DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
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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, February 6, 2020
8:45 a.m.
State Capitol, Conference Room 329

On the following measure:
H.B. 2712, 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 purposes of this bill are to: (1) ensure the community health system remains financially viable in the face of healthcare value transformation; and (2) ensure access to quality and affordable prescription drugs by vulnerable populations served by community health centers, special needs clinics, and other nonprofit healthcare entities covered by the federal 340B pharmacy program.

The definition of "insurer" on page 5, lines 12 to 13 does not include mutual benefit societies, and it is unclear whether this was an intentional omission. Further, on page 6, lines 8 to 13, the definition of "spread pricing" may require using consistent terms to provide clarity, if the intent is to refer to the difference between the contracted price for drugs and the amount paid for those drugs.

In addition, page 9, lines 16 to 19 prohibits a pharmacy benefit manager from reimbursing on a "maximum allowable cost basis" unless it complies with Hawaii Revised Statutes (HRS) section 328-106, including the appeals process under 328-106(f) and the obligation on contracting pharmacies, rather than pharmacy benefit managers, in 328-106(g). As HRS section 328-106 is outside the Insurance Division's staff expertise and jurisdiction, the Department respectfully requests striking the references to compliance with HRS section 328-106 on page 9, lines 8 and 16 to 19.

The Insurance Division also lacks expertise to assess the sufficiency of the quarterly reports required on page 11, line 8 to page 12, line 13. The Department could consider this proposal if it included a revenue stream to carry out its intent, as an outside consultant or additional staffing with requisite expertise would be needed to comply with this requirement.

Finally, the Department notes there are two references to "section 256***6***(a)(4) of title 42 of the United States Code" (emphasis added): on page 4, lines 17 to 18 and on page 7, lines 13 to 14. It appears this language was intended to reference section 256b of title 42 of the United States Code.

Thank you for the opportunity to testify on this bill.

TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
THIRTIETH LEGISLATURE, 2020

ON THE FOLLOWING MEASURE:
H.B. NO. 2712, RELATING TO PHARMACY BENEFIT MANAGERS.

BEFORE THE:
HOUSE COMMITTEE ON HEALTH

DATE: Thursday, February 6, 2020 **TIME:** 8:45 a.m.

LOCATION: State Capitol, Room 329

TESTIFIER(S): Clare E. Connors, Attorney General, or
Daniel K. Jacob, Deputy Attorney General

Chair Mizuno and Members of the Committee:

The Department of the Attorney General makes the following comments about the bill.

The purposes of this bill are to: (1) establish reporting requirements for pharmacy benefit managers; (2) require certain reimbursement duties; (3) increase penalties for violations of the pharmacy benefit managers law; and (4) permit the Insurance Commissioner to commence audits.

The portion of the bill that establishes reporting requirements for pharmacy benefit managers may be subject to an Employee Retirement Income Security Act (ERISA) preemption challenge. ERISA is a comprehensive federal legislative scheme that "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C.A. § 1144(a).[1] A state law relates to an ERISA plan and is preempted if it has a prohibited connection with or reference to an ERISA plan.

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[1] 29 U.S.C.A. § 1144(a), in full, provides as follows:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

The bill requires pharmacy benefit managers to make reports to the Insurance Commissioner regarding the benefits they manage on behalf of covered entities within the "340B Program." The current definition of "covered entity" includes "an employer." *See* Hawaii Revised Statutes, Section 431S-1. Accordingly, a pharmacy benefit manager that provided services to an employer who manages a self insured plan would also be required to make the quarterly reports proposed by the bill and therefore, the regulation of Pharmacy Benefit Managers raises preemption concerns.

With respect to the regulation of pharmacy benefit managers who are servicing a self insured plan, there is a split among the circuits as to the extent of regulation which may be permissible. The United States Court of Appeals, Ninth Circuit has not issued a decision regarding the regulation of pharmacy benefit managers.

A state law has an impermissible connection with ERISA plans when it governs a central matter of plan administration or interferes with nationally uniform plan administration. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148, 121 S. Ct. 1322, 149 L. Ed. 2d 264 (2001).

In *Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005), the United States Court of Appeals, First Circuit, held that Maine's Unfair Prescription Drug Practices Act was not preempted by ERISA. The Unfair Prescription Drug Practices Act imposed a number of requirements on pharmacy benefit managers that entered into contracts with covered entities. In the *Rowe* Court's analysis, although the regulation may prompt ERISA plans to re-evaluate their working relations with the pharmacy benefit managers, nothing in the Unfair Prescription Drug Practices Act compelled them to do so, and ERISA plans still had a free hand to structure the plans as they wish. *429* F.3d at 303.

In *Pharm. Care Mgmt. Ass'n v. D.C.*, 613 F.3d 179 (D.C. Cir. 2010), the United States Court of Appeals, District of Columbia, reviewed the District of Columbia's Access RX Act, which was similar to Maine's Unfair Prescription Drug Practices Act. The United States Court of Appeals, D.C. Circuit reached an opposite conclusion, finding that D.C.'s Access RX Act was preempted due to an improper "connection to" an

ERISA plan. Rejecting the holding in *Rowe*, that the regulation of pharmacy benefit managers left ERISA plans with a free hand to structure the plans as they wish, the *D.C.* Court found that the Access RX Act binds plan administrators because the economies of scale, purchasing leverage, and network of pharmacies could only be offered by a pharmacy benefit manager. 613 F.3d at 188.

In this case, similar to both Maine's Unfair Prescription Drug Practices Act and D.C.'s Access RX Act, the bill would compel pharmacy benefit managers to file reports with the Insurance Commissioner. Accordingly, there is a split in jurisdictions as to whether this mandate implicates an area central to plan administration.

In addition, we note a technical concern. On page 4, lines 17 and 18, and page 7, lines 13 and 14, the bill refers to section 2556(a)(4) of title 42 of the United States Code. We believe the appropriate citation is section 256(a)(4) of title 42 of the United States code.

Thank you for the opportunity to comment.

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: February 6, 2020, 8:45 a.m.
State Capitol, Conference Room

Re: Testimony on H.B. No. 2712
Relating to Pharmacy Benefit Managers

Thank you for the opportunity to submit testimony on this bill, which would, among other things, require pharmacy benefit managers to submit quarterly reports to the Insurance Commissioner. The Office of Information Practices (OIP) takes no position on the substance of this bill, but offers comments on a proposed confidentiality provision (on bill page 12, lines 11-13) regarding the quarterly reports.

First, OIP notes two technical issues with the confidentiality provision. A confidentiality provision should say that information is "not subject to **disclosure under** chapter 92F" rather than saying it is "not subject to . . . the Uniform Information Practices Act" (UIPA) as this proposal does. Saying that information is not even subject to the UIPA would mean that the agency had no obligation to even provide a denial in response to a record request, as the UIPA generally requires even for records containing confidential information; rather, the agency could simply ignore all requests. Also, the provision's purported exemption of the information from the Freedom of Information Act, a federal law, is both (1) confusing insofar as implies that a law applicable to the records of federal agencies

would otherwise apply to the State's Insurance Commissioner, and (2) ineffective because a state law generally cannot create exemptions to a federal law.

Second, OIP questions why complete confidentiality is necessary for information included in the quarterly reports, rather than allowing the Insurance Commissioner to publicly disclose aggregated information that is not identifiable to a particular pharmacy benefits manager as other versions of this bill have proposed.

OIP defers to the Insurance Commissioner as to the appropriateness of proposed § 431S-B(b)(1), which would treat these quarterly reports as "reports of the commissioner's proceedings, hearings, investigations, and examinations" subject to § 431:2-209(e), HRS. However**, OIP recommends that proposed § 431S-B(b)(2) be replaced with the following:**

> **Not subject to disclosure under chapter 92F; provided that the insurance commissioner may publicly release aggregated or deidentified information from such reports that does not allow identification of an individual pharmacy benefit manager and would not cause competitive harm to the pharmacy benefit manager who submitted it.**

Thank you for considering OIP's comments and recommendation.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Health
Thursday, February 6, 2020; 8:45 a.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO. 2712, RELATING TO PHARMACY BENEFIT MANAGERS.

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS THE INTENT** of House Bill No. 1609, RELATING TO PHARMACY BENEFIT MANAGERS.

The bill, as received by your Committee, would enhance disclosure and transparency requirements on pharmacy benefit managers, and prohibit certain billing practices related to the disposition of discounted pharmaceutical drugs to patients.

This measure is substantively similar to House Bill No. 1609, which was heard by this Committee on January 28, 2020, and reported as a House Draft 1.

By way of background, the HPCA represents Hawaii Federally-Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

The federal 340B Drug Pricing Program (340B Program) provides eligible health care providers, such as FQHCs, the ability to purchase outpatient drugs for patients at significantly reduced costs. By purchasing medications at a much lower cost, FQHCs are able to pass the savings on to their patients through reduced drug prices and the expansion of access and service to underserved populations. The discounts provided in the Program are financed by the drug manufacturers, not the government.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

In recent years, a growing number of outside organizations called PBMs have determined how to access the 340B savings intended to accrue to FQHCs and other 340B providers. Among other things, PBMs have structured their contracts with FQHCs to retain part or all of the 340B savings. Examples of this include:

- A third party insurer determines that the FQHC is 340B eligible, but reduces reimbursement to the estimated 340B ceiling price;

- A retail pharmacy requests a sizeable percentage of the "spread" between the 340B purchase price and the insurance reimbursement of a higher dispensing fee than they charge for non-340B drugs; and

- A claims processor charges a higher fee for the 340B drugs (more than is justified by higher administrative costs) on the grounds that the health center is paying less for these drugs.

At this time, the federal 340B statute does not prohibit outside groups from accessing 340B savings intended for safety net providers and their patients. While the Congressional Record is clear that the 340B Program was intended to assist safety net providers to "stretch scarce federal resources", the statute does not explicitly prohibit the types of contracting arrangements described above. As such, FQHCs cannot reject these contracts on the grounds that they are illegal under law.

The practices of PBMs have had an enormous impact on limited State resources as well. In late 2018, the Ohio State Department of Medicaid required its five managed care plans to terminate contracts with PBMs after the State Auditor found that PBMs had been skimming hundreds of millions of dollars from the Ohio Medicaid Program through previously-hidden spread pricing tactics.

The HPCA notes that many of the concepts in this bill mirror laws enacted in Ohio (transparency), and West Virginia (fiduciary responsibility). However, other states have specifically included statutory protections for the 340B Program, which this bill, in its current form, does not have. These states include Oregon, Montana, and South Dakota.

Because of this, the HPCA supports any and all legislative efforts to protect the 340B Program, including House Bill No. 2712. To ensure continued discussion on this issue, and provide the Legislature with additional flexibility during the remainder of the 2020 Legislative Session, the HPCA urges your favorable consideration of this bill.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

THE CIVIL BEAT
LAW CENTER FOR THE PUBLIC INTEREST

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

RE: Testimony Commenting on H.B. 2712,
Relating to Pharmacy Benefit Managers
Hearing: February 6, 2020 at 8:45 a.m.

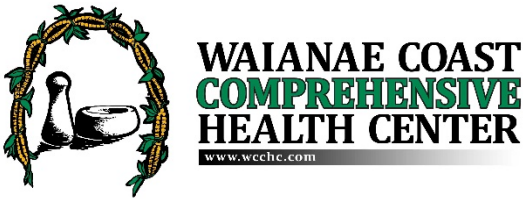
Dear Chair and Members of the Committee:

My name is Brian Black. I am the Executive Director of the Civil Beat Law Center for the Public Interest, a nonprofit organization whose primary mission concerns solutions that promote government transparency. Thank you for the opportunity to submit comments on H.B. 2712.

This bill, among other things, requires certain quarterly reports to the Insurance Commissioner. Proposed § 431S-B. The confidentiality provision for those reports need **simply state that the report shall be kept confidential pursuant to section 92F-13(4)**. The cross-reference to the confidentiality provision at HRS § 431:2-209(e)(3) is unnecessary. And, contrary to the language of the bill, a state statute cannot exempt government records from the federal Freedom of Information Act.

Consistent with the concerns raised in the preamble to H.B. 2712 about the lack of general transparency in this industry, the Law Center also requests that the Committee **consider requiring the Insurance Commissioner to publish a transparency report with aggregated information**. *See, e.g.*, S.B. 2280 § 2, proposed 431S- [Transparency Report](b)-(d). An aggregated report can protect the confidential business information of individual pharmacy benefit managers while better educating the people of Hawai`i about these issues.

Thank you again for the opportunity to provide comments on H.B. 2712.



Testimony to the House Committee on
Health Thursday, February 6, 2020; 8:45 a.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO. 2712, RELATING TO PHARMACY BENEFIT MANAGERS.

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

The Waianae Coast Comprehensive Health Center (WCCHC) is a 501(c)(3) organization and a federally qualified health center (FQHC) established to provide comprehensive primary care, specialty care, emergency care, other health and wellness services to the residents of the Waianae Coast and West Oahu. WCCHC **SUPPORTS** House Bill No. 2712, RELATING TO PHARMACY BENEFIT MANAGERS, and offers **PROPOSED AMENDMENTS** for your consideration.

The bill, as received by your Committee, would:

(1) Establish a class of eligible community health care providers as "340B covered entity" and add other related definitions;

(2) Amend the definition of "pharmacy benefit manager;"

(3) Amend the duties of pharmacy benefit managers (PBMs);

(4) Establish business practices and transparency reporting requirements for PBMs;

(5) Establish program 340B program integrity requirements; and

(6) Increase penalties for violations of the PBM law.

By way of background, WCCHC's mission is to provide accessible and affordable medical and traditional healing services with aloha, to offer health career training to ensure a better future for our communities, and to use leading edge technology to deliver the highest quality health care services. WCCHC provides desperately needed health care services at the frontlines in rural and underserved communities.

86-260 Farrington Highway, Waianae, Hawaii 96792 - Telephone: (808) 697-3457 - Fax: (808) 697-3687
Web: www.wcchc.com

The federal 340B Drug Pricing Program (340B Program) provides eligible health care providers, such as WCCHC, the ability to purchase outpatient drugs for patients at significantly reduced costs. By purchasing medications at a much lower cost, WCCHC is able to pass the savings on to its patients through reduced drug prices and the expansion of access and service to underserved populations. The discounts provided in the Program are financed by the drug manufacturers, not the government.

In recent years, a growing number of outside organizations called PBMs have determined how to access the 340B savings intended to accrue to the benefit of "340B covered entities" such as community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs) and public and nonprofit disproportionate share hospitals (DSHs). Among other things, PBMs have structured their contracts with 340B covered entities to retain part or all of the 340B savings. Examples of this include:

- A PBM determines that an FQHC is 340B eligible, but offers lower reimbursement to the 340B covered entity than other retail pharmacies;

- A PBM requests a larger percentage of the "spread" between the amount that the PBM charges to a plan sponsor and the amount that the PBM pays to a 304B covered entity than the "spread" between what it charges to a plan sponsor and what it pays to another pharmacy that is not a 340B covered entity, including the PBM owned or affiliated pharmacies; and

- A PBM or its authorized claims processor charges a higher fee for the 340B drugs (more than is justified by higher administrative costs) on the grounds that the 340B covered entity is paying less for these drugs.

The practices of PBMs have had an enormous impact on limited State resources as well. In late 2018, the Ohio State Department of Medicaid required its five managed care plans to terminate contracts with PBMs after the State Auditor found that PBMs had been skimming hundreds of millions of dollars from the Ohio Medicaid Program through previously-hidden spread pricing tactics.

WCCHC notes that many of the concepts in this bill mirror laws in other states which have specifically included statutory protections for the 340B Program. These states include Oregon, Montana, and South Dakota.

Because of this, WCCHC strongly supports all legislative efforts to protect the 340B Program, including House Bill No. 2712. To further strengthen these protections, we recommend that the bill be amended to (a) consistently use the reference of "340B covered entity" as defined under lines 17 and 18, paragraph 1 of section 2; and (2) remove paragraph 2, section 2, in its entirety to avoid the introduction of a conflict between the "340B covered entity" definition and the existing "covered entity" definition under the Statutes.

Specifically, under sections 2 and 3 of House Bill No. 2712 (beginning with line 19, page 4, and ending with line 21, page 21), we ask that a phrase "340B" be added in front of all references of "covered entity," such that together they are specified as "340B covered entity.

In addition, we ask the following language be deleted in its entirety:

~~2. By amending the definition of "covered entity" to read:~~
~~""Covered entity" means:~~

~~(1) A health benefits plan regulated under chapter 87A; health insurer regulated under article 10A of chapter 431; mutual benefit society regulated under article 1 of chapter 432; or health maintenance organization regulated under chapter 432D; provided that a "covered entity" under this paragraph shall not include a health maintenance organization regulated under chapter 432]D that owns or manages its own pharmacies;~~
~~(2) A health program administered by the State in the capacity of a provider of health coverage; or~~
~~(3) An employer, labor union, or other group of persons organized in the State that provides health coverage to covered persons employed or residing in the State~~ [-] ~~; and~~
~~(4) The same as it means in section 2566 (a) (4) of title 42 of the United States Code.~~

Lastly, we ask that the paragraph 3. (line 18, page 4) be renumbered as paragraph 2.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact James Z. Chen, Chief Financial Officer, at 808-697-3457, or jchen@wcchc.com.

HB-2712
Submitted on: 2/5/2020 9:35:57 AM
Testimony for HLT on 2/6/2020 8:45:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Cheryl Vasconcellos	Hana Health	Support	No

Comments:

Hana Health is in support of this bill with the following amendments;

To further strengthen these protections, we recommend that the bill be amended to (a) consistently use the reference of "340B covered entity" as defined under lines 17 and 18, paragraph 1 of section 2; and (2) remove paragraph 2, section 2, in its entirety to avoid the introduction of a conflict between the "340B covered entity" definition and the existing "covered entity" definition under the Statutes.

In addition, we ask that the following language be deleted in its entirety;

~~By amending the definition of "covered entity" to read:~~

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1. ~~A health benefits plan regulated under chapter 87A; health insurer regulated under article lOA of chapter 431; mutual benefit society regulated under article 1 of chapter 432; or health maintenance organization regulated under chapter 432D; provided that a "covered entity" under this paragraph shall not include a health maintenance organization regulated under chapter 432]D that owns or manages its own pharmacies;~~
2. ~~A health program administered by the State in the capacity of a provider of health coverage; or~~
3. ~~An employer, labor union, or other group of persons organized in the State that provides health coverage to covered persons employed or residing in the State [-] ; and~~
4. ~~The same as it means in section 2566 (a) (4) of title 42 of the United States Code.~~

Thank you.

CVSHealth

1275 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

February 6, 2020

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

RE: HB 2712 Relating to Pharmacy Benefit Managers
February 6, 2020, 8:45 a.m., conference room 329

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

CVS Health has a number of concerns regarding House Bill 2712 ("HB 2712"), relating to pharmacy benefit managers (PBMs) as it is currently drafted and would be happy to work with legislators and stakeholders as discussion on this bill continues. HB 2712 seeks to regulate private business contracts between PBMs, their clients, including employers and health plans, and pharmacies. We believe that provisions in this bill would interfere in private contracting and greatly increase costs for Hawaii employers and health plans.

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.

As noted above, we have a number of concerns with HB 2712, including the ban of spread pricing arrangements and the disclosure of competitively sensitive information. We believe these provisions will take away contract flexibility for employers and plan sponsors and could lead to higher health care costs.

HB 2712 seeks to prohibit the use of spread pricing arrangements. CVS Health offers PBM clients a variety of contractual options to pay for our PBM services and they choose the one that is best for them based on the services they need and their plan membership. Each employer and plan sponsor evaluates and determines the financial arrangement that meets its needs for PBM services.

Many clients choose a spread pricing arrangement because it provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Reducing options in the marketplace that employer and plan sponsors are currently choosing takes away flexibility in contracting that may lower health care costs for them and their employees and members.

HB 2712 would also require the disclosure of competitively sensitive information. CVS Health believes that it is important to keep the competitive marketplace among drug manufacturers in place in order to drive down the cost of prescription medications. Any public disclosure of rebate information could allow manufacturers to learn what type of price concessions other manufacturers are giving and could disincentivize them from offering deeper discounts, which benefit plan sponsors and their beneficiaries.

The FTC has reviewed a number of state legislative proposals that would have required the public disclosure of competitive rebate information and opined that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors, then tacit collusion among them is more feasible" and that such knowledge of competitors' pricing information would dilute incentives for manufacturers to bid aggressively "which leads to higher prices."[1] The FTC also concluded that "[a]ny such cost increases are likely to undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford." [2]

While the bill includes provisions that attempt to protect confidential, trade secret, or sensitive information provided to the state, we believe the risk of any disclosure at all of proprietary competitive information is too great.

On behalf of CVS Health, thank you for allowing us to express our concerns and we welcome the opportunity to work with you on these important issues.

Respectfully,

Shannon Butler
Senior Director of Government Affairs
CVS Health

[1] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, Jul. 15, 2005.
[2] Id.

LATE

Testimony to the House Committee on
Health Thursday, February 6, 2020; 8:45 a.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO. 2712, RELATING TO PHARMACY BENEFIT MANAGERS.

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

KKV is a 501(c)(3) organization and a federally qualified health center (FQHC) established to provide comprehensive primary care, specialty care, emergency care, other health and wellness services to the residents of Kalihi. KKV **SUPPORTS** House Bill No. 2712, RELATING TO PHARMACY BENEFIT MANAGERS, and offers **PROPOSED AMENDMENTS** for your consideration.

The bill, as received by your Committee, would:

(1) Establish a class of eligible community health care providers as "340B covered entity" and add other related definitions;

(2) Amend the definition of "pharmacy benefit manager;"

(3) Amend the duties of pharmacy benefit managers (PBMs);

(4) Establish business practices and transparency reporting requirements for PBMs;

(5) Establish program 340B program integrity requirements; and

(6) Increase penalties for violations of the PBM law.

The federal 340B Drug Pricing Program (340B Program) provides eligible health care providers, such as KKV, the ability to purchase outpatient drugs for patients at significantly reduced costs. By purchasing medications at a much lower cost. We are then able to pass the savings on to its patients through reduced drug prices and the expansion of access and service to underserved populations. The discounts provided in the Program are financed by the drug manufacturers, not the government.

In recent years, a growing number of outside organizations called PBMs have determined how to access the 340B savings intended to accrue to the benefit of "340B covered entities" such as community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs) and public and nonprofit disproportionate share hospitals (DSHs). Among other things, PBMs have structured their contracts with 340B covered entities to retain part or all of the 340B savings. Examples of this include:

- A PBM determines that an FQHC is 340B eligible, but offers lower reimbursement to the 340B covered entity than other retail pharmacies;

- A PBM requests a larger percentage of the "spread" between the amount that the PBM charges to a plan sponsor and the amount that the PBM pays to a 304B covered entity than the "spread" between what it charges to a plan sponsor and what it pays to another pharmacy that is not a 340B covered entity, including the PBM owned or affiliated pharmacies; and

- A PBM or its authorized claims processor charges a higher fee for the 340B drugs (more than is justified by higher administrative costs) on the grounds that the 340B covered entity is paying less for these drugs.

The practices of PBMs have had an enormous impact on limited State resources as well. In late 2018, the Ohio State Department of Medicaid required its five managed care plans to terminate contracts with PBMs after the State Auditor found that PBMs had been skimming hundreds of millions of dollars from the Ohio Medicaid Program through previously-hidden spread pricing tactics.

Because of this, _KKV strongly supports all legislative efforts to protect the 340B Program, including House Bill No. 2712. To further strengthen these protections, we recommend that the bill be amended to (a) consistently use the reference of "340B covered entity" as defined under lines 17 and 18, paragraph 1 of section 2; and (2) remove paragraph 2, section 2, in its entirety to avoid the introduction of a conflict between the "340B covered entity" definition and the existing "covered entity" definition under the Statutes.

Specifically, under sections 2 and 3 of House Bill No. 2712 (beginning with line 19, page 4, and ending with line 21, page 21), we ask that a phrase "340B" be added in front of all references of "covered entity," such that together they are specified as "340B covered entity.

~~2. By amending the definition of "covered entity" to read:~~
~~""Covered entity" means:~~

~~(1) A health benefits plan regulated under chapter 87A; health insurer regulated under article 10A of chapter 431; mutual benefit society regulated under article 1 of chapter 432; or health maintenance organization regulated under chapter 432D; provided that a "covered entity" under this paragraph shall not include a health maintenance organization regulated under chapter 432]D that owns or manages its own pharmacies;~~
~~(2) A health program administered by the State in the capacity of a provider of health coverage; or~~
~~(3) An employer, labor union, or other group of persons organized in the State that provides health coverage to covered persons employed or residing in the State[-] ; and~~
~~(4) The same as it means in section 2566 (a) (4) of title 42 of the United States Code.~~

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact me at dderauf@kkv.net

PCMA

LATE

February 6, 2020

Representative John Mizuno, Chair
Representative Bertrand Kobayashi, Vice Chair
Committee on Health

RE: H.B. 2712 Relating to Pharmacy Benefit Managers
February 6, 2020, 8:35 a.m., conference room 329

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

On behalf of the Pharmaceutical Care Management Association (PCMA), we greatly appreciate the opportunity to testify on the provisions in H.B. 2712 relating to Pharmacy Benefit Managers. We respectfully request the committee to consider our comments in the interest of payers and patients.

PCMA is the national trade association representing America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D. PBMs are engaged by clients including health insurers, government agencies, unions, school districts, and large and small employers, to manage pharmacy benefits pursuant to health insurance benefits and contracts. PBMs are projected to save payers over $30 billion through the next decade thanks to tools such as negotiating price discounts with drug manufacturers, establishing pharmacy networks and disease management and adherence programs.

H.B. 2710 would prohibit the use of spread pricing arrangements between PBMs and their clients, who are health plan sponsors. PBMs offer plan sponsors a variety of contractual options to pay for PBM services and they choose the one that is best for them based on the services they need and their plan membership. Each employer and plan sponsor evaluates and determines the financial arrangement that meets their specific needs for PBM services.

One option clients elect is a pass-through pricing arrangement for pharmacy reimbursement. Under a pass-through contract, the reimbursement negotiated with the retail pharmacies is passed along to the client to pay. The PBM collects fees from the client to pay for the services it performs for the client. In this case, there would be no difference between what the client pays the PBM and what the pharmacy is reimbursed by the PBM. This approach may involve more variation in cost in the face of drug price fluctuation due to drug shortages, patent expirations, and other market pressures.

Many PBM clients choose a spread pricing arrangement because it provides clients with more certainty in managing their pharmacy costs, enabling them to budget in a more predictable manner. Reducing options employers and plan sponsors have in the marketplace will ultimately reduce their flexibility to contract in the best way that meets their specific needs.

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PCMA

H.B. 2712 would also require the disclosure of competitively sensitive information. It is important to keep the competitive marketplace among drug manufacturers in place in order to drive down the cost of prescription medications. Any public disclosure of rebate information could allow manufacturers to learn what type of price concessions other manufacturers are giving and could disincentivize them from offering deeper discounts, which benefit plan sponsors and their beneficiaries.

The Federal Trade Commission (FTC) has reviewed a number of state legislative proposals that would have required the public disclosure of competitive rebate information and opined that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors, then tacit collusion among them is more feasible" and that such knowledge of competitors' pricing information would dilute incentives for manufacturers to bid aggressively "which leads to higher prices."[1] The FTC also concluded that "[a]ny such cost increases are likely to undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[2]

Again, thank you for the opportunity to testify on H.B. 2712 and we look forward to working with the Committee to develop solutions that will demonstrably benefit Hawaii's residents.

Sincerely,

Bill Head
Assistant Vice President
State Affairs

[1] Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, Jul. 15, 2005.
[2] Id.

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LATE

Testimony to the House Committee on
Health Thursday, February 6, 2020; 8:45 a.m.
State Capitol, Conference Room 329

RE: HOUSE BILL NO. 2712, RELATING TO PHARMACY BENEFIT MANAGERS.

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

The West Hawaii Community Health Center is a 501(c)(3) organization and a federally qualified health center (FQHC) established to provide comprehensive primary care that seeks to improve the health and wellness of our West Hawaii community. West Hawaii Community Health Center (WHCHC) **SUPPORTS** House Bill No. 2712, RELATING TO PHARMACY BENEFIT MANAGERS, and offers **PROPOSED AMENDMENTS** for your consideration.

The bill, as received by your Committee, would:

(1) Establish a class of eligible community health care providers as "340B covered entity" and add other related definitions;

(2) Amend the definition of "pharmacy benefit manager;"

(3) Amend the duties of pharmacy benefit managers (PBMs);

(4) Establish business practices and transparency reporting requirements for PBMs;

(5) Establish program 340B program integrity requirements; and

(6) Increase penalties for violations of the PBM law.

By way of background, WHCHC's serves 25% of the West Hawaii community and 80% of our patients have incomes less than 200% of the federal poverty guidelines. WHCHC services a rural and underserved population and our mission is "to make integrated health services accessible to all who pass through our doors regardless of their ability to pay."

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The federal 340B Drug Pricing Program (340B Program) provides eligible health care providers, such as WHCHC, the ability to purchase outpatient drugs for patients at significantly reduced costs. By purchasing medications at a much lower cost, WHCHC is able to pass the savings on to its patients through reduced drug prices. The discounts provided in the Program are financed by the drug manufacturers, not the government.

In recent years, a growing number of outside organizations called PBMs have figured out how to access 340B savings that should be going to "340B covered entities" such as community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs) and public and nonprofit disproportionate share hospitals (DSHs). Among other things, PBMs have structured their contracts with 340B covered entities to retain part or all of the 340B savings. Examples of this include:

- A PBM determines offers lower reimbursement to the 340B covered entity than other retail pharmacies;

- A PBM gets a larger percentage of the "spread" between the amount the PBM charges to a plan sponsor and the amount the PBM pays to a 304B covered entity when compared to the "spread" between what it charges to a plan sponsor and what it pays to another pharmacy that is not a 340B covered entity, including the PBM owned or affiliated pharmacies; and

- A PBM or its authorized claims processor charges a higher fee for the 340B drugs (more than is justified by higher administrative costs) on the grounds that the 340B covered entity is paying less for these drugs.

The practices of PBMs have had an enormous impact on limited State resources as well. In late 2018, the Ohio State Department of Medicaid required its five managed care plans to terminate contracts with PBMs after the State Auditor found that PBMs had been skimming hundreds of millions of dollars from the Ohio Medicaid Program through previously-hidden spread pricing tactics.

WHCHC notes that many of the concepts in this bill mirror laws in other states which have specifically included statutory protections for the 340B Program. These states include Oregon, Montana, and South Dakota.

Because of this, WHCHC strongly supports all legislative efforts to protect the 340B Program, including House Bill No. 2712.

To further strengthen these protections, we recommend that the bill be amended to (a) consistently use the reference of "340B covered entity" as defined under lines 17 and 18, paragraph 1 of section 2; and (2) remove paragraph 2, section 2, in its entirety to avoid the introduction of a conflict between the "340B covered entity" definition and the existing "covered entity" definition under the Statutes.

Specifically, under sections 2 and 3 of House Bill No. 2712 (beginning with line 19, page 4, and ending with line 21, page 21), we ask that a phrase "340B" be added in front of all references of "covered entity," such that together they are specified as "340B covered entity.

In addition, we ask the following language be deleted in its entirety:

~~2. By amending the definition of "covered entity" to read:~~
~~""Covered entity" means:~~

~~(1) A health benefits plan regulated under chapter 87A; health insurer regulated under article 10A of chapter 431; mutual benefit society regulated under article 1 of chapter 432; or health maintenance organization regulated under chapter 432D; provided that a "covered entity" under this paragraph shall not include a health maintenance organization regulated under chapter 432]D that owns or manages its own pharmacies;~~
~~(2) A health program administered by the State in the capacity of a provider of health coverage; or~~
~~(3) An employer, labor union, or other group of persons organized in the State that provides health coverage to covered persons employed or residing in the State[-] ; and~~
~~(4) The same as it means in section 2566 (a) (4) of title 42 of the United States Code.~~

Lastly, we ask that the paragraph 3. (line 18, page 4) be renumbered as paragraph 2.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Richard Taaffe, CEO West Hawaii Community Health Center, at 808-756-5255.

THE QUEEN'S HEALTH SYSTEMS

LATE

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

From: Rowena Buffett Timms, Executive Vice President & Chief Administrative Officer, The Queen's Health Systems
Colette Masunaga, Manager, Government Relations & External Affairs, The Queen's Health Systems
Date: February 5, 2020
Hrg: House Committee on Health Hearing; Thursday, February 6, 2020 at 8:45 a.m. in Room 329

Re: **Support for HB 2712, 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 offer support on HB2712, relating to pharmacy benefit managers. The proposed bill ensures financially viability for the community health system; ensures access to quality and affordable prescription drugs by vulnerable populations served by community health centers, special needs clinics and other nonprofit healthcare entities covered by the federal 340B pharmacy program.

The 340B drug program was established to allow certain providers a mechanism to acquire outpatient drugs at lower costs and stretch federal resources as far as possible to reach more eligible patients. Our flagship hospital, The Queen's Medical Center, qualifies as a 340B drug provider because it is a disproportionate share hospital, serving a large low-income uninsured, underinsured, and Medicaid patient populations.

We appreciate the additional oversight of PBM under the measure. Queen's outpatient pharmacies take on the responsibility of due diligence in working to find the lowest costs possible for our patients. However, when PBMs reimburse our pharmacies for half of what the costs are to acquire a drug, there is no process for us to know where that drug is being purchased, in what market, and/or if it is even available at that price in Hawaii. Price transparency and oversight of PBMs will greatly benefit our pharmacies, patients, and community. Thank you for the opportunity to testify on this measure.

WAIANAE COAST
COMPREHENSIVE
HEALTH CENTER
www.wcchc.com

Aili Hallstone, PharmD, Director of Pharmacy from Waianae Coast Comprehensive Health Center, Strongly Supports HB 2712 WITH AMENDMENTS

Aloha Chair Mizuno, Vice Chair Kobayashi, and Respected Members of the Committee

As Federally Qualified Health Center not-for-profit pharmacies, we at Waianae and Kapolei Professional Pharmacy provide a number of free services to our community thanks to the Section 340B of the Public Health Service Act. These services include compliance blister packaging, self-monitoring blood pressure programs, and medication adherence programs, to name a few. The 340B program also allows our parent health center, Waianae Coast Comprehensive Health Center (WCCHC), to incorporate care coordination of our high risk patients, community wellness programs, preventive health programs, outreach, transportation, and health education as part of the patient care services for our community. This act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. These organizations include community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs), and public and nonprofit disproportionate share hospitals (DSH) that serve low-income and indigent populations. The program allows 340B covered entities to stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services to the patients and communities they serve. These entities use 340B savings to provide free care for uninsured patients, offer free vaccines, provide services in mental health clinics, and implement medication management and community health programs.

According to the Health Resources and Services Administration (HRSA), which is responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50% in pharmaceutical purchases. Despite increased oversight from HRSA and the program's proven record of decreasing government spending and expanding access to patient care, some want to scale it back or significantly reduce the benefits that eligible entities and their patients receive from the program. PBMs are among those who want to reduce the benefits to the people of the communities we serve and instead keep those monies for their own for-profit sector.

As of late, we have been targeted by various PBMs to identify ourselves as 340B pharmacies and thus been given a reimbursement rate schedule that is different from non-340B pharmacies. At times with these lower reimbursement rates, and even with 340B pricing, we would be reimbursed below the cost of acquiring certain medications.

So much so that we would be unable to continue to provide free services to our community.

The intent of this bill is to protect the integrity of the 340B program to continue to assist the at-risk populations that 340B covered entities serve. If PBMs continue to threaten the livelihood of this program our at-risk populations will not have safe havens to go to that provides them the health and overall well-being that they deserve. We hope the legislature recognizes that FQHCs like WCCHC are an important part of the State of Hawaii's comprehensive system of health and are critical safety net providers that provide desperately needed medical, dental, mental health, and other health and wellness services in underserved areas and to underserved populations. By establishing requirements for PBMs, you are preserving community resources for community health and wellness in our island state including rural communities that are underserved. We respectfully request that you support HB 2712 with amendments.

Thank you for the opportunity to provide testimony on HB2712.

HB-2712
Submitted on: 2/3/2020 11:09:59 PM
Testimony for HLT on 2/6/2020 8:45:00 AM

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

Comments: