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Chairwoman Lori Houghton
House Committee on Health Care
Via-email

Dear Chairwoman Houghton and members of the House Committee on Health Care,

Thank you for the opportunity for Cigna Healthcare to review and provide comments on Draft No. 1.2 of H. 233. While we appreciate the work that has been done on this proposal to date, Cigna continues to have some concerns and would request consideration of the following:

Definitional Concerns:
The definition of "Health plan benefit" should be limited to health insurers in Vermont. We recommend adding "in this state" after "health insurer" to that definition. Additionally, the bill should be limited to only fully insured plans. We request you end the definition of health benefit plan after the phrase "to State government" deleting the reference to section 9402 and (A), (B) and (C). ERISA plans operating across multiple states rely on a single set of federal rules so that they may offer a uniform benefit. Introducing state by state complexities undermines the purpose of ERISA by creating additional cost and complexity for ERISA plan sponsors, ultimately resulting in reduced benefits and increased premiums. At a minimum, employers should have a choice of whether to implement or offer the provisions in this legislation as part of their benefit designs.

Spread Pricing:
While not required, spread pricing should be available as an option for plan sponsors. 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, after examining all their options in a fiercely competitive market, they conclude that it is the best option for the members they serve. 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.

Instead of prohibiting spread pricing we would suggest language that says a PBM shall make available to health benefit plans the option of charging such health benefit plans the same price for a prescription drug as it pays a pharmacy for the prescription drug.

Rebate pass-through:
It is unclear if the novel approach to rebates proposed in this version of legislation would be operationally feasible. Alternatively, we would recommend requiring a pharmacy benefit manager to make available to a health benefits plan the option of using the rebate for a prescription drug to calculate reduced cost sharing requirements for the insured at the point of sale. This allows plan choice on whether to pass through the rebate to the member at the point of sale or allow clients to choose to retain and apply rebates to offset future plan premiums or enrich benefit offerings to members. We would be happy to provide alternative language to accomplish this if the committee would be willing to consider it.

Copay accumulator:
We appreciate that you added language to protect a high deductible health plan from this provision, however, the bill still requires that a PBM attribute any amount paid by or on behalf of a patient toward the deductible and out-of-pocket maximums. We strongly recommend that at a minimum, this language be clarified so that drug manufacturers cannot use coupons to bypass a formulary. Copay coupons can undermine health insurers' programs to incentivize use of generics and lower cost. The language should add exceptions to application of accumulator bans where there is a covered interchangeable bio-similar or there is a covered drug in the same therapeutic class that may be preferred under the plan's formulary. Or where the health benefit plan reduces or eliminates cost sharing requirements when a manufacturer or other person makes payments on behalf of the enrollee. We would be happy to offer proposed language for this provision as well.

Additionally, requirements should be added requiring that any third party that pays any amount on behalf of an enrollee for a covered prescription drug must offer the assistance for the full plan year, must notify the enrollee prior to an open enrollment period if the financial assistance will be discontinued in a subsequent plan year, and may not condition the assistance on enrollment in a health plan or type of health plan, to the extent permitted under federal law. As expressed previously, patients are vulnerable to financial exposure or disruptions in care if payments stop in the middle of treatment. Requiring assistance to be provided for the entire plan year and requiring notice when that assistance will be discontinued provides predictability, ensures patients can focus on their health, and allows patients to choose the right health plan for their needs.

Private right of action:
It is not necessary to codify a private right of action for pharmacy/pharmacist/members since these entities may already bring legal action against PBMs. There are numerous legal mechanisms currently in place that a party may pursue for recourse when it believes it has been injured by a PBM's conduct. As written, this provision introduces uncertainty & confusion into the process and has the potential to create unintended consequences of unwarranted, baseless and costly litigation. We therefore respectfully request its removal.

Thank you again for the opportunity to submit additional comments on the revised draft for your consideration. If you have any questions, or would like to discuss potential language to implement some of our suggestions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cignahealthcare.com.

Sincerely,

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