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TO THE HOUSE COMMITTEE ON
CONSUMER PROTECTION & COMMERCE

TWENTY-SIXTH LEGISLATURE
Regular Session of 2011

Monday, March 21, 2011
2 p.m.

TESTIMONY ON SENATE BILL NO. 591, S.D. 2, H.D. 1 – RELATING TO PHARMACY BENEFIT MANAGEMENT COMPANIES.

TO THE HONORABLE ROBERT N. HERKES, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner'), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department").

The Department opposes this bill, which creates a regulatory scheme for pharmacy benefit management companies enforced by the Commissioner. The Department does not oppose the regulation of pharmacy benefit managers, but does not believe that pharmacy benefit managers should be regulated by the Commissioner since the Commissioner does not have staff with the expertise or experience in this subject matter.

The primary justification for regulation of insurance companies is that they are risk-bearing and that therefore potential insolvencies can be harmful to consumers and disruptive to the market. Pharmacy benefit management companies do not present these issues. Simply put, the regulation contemplated by this bill is not insurance regulation and therefore does not belong under the Commissioner.

We thank this Committee for the opportunity to present testimony on this matter.

Brian Carter RPh.
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Hanapepe, HI 96716
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wbkotter@hotmail.com

I SUPPORT SB 591/HB 275

I am an independent community pharmacist on the west side of Kauai. I am testifying in support of HB 275/ SB 591.

This bill will protect the patient right to choose a healthcare provider, improve compliance to drug therapy, minimize healthcare costs to the state, create a more sustainable drug delivery system, and help to create a healthier and happier workforce.

The patient's right to choose a provider is one that has been compromised by the **mandatory mail order** clauses in the current insurance plan offered by the EUTF. This has caused much frustration by county and state employees. Many errors in medication delivery have resulted in hospitalization and increased cost to the patient as well as the state. This bill will enable for patients a right to receive prescriptions from whomever they choose, whenever they choose.

This ability to go to the local drug store and receive medication has been available during the past 2 years under the EUTF plan but the patient has been severely punished by having to pay out of pocket for medicine that they have not received by mail order. Having the option to go to their local drug store without penalty will increase compliance with physician's orders and give a more supportive care system for our patients.

The cost of doing business outside the state can only be seen as foolish in many ways. The current mail order facility in Florida that has been receiving **ALL** of the prescriptions for state and county employees does not pay taxes in Hawaii. All of the revenue generated by the facility stays in Florida. This "mail order to save money" strategy that has been used by the state has no statistical backing. There has never been any study that finds the mail order is saving money and if one is eventually released it will not encompass costs like Emergency Room costs due to failure to receive medication on time. How much is it worth to have patients having to be hospitalized due to missed heart or blood pressure medication? There are studies that have shown the waste and higher cost of using mail order. See http://www.ncpanet.org/pdf/leg/falsesavingsofmailorder.pdf or www.ncpanet.org/pdf/leg/ncpamailorderpres.ppt for more information regarding the higher costs of mail order. One study "Effects of Mail Order Incentives on Prescription Plan Costs" by the University of Arkansas clearly debunks the mail order savings myth. (see above for link or call me I will e-mail it to you)

With the implementation of this bill, increased competition in the marketplace will allow for a more sustainable drug delivery system. It is not to say that by the passage of this bill we will see a return to "old times" without mail order in the marketplace. Community pharmacies will have to work hard to provide a level of care that will compete with a mail order alternative. The service that we provide must be superior or patients won't mind the hassles associated with mail order or may find it easier than going into a local pharmacy. The competitive market has been shown to bring out the best in many industries, this will be no different.

With mail order not being a mandatory requirement to receive medication people will be happier. Patients will respect their legislators giving them the freedom of choice and the opportunity to support their local economy. The pride of a self sustained community is in everyone within that community. **I care** for my neighbors and their needs. I want to live in a healthy community and am willing to do whatever it takes to make it a better more vibrant society.

I appreciate the opportunity to express my support for HB 275/ SB 591. I hope you will realize the value of this bill and what it means to the people of Hawaii. Thank you for taking the time to read my testimony.

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 21, 2011

The Honorable Robert N. Herkes, Chair
The Honorable Ryan Yamane, Vice Chair
House Committee on Consumer Protection and Commerce

Re: SB 591 SD2 HD1 – Relating to Pharmacy Benefit Management Companies

Dear Chair Herkes, Vice Chair Yamane and Members of the Committee: OPPOSED

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 591 SD2 HD1 which would regulate pharmacy benefit management companies (PBMs) in Hawaii. HMSA has concerns with this measure in its current form.

HMSA's goal in the provision of outpatient pharmacy services is to ensure our members have access to affordable, high quality medication. HMSA believes that optimal drug therapy results in positive medical outcomes, which helps to manage overall health care costs. We believe that some of the language in SB 591 SD2 HD1 which could prohibit health plans from utilizing cost-saving methods. While we appreciate changes made to this measure by the previous Committee we continue to have concerns around some of the language including:

Page 5, Line 20
Under the reporting section, a PBM contracting with an "auditing" entity to provide prescription drug coverage in the state is annually required to perform certain reporting to health plans. The addition of the word "auditing" to this sentence seems to imply that only PBMs contacted to provide prescription drug coverage with an auditing entity would need to comply with filing reports.

Page 8, Line 16 through Page 10, Line 9
Language in this section would impact PBMs and any cost savings as the result of the use of these entities would ultimately be lost at a time when the cost of prescription drug coverage continues to climb.

- Section (b) restricts a PBM from being able to utilize mail order pharmacy. This implies that PBMs dictate pharmacy benefits – such as restrictive networks, mandatory mail order and co-payments however, this is not the case. These types of benefit design decisions are made by employer groups or other payers utilizing the services of the PBM
- Section (c) restricts incentive co-payments. While specifically attempting to exclude these types of incentive co-payments to persuade members to obtain medications through mail-order members, we believe that the broad language could also affect incentive co-payments being used to encourage members to take an active role in choosing cost-effective drugs, such as generics
- Section (d) sets reimbursements at a level not less than a provider's acquisition cost plus a professional dispensing fee. On the surface this language seems benign however it is important to note that there is currently no industry standard resource to obtain a pharmacy's true drug acquisition costs. This is why reimbursement contracts are based on available industry pricing metrics such as discounted Average Wholesale Price or

Wholesale Average Cost plus. For the same drug, true acquisition cost will vary from pharmacy to pharmacy and over time

- Section (e) pertains to rebranded products. We are uncertain of the definition of a "rebranded" pharmaceutical product or a pharmaceutical product with an altered National drug code. However, HMSA currently does not cover medications from re-packagers
- The violations and penalties section of this measure is extremely onerous due to its broad language

We understand and support the legislature's desire to gain additional information around the operation of PBMs within the state. Unfortunately we believe that the language in SB 591 SD2 HD1 could ultimately end up harming consumers and increasing costs.

Thank you for the opportunity to provide testimony.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

CVS CAREMARK

Representative Robert Herkes, Chair
House Committee on Consumer Protection & Commerce

Monday, March 21, 2011
State Capitol, Conference Room 325

CVS CAREMARK TESTIMONY
SB 591 SD2 HD1 Relating to Pharmacy Benefit Management Companies – In opposition

Chair Herkes, Vice Chair Yamane and members of the Committee on Consumer Protection & Commerce:

My name is Todd Inafuku, testifying on behalf of CVS Caremark Corporation ("CVS Caremark") in opposition to SB 591 SD2 HD1 Relating to Pharmacy Benefit Management Companies.

CVS Caremark is one of the nation's largest independent providers of health improvement services, touching the lives of millions of health plan participants. As CVS Pharmacy and Longs Drugs in Hawaii, we are the largest employer of licensed pharmacists in the United States with over 25,000 pharmacists.

Caremark, our pharmacy benefit manager (PBM) offers our health plan customers a wide range of health improvement products and services designed to lower the cost and improve the quality of pharmaceutical care delivered to health plan participants. Through our unique healthcare model and clinically-based services, CVS Caremark is able to reduce medication errors, increase adherence with drug therapies, and improve health outcomes. In addition, through the use of cost containment and formulary management tools that Caremark clients utilize, they in turn are able to offer a high-quality, cost effective outpatient drug benefit for their enrollees. CVS Caremark clients include a broad range of highly sophisticated private and public health plan sponsors, including Blue Cross Blue Shield plans, health insurance plans, employers, governments, third-party administrators and Taft-Hartley plans.

CVS Caremark has the following concerns with SB 591 SD2 HD1 Relating to Pharmacy Benefit Management Companies:

Disclosure Mandates Undermine Price Competition and Increase Costs

SB 591 SD2 HD1 would require a PBM to disclose proprietary contract information to health plan clients. We believe this will adversely impact competition in the marketplace and create a "cookie cutter" approach for PBM contracting, which would ultimately result in higher prescription drug costs for consumers.

The Federal Trade Commission (FTC) has warned several states that legislation requiring PBM disclosure could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[1] According to the FTC and the Department of Justice, "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[2]

Transparency is already available in today's competitive marketplace. Each PBM client is uniquely situated and some have elected to not request disclosure for business reasons of their own. If a health plan or employer wants certain financial information to make a purchasing decision, CVS Caremark believes that it

[1] FTC letter to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004); *see also* FTC Letter to Senator James Seward, New York Senate, (March 31, 2009).
[2] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004

should be left to decision of the PBM client to make it a requirement of their bid and negotiate the terms in their contract with PBMs.

Uncertainty on prohibited activities

Under section 6 Prohibited activities subsection (a) it is unclear as to the activity a PBM not exclude in their contractual arrangements within the state to prevent being found in violation of this chapter and being assessed a fine of up to $10,000 for each violation.

Dictating Private Contract Rights Only Benefits Network Pharmacies While Hurting Consumers

PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates, but must do so while meeting network adequacy requirements. It is important to have pharmacies compete to be part of the pharmacy network for a particular PBM in order to keep the rising costs of prescription drugs down. Network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan. Further, the ability of PBMs to negotiate with pharmacies in the private marketplace without government interference plays a critical role in reducing prescription drug benefit costs to health plans and employers, and ultimately consumers.

CVS Caremark believes that government should not create private contract rights that would hinder the ability of PBM clients to create pharmacy networks that meet their needs while providing health benefits at a lower cost.

In closing, a PBM contracts with very sophisticated purchasers of health care and are required to respond to very specific requirements in a Request for Proposal (RFP) and must vigorously compete with other PBMs for that business. **Ultimately, it is the purchaser of the PBM services who determines what the benefit design will be for its beneficiaries and the PBM that can offer the best value in administering that benefit is the one they hire.**

Based on the above concerns, CVS Caremark respectfully requests that you hold this measure. Thank you for the opportunity to testify.

Todd K. Inafuku

Director of Government Affairs

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medco

March 20, 2011

To: Representative Herkes and Members of the House Consumer Protection & Commerce Committee

Fr: Cynthia Laubacher, Senior Director, State Government Affairs
Medco Health Solutions, Inc.

Re: Senate Bill 591 HD1 – Oppose
Hearing: March 21, 2011 2 p.m.

On behalf of Medco Health Solutions, Inc., I regret to inform you that we must respectfully oppose Senate Bill 591 relating to regulation of pharmacy benefits and pharmacy audits. Medco is a leading provider of comprehensive, high-quality, affordable prescription drug care in the United States, including over 650,000 residents of Hawaii. As a PBM, Medco is hired by large employers, unions, health plans and public sector entities to help manage the quality and affordability of the drug benefit these plans offer to their members or employees.

PBMs are Regulated

- PBMs comply with numerous already existing regulatory requirements as third party administrators, preferred provider organizations, utilization review organizations, resident and non-resident pharmacies, etc., where required by law.

- State boards of pharmacy regulate PBM activities including dispensing, labeling, counseling, generic substitutions, controlled substances, etc. In the state of Hawaii, the Medco enterprise holds 37 licenses with the Hawaii Board of Pharmacy.

- Through contracts with health plans and insurers, PBMs are required to comply with the same consumer protection laws and regulations governing utilization review and prior approval, timely claims payment, and dispute resolution systems, among others.

S.B. 591 Increases Costs for Employers, Plans and Consumers

Reporting

- SB 591 requires PBMs to disclose proprietary information. The Federal Trade Commission (FTC) has warned several states that legislation requiring PBM disclosure

could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."

- The Department of Justice and the FTC issued a July 2004 report noting that "states should consider the potential costs and benefits of regulating pharmacy benefit transparency" while pointing out that "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimum level of transparency than regulation of those terms."

- Legislation requiring public disclosure of private PBM contract terms would increase managed drug spending by $127 billion over the next decade, according to a 2007 study by PricewaterhouseCoopers.

- PBMs already appropriately address disclosure of financial agreements in their contractual agreements with their clients. Clients also contract for audit rights to verify the accuracy of the disclosed information.

Prohibited Activities

- Health plans and employers frequently choose to provide their members and employees with the option of a lower copayment on a 90-day supply of their medications through the use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions.

- Mandates a PBM to contract with any provider that wants to join their pharmacy network, regardless of whether they have committed illegal activities or are not as competitive in service or quality as other pharmacies.

- PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates. It is important to have pharmacies compete to be part of the pharmacy network for a particular PBM in order to keep the rising costs of prescription drugs down. Network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan.

- Increases costs by prohibiting plans and employers from utilizing a variety of tools currently available to manage their prescription drug costs, including incentives for using mail service. Mail service pharmacies, through a credible source such as Medco, help payors and patients lower the cost of quality care. According to a 2004 report by the General Accounting Office (GAO-03-196), at mail, PBMs provide plans with savings over retail prices paid by patients without third-party coverage - about 27% and 53% for brand and generic drugs, respectively.

For these reasons, Medco must respectfully oppose Senate Bill 591. Please feel free to contact me with any questions. Thank you.

Hawaii Association of Health Plans

March 21, 2011

The Honorable Robert Herkes, Chair
The Honorable Ryan Yamane, Vice Chair

House Committee on Consumer Protection and Commerce

Re: SB 591 SD2 HD1 – Relating to Pharmacy Benefit Management Companies

Dear Chair Herkes, Vice Chair Yamane and Members of the Committee:

My name is Howard Lee and I am President of the Hawaii Association of Health Plans ("HAHP"). HAHP is a non-profit organization consisting of eight (8) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.
Kaiser Permanente
MDX Hawai'i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify on SB 591 SD2 HD1 which would regulate pharmacy benefit management companies (PBMs) in the state. HAHP member organizations are unable to support the language contained in this measure.

While we understand the genesis for this legislation, we believe that it could have harmful impacts on Hawaii's health care system as a whole. Stringent regulatory schemes will only serve to increase health insurance costs, create disincentives to PBMs operating in the state and prevent others from entering Hawaii's marketplace. PBMs give Hawaii's health plans opportunity and options to work towards decreasing the cost of prescription medications which account for approximately 20% of all health care costs.

Due to these factors, we believe that SB 591 SD2 HD1 is unnecessary and would respectfully urge the Committee see fit to hold it. Thank you for the opportunity to testify today.

Sincerely,

Howard Lee

Howard Lee
President

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Monday, March 21, 2011, 2:00 pm, Conference Room 325

To: COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Robert N. Herkes, Chair
Rep. Ryan I. Yamane, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 591, SD2, HD 1 RELATING TO PHARMACY BENEFIT MANAGEMENT COMPANIES

Chairs & Committee Members:

The Hawaii Medical Association supports this bill, as the HMA supports the regulation of mainland pharmacy benefit management across the board.

In the past the HMA has submitted legislation that would require health plans to utilize local (Pharmacy and Therapeutics) P&T committees and local pharmacy benefit management. It is important to maintain local access to pharmacy services, especially in rural areas.

This bill addresses a broader philosophy of keeping healthcare local and not exporting important services, services, which once lost, will be very difficult to rebuild. It is a problem that spans the entire healthcare continuum.

Independent community pharmacies provide much-needed access to care to patients in traditionally underserved and rural areas, including seniors and low-income individuals. Independents represent 39% of all retail pharmacies, but represent 52% of all rural retail pharmacies. Over 1,800 independent community pharmacies operate as the only retail pharmacy within their rural community.

This year at a conference in Washington, Senate Appropriations Chairman Daniel Inouye touted the importance of pharmacists practicing in rural areas – one of the reasons for a new pharmacy school at the University of Hawaii at Hilo. **The HMA would like to join Sen. Inouye in supporting rural access to healthcare.**

Thank you for the opportunity to provide this testimony.

94-450 Mokuola Street, Suite 106, Waipahu, HI 96767
808.675.7300 | www.ohanahealthplan.com

Monday, March 21, 2011

To: The Honorable Robert N. Herkes
Chair, House Committee on Consumer Protection and Commerce

From: 'Ohana Health Plan

Re: Senate Bill 591, Senate Draft 2, House Draft 1-Relating to Pharmacy Benefit Management Companies

Hearing: Monday, March 21, 2011, 2:00 p.m.
Hawai'i State Capitol, Room 325

OPPOSED

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to testify in opposition to Senate Bill 591, Senate Draft 2, House Draft 1-Relating to Pharmacy Benefit Management Companies.

The purpose of this bill is to require the registration of and regulation of pharmacy benefit management companies (PBMs) practices, and additionally includes reporting requirements of information that are considered to be proprietary.

While we understand the reasons behind this legislation, we cannot support it as it could prevent `Ohana Health Plan's current PBM from fulfilling its contractual requirements that maintain our compliance with State and Federal contracts and regulations. This may also become a disincentive for mainland-based PBMs to enter into contracts with local-based health insurance companies. If the genesis of this measure is to address a specific problem or PBM, we would respectfully request that this bill be amended to limit its impact against other PBMs that have maintained good standards and practices within the State and would be unnecessarily impacted by this bill's passage.

Health Plan Pharmacy & Therapeutics (P&T) Committee; or physicians and pharmacists decide on the prescription benefits and the PBM implements the benefit through sophisticated information technology systems. The Health Plans also develop policies and procedures, for which they are solely responsible, and the PBMs develop and implement the processes that enact the policies, such as mail order programs. Any issues that occur with administering the pharmacy benefit should be directed to the Health Plan, not the PBM.

The PBM market is very competitive and releasing proprietary contractual information will dissuade health plans from doing business in Hawaii. Since advanced information technology infrastructure is required and Hawai`i's small market size cannot support this level of sophistication, this legislation may deprive Hawai`i people of the advantages of state-of-the-art PBM technology. PBM technology automates the claims process so eligibility and benefits are checked instantly unlike claims for other medical claims which typically take weeks. PBM technology also provides immediate patient safety features which address overdoses, drug-drug interactions and other possible dangers to patients.

Many of Hawi'i's locally-based health care insurance providers with local staff choose to contract with PBMs in order to better manage the complex business of managing pharmacy benefits for their members. Pharmacy costs account for approximately 20% of health care costs and therefore is an area that needs to be very carefully managed in order to better control the rising cost of health care. Without state-of-the-art PBM services, Hawai`i would experience increased costs for the same level of care.

We would respectfully request that the definition of "auditing agency" as a managed care company, insurance company, third-party payor or the representatives of the managed care company, insurance company or third-party payor in the bill be deleted as that component of the bill no longer exists.

The reporting section (§ -3) of this measure is also confusing as it requires a PBM contracting with an auditing entity to provide prescription drug coverage in the State of Hawaii to provide at least annually a report to each group health plan. A health plan contracts a PBM to administer and implement a health plan's prescription drug benefits, not an auditing entity. Health plans also contract with auditing entities to conduct regular audits on their contracted PBMs to ensure that their contracts, policies and procedures are being properly enacted. Reports are already required of each plan's PBM to the respective health plan that they are contracted with. Therefore this section of the bill is also unnecessary. However, if the Legislature is seeking another type of information or further information then the language in the bill should be amended to more clearly reflect that objective.

This bill also prohibits the exclusion of any willing provider from any contract offered within the State, regardless of the pharmacies standing in regard to fraud, waste and abuse. PBMs provide network contracting services to health plans that set standards and criteria for participation in their pharmacy network. With over 200 pharmacies in the State of varying sizes and business practices, 'Ohana Health Plan provides quality oversight of their pharmacy providers to insure our members get the standard of care they require. This bill would allow a poor performing pharmacy to continue to see 'Ohana members.

We also have concerns about § -6(c), which would prohibit enrollees who choose to utilize mail-order options offered by PBMs from benefiting from the cost savings that mail-order prescription drugs can provide. Ultimately, this section would limit consumer choice.

If the Legislature feels that there is continued problems with one particular PBM's delivery of service, we would recommend that this bill be amended to be limited to address only those specific issues rather than impacting the state's entire health care system overall.