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TO: Members of the Senate Committee on Health & Welfare

FROM: Charles Storrow, Leonine Public Affairs, LLP, on behalf of MVP Health Care

SUBJECT: H.353 – An Act Relating to Pharmacy Benefit Management

DATE: April 6, 2022

This memorandum is submitted on behalf of MVP Health Care ("MVP") concerning H.353, "An Act Relating to Pharmacy Benefit Management." MVP does not object to the bill's intent, which is to establish licensure and oversight of pharmacy benefit managers (PBMs). However, MVP urges the Committee to reject Section 4 on the grounds that it would eliminate important patient safety standards and requirements that exist today, unnecessarily limit targeted patient outreach programs, and undermine how pharmacy benefits are currently managed. At a minimum, Section 4 should be rejected in favor of closer study and examination to protect patients and guard against unintended consequences.

About MVP and its PBM

MVP, which is headquartered in Schenectady, NY, provides coverage to more than 700,000 members, including roughly 40,000 Vermonters. It is one of two health insurance companies that offer fully insured small group and individual health benefit policies in Vermont. CVS/Caremark manages the prescription drug benefit in its capacity as a PBM for MVP's members in Vermont and New York State.

Existing Statute Concerning Retail/Mail Order Parity

Section 4 (p.16-17 of the House passed version) would amend 8 V.S.A. §4089j in a few important ways, but it's helpful to first understand the statute as it currently exists. This section of law—dubbed the "mail order parity" statute—permits retail pharmacies to fill prescriptions in the same manner and at the same reimbursement level as they are filled by mail order pharmacies with respect to 1) the quantity of drugs or 2) days' supply of drugs dispensed under each prescription. Further, in HCA Bulletin 114 the Department of Financial Regulation states that section 4089j provides that if a person wants to use a retail pharmacy instead of an insurers/PBM's mail order pharmacy, a retail pharmacy is entitled to fill the prescription if: (1) the out-of-pocket amount the person must pay to the retail pharmacy is no more than what they would pay the mail order pharmacy, and (2) the retail pharmacy is willing to accept the same level of reimbursement as the mail order pharmacy will receive.

Section 4 Concerns
The bill would add a new subsection (d) to 8 V.S.A. §4089j, expanding on the existing statute summarized above.

Pharmacy Choice
Proposed subsection (d)(1) would require health insurers and their PBM to permit beneficiaries to fill a prescription at the in-network pharmacy of the beneficiary's choice without imposing differential cost-sharing requirements based on that choice (with some exceptions). While there is no harm in stating that in law, MVP respectfully suggests that this proposal is redundant given that an MVP beneficiary can fill a prescription at any pharmacy within MVP's pharmacy network without any difference in their out of pocket exposure.

Pharmacy Promotion
Proposed subsection (d)(1) would also prohibit any health insurer or PBM efforts to "promote the use of one pharmacy or another." As noted above, MVP does not charge differential cost-sharing amounts based on where a beneficiary chooses to fill their prescriptions. However, a statutory restriction expressly prohibiting the promotion of any pharmacy over another would unnecessarily block innovative patient outreach programs that have nothing to do with a member's cost-share or a pharmacy's reimbursement. For example, a theoretical program between a pharmacy and MVP proactively engaging patients with certain health conditions would seem to be prohibited, despite there being no differential on reimbursement.

Drug Classifications
Proposed subdivision (d)(3) would prohibit a health insurer or PBM from "establishing classifications of or distinctions between prescription drugs." This seems to undermine the very structure of prescription drug benefits, which are currently classified in a number of different ways in health plan benefits—such as by brand or generic, maintenance medications for chronic or long-term conditions, complex specialty medications, and member cost-sharing tiers. Notably, MVP works with its PBM to develop a tiered drug formulary that provides incentives to utilize lower cost generic drugs as opposed to higher cost brand drugs. Having such a formulary would seemingly be prohibited under this provision.

Credentialing Requirements
Proposed subdivision (d)(3) would also prohibit any "restrictions on pharmacies or pharmacists that are more restrictive than or inconsistent with State or federal law or with rules adopted or guidance provided by the Board of Pharmacy." Proposed subdivision (d)(2) is similar in nature. These provisions are especially concerning regarding the dispensing of specialty medications, which generally are high-cost medications used to treat chronic, complex or genetic diseases. These drugs require specialized handling (e.g. refrigeration) or may require certain methods of administration (e.g. injection/infusion). Pharmacists working with these drugs typically have received specific education and training with preparing, handling and educating patients about these drugs. Given the complexity of these drugs and the patient populations served, independent bodies like the Utilization Review Accreditation

Commission (URAC), Joint Commission, and Accreditation Commission on Health Care (ACHC) accredit pharmacies specifically around the practice of specialty pharmacy. So, MVP has significant concerns with proposed subsection (d)(3) in that it would seem to undermine broadly established credentialing standards for dispensation of these complex drugs.

Questions

Thank you for your time and consideration. Please don't hesitate to contact me with any questions.