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To: House Health Care Committee

From: Christine Cooney, Cigna State Government Affairs Manager, New England

Re: H. 353

Dear Chairman Lippert and Members of the Committee:

For background, Cigna Corporation is a global health service company dedicated to improving the health, well-being and peace of mind of those they serve. Cigna delivers choice, predictability, affordability and access to quality care through integrated capabilities and connected, personalized solutions that advance whole person health. All products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth companies or their affiliates, and Express Scripts companies or their affiliates. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products. Cigna maintains sales capability in over 30 countries and jurisdictions, and has more than 175 million customer relationships throughout the world.

We appreciate the opportunity to provide comments and share concerns regarding H. 353, An Act Relating to Pharmacy Benefit Management. Pharmacy Benefit Managers (PBMs) work to reduce prescription drug costs for health plans so that consumers can access necessary affordable prescription drugs. PBMs also provide many valuable services to their health plan clients and patients in ways such as improving prescription adherence, reducing medication errors, and managing overall drug cost spending.

This bill encompasses numerous provisions related to pharmacy benefit management, many of which are complex and require thoughtful consideration to avoid potential unintended consequences. We have identified numerous problematic provisions in the bill as drafted that will have a negative impact on the quality and affordability of prescription drug coverage available to Vermonters. It will deprive employers, health insurers, and other entities providing prescription drug coverage of the freedom to make choices about how best to design their prescription drug benefit to meet their unique needs. Finally, it will create confusion and conflict and reduce transparency in the prescription drug supply chain.

While not an all-inclusive list, we appreciate the opportunity to highlight a handful of concerning provisions in the proposed bill:

> Mandatory Dispensing fee:
> The mandatory dispensing Fee provision will cause an increase in the cost of health care. It would mandate use of the same dispensing fees used in the Vermont Medicaid program, which are significantly higher than the average dispensing fee paid today. For example, the bill would mandate that retail pharmacies receive a minimum dispensing fee of $11.13. This is significantly higher than the average dispensing fee paid today, estimated in one recent study to be $2. Using these numbers, prescription drug costs will increase $9.13 for every prescription filled at a retail pharmacy. Much of this additional cost will be shouldered by health benefit plans, such as the state employee plan, and the individuals they provide coverage for.

Spread Pricing Prohibition:
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 they believe it is the best option for them. 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.

Frozen Formulary:
The provision that restricts PBMs and health benefit plans from making formulary changes more than twice a year reduces the ability of PBMs to respond to financial and clinical developments, which arise frequently in this dynamic environment. We are concerned that, at a minimum, exceptions should be permitted where:

- An FDA-approved generic alternative is added to a formulary at a lower cost-sharing tier than its branded counterpart;
- An FDA-approved biosimilar medication is available and covered by the plan at a lower cost than its biologic product;
- The drug being moved to a higher cost-sharing tier is also available in-network for $40 or less per month in any tier; and
- The FDA questions the drug's clinical safety or approves the drug for over-the-counter use.

Pharmacy Audits:
The language around pharmacy audit restrictions appears to undermine the pharmacy audit objectives of promoting accurate, professional and legally-compliant pharmacy practice from our network pharmacies. The practical consequence of this could result in cost increases, problems with quality of care and decreased transparency.

PBM Reporting:
While we support transparency, we must caution against implementing such broad reporting requirements that would impose a significant cost and administrative burden for PBMs, health benefit plans, and the state alike. It would be helpful to understand what specifically the legislature is attempting to accomplish and narrow down the provisions to more efficiently and effectively achieve that objective. Additionally, we would assert that financial reporting between PBMs and their clients is certainly something that can be, and routinely is, negotiated in the contracting process between the entities.

Definitional Concerns:
The definition of "Health plan benefit" is vague and ambiguous and should be limited to clients sitused in VT. The definition of "Health insurer" is too broad and appears to include preempted ERISA plans. We would request that if the bill moves forward that it be limited to only fully insured plans. The MAC Appeals definition is unclear in that it talks about paying a pharmacy a "reasonable acquisition cost" however, that term has no generally understood meaning within the industry and therefore likely invites disagreement as to how it would be implemented.

Again, these are just some of the provisions we are concerned with. A bill of this magnitude and complexity requires thoughtful engagement from a variety of stakeholders to avoid unintended consequences and the potential for significant increased costs. We suggest that it might make sense to take some additional time to review and think through the many provisions of the bill, to allow for better articulation of the issue(s) that are looking to be solved for and an opportunity to engage stakeholders in a conversation to better understand and potentially solve for them. We appreciate that the committee has indicated its desire and

intent to hear from others about the proposed legislation. It is likely that through this type of engagement, you will find that the intentions of stakeholders are often aligned, particularly as they relate to the impact on health care customers and prescription drug access and affordability. We hope you will consider the detrimental impact this legislation could have on the health care system as a whole, and most importantly on customers and patients.

Once again, thank you for the opportunity to weigh in on this proposed bill.

If you have any questions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cigna.com.