and 24/7 phone access. These contractual agreements are especially critical for the handling and delivery of highly complex specialty drugs to treat rare diseases. Quality standards are a crucial component of managing chronic conditions and improving patient health. Negating these contractual obligations will limit health plans' ability to ensure that all members receive access to the same high-quality pharmacy services, regardless of where they choose to fill their prescriptions.