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To: Senate Committee on Health and Welfare

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

Re: H. 353

Dear Chair Lyons 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.

Although we have already submitted comments to raise concerns with several provisions of H. 353, I wanted to take the opportunity to reach back out to reiterate previous concerns while also sharing additional ones with the bill as amended (draft 4.1). Section 4 of the bill, is still problematic as drafted. Provisions of the bill would prohibit incentivizing patients to use lower cost providers or pharmacies. Additionally, it prohibits requiring accreditation or setting network terms for specialty pharmacies. As written, the "any willing pharmacy" provision will undoubtedly lead to less competition and higher prices for consumers. The bill 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.

Section 4 also appears to restrict the practice of "white bagging" which is a way to safely deliver drugs directly to a physician's office before a patient's appointment while protecting patients from inflated fees and other costs or markup that hospitals and physicians charge to buy and store specialty medications themselves. Passing a restriction on white bagging takes away a tool from plan sponsors to control costs that will be borne by Vermont consumers and businesses. If it should move forward, we would respectfully ask that consideration be given to ensure accessibility by limiting the provider mark-up or tying the reimbursement to wholesale acquisition cost (WAC). If not, the impact of this language will inhibit savings for plan sponsors and ultimately, negatively impact their members. Language that prohibits accreditation and setting network terms for specialty pharmacies, would eliminate our ability to establish basic cost and quality controls.

The restrictions related to 340B seem to have been changed and are somewhat unclear. Cigna understands the unique role that 340B covered entities and their contract pharmacies perform in providing affordable access to health care for vulnerable populations. As such, we support minimizing administrative burden to

the 340B Program and the patients it serves. However, as a PBM, we require transparency when a prescription claim is processed by one of our network pharmacies for a 340B patient to ensure that rebates are appropriately adjusted. Rebates connected to those 340B prescriptions must be accounted for, and ultimately removed from rebate reporting, by the PBM to its clients. For this reason, the provision passed last year that prohibits requiring a 340B claim to include a modifier identifying it as such, should be removed from law. As a PBM, we do not lower reimbursement amounts because a drug was purchased through the 340B program. We also do no not change network participation standards or limit a pharmacy's ability to serve as a contract pharmacy for 340B covered entities. This ensures the 340B benefit is not diminished for 340B covered entities or their contract pharmacies.

As raised previously, 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.

If the intent is to allow for a change if agreed to by the health plan and PBM, it is not clear the way it is currently drafted. We believe it should be clarified that these important exceptions would be allowed.

And we must reiterate that the legal term "fiduciary" is not applicable to the relationship between a PBM and a health plan, and its use in statute creates the potential for unnecessary litigation due to the uncertain impact of its application. PBMs don't make decisions about whether the plan should offer pharmaceutical benefits or the scope or design of those benefits—that's the role of the plan sponsor. PBMs carry out the terms of their contracts with their customers, who are usually large, sophisticated health care purchasers. Moreover, "fiduciaries" are those persons or entities who exercise discretionary authority over plan/client assets or management, PBMs don't have such control or authority. If it is necessary to speak to this relationship in statute, we suggest that the existing statutory language is more appropriate than a fiduciary standard. An alternative would be to clarify in statue the specific things Vermont is looking to ensure, for example, "a duty of good faith and fair dealing".

We urge you to consider the negative consequences this legislation will have on Vermonters and the cost of health care. We strongly recommend that the legislature allow more time for further study of these items and a thoughtful discussion of the issues with input from all stakeholders. By keeping cost-containment measures intact and codifying safety guardrails, we can ensure safe, accessible, affordable prescription drugs.

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.

Sincerely,

Christine Cooney

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