SB667

TESTIMONY

HMSA Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 6, 2013

The Honorable Josh Green, M.D., Chair
The Honorable Rosalyn H. Baker, Chair
Senate Committees on Health and Commerce and Consumer Protection

Re: SB 667 – Relating to Health

Dear Chair Green, Chair Baker and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 667 which would regulate pharmacy benefit management companies (PBMs) in Hawaii. HMSA opposes this Bill.

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.

This Bill addresses two facets, rebates and audits, out of a multitude of PBM services offered to clients. HMSA provides some pharmacy services directly for our employer groups, while other services are provided through our contracted arrangement with a PBM vendor, CVS-Caremark-Longs. We believe this legislation will apply to HMSA.

There is an implication that PBMs dictate pharmacy benefits – such as restrictive network, mandatory mail order and copayments. This is not the case. The employer groups or other payers are the entities that make these benefit design decisions. Regulation of PBMs as outlined in this legislation will prohibit health plans from utilizing cost-saving methods.

While there are numerous concerns with this Bill, as drafted, they include:

Page 3, Line 6
The definition of "pharmacist services" is inconsistent with the definition in Chapter 461, which regulate pharmacists.

Page 2, Line 9 through Page 6, Line 7 - Registration
Section 2 of the bill speaks to Registration of PBMs. However, while it requires annual statements to be filed with the Insurance Commissioner, it does not include details regarding what a PBM must include in its filing and the Commissioner's approval process.

Page 6, Line 8 through Page 10, Line 3– Audit of Pharmacy Records
This section requires a an audit of a "pharmacy" by an "auditing entity," which is defined as a "managed care company, insurance company, third-party payor or the representative of the managed care company, insurance company, or third-party payor." It is not clear if mutual benefit societies are included.

Subsection __-3(a)(11) prohibits the auditing entity from using extrapolation in calculating recoupment. This would pose a major concern since extrapolation is a reasonable technique of calculating recoupment and penalties for audits.

Page 10, Line 4 – Reporting
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 13, Line 4 through Page 14, Line13 – Prohibited Activities 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 __7(a)** will remove the employers' and health plan's ability to exclude "unwanted" providers who do not meet standards of practice, have regulatory concerns, or are likely to offer our members substandard care. This language also will remove the employers' and health plan's ability to manage cost through best pricing via restricted or closed networks. HMSA has employer groups who ask for these types of cost-management and/or business strategies.

- **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. **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) r**estricts 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**) prohibits differential reimbursement to pharmacies. This language will remove the employers' and health plans' ability to differentially reimburse access-critical pharmacies in rural locations or other pharmacies who may have additional cost-of-business expenses – such as on the Neighbor Islands. Additionally, there is 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.

- **Section __ (g)** will impact drugs obtained by our members through mail order pharmacies, specialty drugs pharmacies, and the few out-of-state pharmacies that provide medications which are limited to specific pharmacy providers approved by the FDA. An example would be medication for cystic fibrosis.

- 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 SB 667 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 | 1300 I Street, N. W., Suite 525 West | Washington, DC 20005 | T: 202-772-3500

Senate Committee on Health
Senator Josh Green, Chair
Senator Rosalyn H. Baker, Vice Chair

Senate Committee on Commerce and Consumer Protection
Senator Rosalyn H. Baker, Chair
Senator Brickwood Galuteria, Vice Chair

Wednesday February 6, 2013, 2:00pm
State Capitol, Conference room 229

RE: SB 667 Relating to Health – In Opposition

Chair Green, Chair Baker, and members of the committees:

My name is Todd Inafuku, testifying on behalf of CVS Caremark Corporation ("CVS Caremark") in opposition to SB 667 Relating to Health. This measure imposes requirements that would stifle price and product competition and hurt all plan sponsors, including self-insured employer plans, commercial health plans, Medicare Part D plans, state government employee plans such as the Employer Union Trust Fund (EUTF), union plans, and the Federal Employees Health Benefits Program (FEHBP) who want to provide access to high quality, affordable prescription drug benefits to their beneficiaries and employees.

Plan Sponsor Decisions Determine Savings

Plan sponsors - not pharmacy benefit managers (PBMs) – determine how the pharmacy benefits provided to their beneficiaries and employees are managed. They also determine formulary coverage, copayment tiers, utilization management, and pharmacy channel options including mail order, specialty and preferred or limited pharmacy networks. In making these choices, plan sponsors weigh many factors, including clinical quality, cost, and member satisfaction.

Pharmacy Benefit Managers' (PBMs) Save Consumers' Money and Add Quality

- In Hawaii, PBMs will save $8.3 billion over the next ten years, including $5.5 billion for consumers, employers, unions, and the state government and $2.8 billion for Medicare and its beneficiaries.[1]
- PBMs ability to negotiate discounts with manufacturers and pharmacists enables consumers to receive lower prices for their prescription medications.
- Through clinically-based services, PBMs are able to reduce medication errors, increase compliance with drug therapies, and improve health outcomes.
- This legislation, although it appears to help pharmacies, will actually have the unintended consequence of opening the door to fraud, abuse, and wasteful spending in health care. Plan sponsors with pharmacy benefit plans rely on audits of their network pharmacies to recoup monies incorrectly

[1] "Pharmacy Benefit Managers (PBMs): Generating Savings for Plan Sponsors and Consumers," Visante, September, 2011.

paid for claims with improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities.

- Plan sponsors should have the right to ensure that the pharmacy claims that they are paying for are legitimate. Audit and appeals procedures are already contained in contracts between PBMs and pharmacies.
- "Health care fraud is a pervasive and costly drain on the U.S. health care system. In 2008, Americans spent $2.34 trillion dollars on health care. Of those trillions of dollars, the Federal Bureau of Investigation (FBI) estimates that between 3 and 10 percent was lost to health care fraud." [2]
- In 2010 alone, a joint health care fraud prevention effort between the Department of Justice and the Department of Health and Human Services resulted in the recovery of more than $4 billion in taxpayer dollars. Some of the recovered money came from uncovering pharmacy fraud schemes that included fraudulent billing practices and illegal dispensing of medications. [3]

Mandated Disclosure Undermines Price Competition and Increases Costs

- Section 4 (b) & 5 would require PBMs to disclose highly confidential and proprietary financial information to group health plans and pharmacies, with no requirement that plans or pharmacies keep that information confidential. The FTC has stated that a mandate by law of the disclosure of proprietary financial information would "hold PBMs to a standard that does not apply to other industries."[4]
- Requiring PBMs to disclose their price negotiation strategies with manufacturers damages competition. This legislation would stifle the innovative marketplace and would only result in increased costs for health plans, employers and ultimately for consumers.[5]
- The FTC recently stated that similar disclosure provisions "may increase the cost of the PBM's services because it will preclude health plans and PBMs from entering into efficient (*i.e.*, cost-effective) contracts for the administration of pharmacy benefits; and second, they may have the unintended consequence of publicizing proprietary business information in a way that could foster collusion among third parties."[6]
- "Vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms," according to a 2004 report by the FTC and the Department of Justice.[7]
- The 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." [8]

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[2] National Health Care Anti-Fraud Association, "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," October 2010, available at http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/WhitePaper_Oct10.pdf.
[3] U.S. Department of Health and Human Services & U.S. Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," January 2011, available at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.
[4] FTC letter to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).
[5] FTC letter to Assemblywoman Nellie Pou, *supra* note 2.
[6] FTC letter to Senator James L. Seward, New York Senate, (March 31, 2009).
[7] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004.
[8] 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).

Dictating Private Pharmacy Network Contracts Raises Costs and Hurts Consumers

- Section 7 imposes a host of burdensome requirements on private pharmacy network contracts. It eliminates consumer choice and would force one-size-fits-all co-payments by prohibiting a plan benefit design from having different co-payments.
- Plan sponsors frequently choose to provide their beneficiaries and employees with the option of a lower co-payment on a 90-day supply of their medications through use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions.

Mail-Service Pharmacies Make Prescriptions More Affordable

- Restricting the appropriate use of mail service for long-term prescriptions will raise costs for consumers.
- A recent study by Visante concluded that mail-service pharmacies will save employers, unions, government employee plans, consumers, and other commercial-sector payers $203 million over the next ten years in Hawaii.[9]

Consumers Benefit from Mail-Service Safety and Cost-Savings

- One study found a highly automated mail-service pharmacy dispensed prescriptions with 23-times greater accuracy than retail pharmacies. The mail-service error rate was zero in several of the most critical areas, including dispensing the correct drug, dosage, and dosage form.[10]
- A study published in the American Journal of Managed Care found that consumers receiving their prescription medications for chronic conditions through a mail-service pharmacy "were more likely to take them as prescribed by their doctors than did patients who obtained them from a local pharmacy." Key findings from the study include:
    - Mail-order pharmacy users were more likely than local pharmacy users to have a financial incentive to fill their prescriptions by mail (49.6 percent vs. 23.0 percent), and to live a greater distance away from a local pharmacy (8.0 miles vs. 6.7 miles).
    - 84.7 percent of patients who received their medications by mail at least two-thirds of the time stuck to their physician-prescribed regimen, versus 76.9 percent who picked up their medications at "brick and mortar" Kaiser Permanente pharmacies.[11]

State-Mandated Contract Terms on Private Market Agreements Unnecessary

- SB 667 would mandate a state-prescribed business model for contractually negotiated private payment agreements between PBMs and their plan sponsors, thereby limiting the ability to tailor a contract that best suits the client's interests and goals.
- PBMs' clients are sophisticated purchasers of health care. Based on a client's Request for Proposals (RFPs), a PBM may offer the client multiple variations of models from the more basic plan to the most comprehensive plan relying on multi-tiered co-payments, formularies developed with physicians and pharmacists, pharmacy networks, mail-service pharmacy, and other similar tools that make drugs more affordable and accessible.

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[9] "How Mail-Service Pharmacies will Save $46.6 Billion Over the Next Decade," Visante, February, 2012.
[10] J. Russell Teagarden et al., "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice," Pharmacotherapy: Official Journal of the American College of Clinical Pharmacy, Volume 25, Issue 11, pgs 1629 –1635 (2005).
[11] O. Kenrik Duru et al., "Mail-Order Pharmacy Use and Adherence to Diabetes-Related Medications," The American Journal of Managed Care, Volume 16, No. 1, pgs. 33-40 (2010).

1300 I Street, N. W., Suite 525 West| Washington, DC 20005 | T: 202-772-3500

SB 667 takes away the ability of plan sponsors to design a cost effective pharmacy benefit plan that best suits their need and the needs of their beneficiaries and employees. For the reasons outlined above, CVS Caremark respectfully requests this bill be held.

Thank you for the opportunity to testify on this matter of importance,

Todd K. Inafuku

Cell – (808) 620-2288

CVS Caremark is dedicated to helping people on their path to better health as the largest integrated pharmacy company in the United States. Through the company's more than 7,400 CVS/pharmacy stores including Longs Drugs in Hawaii; its leading pharmacy benefit manager serving more than 60 million plan members; and its retail health clinic system, the largest in the nation with more than 600 MinuteClinic locations, it is a market leader in mail order, retail and specialty pharmacy, retail clinics, and Medicare Part D Prescription Drug Plans. As a pharmacy innovation company with an unmatched breadth of capabilities, CVS Caremark continually strives to improve health and lower costs by developing new approaches such as its unique Pharmacy Advisor program that helps people with chronic diseases such as diabetes obtain and adhere to their medication therapies.

February 5, 2013

TO: Chair Josh Green and Members of the Committee on Health

Chair Rosalyn Baker and Members of the Committee on Commerce and Consumer Protection

FROM: Pharmaceutical Research and Manufacturers of America
(William Goo)

RE: **SB 667** - Relating to Health
Hearing Date: February 6, 2013
Time: 2:00 pm

My name is William Goo. I represent the Pharmaceutical Research and Manufacturers of America (PhRMA).

PhRMA respectfully opposes passage of **SB 667.** Attached is PhRMA's testimony in opposition.

Thank you for considering this testimony.

Statement PhRMA

Statement of Opposition to Hawaii SB 667
February 5, 2013

Position: PhRMA opposes SB 667 in Hawaii as currently written because it requires pharmacy benefit managers to disclose proprietary contracts and financial agreements with prescription drug manufacturers to covered entities. As a result, the legislation may result in higher healthcare costs in the long-run for patients and businesses in Hawaii.

SB 667 calls for assignment of fiduciary responsibility to pharmacy benefit managers (PBMs) and would require disclosure of all contracts and agreements between a PBM and prescription drug manufacturers to any plan or covered entity that contracts with the PBM for services. The bill compromises the business agreements between drug manufacturers and PBMs under the premise of patient protection.

A trade secret is "any information that can be used in the operation of a business or other enterprise and that is sufficiently valuable and secret to afford an actual or potential economic advantage over others." *Restatement (Third) of Unfair Competition § 39 (1995).* The definition includes compilations of data, pricing, marketing techniques, and the identity of customers. Business and negotiating strategies vary by manufacturer, and those strategies are the product of focused research and ongoing relationships with healthcare providers. Manufacturers engage in strategic negotiations with clients to ensure that the most appropriate contract is approved for each individual client's needs. Disclosure of the agreed upon terms for one client might compromise competition in drug negotiations with other clients. Such financial strategies are closely guarded by each manufacturer and are not commonly known.

During the 2010 passage of federal health reform legislation, the proponents of this type of PBM legislation attempted to do nationally exactly what this legislation is trying to do for Hawaii. However, federal lawmakers understood that there are great unforeseen consequences and after taking the advice of the Federal Trade Commission (FTC), lawmakers limited any disclosures only to an aggregate, non-specific form. In Hawaii's proposed legislation, the decision to make disclosures of such sensitive information lies with the Board of Pharmacy and manufacturers are left without protections from such disclosures. Patients and businesses may end up paying higher prices for healthcare services as a result of the disclosures that will result from specific disclosures in SB 667. Furthermore, the legislation could negatively impact the penetration of PBMs in Hawaii. A decrease in competition can lead to higher prices for all purchasers of health insurance and PBM services, including Hawaii retirees, state employees, businesses and self-insuring union health funds.

PhRMA urges Hawaii legislators to oppose SB 667.

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: mendezj@hawaii.edu
Subject: *Submitted testimony for SB667 on Feb 6, 2013 14:00PM*
Date: Friday, February 01, 2013 1:59:24 PM

SB667
Submitted on: 2/1/2013
Testimony for HTH/CPN on Feb 6, 2013 14:00PM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Javier Mendez-Alvarez	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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