April 16th, 2024

The Honorable Virginia Lyons
Members, Senate Committee on Health and Welfare
109 State Street
Montpelier, VT 05609

RE: H 233 - An act relating to pharmacy benefit managers; Opposed

Chair Lyons, and Members of the Committee,

On behalf of the Pharmaceutical Care Management Association (PCMA), we wish to share comments as opposed to H 233. PCMA is the national association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for millions of Americans with health coverage provided through large and small employers, health plans, labor unions, state, and federal employee benefit plans, and government programs.

H 233 proposes several wide-ranging and costly changes to the pharmacy market in Vermont. Although the assumption is this assault on pharmacy benefit managers will lead to lower drug costs for the consumer, these changes do nothing to lower consumer drug costs. In fact, the passage of H 233 will place added costs onto Vermonters while subsidizing for-profit pharmacies. Specifically, the bill:

- ERISA Preemption
- Ban spread pricing contracts.
- Require copay coupons be applied to a patient's deductible and out-of-pocket maximums
- Creating a private right of action

We believe that H 233 will have a detrimental impact on pharmacy benefit services in the State of Vermont and urge you to vote no.

ERISA Preemption

Congress enacted ERISA to provide a "uniform regulatory regime over employee benefit plans." Aetna Health Inc. v. Davila, 542 U.S. 200, 248 (2004). "[B]y mandating certain oversight systems and other standard procedures" pursuant to uniform federal rules, ERISA "make[s] the benefits promised by an employer more secure" for employees while at the same time reducing the administrative burdens for multi-state employers. Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016).

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To achieve this objective, Congress included a "comprehensive" express preemption clause in ERISA, id., which was "intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." Shaw v. Delta Air Lines, 463 U.S. 85, 99 (1983). As a corollary, "[s]tates are precluded from regulating in a field that Congress, acting within its proper authority has determined must be regulated by its exclusive governance." Arizona v. United States, 567 U.S. 387, 399 (2012). By protecting plans from competing state laws, ERISA's preemption clause "minimiz[es] the administrative and financial burdens on plan administrators – burdens ultimately borne by the beneficiaries." Egelhoff v. Egelhoff, 532 U.S. 141, 149-50 (2001) (internal quotation omitted).

Consistent with this Congressional intent, it is well-established under current Supreme Court precedent that state laws may be preempted where they bear an impermissible "connection with" ERISA plans. This may occur where a state law "bind[s] plan administrators to [a] particular choice" concerning the substance of plan benefits. Rutledge, 141 S. Ct. at 480. Such provisions stand in contrast to mere "rate regulation[s]," which have "an indirect economic effect on choices made by . . . ERISA plans" but do not "bind plan administrators to any particular choice" concerning plan design. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645, 667 (1995). In addition, "state laws dealing with the subject matters covered by ERISA" also have a "connection with" ERISA plans and are preempted.[1] Shaw, 463 U.S. at 98. Finally, state laws that "'govern[] a central matter of plan administration" have a connection with ERISA plans and are preempted. Gobeille, 136 S. Ct. at 943 (internal quotes omitted).

PCMA requests the definition of "health insurer" be struck from the bill as it is already found in 18 V.S.A. § 9402 which includes "to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.". We are concerned that the expansive definition of "health insurer" may be viewed as applying to ERISA-covered plans.

Ban spread pricing contracts

PBMs offer payer clients a variety of contractual options to pay for PBM services, and they choose the one that is best for them based on the services they need and their plan membership. Each client evaluates and determines the financial arrangement that meets their specific needs for PBM services. One option for clients is to elect a pass-through pricing arrangement for pharmacy reimbursement. Under a pass-through contract, the reimbursement negotiated with the retail pharmacies is passed along to the client to pay, and the PBM collects

[1] In *Gobeille*, for example, the Court explained that "ERISA's reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive." 136 S. Ct. at 944. The Court thus concluded that a state law that "compels [the disclosure of] detailed information" by third-party administrators to state authorities was preempted. *Id.* at 945.

fees from the client to pay for the entirety of the services it performs for the client. In this case, there would be no difference between what the client pays the PBM and what the pharmacy is reimbursed by the PBM. This approach may involve more variation in cost along with drug price fluctuation due to drug shortages, patent expirations, and other market pressures.

Another option for clients is spread pricing. In spread pricing, clients choose a financial arrangement for pharmacy reimbursement where the price paid to the pharmacy by the PBM may not equal the price billed to them. In this case, the difference in the amount paid by the client to the PBM and the amount the PBM reimburses a pharmacy is how the PBM is paid for the services it provides to the client. Many clients choose a spread pricing arrangement because it achieves a pricing level guarantee to the client. It provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Employers and plan sponsors often want to maintain this option in the marketplace because they do not want to pay per member or per claim fees for the services provided by the PBM. Reducing contracting options will ultimately reduce employer and health plan flexibility to contract in the best way to meet their needs.

The Department of Medicaid in Ohio released an Executive Summary Assessing the Impact of Pass-Through Pricing. HealthPlan Data Solutions Inc. (HDS) released a report with data that shows the Ohio Medicaid switching to a pass-through model increased prescription drug spending in the State. “HDS found that the implementation of pass-through was associated with a 5.74% increase in amounts paid to pharmacies between Q4 2018 and Q1 2019. This is an increase of $38.4M in payment to pharmacies.”[2] In other words they are spending more money paying pharmacies, on top of now paying administrative fees. Also, the report notes that PBMs spend about $50 million per quarter administering the pharmacy benefit. Which means we are looking at over $238 million spend, which is more than the amount of spread we retained (about $225 million).

We request that you strike Section 3612 (f) for the reasons mentioned above and allow plans to continue to have the choice to select their contracts to pay for drugs.

Require copay coupons to be applied to a patient’s deductible and out-of-pocket maximums

The unfettered price increases of prescription drugs put patients at risk and health plan sponsors in the difficult position of either having to cut benefits or increase premiums, copays, and deductibles. While health plans pay the vast amount of their members’ prescription drug

[2] Corcoran, M. (2019, September). Executive Summary: Assessing the Impact of Pass-Through Pricing. https://owl.purdue.edu/owl/research_and_citation/mla_style/mla_formatting_and_style_guide/mla_works_cited_electronic_sources.html#:~:text=Cite%20web%20postings%20as%20you,author%20name%20is%20not%20known.

costs, drug manufacturers' price increases have forced health plans to be selective in the drugs they will cover and create benefit designs that incent patient choice for the lowest-cost drug that treats the condition experienced. Copay coupons may come in the form of a coupon, debit card, or some other arrangement.

Drug manufacturers encourage patients to disregard formularies and lower-cost alternatives by offering "coupons" to help the patient cover that higher cost. This ultimately steers patients away from cheaper alternative drugs such as generic drugs (with low copays) and toward more expensive brand drugs (with high copays) or more expensive brand name drugs, ignoring potentially equally or more effective and less expensive alternative medications. By definition, copay coupons target only those who already have prescription drug coverage (i.e., those who pay copays). Copay coupons are not means-tested or designed to help the poor or uninsured. Considered illegal kickbacks in federal health programs, copay coupons are still allowed in the commercial market.

Copay accumulator programs are health plan programs designed to thwart drug manufacturers' efforts to force employers, unions, and public programs to pay for expensive, unnecessary brand medications through the use of copay coupons. Accumulators typically disallow the counting of the manufacturer's coupon towards the patient's out-of-pocket max and deductible because the patient hasn't actually incurred the cost. This ensures that the patient is incentivized to use the plan formulary and that the plan functions as designed.

Here are the facts when it comes to manufacturer coupons:

- The prices for drugs with manufacturer coupons increase faster (12-13% per year) compared to non-couponed drugs (7-8% per year).
- If Medicare's ban on coupons were not enforced, costs to the program would increase by $48 billion over the next ten years.
- For every $1 million in manufacturer coupons for brand drugs, manufacturers reap more than $20 million in profits (20:1 return).
- A 2020 study by the Commonwealth of Massachusetts Health Policy Commission, estimates that coupons increased premiums in the Group Insurance Commission program by $18 for a single premium and $52 for a family - increasing costs by over $44 million in excess spending.

Supporters of coupons say that they decrease costs for patients. While they can decrease an individual patient's cost at the pharmacy counter, the patient and the plan ultimately pay more overall. Coupons are temporary—the individual patient likely pays more when the coupon goes away instead of being started on the formulary drug from the start. It is the manufacturer who benefits by forcing the plan (indirectly the patient) to pay for the more expensive drug.

PCMA does not oppose true means-tested patient assistance programs that help individuals afford prescription drugs. There is an important difference between means-tested patient assistance programs and copay coupons, which are targeted to individuals with health insurance.

If drug companies are concerned about patients accessing medications, they should simply lower their prices, yet drug makers have determined that it is more profitable to increase copay assistance rather than just making their medications more affordable. The simplest, most effective way to reduce patient costs on drugs is for manufacturers to drop the price of the drug. State legislation that seeks to disallow the use of accumulators eliminates an essential tool in the fight against rising pharmaceutical costs.

Therefore, we request you strike Section 3612 (F)(i)

Creating a private right of action

The language of Section 3613 of H 233 is both unclear and troublesome. On the one hand, the section appears to create a private right of action on behalf against PBMs. On the other hand, in its entirety, the language of this section is superfluous in that it appears redundant by restating the judicial process for a private entity to initiate a lawsuit. Such prescriptive language also raises concerns over the separation of powers. In such a scenario, the judicial process should be left to the purview of the judiciary.

Moreover, this section would encourage pharmacies (including those owned by large health systems) — who are market competitors of PBMs and health plans — to file frivolous lawsuits aimed at disrupting the business operations of payors and the normal contracting process between PBMs operating in Vermont. The state would be placing its finger on the scale and distorting relationships between competing private stakeholders. It would be favoring one discrete special interest group to the detriment of PBMs. Resulting in higher plan costs stemming from frequent and ruinous litigation. In turn, this state-imposed distortion would likely result in higher premiums or narrower benefits for beneficiaries in the state. It could also increase the cost of doing business for major employers in Vermont who seek to offer drug benefits.

Therefore, PCMA respectfully requests that the language of section 3613 be struck from the bill.

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We stand ready to work with the committee to find ways to ensure access to affordable prescription drugs in Vermont, but not at the expense of Vermont citizens. We urge you to consider our suggestions mentioned above in opposition to H 233. Thank you for your consideration.

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