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Express Scripts	Oppose	No

February 17, 2016

To: Senator Rosalyn Baker, Chair
Senator Michelle N. Kidani, Vice Chair
Committee on Commerce, Consumer Protection and Health

Fr: Cynthia Laubacher, Senior Director, State Affairs
Express Scripts Holding Company

Re: Senate Bill 2376 – Pharmacy Networks
Hearing Date: Wednesday, February 17, 2016 9:00am

Express Scripts appreciates the opportunity to submit testimony regarding Senate Bill 2376, which seeks to allow patients to use non-network pharmacies if an in-network pharmacy is not within ten miles. Express Scripts manages the pharmacy benefit for 85 million Americans.

House Bill 65/Act 226 of 2013, allows all retail pharmacies in the state the opportunity to contract with us. This language was the result of extensive negotiations involving plans, pharmacy benefit managers and the local retail pharmacists.

SB 2376 seeks to undo those agreements and creates numerous problems as a result. First, pharmacy networks are designed to provide consumers convenient access to prescriptions at discounted rates. Pharmacies offer discounted reimbursements in exchange for being included in our networks. The more limited the network, the greater the discount in exchange for the expected increase in business. SB 2376 eliminates the incentive for pharmacies to offer discounts to be in networks because they will no longer have that expectation of increased business from patients using network pharmacies in exchange for lower copayments. As a result, plan costs will increase.

Second, PBMs monitor prescription safety across all of the network pharmacies, alerting pharmacists to potential drug interactions, even if a consumer uses multiple pharmacies. Pharmacies outside our network cannot bill us for their services, access patient information regarding their formulary or cost share, nor any patient history determine if there may be the potential for a drug interaction. PBMs are also able to monitor fraud, waste and abuse with pharmacies in their networks, such as whether a patient is attempting to fill multiple prescriptions for controlled substances at different pharmacies. We cannot do any of this if the pharmacy is not in our network.

In summary, SB 2376 will hurt pharmacies that choose to participate in networks, eliminate incentives for pharmacies to join networks, thereby increasing costs for plan sponsors in the state. For these reasons, we respectfully request that the committee defer action on this proposal. Thank you for the opportunity to submit testimony on this matter.

baker3 - James

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 16, 2016 4:10 PM
To: CPH Testimony
Cc: kaiulani@kalo.org
Subject: *Submitted testimony for SB2376 on Feb 17, 2016 09:00AM*

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Categories: Late

SB2376
Submitted on: 2/16/2016
Testimony for CPH on Feb 17, 2016 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Ka'iulani Pahi'o	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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SB 2376 Testimony- Committee on Commerce, Consumer Protection & Health
Chair Roselyn Baker - Wednesday, February 17, 2016 9:00 am conference room 229

My name is Eileen Cheng. I am the pharmacist-in-charge of an independent community pharmacy located in the rural town of Honoka'a on the Big Island. We serve a trading population about 7000 along the Hamakua Coast, from Hilo to Waimea, for a distance of 60 miles, about one and a half hours driving time.

I **support SB 2376** because I believe in fair choice for rural residents who have limited accessibility to other network pharmacies. Yes. It is true that insurance network contracts are available to the pharmacies. But the real issue here is that community pharmacies are not getting paid enough to survive even if they are network pharmacies. And if they are not getting paid enough to do their jobs right, why would they put their service under the restriction of insurance network?

Case in point, I am contracted with all manner of insurance networks, but when I asked the insurance companies to pay me enough to cover only the cost of the medication without including shipping or labor compensation so we can send the patient home, they told me to ask the patient to go to another pharmacy. The nearest one from us is 15 miles away. It will cost the patient ~$15 IRS mileage and one hour round trip driving time. Have the pharmacy benefit managers (PBMs) considered the social cost when they talk about the Health Care cost?

There may not be many patients in the rural area, but they are often the most vulnerable patient population because they are furthest away from health care services. For example, the community we service has one of the highest rates of diabetic patients in Hawaii. We also have a high ratio of poverty and seniors. Many of them cannot drive and the Hele-on schedule is so infrequent that if they miss a bus in Waimea, they will have to wait hours before catching another one or get stranded.

Pharmacists are the front line soldiers of the health care industry. Once patients get discharged from the hospitals or the 10 minute doctors' visits, we are their safety net. The questions that didn't get answered come to us. We don't charge the patients for answering questions, and yet, far too often, we get paid $0.50 or $1.00 for dispensing medication. Would you ask for a perfect hamburger prepared by 4 people and pay for only $1.00? Because each prescription we dispense takes 4 people to prepare, and it has to be perfect or the patient may die. In my pharmacy, sometimes we see patients more often than their children see them. And we are there to care for them when they have no one else.

According to a 2015 NCPA (National Community Pharmacy Association) report, the average dispensing cost of each medication is about $11.

It is time for the PBMs to consider pharmacies as their partners. We are not a cost saving tool. We want to help the patients in the rural areas and help save future health care costs by early intervention. We can work together. I ask the PBMs to make it easier for rural pharmacies to survive by giving them fair compensation, so **SB 2376** would not become our last resort.

CVSHealth

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The Honorable Rosalyn Baker
Chair, Senate Committee on Commerce, Consumer Protection & Health

Wednesday, February 17, 2016
Conference Room 229; 9:00 AM

RE: SB 2376 – Relating to Prescription Drug Benefits

Aloha Chair Baker, Vice Chair Kidani and members of the Committee:

CVS Health would like to offer the following comments at this time. CVS Health's Pharmacy Benefit Management ("PBM") division, CVS/caremark, maintains a robust retail pharmacy network for our PBM clients encompassing in excess of 92 percent of all pharmacies in Hawaii. We are concerned that SB 2376, though well intended, will likely increase upfront costs to certain plan members and also serve as a deterrent toward utilization of cost saving measures adopted by plan sponsors (i.e. health plans, Taft-Hartley trusts, state employee/retiree plans, etc.).

Specifically, we would like to offer the following comments:

- Very few retail pharmacies in Hawaii are not in the CVS/caremark PBM network, if SB 2376 were to pass we are unsure how it would serve as a convenience to patients. If a pharmacy is not part of the CVS/caremark network and has no contract with us, they cannot bill an Rx claim and would be forced to bill the patient a cash price. This results in having the patient chase their own claim. More importantly, as a non-network pharmacy, they cannot access patient Rx history or plan formulary because they will not have access to our network—including billing.

- Depending on the total volume of prescriptions and the overall monetary impact of Rx's eligible under SB 2376, the potential exists for higher costs passed on to health plans, which can trigger a need to review the underwriting and rates, again directly and negatively impacting consumers and plan beneficiaries.

- Pursuant to HB65/Act 226 of 2013 every retail pharmacy in Hawaii is eligible to be in the CVS/caremark network. The retail pharmacies who are not within a network made a business decision not to join a retail pharmacy network—therefore, SB 2376 is adverse to the pharmacies that have made a decision to join a retail pharmacy network. It has the potential to negate all of the cost-savings measures and health benefits such as DUR, adherence/compliance and generic utilization targets such networks ensure along with it.

CVS Health proudly operates as the largest pharmacy chain in Hawaii, under our Longs Drugs banner and we also offer our patients and clients a wide range of comprehensive, integrated pharmacy and health operations statewide including: Pharmacy Benefit Management (PBM) services (CVS/caremark), Specialty Pharmacy (CVS/specialty), Mail-Order and Retail Pharmacy (CVS/pharmacy/Longs Drugs), Retail Health Clinics (CVS/minute clinic) and a distribution center.

We thank you for your consideration of our comments and ask that the Committee defer decision making on SB 2376 so that we may work to address the concerns that triggered this legislation.

Respectfully,

Eric P. Douglas

Eric P. Douglas

SB2376 Testimony

Feb 24, 2016

Good morning Senator Roz Baker and other members of the legislature. Thank you for opening your ears to us today. Your potential assistance could mean the lifeline for my pharmacy and countless independent pharmacies in Hawaii. I am Jessica Lo, owner of Good Health Pharmacy right here in Chinatown.

Just like Eilene Ching of Hamakua Pharmacy, I was contemplating closing my pharmacy since the beginning of this year. I reached out to pharmacy brokers and chain pharmacies, trying to see what I could receive for my pharmacy, the business that took countless energy to build. My brother the contractor renovated the pharmacy. My husband the mathematician and computer scientist handled all my computer set-up and maintenance. He sacrificed his second job, as mathematics professor, to lend more time to my business. My mom advertised to all her friends, to people she met on the bus, to doctors that she saw, and any other acquaintance that she met . I visited doctors offices. My technicians visited doctors offices and passed out our calendars and business cards. Almost 5 years later, all I see is gloom—a very bleak future. Having been a pharmacist for almost 19 years, I had hoped that my daughter could walk in my footsteps. I could pass down the experience I have accumulated, and teach her excellent customer service. Unfortunately, all that my colleagues and I say to our children nowadays is: steer clear of the pharmacy profession, especially independent pharmacy—it will destroy you.

How else can you describe a profession, where, after you study hard to get into the competitive program and pay college tuition for years, then save up for many more years until you have money to buy pharmacy inventory, then work hard to build up your reputation, and finally open your own business, only to receive negative reimbursement? Negative reimbursement means you get paid less than the cost to fill the medicine. Often times, it means not even getting the cost of the drug itself.

Just the other week, my former customer Ms. H. asked whether I could fill her Hepatitis B medicine again. She said her current pharmacy, which had been helping her for the last year since I turned her away, refused to fill her prescription as of this month. Times, the other contracted pharmacy, also refused to fill her prescription. She asked other pharmacies, with no solution. Feeling sorry for her, I finally explained that for her Hepatitis B medicine, the cost for

my work was negative reimbursement. Instead of getting rewarded, I got punished. What is worst is that when I continued to fill 3 months at a time, for brand drugs, where we are shelling out hundreds of dollars of acquisition cost per prescription, the reimbursement actually DECREASED, to anywhere between$10 to $70 less than the cost of the drug!!! I feel so used by the insurance companies. Now, when insurance companies send me the alerts, which are piling up by the scores, I am too scared to even look at them.

I used to have a casual on-call pharmacist that worked 4 hours per week. Now I cannot even afford that. He now works at a non-pharmacy job, while I work 7 days a week, 6 days at the pharmacy plus Sundays doing paper work and continuing education. I cannot afford to hire someone, and more importantly I cannot afford to NOT be there to watch every prescription that comes through the pharmacy.

There was an instance where I was filling the drug Vimovo, a medicine combining 2 very common ingredients into 1 pill. The original price of the drug was around $100. When I was refilling the prescription for a patient, I almost handed it to him and incurred a $900 loss, because the acquisition cost of the drug had risen to $1000. And the insurance company was only paying the old price of $100. Needless to say, I did not fill that prescription. And in fact, the cost of that drug is now costing $1600 for 30 days' supply.

When drugs expire, we have to get rid of the drugs, and we get pennies on the dollar. We have plenty of ways to lose money, but hardly any way to make money.

When I appealed to the insurance companies or their PBMs that run them, their reply is basically, "If you don't fill the prescription, someone else will." All businesses want to have lots of customers. But nowadays, the pharmacies do not necessarily feel that way. In fact, at this point, at the pharmacy, our crowning achievement of the day is to have turned away a customer whose insurance would have dug a hole in our pockets. We are proud when we have turned away such a customer, who would otherwise inevitable force our pharmacy to shut down. We try to turn down customers while trying not to say the wrong thing so as to not jeopardize our contracts.

It's really sad. The insurance companies do not care how many pharmacies these patients have to hop to before finding a willing pharmacy to fill their prescriptions. Most insurance companies also do not care how personalized pharmacies like mine have helped the insurance companies save money. Countless times, since my patients do not speak English, they bring letters for me and my staff to translate for them, including letters from insurance companies. Our immediate attention and translation saves the insurance companies from having to hire extra translation personnel, and saves them complaints from patients who say they have to hold a long time on the phone waiting for the insurance companies' translators.

And countless times, because the patients do not know English, our explanations to them on how to take their medicines have avoided drug misadventures. For example, some of you might have already performed a colonoscopy. Well, some of my patients do not know that you are supposed to be on liquid diet only on the day prior to the procedure. But just because we counsel them in Chinese about their Colyte drink, we are able to correct them on their misunderstandings, and save insurance companies from having to schedule an additional colonoscopy after a failed first one.

And countless times, we tell them they must finish all their antibiotic, or that they must taper down their corticosteroid medicines and that they use their maintenance asthma inhaler on a daily basis and the rescue inhaler on an urgent basis.

And for the mentally ill, who do come by the Chinatown area, because trust us and listen to us to refill their medications punctually, we are preventing psychotic episodes and keeping the community safe to some degree.

Pharmacist have a very stressful life. That's why among professionals, they rank among the top for suicide rates. Now add to the mix, negative reimbursement, and this is a recipe for disaster. Even for me personally, my talk of wanting to close the pharmacy created much stress in the household, because of how much blood and sweat had been put into this business.

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STATE	INGREDIENT COST	DISPENSING FEE	STATE MAC
State of Colorado	Ingredient cost for all drugs for retail pharmacies, 340B pharmacies, institutional pharmacies, government pharmacies, and mail order pharmacies shall be based upon the lower of: 1. The usual and customary charge to the public minus the client's copayment; or 2. The allowed ingredient cost, The allowed ingredient cost is the lesser of AAC or submitted ingredient cost. If AAC is not available the allowed ingredient cost is the lesser of WAC or the submitted drug ingredient cost. Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the 340B Drug Pricing Program, the submitted ingredient cost means the 340B purchase price. Ingredient cost for designated rural pharmacies: • The allowed ingredient cost shall be AAC. If AAC is not available, the allowed ingredient cost shall be WAC.	The dispensing fees for retail pharmacies, 340B pharmacies, institutional pharmacies, and mail order pharmacies shall be tiered based upon annual total prescription volume. The dispensing fees shall be tiered at: • Less than 60,000 total prescriptions filled per year = $13.40 • Between 60,000 and 90,000 total prescriptions filled per year = $11.49 • Between 90,000 and 110,000 total prescriptions filled per year = $10.25 • Greater than 110,000 total prescriptions filled per year = $9.31 Dispensing fee is $14.41 (rural pharmacies); no dispensing fee (government pharmacies)	STATE MAC No
State of Connecticut	Ingredient cost is AWP minus 72% to step down tiers through AWP minus 20 percent based on meeting specific invoice pricing criteria (selected multi-source brand and generic); AWP minus 16% (brand)	Dispensing fee is $1.70*	STATE MAC Yes
State of Delaware	Ingredient cost is NADAC	Dispensing fee is $10.00	STATE MAC Yes
District of Columbia	Ingredient cost is WAC plus 3%	Dispensing fee is $4.50	STATE MAC Yes
State of Florida	Ingredient cost is lower of AWP minus 16.4% or WAC plus 1.5%	Dispensing fee is $3.73 (for non-340B billed drugs); $7.50 (340B billed drugs)	STATE MAC Yes

STATE	INGREDIENT COST	DISPENSING FEE	STATE MAC
State of Georgia	Ingredient cost is AWP minus 11%; Select Specialty Pharmacy Rate for certain disease states that are rare and/or complex with a reimbursement methodology determined by wholesaler/manufacturer data, a comparison to other State agencies' reimbursement information, and publicly available drug prices from other payers; Maximum allowable reimbursement for an injectable drug administered by a provider or their designee in an outpatient setting is ASP plus 6% as determined on January 1st of the applicable year; Most Favored Nations rate submitted by the provider and accepted by the State	Dispensing fee is $4.63 (for-profit pharmacy); $4.33 (not-for-profit)	STATE MAC Yes
State of Hawaii	Ingredient cost is WAC	Dispensing fee is $5.00	STATE MAC Yes
State of Idaho	Ingredient cost is AAC, or where there is no AAC reimbursement is WAC	Tiered dispensing fees: Less than 39,999 claims a year = $15.11 Between 40,000 and 69,999 claims per year = $12.35 70,000 or more claims per year = $11.51	STATE MAC Yes
State of Illinois	Ingredient cost is WAC plus 1% (multiple source legend); WAC plus 1% (single source legend); WAC plus 25% (over-the-counter drugs); AAC for implantable contraceptive devices purchased under the 340B Drug Pricing Program via FQHC or rural health centers	Dispensing fee is $5.50 (multiple source); $2.40 (single source); $12.00 for both single source and multiple source drugs purchased through the 340B Drug Pricing Program	STATE MAC Yes
State of Indiana	Ingredient cost is AWP minus 16% (brand); AWP minus 20% (generic); Reimbursement for physician administered drugs is WAC plus 5% or ASP plus 6% for those drugs without a published WAC	Dispensing fee is $3.90	STATE MAC Yes