HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

LATE TESTIMONY

February 23, 2011

The Honorable Clayton Hee, Chair
The Honorable Maile S. L. Shimabukuro, Vice Chair
Senate Committee on Judiciary and Labor

Re: SB 591 SD1 – Relating to Pharmacy Benefit Management Companies

Dear Chair Hee, Vice Chair Shimabukuro, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 591 SD1, which would regulate pharmacy benefit management companies (PBMs) in Hawaii. HMSA opposes this measure. This Bill restricts the use of out-of-state and mail order pharmacies. In doing so, it will increase the cost of pharmacy benefits without providing a concomitant increase in quality of care.

HMSA's goal in the provision of outpatient pharmacy services is to ensure our members have access to affordable, high quality medication. HMSA believes that optimal drug therapy results in positive medical outcomes, which helps to manage overall health care costs. That being said, we did want to provide you with some of our concerns regarding the current language of SB 591 including:

- The bill addresses two facets, rebates and audits, out of a multitude of PBM services offered to clients. HMSA provides some pharmacy services directly for our employer groups, while other services are provided through our contracted arrangement with a PBM vendor, Medco. We believe that the language of the bill, as drafted could apply to HMSA

- There is implication that PBMs dictate pharmacy benefits – such as restrictive networks, mandatory mail order and copayments. This is not the case. The employer groups or other payers are the entities which make these benefit design decisions. Regulation of PBMs as outlined in this measure will prohibit health plans from utilizing cost-saving methods

- Section A(b) - Registration of PBMs: HMSA provides pharmacy services for the majority of our members. We process 100,000 prescriptions each week, amounting to 1.4 million prescriptions per quarter. Claims are submitted real-time by pharmacies which results in immediate servicing for our members. Our PBM, Medco, is responsible for claims processing functions. If their registration were to be suddenly suspended or revoked, this may lead to immediate problems for many of our members in trying to obtain their prescriptions

- Section C(a) - Any willing provider: This language will remove the employers' and health plan's ability to exclude "unwanted" providers, who do not meet standards of practice, have regulatory concerns, or are likely to offer our members substandard care. This language also will remove the employers' and health plan's ability to manage cost through best pricing via restricted or closed networks. HMSA has employer groups who ask for these types of cost-management and/or business strategies

- Section C(d) - Prohibition of differential reimbursement to pharmacies: This language will remove the employers' and health plan's ability to differentially reimburse access-critical pharmacies in rural locations or other pharmacies who may have additional cost-of-business expenses. Examples would be that pharmacies on the neighbor islands have added charges (as compared to their Oahu counterparts) for shipping, charges for hazardous materials, and (ground) delivery

- Section C(g) - Registration for Non-resident pharmacies: This language may impact drugs obtained by our members through mail order pharmacies, specialty drug pharmacies and the few out-of-state pharmacies who provide medications which are limited to specific pharmacy providers approved by the FDA. An example would be a medication for cystic fibrosis

- Section E(b) - Auditors: Pharmacy audits are intended to assure our pharmacy providers comply with pharmacy practice laws, as well as identify situations of fraud, waste and abuse. These audits are designed to protect the employer groups and our members. It is not likely that an accountant would be able to conduct such an audit. In addition, the language implies the PBM must use Hawaii licensed auditors. We are not familiar with a local auditing company with these audit services. HMSA's current audit program is comprised of a desk-top audit of 100% of all HMSA prescription claims. In addition, our auditor conducts on-site pharmacy audits on our behalf

- Section E(d)(2) - All parties agree: The language describes a subjective process for appeals – "all parties agree". HMSA processes 100,000 prescription claims per week and less than 1% of these claims are identified as audit findings. However, this still represents a real volume of cases. The appeal process will need to be functional to support capacity. HMSA's current audit program includes a defined review process for appeals

- Section E(e) - Record-keeping: The language holds a pharmacy harmless for clerical or record-keeping errors. This is not a standard of care that would be beneficial for medications that are federally regulated and/or controlled substances. Our expectations of the precision of our pharmacies should be kept high, as they are responsible for medications that can cause negative medical outcomes or can be subject to diversion

- Section E(h) - Generic vs. non-generic drugs: The language would prohibit HMSA in its current procedures of auditing 100% of all prescription claims. This would make HMSA less efficient and diligent vs. its current practice

These are just some of the myriad issues with SB 591 SD1, which HMSA is concerned with. While we understand the desire to have local access to pharmacy services, strict regulation of PBMs would ultimately be counter-productive to the overall effort to reduce health care costs. Thank you for the opportunity to provide testimony. We would respectfully request the Committee sees fit to hold this measure today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

LATE TESTIMONY

PCMA
PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

TO: Senator Clayton Hee, Chair and Members of the Senate Judiciary and Labor Committee

FROM: Jessica S. Mazer, Esq., Senior Director, State Affairs
Pharmaceutical Care Management Association

RE: S.B. 591 – Opposed
Senate Judiciary and Labor Committee: Hearing 2/23/11 9:00 A.M.

Thank you for the opportunity to comment on Senate Bill 591. The Pharmaceutical Care Management Association (PCMA) and its members would like to express our serious concerns with, and opposition to S.B. 591– legislation that would impose mandates on pharmacy benefit managers (PBMs) that will lead to increased health care costs for the citizens of Hawaii. PCMA is the national association representing America's PBMs, which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D. PCMA is dedicated to enhancing the proven tools and techniques pioneered by PBMs that generate savings and access for consumer and payors.

PBMs provide tremendous advantages to consumers by holding down the cost of prescriptions, helping pharmacists to monitor potential adverse drug events, and providing consumers with wide access to medications and pharmacies. It is important for policymakers to fully understand the function of PBMs in the health care system. PBMs are the cornerstone for any system seeking to manage a prescription drug benefit. PBMs' clients are sophisticated purchasers of health care, including health plans, insurers, major employers, unions, the federal government, and state and local governments that rely on PBMs to manage their drug benefit. Not only do PBMs drive down costs for prescription drugs, they are able to reduce instances of inappropriate and unsafe medicating, increase compliance and persistency with drug regimens, and generally improve health outcomes through clinically based services.

While PCMA is opposed to this bill in its entirety, the following are some specific issues that we would like to address:

PBMs Already Regulated

- PBMs comply with numerous already existing licensure requirements as third party administrators, preferred provider organizations, utilization review organizations, resident and/or non-resident pharmacies, etc., where required by law.
- When performing services for health plan sponsors, PBMs must comply with state and federal requirements imposed on insurers, HMOs, and other employer-sponsored ERISA plans. PBMs are also held accountable for consumer protections, including grievance and appeals processes, through their contractual obligations with their clients.
- The Board of Pharmacy already regulates PBM activities in the mail-order arena in several different areas of pharmacy services, including prescription drug dispensing and labeling, patient counseling, generic substitutions, etc.
- Compliance with additional and potentially conflicting state and federal laws would unnecessarily raise operating costs for PBMs and would diminish their ability to pass on cost-savings to their clients, and ultimately the consumer.

Disclosure Mandates Undermine Price Competition and Increase Costs

- Section B of S.B. 591 would require a PBM to disclose proprietary contract information to a purchaser before and after entering into a contract. In addition, a PBM would also have to disclose such information to the Insurance Commissioner on a quarterly and yearly basis.
- The Federal Trade Commission (FTC) has warned several states that legislation requiring PBM disclosure could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[1]
- In fact, in a March 2009 analysis of similar provisions, the FTC stated that such disclosure mandates would "preclude health plans and PBMs from entering into efficient *(i.e.,* cost-effective) contracts for the administration of pharmacy benefits" and "they may have the unintended consequence of publicizing proprietary business information in a way that could foster collusion among [pharmaceutical manufacturers]."[2]
- Requiring PBMs to disclose their price negotiation strategies with pharmaceutical manufacturers also damages competition. In fact, the FTC looked at the likely effect of making such information publicly available and found that "[i]f pharmaceutical manufacturers learn the exact amount of rebates being offered by their competitors . . . then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[3]
- According to the FTC and the Department of Justice, "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[4]
- Transparency is already available in today's competitive marketplace. Each PBM client is uniquely situated and some have elected to not request disclosure for business reasons of their own.
- The FTC has also stated that a mandate by law of the disclosure of proprietary financial information would "hold PBMs to a standard that does not apply to other industries."[5]
- It should be up to health plans and employers to decide to what extent certain disclosures are needed to make informed purchasing decisions. If a health plan or employer wants certain financial information, they make this a requirement of their bid and negotiate the terms in their contract.

State-Mandated Contract Terms on Private Market Agreements Unnecessary

- S.B. 591 would mandate a state-prescribed business model for contractually negotiated private payment agreements between PBMs and their health plan and employer clients, thereby limiting the ability to tailor a contract that best suits the client's interests and goals.
- PBMs' clients are sophisticated purchasers of health care, including health plans, insurers, major employers, unions, the federal government, and state and local governments that rely on PBMs to manage their drug benefit.
- Based on a client's Request for Proposals (RFPs), a PBM may offer the client multiple variations of models from the more basic plan to the most comprehensive plan relying on multi-tiered co-payments, formularies developed with physicians and pharmacists, pharmacy networks, mail-service pharmacy, and other similar tools that make drugs more affordable and accessible.
- State-mandated contract terms on private market agreements would impede the health plans' and employers' ability to dictate favorable terms through bid and contract negotiations.

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[1] FTC letter to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004); *see also* FTC Letter to Senator James Seward, New York Senate, (March 31, 2009).
[2] FTC letter to Sen. James Seward, New York Senate, (March 31, 2009).
[3] FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004); FTC letter to Assemblywoman Nellie Pou, New Jersey General Assembly, (April 17, 2007); *see also* FTC Letter to Senator James Seward, New York Senate, (March 31, 2009).
[4] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004
[5] FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004).

Consumers Benefit from Mail-Service Pharmacy Safety and Cost-Savings

- Section C of S.B. 591 takes choices away from consumers and would force one-size-fits-all copayments. Mail-service pharmacies are able to keep prescription drug costs down because they have greater efficiency and lower overhead costs than independent pharmacies.
- Health plans and employers frequently choose to provide their members and employees with the option of a lower copayment on a 90-day supply of their medications through the use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions.
- A recent study found a highly automated mail-service pharmacy dispensed prescriptions with 23-times greater accuracy than retail pharmacies. The mail-service error rate was zero in several of the most critical areas, including dispensing the correct drug, dosage, and dosage form.[6]
- The FTC concluded in a 2005 report that PBM-owned mail-order pharmacies offer lower prices on prescription drugs than retail pharmacies and are very effective at capitalizing on opportunities to dispense generic medications.[7]
- According to a 2003 study by the U.S. General Accounting Office (GAO), the average price of prescriptions through mail-service pharmacies was 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs, and 53 percent below the retail cash price for generic drugs. [8]
- Anti-mail legislation that restricts the appropriate use of mail-service for long-term prescriptions amounts to nothing more than special-interest legislation that will raise costs for health plans, employers, and consumers.

Dictating Private Contract Rights Only Benefits Network Pharmacies While Hurting Consumers

- Section C of S.B. 591 also mandates that a PBM would have to allow any provider that wants to join their pharmacy network in, regardless of whether they have committed illegal activities or are not as competitive in service or quality as other pharmacies.
- PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates. It is important to have pharmacies compete to be part of the pharmacy network for a particular PBM in order to keep the rising costs of prescription drugs down. Network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan.
- The ability of PBMs to negotiate with pharmacies in the private marketplace without government interference plays a critical role in reducing prescription drug benefit costs to health plans and employers, and ultimately consumers.
- The establishment of pharmacy networks through aggressive provider bidding is an effective cost management tool for health plans and employers. Thus, legislation that reduces such incentives would hinder the ability of health plans and employers to create pharmacy networks that meet their needs while providing health benefits at a lower cost.

Pharmacy Audit Restrictions Increase Costs and Encourage Fraudulent Activity

- This legislation, although it appears to help pharmacies, will actually have the unintended consequence of opening the door to fraud, abuse, and wasteful spending in health care.
- Health plans and employers with pharmacy benefit plans rely on audits of their network pharmacies to recoup monies incorrectly paid for claims with improper quantity, improper days supply, improper coding, duplicative claims, and other irregularities.

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[6] J. Russell Teagarden et al., "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice," Pharmacotherapy: Official Journal of the American College of Clinical Pharmacy. Volume 25, Issue 11, pgs 1629 -1635 (2005).
[7] Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005, available at http://ftc.gov/reports/index.htm#2005
[8] US General Accounting Office, "Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees and Pharmacies," GAO-03-196, January 2003.

- Health plans and employers should have the right to ensure that the pharmacy claims that they are paying for are legitimate. In a time of rising health care costs, preventing fraudulent activity is an important tool to keeping health care costs down.
- This legislation severely restricts the ability of health plans and employers to make sure they are getting what they pay for. Auditing is part of the cost of doing business. That goes for any type of business – pharmacies should not be an exception to the rule.
- Legislation that requires entities to provide pharmacies/pharmacists with an advanced notice of two weeks before an audit would give individuals ample time to hide evidence of fraudulent activities or evade authorities altogether.
- PBMs look for errors, irregularities, and suspicious patterns over time. Claims are compared with historical information as well as claims submitted by similarly situated pharmacies. Substantial changes in the volume of claims or the dollar amount of claims from particular pharmacies can indicate fraudulent activity.
- In addition to detecting fraud, audits also have a patient safety aspect. Auditors ensure that pharmacies are complying with Board of Pharmacy rules including the proper storage of prescription drugs or posting of required signs.
- Audit and appeals procedures are already contained in contracts between PBMs and pharmacies. PBMs also supply pharmacies/pharmacists with provider manuals, which contain information about audits and examples of fraud, waste, and abuse. Additionally, some PBMs also distribute provider tip sheets quarterly which may contain additional information related specifically to what audits entail.
- "Health care fraud is a pervasive and costly drain on the U.S. health care system. In 2008, Americans spent $2.34 trillion dollars on health care. Of those trillions of dollars, the Federal Bureau of Investigation (FBI) estimates that between 3 and 10 percent was lost to health care fraud." [9]
- In 2010 alone, a joint health care fraud prevention effort between the Department of Justice and the Department of Health and Human Services resulted in the recovery of more than $4 billion in taxpayer dollars. Some of the recovered money came from uncovering pharmacy fraud schemes that included fraudulent billing practices and illegal dispensing of medications. [10]

In a time of rapidly escalating health care costs, policymakers should be focused on encouraging the use of innovative and effective cost-control techniques rather than discouraging them with this type of regulation. For the above reasons, PCMA and its member companies respectfully oppose S.B. 591. Please let us know if we can provide any additional information. Thank you for your consideration.

[9] National Health Care Anti-Fraud Association, "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," October 2010, available at http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/WhitePaper_Oct10.pdf.

[10] U.S. Department of Health and Human Services & U.S. Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," January 2011, available at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.

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LATE TESTIMONY

Senator Clayton Hee, Chair
Senator Maile S. L. Shimabukuro, Vice Chair
Committee on Judiciary and Labor

Wednesday, February 23, 2011 – 9:00a.m.
State Capitol, Conference Room 016

CVS CAREMARK TESTIMONY
SB 591 SD1 Relating to Pharmacy Benefit Management Companies

Chair Hee, Vice Chair Shimabukuro, members of the Committee on Judiciary and Labor. My name is Todd Inafuku, testifying on behalf of CVS Caremark Corporation ("CVS Caremark") in opposition to SB 591 SD1, Relating to Pharmacy Benefit Management Companies.

CVS Caremark is one of the nation's largest independent providers of health improvement services, touching the lives of millions of health plan participants. As CVS Pharmacy and Longs Drugs in Hawaii, we are the largest employer of licensed pharmacists in the United States with over 25,000 pharmacists.

Caremark, our pharmacy benefit manager (PBM) offers our health plan customers a wide range of health improvement products and services designed to lower the cost and improve the quality of pharmaceutical care delivered to health plan participants. Through our unique healthcare model and clinically-based services, CVS Caremark is able to reduce medication errors, increase adherence with drug therapies, and improve health outcomes. In addition, through the use of cost containment and formulary management tools that Caremark clients utilize, they in turn are able to offer a high-quality, cost effective outpatient drug benefit for their enrollees. CVS Caremark clients include a broad range of highly sophisticated private and public health plan sponsors, including Blue Cross Blue Shield plans, health insurance plans, employers, governments, third-party administrators and Taft-Hartley plans.

CVS Caremark has the following concerns with SB 591 SD1, Relating to Pharmacy Benefit Management Companies:

Disclosure Mandates Undermine Price Competition and Increase Costs

Section B of SB 591 SD1 would require a PBM to disclose proprietary contract information to a purchaser before and after entering into a contract. In addition, a PBM would also have to disclose such information to the Insurance Commissioner on a fiscal quarter and fiscal year basis. We believe this will adversely impact competition in the marketplace and create a "cookie cutter" approach for PBM contracting, which would ultimately result in higher prescription drug costs for consumers.

The Federal Trade Commission (FTC) has warned several states that legislation requiring PBM disclosure could increase costs and "undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[1]

In a March 2009 analysis of similar provisions, the FTC stated that such disclosure mandates would "preclude health plans and PBMs from entering into efficient *(i.e.,* cost-effective) contracts for the

[1] FTC letter to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004); *see also* FTC Letter to Senator James Seward, New York Senate, (March 31, 2009).

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administration of pharmacy benefits" and "they may have the unintended consequence of publicizing proprietary business information in a way that could foster collusion among pharmaceutical manufacturers."[2]

Requiring PBMs to disclose their price negotiation strategies with pharmaceutical manufacturers also damages competition. In fact, the FTC looked at the likely effect of making such information publicly available and found that "if pharmaceutical manufacturers learn the exact amount of rebates being offered by their competitors . . . then tacit collusion among manufacturers is more feasible. Consequently, the required disclosures may lead to higher prices for PBM services and pharmaceuticals."[3] According to the FTC and the Department of Justice, "vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms."[4]

Transparency is already available in today's competitive marketplace. Each PBM client is uniquely situated and some have elected to not request disclosure for business reasons of their own. If a health plan or employer wants certain financial information to make a purchasing decision, CVS Caremark believes that it should be left to decision of the PBM client to make it a requirement of their bid and negotiate the terms in their contract with PBMs.

Dictating Private Contract Rights Only Benefits Network Pharmacies While Hurting Consumers

Section C of SB 591 SD1 mandates that a PBM be required to allow any willing provider to join their pharmacy network, regardless of whether they have committed illegal activities or are not as competitive in service or quality as other pharmacies.

PBMs build networks of pharmacies to provide consumers convenient access to prescriptions at discounted rates, but must do so while meeting network adequacy requirements. It is important to have pharmacies compete to be part of the pharmacy network for a particular PBM in order to keep the rising costs of prescription drugs down. Network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan. Further, the ability of PBMs to negotiate with pharmacies in the private marketplace without government interference plays a critical role in reducing prescription drug benefit costs to health plans and employers, and ultimately consumers.

CVS Caremark believes that government should not create private contract rights that would hinder the ability of PBM clients to create pharmacy networks that meet their needs while providing health benefits at a lower cost.

Pharmacy Audit Restrictions Increase Costs and Encourage Fraudulent Activity

The provisions contained in Section E of SB 591 SD1 are overly prescriptive and would hinder our ability to perform audit functions on behalf of our clients.

Caremark has contracts with over 60,000 pharmacies nationwide including pharmacies in Hawaii. Our relationship with our network pharmacies is a critical component to the value we bring to our clients and their beneficiaries. To deter fraud and ensure contract pharmacies comply with Caremark quality assurance requirements, Caremark audits at least 5 percent of its contracted pharmacies annually. Caremark audits network pharmacies based on statistical analysis of claims data or as a result of state regulatory authorities and clients informing Caremark about potential violations. PBMs look for errors, irregularities, and suspicious patterns over time. Claims are compared with historical information as well as claims submitted

[2] FTC letter to Sen. James Seward, New York Senate, (March 31, 2009).
[3] FTC letter to Assembly Member Greg Aghazarian on California's AB 1960, (September 3, 2004); FTC letter to Assemblywoman Nellie Pou, New Jersey General Assembly, (April 17, 2007); *see also* FTC Letter to Senator James Seward, New York Senate, (March 31, 2009).
[4] US Federal Trade Commission & US Department of Justice Antitrust Division, "Improving Health Care: A Dose of Competition," July 2004

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by similarly situated pharmacies. Substantial changes in the volume of claims or the dollar amount of claims from particular pharmacies can indicate fraudulent activity.

Following an audit, Caremark allows a pharmacy 30 days to submit additional documentation on claim discrepancies. This is especially important to a pharmacy that has itself been the victim of a fraudulent activity by one of its employees. Unacceptable findings discovered by an audit may include the submission of a fraudulent claim or a pharmacy consistently not following the claims submission policies outlined in their provider manual. However, the most common type of fraud discovered is a "phantom" billing where a claim is submitted by the pharmacy but not supported by a valid prescription.

For pharmacies that have unacceptable audits or have submitted fraudulent claims, the Caremark Pharmacy Management Review Committee meets quarterly to review unacceptable and fraudulent activity to determine if continued membership in our network places our clients and their beneficiaries at risk. The Committee is made up of Caremark employees from various cross functional departments. Additionally, when we find irrefutable evidence of fraud we report it to the appropriate authorities and state agencies. Caremark is active in both the National Association of Drug Diversion Investigators (NADDI) and the National Health Care Anti-Fraud Association (NHCAA), two organizations whose mission is to investigate and prosecute pharmaceutical drug diversion.

"Health care fraud is a pervasive and costly drain on the U.S. health care system. In 2008, Americans spent $2.34 trillion dollars on health care. Of those trillions of dollars, the Federal Bureau of Investigation (FBI) estimates that between 3 and 10 percent was lost to health care fraud." [5]

In 2010 alone, a joint health care fraud prevention effort between the Department of Justice and the Department of Health and Human Services resulted in the recovery of more than $4 billion in taxpayer dollars. Some of the recovered money came from uncovering pharmacy fraud schemes that included fraudulent billing practices and illegal dispensing of medications. [6]

CVS Caremark believes that government should not impose any pharmacy audit restrictions that will lessen the PBM's ability to detect and recover monies resulting from fraud, abuse, and wasteful spending in healthcare.

Insurance Commissioner Adoption of Rules Which Include a Schedule of Allowable Acquisition Cost and Professional Dispensing Fees Would Prevent the Delivery of an Affordable Prescription Drug Benefit

Section F of SB 591 SD1 would require that the insurance commissioner adopt rules that would include a schedule of allowable acquisition costs and professional dispensing fees.

CVS Caremark believes that the insurance commissioner should not adopt rules containing a schedule of allowable acquisition cost and professional dispensing fees. Pharmacy reimbursement for drugs and services, which includes an allowable acquisition cost and professional dispensing fee, is determined, negotiated and agreed upon contractually between the contracting network pharmacies and the PBM and plays a critical role in the delivery of an affordable prescription drug benefit to health plans and employers and ultimately the consumer.

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[5] National Health Care Anti-Fraud Association, "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," October 2010, available at http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/WhitePaper_Oct10.pdf.

[6] U.S. Department of Health and Human Services & U.S. Department of Justice, "Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010," January 2011, available at http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf.

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In closing, a PBM contracts with very sophisticated purchasers of health care and are required to respond to very specific requirements in a Request for Proposal (RFP) then must vigorously compete with other PBMs for that business. Ultimately, it is the purchaser of the PBM services who determines what the benefit design will be for its beneficiaries and the PBM that can offer the best value in administering that benefit is the one they hire.

CVS Caremark respectfully request that the Senate Committee on Judiciary and Labor consider our opposition to SB 591 SD1, Relating to Pharmacy Benefit Management Companies and hold this measure.

Thank you for the opportunity to testify,

Todd K. Inafuku

Director of Government Affairs

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Phone (808) 620-2288

LATE TESTIMONY

TESTIMONY ON BEHALF OF S.B. 591-SD1

From: Les Krenk, RPh,
By Rafael del Castillo, Attorney at Law

To: Senate Committee on Judiciary and Labor
Hon. Clayton Hee, Chair; Hon. Maile S.L. Shimabukuro, Vice Chair

Hearing: February 23, 2011, 9:00 a.m., Conference Room 016
1 paper copy of late testimony requested

Thank you for the opportunity to offer testimony in **strong support** of this Senate Bill 591-SD1. I will give you 2 examples involving patients, and one example of a PBM acting as an insurance company. Understand that the vast majority of the prescriptions that leave my pharmacy are paid for through PBMs, which not only own and operate mailorder pharmacies, and some own a chain of pharmacies, ie CVS and Walgreens, but also contract with health plans and union trusts to manage pharmacy benefits.

Late last year Mercer "Chubby" Vicens called my pharmacy to ask me my advice on a situation that he had encountered or maybe that had encountered him. He was vacationing on the mainland and got a call on his cell phone from a person requesting his credit card number to run charges for the copays and mailing charges for his medication. This confused Chubby because he had not asked anyone to mail him medication. He refused to give his credit card number, and told the caller they could clear the matter up when he returned from vacation. When Chubby got home he had two boxes of medication waiting for him. They had been delivered during his absence. One box contained insulin, which must be refrigerated, but had sat out since delivery. No one had been told to expect insulin, so the person who accepted the delivery did not know to refrigerate the box. Chubby's questions, which have yet to be answered, are, how can a mailorder pharmacy get his records without his authorization? Where did the mailorder pharmacy get his cell phone number? Who authorized the mailorder pharmacy to send the medications? Where did they get a prescription, which is required to dispense medication?

The point I wish to make with this real life example is to encourage to you pass the PBM law without changes. We very frankly need this law to help protect the citizens of this state from financial giants which have no respect for the law. What law you ask? Well, in this case several laws were violated and they include, the state privacy law, HIPAA, some state pharmacy laws, and another state's pharmacy laws.

Is this a rare occurrence? NO, as Nida J. and Benjamin J. can attest. Both of them tried to pick up their refills at my pharmacy. When we attempted to refill their prescriptions, the online processor informed us that their refills had already been processed, and were awaiting pickup at another pharmacy. We asked Nida and Ben if we could contact the processor on their behalf to find out what pharmacy had processed the prescriptions and they granted our request. The processor told us that the prescriptions were at the CVS-Longs pharmacy next door. Benjamin stated that he had not done business with Longs for 10 years, and he asked how they had his prescriptions ready at their pharmacy 'without his knowledge.

Chubby's and Mr. and Mrs. J's cases have one thing in common: a PBM, out of control, that has access to a national database of patients and prescriptions. My pharmacy does not have

access to that database, nor do any of my colleagues. The PBMs gain access through a variety of means which I believe violate HIPAA and our state privacy laws. Chubby and Mr. and Mrs. J were selected because they regularly take several prescription medications (14 total for Mr and Mrs J. and 18 for Chubby). The PBM has tried to capture their business under the guise of either "the insurance company gave us permission" or the "the patient gave us permission." The latter was the reason the head pharmacist at CVS-Longs gave our staff when we asked why Mr. and Mrs. J's prescriptions were awaiting pickup at Long's. The CVS PBM that accessed the database and transferred Mr. and Mrs. J's prescriptions happens to be co-owned with the Long's pharmacy where the prescriptions were filled. It therefore appears that the CVS PBM invaded Mr and Mrs J.'s privacy, at the very least. They want to know what will be done about it.

The PBM that attempted to obtain Chubby's credit card number and had medication delivered to his home without authorization is Medco, and Chubby's insurance is with HMSA. According to HMSA, it saves money when mailorder fills its member's prescriptions. I sit on an advisory board for HMSA (at least until this testimony) and they have stated as much in meetings I have attended. Chubby wants to know how Medco obtained his information. He and I believe you should be demanding to know the answer to that question as well. These cases are not random mistakes. My colleagues and I frequently hear similar complaints, including complaints that a mailorder pharmacy has called the patient's physician and secured a prescription by telling the doctor that patient had authorized the request.

Next, we have the fact that PBMs are operating in our State as insurers unregulated. They contract with health plans for a monthly premium to provide prescriptions the health plans then pass through to their members like a middle man or insurance broker, and the PBM assumes the risk for the cost of prescriptions, exactly like any other insurer. One such PBM is the giant Medco, and the health plan is one of the QUEST plans, Alohacare. PBMs are fighting regulation and transparency across the country while they pocket billions, and if you question Medco, it will tell you that there are proprietary secrets you should not force it to make open to the public. If I were one of those PBMs running roughshod over our laws and our consumers, I would want it to remain private under the guise of proprietary secrets too.

S.B. 591 also contains some minor provisions concerning audits PBMs conduct on pharmacies like mine because they pay for the prescriptions we fill under the health plan pharmacy benefit management contracts. Health plans and PBMs use those audits for illegitimate reasons as often, or more often, than they do for legitimate ones. The incentive for a PBM that has assumed risk is all too obvious. I recently had to engage an attorney to persuade Informed Rx, the infamous EUTF PBM, to tell me why it had recouped over $12,000 from my pharmacy because for months it refused to give me an answer. Within a few weeks of my attorney's letter to the Informed Rx CFO, I had received a check for the full amount. The only explanation I ever got was that it was a "mistake." Last week, one of my independent pharmacy colleagues suffered a $100,000 recoupment which was purely retaliatory. The pharmacy had supported a patient who was refusing to have his prescriptions transferred to mailorder because, in his case, it is simply too dangerous to switch from a local source to mailorder. We have to stop audit abuses and we can only turn to you for help with what is a very large and growing problem.

Thank you for passing Senate Bill 591-SD1 in its present form.

Les Krenk, R.Ph..

LATE TESTIMONY

Written Testimony Presented Before the
Senate Committee on Judiciary and Labor
February 23, 2011, 9:00 a.m.

Ronald T. Taniguchi, Pharm.D.
Director of Community Partnerships
College of Pharmacy, University of Hawai`i Hilo

Support for SB 591 SD1 Relating to Pharmacy Benefit Companies

Chair Hee, Vice Chair Shimabukuro, and members of the Senate Committee on Judiciary and Labor:

Thank you for the opportunity to present testimony, as an individual, **in support of SB 591 SD1**. This bill offers protections to pharmacies that provide vital prescription drug and medication therapy management services to rural and underserved communities, particularly on the Neighbor Islands. Pharmacists who live in the communities in which they work provide a safety net to the families they serve that cannot be matched by impersonal long distance alternatives such as mail order prescriptions and call center communications.

Thank you again for the opportunity to testify.

LATE TESTIMONY

Michael Taylor, Jr.
University of Hawaii at Hilo
Doctor of Pharmacy Candidate
Class of 2013

Support for SB-591 SD1 - Relating to Pharmacy Benefit Management Companies

Aloha Senator Clayton Hee Chair and Members of the Senate Judiciary and Labor Committee,

Thank you for the opportunity to submit testimony regarding SB-591 SD1. My name is Michael Taylor, Jr. and I am currently enrolled in my second year at the University of Hawaii at Hilo's College of Pharmacy. I have lived in Hawaii for more than 10 years and have worked in a local independent pharmacy for the past 3 years. I am submitting written testimony in **support of SB-591 SD1.**

I have witnessed firsthand the impact that mandatory mail-order has caused on the citizens of Hawaii; patients who have frequented their local pharmacy for many years were suddenly turned away and had to receive their medications from an out-of-state mail order pharmacy and had no say in the matter. Many times I witnessed patients that had to go without their routine medications because of delays in the mail-order process. I even interacted with a patient that had received generic anti-seizure medication from the mail-order pharmacy, even though the patient did not request it and the Doctor had not approved the substitution. These are the pitfalls that can occur when the burden of responsibility is removed from the local pharmacy to an out-of-state mail-order pharmacy.

Local independent pharmacies have also suffered; some have lost more than 40% of their clientele because of mandatory mail-order. These local business that pay state and local taxes are losing revenue to an out-of-state competitor. The local pharmacy has always been a mainstay of the American health care system. The local Pharmacist is a highly respected and trusted member of the community; no other member of the health care system is accessible as the local pharmacist. Having one's prescriptions filled at the local pharmacy, staffed by friendly people the patient has a personal relationship with, improves patient compliance and increases the level of accountability; both of which lead to greater patient care and overall better health.

If a patient picks up a prescription and has questions, they can ask their local pharmacist and it is often in the Pharmacist's best interest to help the customer. Not just to improve the patient's therapy, but because the pharmacy will be reimbursed when the patient picks up their prescriptions. However with mandatory mail-order the patients do not have the level of access to the pharmacist they once had, and often their questions go unanswered. These patients often turn back to their local pharmacies and the pharmacist still has a responsibility to answer the patient's questions, however now they aren't getting reimbursed for their time. This adds an extra burden to an already compromised local business.

As a future pharmacist I must look ahead to the day that I graduate and enter the workforce. If mandatory mail-order is still enforced I and many other newly graduate pharmacists will need to leave the state of Hawaii in search of employment. I feel strongly that SB-591 SD1 is in the best interest of all the citizens of Hawaii and mahalo for this opportunity to testify.

LATE TESTIMONY

94-450 Mokuola Street, Suite 106, Waipahu, HI 96767
808.675.7300 | www.ohanahealthplan.com

Wednesday, February 23, 2011

To: The Honorable Clayton Hee
Chair, Senate Committee on Judiciary and Labor

From: 'Ohana Health Plan

Re: Senate Bill 591, Senate Draft 1-Relating to Pharmacy Benefit Management Companies

Hearing: Wednesday, February 23, 2011, 9:00 a.m.
Hawai'i State Capitol, Room 016

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to testify in opposition to Senate Bill 591, Senate Draft 1-Relating to Pharmacy Benefit Management Companies.

The purpose of this bill is to require pharmacy benefit management companies (PBMs) to register with the insurance commissioner before administering pharmacy benefits of health insurers and implement regulations on PBMs in the state.

While we understand the reasons behind this legislation, we cannot support it as it could prevent `Ohana Health Plan's current PBM from fulfilling its contractual requirements that maintain our compliance with State and Federal contracts and regulations. This may also become a disincentive for mainland-based PBMs to enter into contracts with local-based health insurance companies. If the genesis of this measure is to address a specific problem or PBM, we would respectfully request that this bill be amended to limit its impact against other PBMs that have maintained good standards and practices within the State and would be unnecessarily impacted by this bill's passage.

Health Plan Pharmacy & Therapeutics (P&T) Committee; or physicians and pharmacists decide on the prescription benefits and the PBM implements the benefit through sophisticated information technology systems). The Health Plans also develop policies and procedures, for which they are solely responsible, and the PBMs develop and implement the processes that enact the policies, such as mail order programs. Any issues that occur with administering the pharmacy benefit should be directed to the Health Plan, not the PBM.

The PBM market is very competitive and releasing proprietary contractual information will dissuade health plans from doing business in Hawaii. Since advanced information technology infrastructure is required and Hawai`i's small market size cannot support this level of sophistication, this legislation may deprive Hawai`i people of the advantages of state-of-the-art PBM technology. PBM technology automates the claims process so eligibility and benefits are checked instantly unlike claims for other medical claims which typically take weeks. PBM technology also provides immediate patient safety features which address overdoses, drug-drug interactions and other possible dangers to patients.

Many of Hawi'i's locally-based health care insurance providers with local staff choose to contract with PBMs in order to better manage the complex business of managing pharmacy benefits for their members. Pharmacy costs account for approximately 20% of health care costs and therefore is an area that needs to be very carefully managed in order to better control the rising cost of health care. Without state-of-the-art PBM services, Hawai`i would experience increased costs for the same level of care.

We respectively request that you hold Senate Bill 591, Senate Draft 1- Relating to Pharmacy Benefit Management Companies. Thank you for the opportunity to provide these comments on this measure.

LATE TESTIMONY

THE SENATE

COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON HEALTH
Senator Josh Green, M.D., Chair
Senator Clarence K. Nishihara, Vice Chair

AMENDED NOTICE OF HEARING

DATE: Thursday, February 10, 2011
TIME: 8:30 a.m.
PLACE: Conference Room 229

I SUPPORT SB 591/HB 275

Brian Carter RPh
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wbkotter@hotmail.com

I am an independent community pharmacist on the west side of Kauai. I am testifying in support of HB 275/ SB 591.

This bill will protect the patient right to choose a healthcare provider, improve compliance to drug therapy, minimize healthcare costs to the state, create a more sustainable drug delivery system, and help to create a healthier and happier workforce.

The patient's right to choose a provider is one that has been compromised by the **mandatory mail order** clauses in the current insurance plan offered by the EUTF. This has caused much frustration by county and state employees. Many errors in medication delivery have resulted in hospitalization and increased cost to the patient as well as the state. This bill will enable for patients a right to receive prescriptions from whomever they choose, whenever they choose.

This ability to go to the local drug store and receive medication has been available during the past 2 years under the EUTF plan but the patient has been severely punished by having to pay out of pocket for medicine that they have not received by mail order. Having the option to go to their local drug store without penalty will increase compliance with physician's orders and give a more supportive care system for our patients.

The cost of doing business outside the state can only be seen as foolish in many ways. The current mail order facility in Florida that has been receiving **ALL** of the prescriptions for state and county employees does not pay taxes in Hawaii. All of the revenue generated by the facility stays in Florida. This "mail order to save money" strategy that has been used by the state has no statistical backing. There has never been released any study that finds the mail order is saving money and if one is eventually released it will not encompass costs like Emergency Room costs due to failure to receive medication on time. How much is it worth to have patients having to be hospitalized due to missed heart or blood pressure medication? There are studies that have shown the waste and higher cost of using mail order. See http://www.ncpanet.org/pdf/leg/falsesavingsofmailorder.pdf or www.ncpanet.org/pdf/leg/ncpamailorderpres.ppt for more information regarding the higher costs of mail order. One study "Effects of Mail Order Incentives on Prescription Plan Costs" by the University of Arkansas clearly debunks the mail order savings myth. (see above for link or call me I will e-mail it to you)

The increased competition in the marketplace will allow for a more sustainable drug delivery system. It is not to say that by the passage of this bill we will see a return to "old times" without mail order in the marketplace. Community pharmacies will have to work hard to provide a level of care that will compete with a mail order alternative. The service that we provide must be superior or patients won't mind the hassles associated with mail order or may find it easier than going into a local pharmacy. The competitive market has been shown to bring out the best in many industries, this will be no different.

With mail order not being a mandatory requirement to receive medication people will be happier. Patients will respect their legislators giving them the freedom of choice and the opportunity to support their local economy. The pride of a self sustained community is in everyone within that community. **I care** for my neighbors and their needs. I want to live in a healthy community and am willing to do whatever it takes to make it a better more vibrant society.

I appreciate the opportunity to express my support for HB 275/ SB 591. I hope you will realize the value of this bill and what it means to the people of Hawaii. Thank you for taking the time to read my testimony.