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To:

Senate Committee on Health and Welfare

From:

Helen Labun
Director of Vermont Public Policy
Bi-State Primary Care Association

April 21st, 2021

Re: Addendum to previous testimony on S. 120

Thank you for the opportunity to review additional testimony on S. 120 and provide an addendum to our previously submitted comments. These are additional comments based on ideas raised in committee, they expand our position.

As previously outlined, Bi-State Primary Care Association supports payment reform that brings reimbursement systems closer to a capitated, value-based model and that aligns state and federal priorities. We believe that the All Payer Model is the foundation for that work. We additionally support policy work that would directly reduce health care costs for individuals. We support focusing S. 120 on affordability for individuals and families.

We have reviewed testimony related to S. 120 and would highlight the following options as promising steps to move forward.

We agree with the Vermont Medical Society testimony regarding the different components of reform, and agree with disentangling the focus of financing and coverage from payment and delivery reform. We would go a step further and simply strike the reference to reviewing payment and delivery reform efforts as part of the process outlined in S. 120. That review is already happening in detail in other venues. While it is true that payment reform sets a foundation for reducing costs (as addressed in our previous testimony), we perceive the intent of S. 120 to be immediate, direct action on affordability and coverage, which is its own goal.

We support building from work already completed, as outlined in the Vermont Association of Hospitals and Health Systems (VAHHS) testimony from April 21, 2012. As noted in the underlying S. 120

language, there is a rapidly evolving federal landscape for increased affordability. We support a highly focused response to that landscape so that we do not miss emerging opportunities during what is a chaotic time in health care. A top priority should be preparing Vermont to take advantage of federal opportunities and designing systems to build from those changes to reduce costs and increase coverage.

- *Work should build off previous affordability proposals, and implement opportunities under the American Rescue Plan Act to provide real relief to Vermonters*
  - *Streamlining care coordination*
  - *Cost shift and affordability*
  - *HSA reform to allow for coverage of primary care visits*
  - *Subsidies available for households with income of $76,560 for a single individual or $157,200 for a family of four*
  - *Extending Medicaid postpartum for 12 months*

We support the additional details provided in VAHHS written testimony regarding implementation of these objectives (pp 2-3).

We support bringing in the S. 132, Section 19 language to add two primary care visits to coverage, pending review of the impact on federal regulations for Health Savings Accounts.

We support additional work on the cost of prescription drugs. We support both developing strategic options to address this cost and taking immediate action to protect Vermont health care practices and pharmacies from recent actions by Pharmacy Benefit Managers (PBMs). Please find below our comments on the PBM language, previously submitted via email.

Bi-State's members, including the Federally-Qualified Health Centers and Planned Parenthood of Northern New England, rely on the federal 340B program to invest in their mission to serve all patients, regardless of ability to pay, and a component of that mission is to reduce the cost of pharmaceuticals. They do this through directly passing on significant discounts to patients who struggle to afford prescriptions and through investing in early intervention and prevention efforts that remove the need for drug treatment altogether.

Nationally, the 340B program has come under attack. Both drug manufacturers and pharmacy benefit managers are attempting to block our patients' access to this program. One of the strategies used by PBMs has been to create significant administrative burden that will have a chilling effect on pharmacies' ability to participate in 340B. While there are no federal protections against these actions, states can take steps to protect their residents. The following language is based on successful legislation passed in Utah.

A pharmacy benefit manager may not:

(a) create any additional requirements or restrictions on the 340B entity; or
(b) require a claim for a drug to include a modifier to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the Medicaid program.
(c) restrict access to a pharmacy network, or adjust reimbursement rates based on a pharmacy's participation in a 340B contract pharmacy arrangement.

We believe that adding this language into S.120 will be a step towards protecting patients from increased pharmaceutical costs and contribute to ongoing state efforts to exert greater control over these costs. We see this as a complement to the existing working group on this subject. Because this language is time sensitive in response to current actions by national PBMs, we are recommending it be implemented now, while we consider other, longer term solutions.

Thank you for reviewing this additional testimony.

Sincerely,

Helen Labun
Director, Vermont Public Policy
Bi-State Primary Care Association