DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

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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, Human Services, and Homelessness
Tuesday, February 01, 2022
9:00 a.m.
Via Videoconference

On the following measure:
H.B. 1783, RELATING TO PHARMACY BENEFIT MANAGERS

Chair Yamane 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 address and define pharmacy benefit manager (PBM) practices; create enforcement authority by the insurance commissioner to suspend or revoke a PBM's registration; and impose fines.

The proposed new sections in HRS chapter 431S addressing PBM practices would prohibit contracts between PBMs and pharmacies from including: "gag clauses"; prohibitions on pharmacists selling a more affordable alternative to a consumer when one is available; and prohibitions on pharmacists sharing information with government officials in certain circumstances. The new sections in HRS chapter 431S would also prohibit a PBM from requiring a covered person to pay more than the lesser of a covered person's cost-sharing for a drug or the amount the covered person would pay for the drug if the covered person were paying the cash price.

Finally, sections 5 and 6 of this bill propose to change PBM registration and renewal fees under HRS chapter 431S to a blank amount. However, amounts for these fees are now provided for in HRS § 431:7-101 (see 2021 Hawaii Session Laws, Act 111). Accordingly, we respectfully request the following amendments to this bill to avoid confusion:

1. Amend p.11, line 1, to read: "(3) A nonrefundable issuance fee [~~of $140.~~] as required under section 431:7-101."
2. Amend p.12, line 1, to read: "(2) A service fee [~~of $140.~~] as required under section 431:7-101."

Thank you for the opportunity to testify on this bill.

DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, MD
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
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Testimony COMMENTING on HB1783
RELATING TO PHARMACY BENEFIT MANAGERS.

REP. RYAN I. YAMANE, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: February 1, 2022 Room Number: Videoconference

Fiscal Implications: N/A.

Department Testimony: The Department of Health (DOH) defers to the Department of Commerce and Consumer Affairs regarding the merits of the proposed regulatory authority.

DOH requests an amendment that repeals contradictory and unworkable pharmacy benefit manager statute, specifically section 328-106, Hawaii Revised Statutes, that requires the department to enforce the terms of contracts between private entities and serves no public health purpose.

Thank you for the opportunity to testify.

Offered Amendments:

SECTION . Section 328-106, Hawaii Revised Statutes,is repealed.

["~~**[§328-106] Pharmacy benefit manager; maximum allowable cost.** (a) A pharmacy benefit manager that reimburses a contracting pharmacy for a drug on a maximum allowable cost basis shall comply with the requirements of this section.~~

~~(b) The pharmacy benefit manager shall include the following in the contract information with a contracting pharmacy:~~

~~(1) Information identifying any national drug pricing compendia; or~~

~~(2) Other data sources for the maximum allowable cost list.~~

~~(c) The pharmacy benefit manager shall make available to a contracting pharmacy, upon request, 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, secure, and usable web-based or other comparable format.~~

~~(d) A drug shall not be included on a maximum allowable cost list or reimbursed on a maximum allowable cost basis unless all of the following apply:~~

~~(1) The drug is listed as "A" or "B" rated in the most recent version of the Orange Book or has a rating of "NR", "NA", or similar rating by a nationally recognized reference;~~

~~(2) The drug is generally available for purchase in this State from a national or regional wholesaler; and~~

~~(3) The drug is not obsolete.~~

~~(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 contracted pharmacy until the pharmacy benefit manager next updates the maximum allowable cost list in accordance with this section.~~

~~(f) The pharmacy benefit manager shall have a clearly defined process for a contracting pharmacy to appeal the maximum allowable cost for a drug on a maximum allowable cost list that complies with all of the following:~~

~~(1) A contracting pharmacy may base its appeal on one or more of the following:~~

~~(A) The maximum allowable cost for a drug is below the cost at which the drug is available for purchase by similarly situated pharmacies in this State from a national or regional wholesaler; or~~

~~(B) The drug does not meet the requirements of subsection (d);~~

~~(2) A contracting pharmacy shall be provided no less than fourteen business days following receipt of payment for a claim to file the appeal with the pharmacy benefit manager;~~

~~(3) The pharmacy benefit manager shall make a final determination on the contracting pharmacy's appeal no later than fourteen business days after the pharmacy benefit manager's receipt of the appeal;~~

~~(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; and~~

~~(5) If the maximum allowable cost is not upheld on appeal, the pharmacy benefit manager shall adjust, for 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 appealed claim.~~

~~(g) 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.~~"]

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Health, Human Services, and Homelessness
Tuesday, February 1, 2022; 9:00 a.m.
State Capitol, Conference Room 329
Via Videoconference

RE: HOUSE BILL NO. 1783, RELATING TO PHARMACY BENEFIT MANAGERS.

Chair Yamane, Vice Chair Tam, 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** House Bill No. 1783, RELATING TO PHARMACY BENEFIT MANAGERS, and offers **PROPOSED AMENDMENTS** for your consideration.

By way of background, the HPCA represents Hawaii's 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 bill, as received by your Committee, would protect the consuming public from unscrupulous business practices conducted by pharmacy benefit managers (PBMs). Among other things, this bill would:

(1) Bar PBMs from prohibiting, restricting, or penalizing a pharmacy or pharmacist from disclosing certain health care and cost information to consumers, the Insurance Commissioner, law enforcement, or government officials;

(2) Clarify that the person receiving this information has the obligation to maintain proprietary information as confidential;

(3) Specify that the pharmacy or pharmacist has a duty to treat proprietary information as confidential in the transmission of the information in both written and oral form;

(4) Prohibit PBMs from requiring a consumer of a covered prescription drug to pay an amount greater than the lesser of the consumer's cost-sharing amount under the terms of the

prescription drug benefit plan or the amount the consumer would pay for the drug if the consumer was paying the cash price;

(5) Allow the Insurance Commissioner to enforce compliance by:

(A) Examining and auditing PBM books and records, and clarifies the proprietary and confidential treatment of reviewed information and data;

(B) Levying an administrative penalty not to exceed an unspecified amount for each violation; and

(C) Suspending or revoking the registration of a PBM;

and

(6) Clarify the scope of professional practice by PBMs regarding the negotiating of rebates, discounts and other financial incentives and arrangements with drug companies, disbursing or distributing rebates, and managing and participating in incentive programs or arrangements for pharmacist services.

By way of background, 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.

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.

Because of this, the HPCA supports any and all legislative efforts to protect the 340B Program. To further strengthen these protections, we recommend that the bill be amended to include language found in Ohio statutes to specifically reference the 340B Program.

Starting on page 4, line 12, the HPCA offers the following highlighted language for your consideration:

"(d) A pharmacy benefit manager shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the prescription drug benefit plan or the amount the covered person would pay for

the drug if the covered person were paying the cash price.

In addition, a pharmacy benefit manager shall not reimburse a 340B pharmacy differently than any other network pharmacy based on its status as a 340B pharmacy; provided that for purposes of this section, 340B pharmacy means a pharmacy that is authorized to purchase drugs at a discount under 42 U.S.C. 256b.

Any amount paid by a covered person under this section shall be attributable toward any deductible or, to the extent consistent with section 2707, Public Health Service Act, the annual out-of-pocket maximums under the covered person's health benefit plan."

Regarding the penalty provisions, one could argue that the spread-pricing tactics of PBMs constitute an unfair method of competition and unfair or deceptive acts or practices in the conduct of a trade or commerce. If it is the desire of this Committee to conform the penalty provisions with Chapter 480, HRS, we suggest that the highlighted language be added to page 5, line 18, to establish a new subsection (f):

"(f) Notwithstanding section 480-11, or any other law to the contrary, in addition to any penalty authorized pursuant to this section, each violation of this chapter shall also be a violation of chapter 480 and subject to any penalty authorized thereunder."

By cross-referencing Chapter 480, HRS, to Chapter 431S, HRS, this language would subject persons who violate this law with criminal and civil penalties, and allow injured persons to sue in tort and be eligible to receive, among other things, treble damages, and attorneys fees. Chapter 480, HRS, also allows for class actions by private persons.

Also, if this Committee is inclined to take a similar approach as did the Ohio Medicaid Program, we offer the highlighted language to be added as a new SECTION 8 at page 12, line 10, for your consideration:

"SECTION 8 (a) No contract for managed care entered into pursuant to Part II of Chapter 346, Hawaii Revised Statutes, after December 31, 2022, shall contain a provision that authorizes a pharmacy benefit manager to reimburse a contracting pharmacy on a maximum allowable cost basis in accordance with Section 328-106, Hawaii Revised Statutes, or Chapter 431S, Hawaii Revised Statutes.

(b) Any provision of a contract for managed care authorized pursuant to Part II of Chapter 346, Hawaii Revised Statutes, to reimburse a contracting pharmacy for a drug on a maximum allowable cost basis in accordance with Section 328-106, Hawaii Revised Statutes, or Chapter 431S, Hawaii Revised Statutes, that was in effect on or before December 31, 2022, shall be null and void."

This provision would establish a moratorium to allow the Legislature (and the State Auditor if this Committee is so inclined) to investigate whether the spread-pricing tactics of PBMs had resulted in overpayments by the Department of Human Services in Hawaii's Medicaid Program. The length of the moratorium would be indicated by clarifying the effective date to require SECTION 8 be repealed on a date certain.

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.

HB-1783
Submitted on: 1/30/2022 9:18:52 PM
Testimony for HHH on 2/1/2022 9:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Patrick Uyemoto	Times Pharmacy	Support	No

Comments:

Times Pharmacy Strongly Supports HB1783

Aloha Chair Yamane, Vice Chair Tam, and Members of the Committee on Health, Human Services, and Homelessness

The Pharmacy Benefit Manager (PBM) market has become a highly consolidated industry whose focus is not on serving consumers but on increasing company profits. Egregious and anti-competitive behavior on the part of the major PBMs has caused drug costs to skyrocket and harmed consumers and local community pharmacies.

Three PBMs-Optum Rx, Express Scripts, and CVS Caremark-control 85% of the PBM market according to the President's Council of Economic Advisors. The Council also observed "Over 20% of spending on prescription drugs was taken in as profit by the pharmaceutical distribution system. The size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients are secret." There are also numerous conflicts of interest, with the most significant pertaining to rebates; when PBMs can profit share in rebates they want higher, not lower drug prices. PBMs also have their own pharmacies and drive consumers from their community pharmacy to the PBM owned pharmacy which has forced numerous local independent pharmacies to close their doors. Not only does this negatively affect local business owners and our local economy but it also cuts off vital healthcare resources in some of our most rural areas.

PBM rebates are based on a percentage of the list price of drugs, therefore PBMs inflate the list price and steer patients to drugs where PBM's profit, not patients. PBM rebates, thanks to lack of competition and transparency, now exceed $150 billion per year, but that increase has not resulted in lower prices for patients.

PBMs overcharge states and fail to pass along discounts. An Ohio State Auditor found that the PBM OptumRx earned over $223 million between April 2017 and March 2018. Kentucky found that hidden PBM fees accounted for $125 million in costs to taxpayers. And between April 2017 and April 2018, PBMs overcharged New York taxpayers by over $200 million.

PBMs use hidden fees (among other tactics) to increase their revenue. According to Pew Charitable Trust, PBMs nearly quadrupled fees they charged biopharmaceutical

companies between 2014 and 2016. Growth in alternate PBM revenue streams, such as spread pricing and administrative fees, increased from $5.9 billion in 2012 to $16.6 billion in 2016.

PBMs aggressively fight transparency which is the main reason why there is no meaningful regulation of PBMs. There are a growing number of states that require PBMs to register, but regulation of rebates, transparency, or conflicts of interest are still severely lacking or non-existent.

Local residents and local businesses, your constituents, are being taken advantage of due to these unethical business practices. Just look at the hundreds of millions of taxpayer dollars that other states have found being siphoned into these PBMs and there is a very good chance that is happening in our state as well. Please look into the PBM issues, get educated, and help protect Hawaii. Thank you for the opportunity to provide testimony on HB1783.

KAISER PERMANENTE®

Government Affairs

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
House Committee on Health, Human Services, & Homelessness
The Honorable Ryan I. Yamane, Chair
The Honorable Adrian K. Tam, Vice Chair

February 1, 2022
9:00 am
Via Videoconference

HB 1783 Relating to Pharmacy Benefit Managers

Chair, Vice Chair, and committee members, thank you for this opportunity to provide testimony on HB 1783 relating to pharmacy benefit managers.

Kaiser Permanente Hawaii would like to request an amendment.

Kaiser Permanente Hawaii appreciates the opportunity to testify on HB 1783, which addresses and defines pharmacy benefit manager practices and creates enforcement authority by the insurance commissioner. Notably, one of the purposes of this bill is to "*Amend the definition of "pharmacy benefit manager" in chapter 431R, Hawaii Revised Statutes, to reference registration under chapter 431S* ***to more closely align both chapters***." For consistency and clarity, Kaiser requests an amendment to better align the definitions of PBM in separate sections 431R and 431S. Therefore, Page 5, lines 18-20, and Page 6, lines 1-8, should read as follows:

> SECTION 3. Section 431R-1, Hawaii Revised Statutes, is amended by amending the definition of "pharmacy benefit manager" to read as follows:
>
> ""Pharmacy benefit manager" has the same meaning as in chapter 431S-1 ~~means any person, business, or entity that performs pharmacy benefit management~~ [~~, including but not limited to a person or entity under contract with a pharmacy benefit manager to perform pharmacy benefit management on behalf of a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, or health program administered by the State.~~] and is registered pursuant to chapter 431S."

Thank you for your consideration.

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1275 Pennsylvania Avenue, NW
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January 31, 2022

Representative Ryan Yamane, Chair
Representative Adrian Tam, Vice Chair
Committee on Health, Human Services, & Homelessness
415 South Beretania Street
Honolulu, Hawaii 96813

RE: HB 1783 Relating to Pharmacy Benefit Managers
February 1, 2022; 9 am; Via Videoconference

Aloha Chair Yamane, Vice Chair Tam, and members of the committee:

CVS Health has a few technical concerns and clarifying requests regarding House Bill 1783 ("HB 1783"), relating to pharmacy benefit managers as it is currently drafted and would be happy to work with legislators and stakeholders as discussion on this bill continues.

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses and nurse practitioners. Our unique health care model gives us an unparalleled perspective on how systems can be better designed to help consumers navigate the health care system – and their personal health care – by improving access, lowering costs, and being a trusted partner for every meaningful moment of health. And we do it all with heart, each and every day.

As noted above, we have a few concerns with the legislation and have outlined our suggested changes below.

Section 2

In Section 431S – Business Practices, we suggest a technical amendment in (b) on line 11 so it reads "total cost-share for pharmacist services for a prescription drug." We are requesting this to clarify that the information provided to a covered person is specific to their cost-share obligations under their plan.

We also suggest the following clarifying amendment to ensure the information being disclosed in (c) is limited to the enforcement of the law and to the specific complaint at hand.

> *(c) A pharmacy benefit manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement or state and federal governmental officials for the purpose of filing a complaint; provided that:*
>
> *(1) The recipient of the information has the obligation, to the extent provided by state or federal law, to maintain proprietary information as confidential; ~~and~~*
>
> *(2) Prior to disclosure of information designated as confidential under the pharmacy benefit manager contract, the pharmacist or pharmacy marks as confidential any document in which the information appears or requests confidential treatment for any oral communication of the information~~.~~; and*
>
> *(3) The information is relevant to the subject of the complaint.*

In Section 431S – Enforcement, we suggest the following language to clarify the scope of the exam to the pharmacy benefit manager:

(a) The commissioner is authorized to enforce compliance with the requirements of this chapter.
(b) The commissioner may examine or audit the relevant books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a prescription drug benefit plan to determine compliance with this chapter if a complaint is received.
. . .
(d) The commissioner may use any relevant document or information provided pursuant to this section in the performance of the commissioner's duties to determine compliance.

Section 4

We suggest the following clarifying amendment to the definition of "Pharmacy":

"Pharmacy" means a store, shop, or place located in the State and permitted as a pharmacy by the board of pharmacy of the State pursuant to chapter 461.

Section 5

In Section 431S-3 Registration required, we suggest the following amendment:

(c) The commissioner may suspend or revoke the registration of a pharmacy benefit manager if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant ~~is not competent, trustworthy, financially responsible, of good personal and business reputation, or~~ has been found to have violated the insurance laws of the State or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

We believe the language we have suggested to be deleted is subjective and standards for suspension or revocation of registration should be based on objective findings of the law.

Additionally, we suggest adding the following language to ensure that due process is provided in accordance with the State's Administrative Procedures Act:

(d) The commissioner shall notify the pharmacy benefit manager, specify the reason or reasons for the suspension or revocation, and permit the pharmacy benefit manager a reasonable opportunity to appeal the suspension or revocation in accordance with the State's administrative procedure act.
(e) The commissioner may, in lieu of suspension or revocation of a pharmacy benefit manager's registration, permit the pharmacy benefit manager to submit to the commissioner a corrective action plan to cure or correct deficiencies.

Section 7

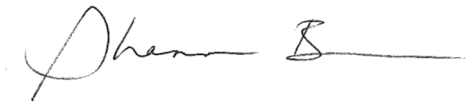
For the penalty, we suggest a fine of $1,000 for each violation.

Lastly, we wanted to point out that there are two different definitions of "pharmacy benefit manager" in the bill (Section 3 and Section 4) and suggest that the amendments in the bill be combined to create one consistent definition.

On behalf of CVS Health, thank you for your consideration of these amendments and we welcome the opportunity to work with you on these important issues.

CVSHealth

Respectfully,



Shannon Butler
Executive Director of Government Affairs
CVS Health

HB-1783
Submitted on: 1/27/2022 9:34:52 PM
Testimony for HHH on 2/1/2022 9:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Ronald Taniguchi, Pharm.D.	Individual	Support	No

Comments:

In strong support.

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

(2) Prior to disclosure of information designated as confidential under the pharmacy benefit manager contract, the pharmacist or pharmacy marks as confidential any document in which the information appears or requests confidential treatment for any oral communication of the information.; and
(3) The information is relevant to the subject of the complaint.

In Section 431S – Enforcement, we suggest the following language to clarify the scope of the exam to the pharmacy benefit manager:

(a) The commissioner is authorized to enforce compliance with the requirements of this chapter.
(b) The commissioner may examine or audit the relevant books and records of a pharmacy benefit manager providing claims processing services or other prescription drug or device services for a prescription drug benefit plan to determine compliance with this chapter if a complaint is received.
. . .
(d) The commissioner may use any relevant document or information provided pursuant to this section in the performance of the commissioner's duties to determine compliance.

We also recommend a penalty of $500 in (e).

Section 5

In Section 431S-3 Registration required, we suggest $300 for the nonrefundable issuance fee in (b)(3).

We also suggest the following amendment:

(c) The commissioner may suspend or revoke the registration of a pharmacy benefit manager if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant ~~is not competent, trustworthy, financially responsible, of good personal and business reputation, or~~ has been found to have violated the insurance laws of the State or any other jurisdiction, or has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

We believe the language we have suggested be deleted is subjective and that the standards for suspension or revocation of registration should be based on objective findings of facts.

Additionally, we suggest adding the following language to ensure that due process is provided in accordance with the State's Administrative Procedures Act:

(d) The commissioner shall notify the pharmacy benefit manager, specify the reason or reasons for the suspension or revocation, and permit the pharmacy benefit manager a reasonable opportunity to appeal the suspension or revocation in accordance with the State's administrative procedure act.

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

(e) The commissioner may, in lieu of suspension or revocation of a pharmacy benefit manager's registration, permit the pharmacy benefit manager to submit to the commissioner a corrective action plan to cure or correct deficiencies.

Section 7

For the penalty, we suggest a fine of $1,000 for each violation.

Section 11

Because most health plans renewal annually, as well as their contracts with PBMs, we request an effective date of January 1, 2023.

Finally, we wanted to note there are two different definitions of "pharmacy benefit manager" in Sections 3 and 4 of the bill and suggest there be one consistent definition.

We greatly appreciate your consideration of these suggested changes and welcome the opportunity work with you on this legislation.

Sincerely,

Bill Head
Assistant Vice President
State Affairs

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325 7th Street, NW, 9th Floor
Washington, DC 20004
www.pcmanet.org

HB-1783
Submitted on: 1/31/2022 3:56:46 PM
Testimony for HHH on 2/1/2022 9:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Kevin Glick, Pharmacist	Individual	Support	No

Comments:

Hohorable House Members: Thank you for hearing this important bill. I strongly support this legislation. Pharmacy Benefit Managers, (PBM's) have the economic power of life over death for pharmacy providers across the country. This bill would bring more transparancy to their market power and bring accountability. Please pass this bill from the committee.

Sincerely,

Kevin Glick

Hawaii Pharmacist for 40 years

February 1, 2022

The Honorable Ryan I. Yamane
Chair, House Committee on Health, Human Services, & Homelessness
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORT FOR HB 1783

Dear Chair Yamane and members of the House Committee on Health, Human Services, & Homelessness:

I am writing to you on behalf of the National Community Pharmacists Association in support of HB 1783, which would help control drug costs in Hawaii, provide greater protections for patients regarding their prescription drug benefits programs, and establish greater oversight of the pharmacy benefit managers that administer those benefits. NCPA represents the interest of America's community pharmacists, including the owners of more than 19,400 independent community pharmacies across the United States and 42 independent community pharmacies in Hawaii.

Nationwide, state lawmakers have found that "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[1] HB 1783 will protect Hawaii patients by giving the insurance commissioner the necessary enforcement authority to put a stop to some of those harmful practices. Ultimately, this bill will benefit Hawaii residents by protecting the patient-pharmacist relationship and allowing community pharmacists to work with patients to make decisions that control drug costs.

To protect patient access to vital pharmacy services, I respectfully ask you to support HB 1783. If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me.

Sincerely,

Matthew Magner, JD
Director, State Government Affairs

[1] New York Senate Committee on Investigations and Government Operations, *Final Investigative Report: Pharmacy Benefit Managers in New York*, (May 31, 2019), *available at* https://www.nysenate.gov/sites/default/files/article/attachment/final_investigatory_report_pharmacy_benefit_managers_in_new_york.pdf.

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HB-1783
Submitted on: 2/1/2022 7:49:46 AM
Testimony for HHH on 2/1/2022 9:00:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
magdi latif	bb inc	Support	No

Comments:

Aloha Rep. Ryan I. Yamane chair and Rep. Adrian K. Tam Vice Chair and the memembers of the Committe On Health, Human Services, & Homelessness

We urge you to pass HB1783 as a pharmacist serving my community for the past 34+ years, we have had our hands tied in enabeling our patients to receive competitive prices that are affordable, due to retaliations from PBM. We've had to overcharge patients beyond copays and give those funds directely to the PBM, in this scenario we were not allowed to reverse the claim and only charge the patient their usual copay. there are many more examples of runaway practices that are unregulated, this bill will only start to clean up some of these inequalities.

We appreciate all you work

Magdi Latif