VERMONT
GREEN MOUNTAIN CARE BOARD

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DELIVERED ELECTRONICALLY

April 1, 2024

Traci Hughes, FSA, MAAA
Vice President & Principal
Lewis & Ellis, Inc.

Allison Young, ASA, MAAA
Vice President & Consulting Actuary
Lewis & Ellis, Inc.

Dear Ms. Hughes and Ms. Young,

To assist the Board with its review of Cigna Health and Life Insurance Company's 2024 large group rate filing (Docket No. GMCB-002-24rr), please ask Cigna to provide the following information sought by the Office of the Health Care Advocate.

1. In Table 33 – Retail AWP per Script Assumptions, non-preferred brands are frequently less expensive on a per script basis than preferred brands across all formularies. For example, on all but the National Preferred Formulary, non-preferred brands are less expensive in six drug categories, whereas preferred brands are less expensive in just two categories. On the National Preferred Formulary, non-preferred brands are less expensive in at least five drug categories.

    a. Please confirm this observation and explain why Cigna would prefer brand drugs with a higher AWP per script.

    b. Is it the case that Cigna expects preferred brand drugs will be cheaper net of rebates and other discounts?

    c. If so, how is this expectation accounted for when Cigna calculates a subscriber's rate? In section 7.9 of the filing, it is stated simply that discounts

are applied to the trended AWP per script and that discount assumptions range from 11% to 58% on brand drugs – without any evident mechanism to distinguish between preferred and non-preferred brands.

d. Regarding the impact to consumers of this preference for higher list price brand drugs, is it correct that, during the deductible phase, beneficiaries will pay those higher list prices, or a set discount off those higher list prices, e.g. AWP minus 15%, and that, at least in some cases, beneficiaries will pay more out-of-pocket during the deductible phase for a preferred brand than they would have paid for an equivalent non-preferred brand?

2. We compared the list of FDA-approved HIV medicines1 with the Specialty Formulary List provided in the filing and observed that all 47 FDA-approved HIV medicines are classified as specialty.2 Further, when generic versions of brand HIV medicines exist, both the generic and brand versions of the medicine are classified as specialty. Lastly, although deemed specialty, each medicine is also assigned to one of four drug tiers.

   a. What are the four drug tiers? Presumably Tier 1 is Generic, Tier 2 is Preferred Brand, and Tier 3 is Non-Preferred Brand. Is that correct? What is Tier 4?

   b. What trend and discount assumptions are applied to the drugs on the Specialty Formulary List? Are these drugs all trended and discounted as specialty drugs or are they trended and discounted based on their drug tier?

   c. How does a drug's classification as specialty affect patient access? Are beneficiaries restricted to using pharmacies that belong to Cigna's or its pharmacy benefit manager's specialty network? If so, please provide a list of all pharmacy locations in or serving Vermont that are in the specialty network.

   d. How does a drug's classification as specialty affect the affordability of those drugs to consumers? Does Cigna offer plans in which all specialty drugs are subject to coinsurance rather than copays? If so, please confirm that, under such plans, all medicines for treatment of HIV would be subject to coinsurance. What are the percentages of coinsurance required under such plans?

Sincerely,

/s/ Michael Barber

General Counsel
Green Mountain Care Board

Cc: GMCB Rate Review Team
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