CHLIC Responses to VT Objections Round 1 (Received on 4/3/2024)

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

Response:

- **a.** Your observation is correct, however Table 33 is an average unit cost across many different drugs and therefore includes the impact of drug mix. Cigna's formulary decisions contemplate clinical efficacy, member cost and net cost. The utilization mix by clinical usage within preferred brand and non-preferred brand would not be consistent, including scenarios where some preferred brand drugs don't have an alternative on the non-preferred brand list.
- **b.** Yes, generally Cigna expects preferred brand drugs to be lower cost net of rebates and other discounts than a-non-preferred brand alternative. But, not all preferred brand drugs have an alternative available on the non-preferred brand list and vice versa.
- **c.** The discounts applied are the same for preferred vs non-preferred brand drugs, but may vary by drug type, channel, pharmacy network, funding type, and client pricing terms.
- **d.** Yes, there could be some cases where a member could pay more for a preferred brand drug during the deductible phase than a non-preferred brand alternative. We don't expect this to generally be the case, but it could happen. Also, projected Rx rebates to be retained by CHLIC serve to lower the projected net claims used to develop premium rates. This is consistent with the way Rx rebates are treated for purposes of calculating the MLR's reflected in the SHCE.

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?

Response:

- **a.** Tier 4 = specialty. For a client that has 4 tier, all specialty drugs are in tier 4. For a client that has 3 tier, specialty drugs can be split to any of the 3 tiers. Typically, tier 1 = generics, tier 2 = preferred brands, tier 3 = non-preferred brands, and where applicable, tier 4 = specialty.
- **b.** Specialty drugs are trended by the specialty trend assumptions.
- **c.** The Mandatory Mail for Maintenance Drugs benefit and the Rx Exclusive Specialty Home Delivery (ESHD) benefits are not permitted to be sold to fully insured or ASO non-ERISA plans issued in VT and therefore have not been approved by the Vermont Department of Financial Regulation. We have rules in our systems that will not allow this rider to be selected for any insured or ASO non ERISA plans issued in VT.
- **d.** If a client elects a 4 Tier plan, then specialty Rx is subject to the Tier 4 cost share. If a client elects a 3 Tier plan, then specialty Rx will be subject to the Generic/Preferred Brand/Non-Preferred Brand cost share, like other drugs. In either scenario, clients have the option to select copay or coinsurance options, with or without a deductible needing to be satisfied first. For the most part, medicines for treatment of HIV would following the applicable cost share for specialty Rx, but there are some that are subject to PPACA mandates and therefore the customer would pay $0 cost share.