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Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Health
Tuesday, February 23, 2021
9:30 a.m.
Via Videoconference

On the following measure:
S.B. 602, S.D. 1, RELATING TO PHARMACY BENEFIT MANAGERS

WRITTEN TESTIMONY ONLY

Chair Baker and Members of the Committee:

My name is Colin M. 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) prohibit certain contracts for managed care entered into after June 30, 2021, from containing a provision that authorizes pharmacy benefit managers (PBMs) to reimburse a contracting pharmacy on a maximum allowable cost basis, and void any such provisions in exiting manage care contracts; (2) prohibit PBMs from engaging in self-serving or deceptive business practices; (3) prohibit PBMs from engaging in unfair methods of competition or unfair practices; (4) prohibit PBMs from reimbursing a 340B pharmacy differently than any other network pharmacy; (5) prohibit PBMs from reimbursing an independent or rural pharmacy an amount less than the rural rate for each prescription drug, under certain circumstances; (6) prohibit

PBMs from prohibiting a pharmacist or pharmacy to provide certain information to insureds; (7) increase PBMs' annual reporting requirements; (8) require the insurance commissioner to file annual reports with the Legislature; (9) increase PBM registration and renewal fees by an unspecified amount; and (10) make certain violations of PBMs subject to the penalties provided in Hawaii Revised Statutes (HRS) chapter 480 and chapter 481.

Several areas of the bill may require further clarity. Page 5, line 16 through page 6, line 20, adds a new section addressing PBM business practices, prohibitions, and reimbursement rates. The Department recommends adding the following language from the National Association of Insurance Commissioners' (NAIC) Draft PBM Model Law regarding prohibited practices:

"(d) A pharmacy benefit manager contract with a participating pharmacist or pharmacy may not prohibit, restrict, or limit disclosure of information to the commissioner, law enforcement, or state and federal governmental officials, provided that:

(1) The recipient of the information represents it has the authority, 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, the pharmacist or pharmacy:

(A) Marks as confidential any document in which the information appears; or

(B) Requests confidential treatment orf any oral communication of the information.

(e) A pharmacy benefit manager may not terminate the contract of or penalize a pharmacist or pharmacy due to the pharmacist or pharmacy:

(1) Disclosing information about pharmacy benefit manager practices, except for information determined to be a trade secret, as determined by state law or the commissioner; or

(2) Sharing any portion of the pharmacy benefit manager contract with the commissioner pursuant to a complaint or a query regarding whether the contract is in compliance with this section."

Page 6, lines 12 through 14, provides that pharmacy benefit managers "shall file with the commissioner a list of rural rates for each prescription drug." The Department respectfully requests that PBMs submit a filing in a form and manner prescribed by the commissioner.

The Department respectfully requests replacing the gag clause prohibition on page 7, lines 1 through 9, with the NAIC's Draft PBM Model Law gag clause prohibition, as follows:

"**§431S- Gag clause prohibited.** [~~A pharmacy benefit manager shall not prohibit a pharmacist or pharmacy from providing an insured individual with information on the amount of the insured's cost share for the insured's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available. Neither a pharmacy nor a pharmacist shall be penalized by a pharmacy benefit manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available.~~] (a) In any participation contracts between a pharmacy benefit manager and pharmacists or pharmacies providing prescription drug coverage for health benefit plans, no pharmacy or pharmacist may be prohibited, restricted, or penalized in any way from disclosing to any covered person any healthcare information that the pharmacy or pharmacist deems appropriate regarding:

(1) The nature of treatment, risks, or alternative thereto;

(2) The availability of alternate therapies, consultations, or tests;

(3) The decision of utilization reviewers or similar persons to authorize or deny services;

(4) The process that is used to authorize or deny healthcare services or benefits; or

(5) Information on financial incentives and structures used by the insurer.

(b) A pharmacy benefit manager may not prohibit a pharmacy or pharmacists from discussing information regarding the total cost for pharmacist services for a

prescription drug or from selling a more affordable alternative to the covered person if a more affordable alternative is available."

Section 5 greatly increases the registration requirements of PBMs. Implementing this section will be difficult, as the Insurance Division lacks expertise to assess the qualifications of PBMs for licensure and to determine what documents would be sufficient or should even be requested. Page 14, lines 3 through 11, provides only broad criteria for the insurance commissioner to consider in determining whether to grant a registration. To prove that this criteria has been met, page 15, lines 9 through 13 provides that applicants shall include "[a]ny other information the commissioner deems necessary or helpful to determine whether the applicant has the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered pursuant to this chapter."

Further, while section 5 authorizes the issuance of a restricted or limited registration on page 14, lines 8 through 11, the penalty provisions neither give the insurance commissioner those same remedies as disciplinary sanctions for HRS chapter 431S violations, nor grant the commissioner enforcement authority for any violation of chapter 431S.

Finally, the issuance, renewal, and penalty fees on page 15, lines 7 and 8, and page 16, lines 13 and 16, are inconsistent with the terms and penalty amounts proposed in S.B. 1096, on page 40, lines 3 through 5 and lines 15 through 22, and S.B. 1098, on page 2, line 10, page 5, lines 14 and 15, and page 8, lines 12 through 17. The Department respectfully requests that any changes to the terms and fees be consistent with S.B. 1096 and S.B. 1098.

Thank you for the opportunity to testify on this bill.

An Independent Licensee of the Blue Cross and Blue Shield Association

February 23, 2021

The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair
Senate Committee on Commerce and Consumer Protection

Re: SB 602 SD1 – Relating to Pharmacy Benefit Managers

Dear Chair Baker, Vice Chair Chang, and Committee Members:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 602, SD1, which prohibits certain contracts for managed care entered into after June 30, 2021, from containing a provision that authorizes a pharmacy benefit manager to reimburse a contracting pharmacy on a maximum allowable cost basis, and voids any such provisions in existing managed care contracts. Prohibits pharmacy benefit managers from engaging in unfair methods of competition or unfair practices. Prohibits a pharmacy benefit manager from reimbursing a 340B pharmacy differently than any other network pharmacy. Prohibits a pharmacy benefit manager from reimbursing an independent or rural pharmacy an amount less than the rural rate for each drug under certain circumstances. Prohibits a pharmacy benefit manager from prohibiting a pharmacist to provide certain information to insureds. Increases pharmacy benefit managers' annual reporting requirements. Requires the insurance commissioner to file annual reports with the legislature. Increases pharmacy benefit manager registration and renewal fees by an unspecified amount. Makes certain violations of pharmacy benefit managers subject to the penalties provided in chapters 480 and 481, Hawaii Revised Statutes. Effective 7/1/2050.

HMSA utilizes a Pharmacy Benefit Manager (PBM) to manage our drug benefit plans, which helps us and our members to control escalating drug costs. We believe this bill increases administrative burden and costs for our PBM, which will lead to increased costs for our members.

Thank you for the opportunity to testify on this measure. Your consideration of our concerns is appreciated.

Sincerely,

Matthew W. Sasaki
Director, Government Relations

1275 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

February 20, 2021

Senator Rosalyn Baker, Chair
Senator Stanley Chang, Vice Chair
Committee on Commerce and Consumer Protection
415 South Beretania Street
Honolulu, Hawaii 96813

RE: SB 602 SD1 Relating to Pharmacy Benefit Managers
February 23, 2021; 9:30 a.m.; Via Videoconference

Aloha Chair Baker, Vice Chair Chang, and members of the committee:

CVS Health has a number of concerns regarding Senate Bill 602 SD1 ("SB 602"), 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. SB 602 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 a different kind of health care company. We are a diversified health services company with nearly 300,000 employees united around a common purpose of helping people on their path to better health. In an increasingly connected and digital world, we are meeting people wherever they are and changing health care to meet their needs. Built on a foundation of unmatched community presence, our diversified model engages one in three Americans each year. From our innovative new services at HealthHUB® locations, to transformative programs that help manage chronic conditions, we are making health care more accessible, more affordable, and simply better.

As noted above, we have a number of concerns with SB 602, including the rural reimbursement rate mandate 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.

Rural Reimbursement Rate

SB 602 seeks to prohibit a PBM from reimbursing an independent or rural pharmacy an amount less than the rural rate for prescription drugs. It should be noted that typically, rural pharmacies get paid higher reimbursement rates because they have lesser patient volume but are important for patient access. Not all independent pharmacies are rural pharmacies and should not be reimbursed at the same rates as rural pharmacies – independent pharmacies in urban and suburban areas have greater volume and therefore their reimbursement rates account for this. If all independent pharmacies must be reimbursed at a rural rate, this rate is likely to be inflated and may create a windfall to those pharmacies at the expense of Hawaii plan sponsors and consumers.

This bill also seeks to prohibit PBMs from making changes to the rate without providing 30 days' notice to pharmacies. Given the complex and dynamic nature of the generic drug marketplace, prices change throughout the year. This bill would cause reimbursement rates to be based on information from 30 days prior, no longer reflecting the actual market price of a drug product when it goes into effect. If

there's a fluctuation in the marketplace that would entitle a pharmacy to a greater reimbursement, they would not be able to receive such reimbursement because the rate would be frozen at the rural rate. For example, if the market price of a drug quickly increases (due to a drug shortage or if a manufacturer drastically increases its price), pharmacies would be under-reimbursed for that drug because the PBM would not be able to adjust the reimbursement rate for 30 days. We also believe the proposed provision may conflict with the existing maximum allowable cost (MAC) law that requires that MAC lists be updated every 7 days.

Additionally, this bill takes away incentives for pharmacies to purchase drugs cost effectively because they will always be guaranteed reimbursement at or above the rural rate. If the market price of a drug decreases, consumers would not get the benefit of the savings. Pharmacies could buy drugs at a cheaper price, but PBMs will be forced to reimburse pharmacies (and bill the health plan) at the higher rural rate since adjustments cannot be made for 30 days. Ultimately, if PBMs were to comply with this bill, prescription drug costs for Hawaiian consumers and employers will increase.

Transparency Report

SB 602 would also require the disclosure of competitively sensitive information with no confidentiality protections. 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]

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
Executive Director of Government Affairs
CVS Health

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

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the Senate Committee on Commerce and Consumer Protection
Tuesday, February 23, 2021; 9:30 a.m.
State Capitol, Conference Room 229
Via Videoconference

RE: SENATE BILL NO. 0602, SENATE DRAFT 1, RELATING TO PHARMACY BENEFIT MANAGERS.

Chair Baker, Vice Chair Chang, 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** Senate Bill No. 0602, RELATING TO PHARMACY BENEFIT MANAGERS.

The bill, as received by your Committee, would, protect the health, welfare, and safety of the consuming public by enhancing the regulation of pharmacy benefit managers.

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.

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. 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, West Virginia, and South Dakota.

Lastly, from a technical perspective, we note that Section 328-106, HRS, provides the Department of Health with regulatory authority over PBMs. If it is the desire of this Committee to transfer all regulatory authority to the Insurance Commissioner under Chapter 431S, HRS, the Committee may want to review that statute to determine whether there are any elements of that law that should be transferred to Chapter 431S, HRS, and repeal Section 328-106, HRS.

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 QUEEN'S HEALTH SYSTEMS

To: The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair
Members, Senate Committee on Commerce &Consumer Protection

From: Colette Masunaga, Director, Government Relations & External Affairs, The Queen's Health Systems

Date: February 23, 2021

Re: Support for SB602, SD1: Relating to Pharmacy Benefits Managers

The Queen's Health Systems (Queen's) is a nonprofit 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, and more than 1,500 affiliated physicians and providers 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 provide testimony in support of SB602, SD1, relating to pharmacy benefits managers, which prohibits pharmacy benefit managers (PBM) from engaging in self-serving business practices, allow pharmacies to provide an insured individual with information about the amount of the insured's cost share for their prescription drug and if a more affordable alternative is available, increases annual reporting for PBMs, and provides the Insurance Commissioner with oversight of PBMs – including the ability to levy fines for violations.

Queen's contracts with over 15 PBMs, with each PBM having their own way of doing business and some with little to no transparency. PBMs control the formularies for prices and have the ability create pricing uncertainty for pharmacies. 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.

In addition to price uncertainty, our pharmacies go through undue burdens when accessing PBMs prices for any given drug and we currently do not receive data in a standard and comprehensive list format, and must obtain prices on an individual prescription basis. With no guideline or standard approach when it comes to the disclosure of pricing, each PBM has been forced to develop their own burdensome process which puts pharmacies at a disadvantage.

SB602, SD1 will contribute significantly to needed transparency and oversight of PBMs that will benefit pharmacies and consumers alike. Furthermore, we support provisions in this measure ensuring that PBM reimburse 340B pharmacies similar to any other network pharmacy.

Thank you for the opportunity to testify in support of SB602, SD1.

KAISER PERMANENTE®

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
Senate Committee on Commerce and Consumer Protection
The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair

February 23, 2021
9:30 am
Via Videoconference

Re: SB 602, SD1 - Relating to Pharmacy Benefit Managers

Chair, Vice Chair, and committee members thank you for this opportunity to provide testimony on this measure regulating pharmacy benefit managers in Hawaii.

Kaiser Permanente Hawaii requests an amendment.

Kaiser Permanente appreciates this bill's intent to regulate pharmacy benefit managers to protect consumers. PBMs can provide value to the health care system, but as third-party business entities, may also have economic interests that can add costs, or keep drug prices higher than they should be. As a fully integrated delivery system, Kaiser Permanente performs many of the value added functions that a PBM performs as a third-party administrator for other entities; but Kaiser Permanente performs these functions for itself, and for the benefit of its members, not for other unaffiliated parties. Accordingly, we do not believe it would be accurate or appropriate to capture Kaiser Permanente under the definition of a PBM and it would not serve any of the bill's purposes.

Kaiser Permanente owns and manages its own pharmacies for the delivery of pharmacy benefits directly to its enrollees. In administering its in-house pharmacy benefits, Kaiser Permanente performs its own "pharmacy benefits management." We have developed each of these functions – mail service, claims processing, disease management, formulary development and aggressive negotiations with manufacturers for the best prices -- over many years to work in concert within Kaiser Permanente's system for the benefit of our members. All of these functions help us to provide the best quality outcomes for our members at an affordable price, thereby managing the ever-increasing costs that pharmaceutical manufacturers impose.

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Because these services are already built into our system, Kaiser Permanente generally has no need to engage others to perform its in-house pharmacy services. More importantly, relevant information about these functions is already available to the Insurance Commissioner. This is not the case for industry standard third-party PBMs who are the subject of this bill. Therefore, since we believe the purpose of this bill is to regulate third-party PBMs, and not internally owned in-house pharmacies, we ask for the following exemption excluding an integrated health system that owns and/or manages its own pharmacies. Therefore, on Page 12, lines 18-21, and Page 12, lines 1-7, Kaiser requests the removal of the amendments to the definition of "Covered Entity" to maintain the current reading of Hawaii Revised Statute § 431S-1, Definitions, which includes an exclusion of health maintenance organization that owns or manage its own pharmacies from the definition of "Covered Entity".

HRS § 431S-1 currently reads as follows:

"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 432D that owns or manages its own pharmacies;

[Red bracketed language is not included in the amended definition of "Covered Entity" but is included in the current law under HRS § 431S-1]

Thank you for your consideration.

PCMA

February 22, 2021

Senator Rosalyn Baker, Chair
Senator Stanley Chang, Vice Chair
Committee on Commerce and Consumer Protection

RE: S.B. 602 Relating to Pharmacy Benefit Managers
Submitted electronically

Aloha Chair Baker, Vice Chair Chang and Members of the Committee:

On behalf of the Pharmaceutical Care Management Association (PCMA), we greatly appreciate the opportunity to testify on S.B. 602 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.

§346 - Pharmacy benefit managers; contracting pharmacies; reimbursements; maximum allowable cost basis; prohibition
The prohibition on using Maximum Allowable Costs for managed care contracts will create a perverse disincentive for pharmacies to shop for the lowest costs drugs available, resulting in higher costs for payers and patients.

The bill also prohibits a PBM from reimbursing an independent or rural pharmacy an amount less than the rural rate for prescription drugs. It's worth noting that more often than not, rural pharmacies are paid higher reimbursement rates because, while they have a smaller patient volume, they are important for patient access. It's important to remember that not all independent pharmacies are rural pharmacies and should not be reimbursed at the same rates as rural pharmacies – independent pharmacies in urban and suburban areas have greater volume and therefore their reimbursement rates reflect this fact. If all independent pharmacies must be reimbursed at a rural rate, this rate is likely to be inflated and may create a windfall to those pharmacies at the expense of Hawaii plan sponsors and consumers.

Additionally, this bill takes away incentives for pharmacies to purchase drugs cost effectively because they will always be guaranteed reimbursement at or above the rural rate. If the market

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

price of a drug decreases, consumers would not get the benefit of the savings. Pharmacies could buy drugs at a cheaper price, but PBMs will be forced to reimburse pharmacies (and bill the health plan) at the higher rural rate since adjustments cannot be made for 30 days. Ultimately, if PBMs were to comply with this bill, prescription drug costs for Hawaiian consumers and employers will increase.

§431S- Gag clause prohibited
Although gag clauses are already prohibited in both the public and commercial markets under federal law, we support this provision.

§431S - Annual transparency report; commissioner report to the legislature
PCMA does do not support the disclosure of rebate data. Rebates are one of the only a few tools PBMs have to exert downward pressure on drug manufacturers to lower their prices. Allowing rebate data to be disclosed only benefits drug manufacturers, allowing them to avoid discounting their drug prices. Even the disclosure of aggregated rebate data could potentially be "reversed engineered" by drug manufacturers, enabling them to know which rebates were given to which PBM, resulting in a race to bottom as manufacturers would no longer have an incentive to offer deeper discounts than their competitors.

The definition of "rebates" includes "price concessions" related to value-based purchasing. Rebates are different than performance-based contracts. Rebates are connected to utilization and market growth for pharmaceuticals, while performance-based or value-based arrangements are linked to the performance of the drug or other arrangements. These should not be considered "rebates."

§431S3- Registration required
This section imposes several new PBM registration requirements. However, these provisions are much more akin to licensing requirements under the guise of the registration nomenclature. The Insurance Commissioner has jurisdiction over the pharmacy benefits of insured plans and the ability to enforce those requirements on plans providing those benefits within the state. PBMs, through their contracts with health plans, cannot do anything that would bring their clients out of compliance with state law. PBMs are required to comply with the same consumer protections governing utilization review, prior approval, and dispute resolution systems, among others. As a condition of registration, the language states that a PBM demonstrate "background expertise" and "financial integrity" and it is unclear as to what these standards are. This enhanced registration to more of a licensing requirement is unnecessary.

Again, thank you for the opportunity to testify on S.B. 602 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

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Washington, DC 20004
www.pcmanet.org

Hawaii Association of Health Plans

February 23, 2020

The Honorable Rosalyn H. Baker, Chair
The Honorable Stanley Chang, Vice Chair
Senate Committee on Commerce and Consumer Protection

Senate Bill 602 SD1 – Relating to Pharmacy Benefit Managers

Dear Chair Baker, Vice Chair Chang, and Members of the Committee:

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to testify on SB 602 SD1.

Pharmacy Benefit Managers help health plans to control drug costs. We believe that this bill will create more administrative burden and increase costs for Pharmacy Benefit Managers and health plans, which in turn will affect the costs to employers, unions, employees, other consumers, and government financed Medicaid and Medicare coverage. As this bill will increase costs, we ask that it be deferred.

Thank you for allowing us to testify expressing concerns on SB 602 SD1.

Sincerely,

HAHP Public Policy Committee

cc: HAHP Board Members

LATE

Times Supermarket and Times Pharmacy Strongly Support SB602

Aloha Chair Baker, Vice Chair Chang, and Members of the Committee on Commerce and Consumer Protection,

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, the most significant are rebates - when PBMs can share in rebates they want higher not lower drug prices. PBMs have their own pharmacies and drive consumers from their community pharmacy to the PBM owned pharmacy.

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. 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. Innovative new therapies are also sent to the back of the line for consumer access.

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 at most 5-6 states that require PBMs to register, but there is no regulation of rebates, transparency, or conflicts of interest.

Local residents and local businesses, your constituents, are being ripped off due to these unethical business practices. I would not be surprised if the state's EUTF program is getting ripped off as well. Just look at the hundreds of millions of taxpayer dollars that other states have found going straight into the PBM's pocket. Please look into the PBM issues, get

educated, and help protect Hawaii. Thank you for the opportunity to provide testimony on SB602.

LATE

SB-602-SD-1
Submitted on: 2/23/2021 9:31:28 AM
Testimony for CPN on 2/23/2021 9:30:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Kevin Glick	Individual	Support	No

Comments:

STRONG SUPPORT SB602

Pharmacy Benefit Managers use maximum allowable cost to underpay pharmacies for the medication we buy. Although there is a MAC law in place it is not enforced. If this was any other business in Hawaii: fish, cable vision services, beer, that was controlled by companies like PBN's who are direct competition the State of Hawaii would be up in arms. Pharmacy Benefit Managers must be made transparent otherwise consumers, the state, the Medicaid program and small businesses will pay the price. Please do not believe the mis-information put out by the PBM and their minions. The only thing friving priices up are the PBM's while they drive their competition out.

Sincerely,

Kevin Glick, R.Ph.