OFFICE OF INFORMATION PRACTICES

STATE OF HAWAII
NO. 1 CAPITOL DISTRICT BUILDING
250 SOUTH HOTEL STREET, SUITE 107
HONOLULU, HAWAII 96813
TELEPHONE: 808-586-1400 FAX: 808-586-1412
EMAIL: oip@hawaii.gov

To: House Committee on Health

From: Cheryl Kakazu Park, Director

Date: January 31, 2019, 9:30 a.m.
State Capitol, Conference Room 329

Re: Testimony on H.B. No. 1442
Relating to Pharmacy Benefit Managers

Thank you for the opportunity to submit testimony on this bill, which would establish requirements for pharmacy benefit managers and maximum allowable cost. The Office of Information Practices (OIP) takes no position on the substance of this bill, but **suggests a technical amendment** to a confidentiality provision. The bill (at page 9, lines 6-10) makes the "maximum allowable cost list and related information" confidential, and states that such information is "not subject to public records requests under chapter 92F." OIP does not object to the substance of the confidentiality provision, but it should state that the information is "not **disclosable under** chapter 92F" rather than "not subject to public records requests under chapter 92F."

This change will make clear that if an agency receives a record request for the information it should not just ignore the request, but instead **the agency should still respond** (as is required for government record requests) by advising the requester that it is denying access to the information based on the confidentiality statute and section 92F-13(4), HRS, the exception to disclosure for information made confidential by law.

Thank you for the opportunity to testify.

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
Members, Committee Health

From: Paula Yoshioka, Vice President, Government Relations and External Affairs, The Queen's Health Systems

Date: January 30, 2019

Hrg: House Committee on Health Hearing; Thursday, January 31, 2019 at 9:30 AM in Room 329

Re: **Support for H.B. 1442, Relating to Pharmacy Benefit Managers**

The Queen's Health Systems (Queen's) is a not-for-profit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, 66 health care centers and labs, and more than 1,600 physicians statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to testify in support of H.B. 1442, Relating to Pharmacy Benefit Managers. Under the insurance commissioner, this measure would establish requirements for pharmacy benefit managers (PBMs) and maximum allowable cost (MAC). Contracted pharmacies will be able to receive comprehensive MAC lists from PBMs as well as know, upon upheld appeal, where an equivalent drug may be obtained at or below the MAC. The measure also clarifies penalties for violations of MAC requirements.

Queen's contracts with over 15 PBMs, with each PBM having multiple MAC lists. Because PBMs control the formularies for prices like those through MAC lists, they have the ability create pricing uncertainty for pharmacies. In addition to price uncertainty, our pharmacies go through undue burdens when accessing MAC prices for any given drug and we currently do not receive data in a standard and comprehensive list format, and must obtain MAC prices on an individual prescription basis. With no guideline or standard approach when it comes to the disclosure of MAC list, each PBM has been able develop their own burdensome process which puts pharmacies at a disadvantage. Over the past year, Queen's has been able to work with a major PBM and appreciate their willingness to meet, discuss, and address some of the challenges pharmacies face. However, the greater is issue how do we make best practices the standard for doing business across the board for PBMs.

Transparency in the data sources that PBMs utilize to derive costs will greatly benefit our pharmacies and patients. Thank you for the opportunity to testify on this measure.

Cynthia M. Laubacher
Senior Director
State Government Affairs
Office: 916.771.3328
Mobile: 916.425.6101
Cynthia_Laubacher@express-scripts.com

January 30, 2018

To: The Honorable John Mizuno, Chair
Members of the House Committee on Health and Human Services

Fr: Cynthia Laubacher, Senior Director, State Affairs

Re: House Bill 1442: January 31, 2018 9:30am hearing

Thank you for the opportunity to provide testimony regarding our concerns with House Bill 1442. Cigna recently completed its purchase of Express Scripts, one of the nation's leading pharmacy benefit managers.

In 2015 Express Scripts worked with plans, PBMs and local pharmacies on legislation that was ultimately enacted to address the pharmacies concerns with generic reimbursements ("MAC"). Last year we returned to the table to discuss issues that have arisen in the time since that initial agreement. We either reached agreement or were close when the session ended. In January, the discussions began again. We are committed to continuing to work with the local pharmacies with the hope of reaching agreement in 2019.

While HB 1442 touches on issues that were part of our 2018 discussions, it includes a new, very problematic provision. Section 2 (f) requires PBMS to notify pharmacies in their network of certain prices increases for drugs on MAC lists, three days in advance of adjusting the price of the drug on the list. No PBM plan could comply with this provision. It would be impossible.

First, AC lists are essentially pricing lists for generic drugs, of which there are hundreds of drugs. Lists take into account the buying power of the pharmacy, e.g., independents, chains, big-box stores. And prices fluctuate, daily. A manufacturer may leave the market and its competitors will increase their prices overnight. Or the opposite occurs and a new product enters the market, sending prices down. A manufacturer may encounter a manufacturing problem at their plant. There may be a shortage. Many factors can cause a generic price to increase – or decrease. We recommend that this language be stricken while work continue on the other issues raised in the bill.

Thank you for your consideration.

DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. BOX 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Health
Thursday, January 31, 2019
9:30 a.m.
State Capitol, Conference Room 329

On the following measure:
H.B. 1442, RELATING TO PHARMACY BENEFIT MANAGERS

Chair Mizuno and Members of the Committee:

My name is Colin Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to establish requirements for pharmacy benefit managers (PBMs) and maximum allowable cost within the purview of the Department, rather than the Department of Health.

By repealing Hawaii Revised Statutes (HRS) section 328-106 and amending HRS chapter 431-R, this bill shifts jurisdiction over the regulation of maximum allowable cost basis reimbursement from the Department of Health to the Insurance Commissioner and amends those regulations.

Page 6, lines 4 to 9 of the bill requires three days' notice "prior to initiating any changes to the maximum allowable cost[.]". Requiring PBMs to provide three days' notice may prompt an increase in appeals, due to discrepancies between wholesale

prices and prices on the maximum allowable cost list. For example, an appeal may arise if wholesale prices increase, and a PBM must wait three days to effect an increase in maximum allowable cost.

Page 8, lines 8 to 13 of the bill provides that if a maximum allowable cost is not upheld on appeal, a contracting pharmacy may "reverse and rebill the claim that is the subject of the appeal, and all claims for the same drug, until the maximum allowable cost list is updated pursuant to subsection (e), to be reimbursed at the maximum allowable cost established by the appeal." However, the bill does not clearly define the maximum allowable cost established by the appeal.

Page 9, lines 11 to 14 of the bill states "The insurance commissioner ***shall*** adopt rules pursuant to chapter 91 to establish a process to subject complaints of violations of this section to an external review process ***and resolve disputed claims, which may be binding.***" The Department respectfully requests that "shall" be replaced with "may" to give the Insurance Division flexibility to determine how best to enforce this bill. Additionally, the Department respectfully requests deleting "and resolve disputed claims[.]" The Insurance Division lacks the expertise to resolve these disputed claims and would not be able to issue binding resolutions that are precluded from judicial review.

Finally, if the Committee chooses to pass this measure, the Department respectfully requests that its budget ceiling be adjusted to cover the fiscal impact of this bill.

Thank you for the opportunity to testify on this bill.

HB-1442
Submitted on: 1/28/2019 9:53:31 PM
Testimony for HLT on 1/31/2019 9:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Ronald Taniguchi, Pharm.D.	Individual	Support	No

Comments:

OFFICE OF INFORMATION PRACTICES

STATE OF HAWAII
NO. 1 CAPITOL DISTRICT BUILDING
250 SOUTH HOTEL STREET, SUITE 107
HONOLULU, HAWAII 96813
TELEPHONE: 808-586-1400 FAX: 808-586-1412
EMAIL: oip@hawaii.gov

To: House Committee on Health

From: Cheryl Kakazu Park, Director

Date: January 31, 2019, 9:30 a.m.
State Capitol, Conference Room 329

Re: Testimony on H.B. No. 1442
Relating to Pharmacy Benefit Managers

Thank you for the opportunity to submit testimony on this bill, which would establish requirements for pharmacy benefit managers and maximum allowable cost. The Office of Information Practices (OIP) takes no position on the substance of this bill, but **suggests a technical amendment** to a confidentiality provision. The bill (at page 9, lines 6-10) makes the "maximum allowable cost list and related information" confidential, and states that such information is "not subject to public records requests under chapter 92F." OIP does not object to the substance of the confidentiality provision, but it should state that the information is "not **disclosable under** chapter 92F" rather than "not subject to public records requests under chapter 92F."

This change will make clear that if an agency receives a record request for the information it should not just ignore the request, but instead **the agency should still respond** (as is required for government record requests) by advising the requester that it is denying access to the information based on the confidentiality statute and section 92F-13(4), HRS, the exception to disclosure for information made confidential by law.

Thank you for the opportunity to testify.

An Independent Licensee of the Blue Cross and Blue Shield Association

LATE

January 30, 2019

The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health

Re: HB 1442 – Relating to Pharmacy Benefit Managers

Dear Chair Mizuno, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1442, which establishes requirements for pharmacy benefit managers (PBMs) and maximum allowable cost, including the ability of pharmacies to receive comprehensive maximum allowable cost lists and bring complaints within the purview of the Department of Commerce and Consumer Affairs, rather than the Department of Health. It also requires PBMs to disclose where an equivalent drug can be obtained at or below the maximum allowable cost when a maximum allowable cost is upheld on appeal and allows contracting pharmacies to reverse and rebill claims if the PBM establishes a maximum allowable cost that is denied on appeal and pay the difference to the contracting pharmacies.

HMSA would like to express our opposition to this measure and offer an amendment. PBMs play an important role in addressing the rising cost of pharmaceutical drugs. We have been working with community pharmacies since last year to address some of the concerns highlighted in this bill. While we appreciate the intent of this measure, we believe this bill will create additional regulations and pose administrative challenges that could increase costs.

Should this bill move forward, we respectfully submit for your consideration the following amendment to Section 3 of the bill, adding a definition for contracting pharmacy:

> "Contracting pharmacy" means an independent pharmacy that is not part of a regional or national chain, or part of a pharmacy services administration organization (PSAO), and there is no other pharmacy within a ten mile radius.

Thank you for the opportunity to provide testimony on this measure.

Sincerely,

Pono Chong
Vice President, Government Relations

PCMA

LATE

January 31, 2019

The Honorable John Mizuno
Chair, Committee on Health and Human Services
415 S. Beretania St, Room 402
Honolulu, Oahu, HI, 96813-2425

Submitted Electronically

Re: H.B. 1442, a bill relating to pharmacy benefit managers

Dear Chair Mizuno:

The Pharmaceutical Care Management Association (PCMA) appreciates the opportunity to provide comments on the provisions in H.B. 1442, a bill relating to pharmacy benefit managers and generic reimbursement using maximum allowable cost (MAC).

PCMA is the national trade association for America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage through independent businesses, health insurers, labor unions, and federal and state-sponsored health programs.

For over two decades, PBMs have delivered innovative solutions based on payer and patient needs. In an age of high-priced and specialty drugs, payers continue to look to their PBMs for solutions to improve affordability, quality, and access for patients. PBMs bring value to their members and health benefit plan sponsors by limiting excessive prescription drug spending and curbing instances of waste, fraud and abuse.

We have concerns around the analysis presented in the bill as inaccurate as it does not correctly reflect pass-through pricing [The amount the PBM pays the pharmacy is charged (or passed-through) to the client] as well as the cost-share calculation used when there are disparate MAC lists. Therefore, PCMA is concerned about the following provisions in the bill and respectfully request the amendments indicated:

Page 4 lines 17 – 21; Page 5 lines 1-3: (c) The pharmacy benefit manager shall make available to a contracting pharmacy~~, not less than once per quarter, and~~ upon request, a comprehensive report for all drugs on the maximum allowable cost list <u>for a plan</u>, which contains the most-up-to-date maximum allowable cost price or prices used by the pharmacy benefit manager for patients served by the pharmacy, in a readily accessible, and secure~~,~~ <u>electronic</u> ~~and~~ or usable web-based ~~or other comparable~~ format.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

Rationale: Pursuant to current law, PBMs make available to all Hawaii contracted pharmacies an easily accessible, electronic method of looking up specific drugs subject to MAC reimbursement rates. This provides pharmacies with the most up-to-date, real-time pricing information applicable to a given drug on a MAC list. They do not, however, automatically provide a list because the lists vary by plan and can become outdated quickly due to the nature of the generic drug marketplace. Therefore, the above requested amendments seek to balance the contracted pharmacy's ability to request a comprehensive MAC list by plan with encouraging the use tools already in use that provide the most current up-to-date reimbursement information.

Page 5 lines 14-21; Page 6 lines 1-3: (e) The pharmacy benefit manager shall review and make necessary adjustments to the maximum allowable cost of each drug on a maximum allowable cost list at least once every seven days using the most recent data sources available, ~~and shall apply the updated maximum allowable cost list beginning that same day to reimburse the contracting pharmacy until the pharmacy benefit manager next updates the maximum allowable cost list in accordance with this section; provided that the pharmacy benefit manager shall reimburse a contracting pharmacy for a drug based on the maximum allowable cost of that drug on the day the drug is dispensed.~~

Rationale: PBMs don't make price changes effective the same day to avoid having prices change mid-day. This would be impossible to do, as any price change would be effective the following day. This provision also appears to conflict with provision F 'that we have to notify pharmacies of any increase of more than 10% and give them at least 3 days' notice. Therefore, we recommend removing this provision from the bill.

Page 6 lines 4-9: <u>(f) The pharmacy benefit manager shall notify all contracting pharmacies of a ten per cent or greater increase in drug acquisition cost for any drug on the maximum allowable cost list from sixty per cent or more regional pharmaceutical wholesalers at least three days prior to initiating any changes to the maximum allowable cost for that drug. The notification required under this subsection may be provided electronically and shall contain the national drug code of the drug whose acquisition cost is increasing.</u>

Rationale: This requirement is <u>**impossible**</u> for a PBM to comply with as PBMs do not have control of or visibility to pharmaceutical wholesalers' pricing. Also, if we were to confirm price changes online, there is a risk of a breach of proprietary information if competitors were to receive our source data. This provision more appropriately should be required by a pharmacy's PSAO. A PSAO not only signs the contracts with PBMs on behalf of the independent pharmacists it contracts with, it is also often the entity that acts as the pharmacies wholesaler to the contracted pharmacy. As the wholesaler to

the pharmacies it contracts with, a PSAO will have the information when the price to the pharmacy for drugs increases.

Page 7 lines 14-21; Page 8 lines 1-2: (4) If the maximum allowable cost is upheld on appeal, the pharmacy benefit manager shall provide to the contracting pharmacy the reason therefor and the national drug code of an equivalent drug that may be purchased by a similarly situated pharmacy at a price that is equal to or less than the maximum allowable cost of the drug that is the subject of the appeal, ~~with the name of the source, including but not limited to the wholesaler or distributor, where the drug may be purchased; and~~

Rationale: This would be impossible for a PBM to comply with. In Hawaii, 60 of the 62 independent pharmacies that use a PSAO are using a PSAO from a large national wholesaler. PBMs cannot make a wholesaler sell to a pharmacy nor can they make a wholesaler sell a drug at a particular price. If the wholesaler won't or can't sell to a pharmacy it is not in the control of a PBM.

Page 8 lines 14-19: ~~(h) Any pharmacy benefit manager that refuses a maximum allowable cost reimbursement for a properly documented claim from a contracting pharmacy under this section shall be deemed to have engaged in an unfair or deceptive act or practice in the conduct of trade or commerce, within the meaning of section 480-2.~~

Rationale: There may be other reasons to refuse a claim such as audit or patient safety. This provision is very broad and could open up Hawaii plan sponsors to fraud, waste and abuse. As written, this provision could circumvent the established MAC Appeals process agreed to in the PBM-pharmacy contract. A prescription could be "properly documented" but been submitted improperly, which could show up in an audit. Additionally, the penalty is extremely excessive, and section 431R-5 already grants the insurance commissioner the authority to assess a fine for violations of sections 431R-2 and 431R-3. Section 4 of this bill would include the section in 431R where this bill would be codified as one of the sections subject to the commissioner's authority to assess fines for violations. Page 10 Line 20.

Page 8 lines 20-21; Page 9 lines 1-10:
(i) A contracting pharmacy shall not disclose to any third party the maximum allowable cost list and any related information it receives, either directly from a pharmacy benefit manager or through a pharmacy services administrative organization or similar entity with which the pharmacy has a contract to provide administrative services for that pharmacy, ~~except to the insurance commissioner or an elected representative. The maximum allowable cost list and related information disclosed to the insurance commissioner or an elected representative shall be considered proprietary and confidential and not subject to public records requests under chapter 92F.~~

Rationale: The information that a contracting pharmacy receives is competitive and proprietary information that is the property of the PBM. A contracted pharmacy should not be permitted to turn over a PBM's competitive and proprietary information without providing proper notice to the PBM so that it may takes steps to protect such information. Additionally, we are concerned that the broad use of the term "elected representative" could mean many things and if an elected representative happens to be a pharmacy owner, they would then have access to competitive reimbursement information regarding their competitors. This would be anti-competitive and could lead to increased costs for plan sponsors and consumers.

Page 9 lines 11-20: (i) The insurance commissioner shall adopt rules pursuant to chapter 91 **to enforce the provisions of this section**. ~~establish a process to subject complaints of violations of this section to an external review process and resolve disputed claims, which may be binding on a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made, except to the extent that the parties have other remedies available under applicable federal or state law, and which may assign the costs associated with the external review process to a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made."~~

Rationale: Private contracts between the PSAO and PBMs, or pharmacies and PBMs, should utilize the resolution process in their contract. We are concerned that having a external review process through the insurance commissioner would lead to frivolous complaints, and would drive up the costs of health care for health plans, employers, and ultimately consumers. If there are any contractual issues that arise between a PSAO and a PBM or a pharmacy and a PBM, they are handled by contract with appropriate remedies available to the parties under the law making an external review process unnecessary

Page 10 lines 7-9: "Maximum allowable cost list" means a list of ~~the maximum allowable reimbursement costs~~ of ~~multi-source~~ drugs for which a maximum allowable cost has been established by a pharmacy benefit manager.

Rationale: Our amendment would restore the definition to the definition that was negotiated in 2015 and what is in current law. The proposed language would significantly alter what drugs may be included on a MAC list. This could lead to higher costs for health plan sponsors and consumers.

We appreciate your consideration of our comments.

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

Sincerely,

Lauren Rowley
VP, State Affairs

cc: House Health and Human Services Committee Members

Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

CVSHealth

1275 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

January 31, 2019

LATE TESTIMONY

LATE

Representative John Mizuno
Chair, Committee on Health
415 South Beretania Street
Honolulu, Hawaii 96813

RE: House Bill 1442– Relating to Pharmacy Benefit Managers

Aloha Chair Mizuno, Vice Chair Kobayashi and members of the committee:

CVS Health is writing to share with you our concerns and some suggested amendments regarding House Bill 1442 ("HB 1442"), relating to pharmacy benefit managers (PBMs). CVS Health is the nation's premier health innovation company helping people on their path to better health. Whether in one of its pharmacies or through its health services and plans, CVS Health is pioneering a bold new approach to total health by making quality care more affordable, accessible, simple and seamless. CVS Health is community-based and locally focused, engaging consumers with the care they need when and where they need it. The Company has more than 9,800 retail locations, approximately 1,100 walk-in medical clinics, a leading pharmacy benefits manager with approximately 93 million plan members, a dedicated senior pharmacy care business serving more than one million patients per year, expanding specialty pharmacy services, and a leading stand-alone Medicare Part D prescription drug plan. CVS Health also serves an estimated 39 million people through traditional, voluntary and consumer-directed health insurance products and related services, including a rapidly expanding Medicare Advantage offering. This innovative health care model increases access to quality care, delivers better health outcomes and lowers overall health care costs.

HB 1442 seeks to amend the existing law relating to "maximum allowable cost" (MAC). MAC is one of the most common methodologies used in paying pharmacies for dispensing generic drugs. A MAC list is a common cost management tool that is developed from a survey of various sources, including wholesale prices existing in the marketplace, taking into account market share, existing inventory, expected inventories, reasonable profits margins and other factors. Each PBM develops and maintains its own confidential MAC list derived from its specific proprietary methodologies. The MAC list helps to ensure that the PBM, on behalf of their clients (employers and health plans), are paying a fair price for widely available generic drugs.

The existing law was carefully negotiated and agreed to by all stakeholders in 2015. CVS Health believes that any proposed changes to the existing law should stay within the spirit of the negotiations. We are requesting the following amendments:

Section 2(b)(2)(c) (Page 4, lines 17-21, Page 5, lines 1-3):

> "(c) The pharmacy benefit manager shall make available to a contracting pharmacy, ~~not less than once per quarter, and~~ upon request, a comprehensive report for all drugs on the maximum allowable cost list for a plan, which contains the most-up-to-date maximum allowable cost price or prices used by the pharmacy benefit manager for patients served by the pharmacy, in a readily accessible~~,~~ and secure~~,~~ electronic ~~and~~ or usable web-based ~~or other comparable~~ format."

CVS Health currently already makes available to all Hawaii contracted pharmacies an easily accessible, electronic method of looking up specific drugs subject to MAC reimbursement rates. This provides pharmacies with the most up-to-date, real-time pricing information applicable to a given drug on a MAC list. Currently, upon a pharmacy's request, CVS Health also provides a comprehensive MAC list by plan sponsor. We do not, however, automatically provide a list because the lists vary by plan and can become outdated quickly due to the nature of the generic drug marketplace. CVS Health believes that our website

portal is the most useful tool for a contracted pharmacy to use to search by individual drug as opposed to working through lists. Therefore, we are requesting the above amendments to balance the contracted pharmacy's ability to request a comprehensive MAC list by plan with encouraging the continued use of the web portal for the most current up-to-date reimbursement information.

Section 2(e) (Page 5, lines 14-21, Page 6, lines 1-3):

> "(e) The pharmacy benefit manager shall review and make necessary adjustments to the maximum allowable cost of each drug on a maximum allowable cost list at least once every seven days using the most recent date sources available…~~provided that the pharmacy benefit manager shall reimburse a contracting pharmacy for a drug based on the maximum allowable cost of that drug on the day the drug is dispensed.~~"

We are unclear as to the intent of the new language included at the end of this section ("provided that the…dispensed"). The MAC reimbursement for the pharmacy would be the rate on the day the drug was dispensed. This language is unnecessary and are therefore requesting that it be deleted.

Section 2(f) (Page 6, lines 4-12):

> "~~(f) The pharmacy benefit manager shall notify all contracting pharmacies of a ten percent or greater increase in drug acquisition cost for any drug on the maximum allowable cost list from sixty percent or more regional pharmaceutical wholesalers at least three days prior to initiating any change to the maximum allowable cost for that drug. The notification required under this subsection may be provided electronically and shall contain the national drug code of the drug whose acquisition cost is increasing.~~"

We are requesting this amendment because the section assumes that a PBM has access to such wholesaler pricing data at a granular level and specific to a particular pharmacy's acquisition costs. PBMs are not privy to the private contracts between pharmacies and wholesalers and do not have access to such information. As such, compliance with this section would be impossible. Additionally, the requirement of a three day notification for changes to MAC reimbursements prior to initiating the change completely conflicts with the law and would likely be harmful to consumers, payers, and the pharmacies themselves. The law already requires the MAC list to be updated at least once every seven days and for the PBM to immediately implement those changes. If a PBM has to immediately implement the changes, a PBM would be unable to then provide three days' notice. It would also be operationally impossible for a PBM to adjust a MAC price upon a successful MAC appeal by a pharmacy within one calendar day of the date of the decision as is required by law if the PBM must give three days' notice first. Ultimately, if PBMs were to comply with the section, PBMs would be violating other sections of the existing law and prescription drug costs for Hawaiian consumers and employers could increase. Therefore, we request that this section be stricken.

Section 2(g)(4) (Page 7, line 21, Page 8, lines 1-2):

> "(4)…~~with the name of the source, including but not limited to the wholesaler or distributer, where the drug may be purchased;~~"

We are requesting this amendment as the new language proposed in this section goes well beyond the intent of the law regarding what should occur if the MAC is upheld on appeal. The provision would require the PBM to provide the specific source where a drug may be purchased. Pharmacy acquisition prices are on an individual basis, and vary by pharmacy and by wholesaler. PBMs do not have access to individual pharmacy acquisition cost information as those arrangements are ultimately negotiated between the wholesaler and the pharmacy based on specific negotiated business terms. Therefore, we request that the above provision be deleted.

CVSHealth

Section 2(g)(5) (Page 8, lines 10-13):

> "(5) If the maximum allowable cost is not upheld on appeal, the pharmacy benefit managers shall adjust, the appealing contracting pharmacy, the maximum allowable cost of the drug that is the subject of the appeal, within one calendar day of the date of the decision on the appeal and allow the contracting pharmacy to reverse and rebill the claim that is the subject of the appeal, and all claims for the same drug at the plan level, until the maximum allowable cost list is updated pursuant to subsection (e), to be reimbursed at the maximum allowable cost established by the appeal."

We are requesting this clarifying amendment to this section to reflect current practice that requires a contracted pharmacy to submit a MAC appeal at the plan level.

Section 2(h) (Page 8, lines 14-19):

> "~~(h) Any pharmacy benefit manager that refuses a maximum allowable cost reimbursement for a properly documented claim by a contracting pharmacy under this section shall be deemed to have engaged in an unfair or deceptive act or practice in the conduct of trade or commerce, within the meaning of section 480-2.~~"

We believe this section is overly broad and out of the context of the bill. It could open up Hawaii plan sponsors to fraud, waste and abuse. A prescription could be "properly documented" but submitted improperly because of a technical or clerical error that resulted in an overpayment to the pharmacy. Such errors should be permitted to be remedied. Additionally, the penalty proposed is overly punitive and unnecessary. Pharmacies already have the right to appeal a disputed reimbursement per their contracts with the PBM/plan sponsor and existing law. Therefore, we are requesting that this section be deleted.

Section 2(i) (Page 9, Lines 5-10)

> (i) A contracting pharmacy shall not disclose to any third part the maximum allowable cost list and any related information it receives…~~except to the insurance commissioner or an elected representative. The maximum allowable cost list and related information disclosed to the insurance commissioner or an elected representative shall be considered proprietary and confidential and not subject public records requests under chapter 92F.~~

We are requesting this amendment because MAC lists are competitive and proprietary information that is owned by the PBM. A contracting pharmacy should not be permitted to disclose such information without providing proper notification to the PBM first so that the PBM can take steps to properly protect such competitive information. Additionally, we are concerned with the use of the broad term "elected representative" – it could mean many things and if an elected representative happens to be a pharmacy owner, they would then have access to the competitive reimbursement information of other pharmacies. This would be anti-competitive and could lead to increased costs for plan sponsors and consumers.

Section 2(j) (Page 9, Lines 11-20):

> "(i) The insurance commissioner shall adopt rules pursuant to chapter 91 to enforce the provisions of this section. ~~establish a process to subject complaints of violations of this section to an external review process and resolve disputed claims, which may be binding on a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made, except to the extent that the parties have other remedies available under applicable federal or state law, and which may assign the costs associated with the external review process to a complaining contracting pharmacy and a pharmacy benefit manager against whom a complaint is made.~~"

CVS Health had serious concerns regarding Section 2(j), which requires the insurance commissioner to establish a process to subject any complaints regarding a potential violation of the law to an external review process. CVS Health does not believe that the enforcement of the law should be assigned to an outside entity. We are unclear as to why this is necessary, are concerned that this would lead to frivolous complaints, and believe that such a process would drive up the costs of health care for health plans, employers, and ultimately consumers. If there are any contractual issues that arise between a pharmacy and a PBM, those are already

CVSHealth

handled by contract with appropriate remedies available to the parties under the law. CVS Health does not believe that an external review process is necessary and requests the above amendment.

Section 3 (Page 10, lines 7-9):

> "Maximum allowable cost list" means a list of ~~the maximum allowable reimbursement costs~~ of ~~multi-source generic~~ drugs for which a maximum allowable cost has been established by a pharmacy benefit manager,"

We are requesting this amendment because the need for the proposed changes in this section are unclear to us. The existing definition was carefully negotiated within the context of the entire bill and is consistent with many other states that have MAC laws in place. For these reasons, we are requesting that the proposed language be amended back to reflect existing law as it was contemplated.

On behalf of CVS Health, I thank you for allowing us to provide our concerns and amendments for consideration.

Respectfully,

Melissa Schulman
Senior Vice President, Government and Public Affairs
CVS Health