SB591

Measure Title:	**RELATING TO PHARMACY BENEFIT MANAGEMENT COMPANIES.**
Report Title:	**Pharmacy Benefit Management Companies**
Description:	**Requires registration of and regulates practices of pharmacy benefit management companies. Requires periodic audits of pharmacies that submit claims to pharmacy benefit management companies.**
Companion:	**HB275**
Package:	**None**
Current Referral:	**HTH/CPN, JDL**

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 10, 2011

The Honorable Josh Green, M.D., Chair
The Honorable Rosalyn H. Baker, Chair
Senate Committees on Health and Commerce and Consumer Protection

Re: SB 591 – Relating to Pharmacy Benefit Management Companies

Dear Chair Green, Chair Baker and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 591 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

- Page 2, Line 8 - 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

- Page 3, Line 12 - 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

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- Page 4, Line 4 - 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

- Page 4, Line 14 - 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

- Page 5, Line 15 - 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

- Page 6, Line 15 - 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

- Page 6, Line 18 - 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

- Page 7, Line 13 - 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 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 Committees see fit to hold this measure today.

Sincerely,

Jennifer Diesman
Vice President
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Thursday, February 10, 2011

To: The Honorable Rosalyn H. Baker
Chair, Senate Committee on Commerce and Consumer Protection

The Honorable Joshua B. Green, M.D.
Chair, Senate Committee on Health

From: 'Ohana Health Plan

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

Hearing: Thursday, February 10, 2011, 8:30 a.m.
Hawai'i State Capitol, Room 229

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-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- Relating to Pharmacy Benefit Management Companies. Thank you for the opportunity to provide these comments on this measure.

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

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

Thursday, February 10, 2011 – 8:30 a.m.
State Capitol, Conference Room 229

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

Chairs Green and Baker, Vice Chairs Nishihara and Taniguchi, and members of the Committees:

Thank you for the opportunity to provide comments on behalf of CVS Caremark Corporation ("CVS Caremark"). CVS Caremark has concerns related to provisions contained in SB 591, Relating to Pharmacy Benefit Management Companies which requires the registration and regulation of pharmacy benefit management companies and periodic auditing of pharmacies that submit claims 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, a 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. Through our unique healthcare model and clinically-based services, CVS Caremark is able to reduce medication errors, increase compliance 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.

After reviewing SB 591 Relating to Pharmacy Benefit Management Companies, CVS Caremark respectfully offers the following comments:

Disclosure Mandates Undermine Price Competition and Increase Costs

Section B of SB 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 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 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. CVS Caremark recommends that it should be left to the decision of the PBM clients to decide to what extent certain disclosures are needed to make informed purchasing decisions. If a health plan or employer wants certain financial information, then they should make this a requirement of their bid and negotiate the terms in their contract.

Dictating Private Contract Rights Only Benefits Network Pharmacies While Hurting Consumers

Section C of SB 591 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 recommends that government 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

[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

The provisions contained in Section E of SB 591 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 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 recommends that the government not impose pharmacy audit restrictions that will lessen the PBM's ability to detect and recover monies resulting from fraud, abuse, and wasteful spending in healthcare.

<u>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</u>

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

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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.

CVS Caremark recommends that the insurance commissioner not publish 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.

In closing, a PBM contracts with purchasers of health care and is required to respond to very specific requirements in a Request for Proposal (RFP) then must vigorously compete with other PBMs for that business. Ultimately, the purchaser of PBM services should determine what the benefit design will be for its beneficiaries.

CVS Caremark appreciates the opportunity to provide comments.

Todd Inafuku

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To: Committee on Health
From: Patrick Adams
2/7/2011
Re: SB 591

Honorable Chair Yamane and committee members,

In support of SB 591 I submit the following testimony:

I am a pharmacist and I support this measure as a needed piece of legislation in Hawaii to support the best and most affordable healthcare for the people of Hawaii. Pharmacy Benefit Managers have had a position that allows them to do business in the state of Hawaii under the radar. PBMs presently have no regulations or regulators in Hawaii law. This has allowed the PBMs to operate as agents of insurance companies or act as insurance companies without the regulations enforced on insurance companies. PBMs have not had to report to the insurance commissioner and have used this to their advantage to create a monopoly that has resulted in practices that exploit the state pharmacies and the people of Hawaii. The following are some of the examples of these actions and the resulting affect:

1. PBMs have established mandatory mail order services that block a patients right to choose where they receive service. The state of Hawaii has blocked this type of business with regard to prescriptions. A physician must offer a patient a prescription and may not designate where a patient fills their prescription. PBMs have been allowed to do exactly what the law forbids a physician from doing. This practices has given the PBMs a monopoly.
2. PBMs have further diverted prescriptions to specific mail order companies by establishing copayments that are not equal for pharmacies that operate within the state of Hawaii
3. PBMs have not operated as transparent companies and have used their position to manipulate the medications a patient would receive to establish a greater profit.
4. PBMs have established an audit system that recoups revenue by extrapolating data from pharmacies. The extrapolation is not a true measure of services not rendered but demand for recoupment even when there is proof of service.

In addition these practices resulted in diversion of funds and services out the state resulting in a loss of business and jobs. There unseen cost has been unemployment, closing of businesses and the taxes they pay. The mail order companys operate out of state pharmacies in a void of regulation as well. Pharmacy law has very few rules regarding mail order and their practices. One company is offering illegal depot pharmacy services and accepting returned medications from customers. Both of these practices are illegal. Unfortunately like PBMs, mail order pharmacies have the ability to fly under the wire. I support this bill as a good starting point to improve our prescription service within the state and level the playing field so that Hawaiian pharmacies can compete with mail order service. Give Hawaii residents a choice. No mandatory mail order.