HB62, HD2

TESTIMONY

HTH HEARING

3-11-13

Cynthia M. Laubacher
Senior Director, State Affairs
(916) 771-3328
Cynthia_Laubacher@express-scripts.com

March 8, 2013

To: Senator Josh Green, M.D., Chair
Members of the Senate Committee on Health

Fr: Cynthia Laubacher, Senior Director, State Government Affairs
Express Scripts Holding Company

Re: House Bill 62 HD 2
Hearing: March 11, 2013 4:00pm

On behalf of Express Scripts I am writing to express our opposition to House Bill 62. Express Scripts administers prescription drug benefits on behalf of our clients – employers, health plans, unions and government health programs — for approximately 109 million Americans. We provide integrated pharmacy benefit management services including pharmacy claims processing, home delivery, specialty benefit management, benefit-design consultation, drug-utilization review, formulary management, medical and drug data analysis services, as well as extensive cost-management and patient-care services.

HB 62 contains many troubling provisions that could result in increasing costs for both plan sponsors and their employees/members. First, the stated purpose of the Act is "to prohibit pharmacy benefits managers from using a patient's claim information to market or advertise to that patient the services of a preferred pharmacy network that is owned by the pharmacy benefits manager." Section 2 implies that patient claim information is used to create a restricted network and prohibits PBMs from requiring patients to use the PBM-owned mail service if they choose to receive their medications through the home-delivery service.

Our clients, the plan sponsors, design their pharmacy benefit to meet their needs and then contract with a pharmacy benefits manager (PBM) to administer that benefit. It is the plan sponsors who determine the size of the pharmacy network and whether that network should include mail service, which may be provided by the contracting PBM. It is also the plan sponsor who sets any restrictions on if or how the PBM is allowed to contact their employees/members.

Regarding Section 2, the Federal Trade Commission has written extensively about the anti-competitive effects of any willing provider legislation, stating it will lead to reduced competition and higher prices. PBMs lower costs and encourage quality care by developing a network of retail pharmacies willing to accept discounted pricing in exchange for access to a plan's members. A PBM must establish a network of retail pharmacies so that consumers with prescription drug insurance can fill their prescriptions. Plan sponsors want members to have convenient access to pharmacies providing high quality service. A consumer with a prescription drug benefit plan must utilize a pharmacy that accepts payment for that plan. Therefore, retail pharmacies must compete to be part of the retail pharmacy network for a particular PBM or risk losing access to the consumer. Store-based retail pharmacies enter into contracts with a PBM to participate in the PBM's retail network and provide prescriptions to a plan's beneficiaries. Network pharmacies compete on service, convenience, and quality to attract consumers within a particular plan. This is good for our plan sponsors and for their members/employees.

Regarding the issue of mail service pharmacies, during the debate leading up to the passage of the Medicare Modernization Act of 2003, the retail pharmacy lobby sought to convince Congress that the use of PBM-owned mail-order pharmacies could result in higher costs. In response to these allegations, the Federal Trade Commission (FTC) was charged with answering a number of very specific questions about the effects that PBM ownership of a mail-order pharmacy can have on overall prescription drug costs. The results of the FTC report were released in August 2005. In short, the FTC determined that allegations of PBMs' conflict of interest were "without merit," and that PBM-owned mail-order pharmacies:

- *Offer lower prices on prescription drugs than retail pharmacies and non-PBM owned mail pharmacies;*
- *Are very effective at capitalizing on opportunities to dispense generic medications; and*
- *Have incentives closely aligned with their customers: the third-party payors who fund prescription drug care*

Finally, the use of patient claim information is highly regulated by state and federal statute. As such, this legislation is unnecessary.

For these reasons we must respectfully oppose HB 62. Thank you for the opportunity to provide testimony on this measure.

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

March 10, 2013

To: The Honorable Josh Green
Chair, Senate Committee on Health

From: ‘Ohana Health Plan

Re: House Bill 62, HD2, Relating to Pharmacy Benefit Managers
In Opposition

Hearing: Monday, March 11, 2013, 4:00 pm
Hawai‘i State Capitol, Conference Room 229

Since February 2009, ‘Ohana Health Plan has provided services under the Hawai‘i MedQUEST Division for QUEST Expanded Access (QExA) program and, since July 2012, the QUEST program. ‘Ohana is managed by a local team of experienced health care professionals who embrace cultural diversity, advocate preventative care and assure access to high quality care for the members we serve. 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., a member of the WellCare Health Plans (“WellCare”) family of Companies. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.6 million Medicaid and Medicare members nationwide. ‘Ohana has utilized WellCare’s national experience to develop a Hawai’i -specific care model that addresses local members’ healthcare and health coordination needs.

We appreciate this opportunity to testify in opposition to House Bill 62, HD2, Relating to Pharmacy Benefit Managers.

While the stated purpose of the measure is to prohibit pharmacy benefit managers (PBMs) from restricting a patient’s choice of pharmacy, the bill goes far further impacting the ability of PBMs to offer competitive pharmacy services in the Hawai`i market. This would deprive Hawai`i consumers of state-of-the-art products and services available to other American consumers.

By restricting the use of prescription drug benefit claim information, prohibiting restriction of pharmacy networks if the pharmacies are affiliated with the PBM and prohibiting requiring enrollees to utilize a mail order pharmacy, this bill will restrict PBMs and their insurer clients from appropriately and effectively controlling costs and improving the quality of care delivered to our members.

As drafted, the measure could prevent `Ohana Health Plan's current PBM from fulfilling its contractual requirements, requirements drawn to comply with State and Federal contracts and regulations. Additionally, 'Ohana and other health plan Pharmacy & Therapeutics (P&T) Committees define prescription benefits based on the needs of their members, the requirements of their customers and the statutory and regulatory requirements governing the contract. Each health plan's PBM partner implements the pharmacy benefit through sophisticated information technology systems providing a broad array of services including implementation of health plan prior authorization requirements, evaluation of prescriptions for potential negative interactions or side effects, patient compliance with drug regimens, negotiation of rebate agreements with pharmaceutical manufacturers, and, in some cases, the development and contracting of pharmacy networks.

Where pharmacy networks are contracted through a PBM, those networks are defined by the health plan's network adequacy needs and quality goals. The measure would impair the ability of PBMs to meet these requirements by restricting the ability of PBMs to limit the pharmacies that can be included in those networks and by preventing the requirement that health plan participants utilize a mail order pharmacy.

In a state like Hawaii with its many remote areas, mail order pharmacy is often the most accessible means of assuring that prescriptions are delivered on time and that prescription pricing is cost effective.

By prohibiting PBM from excluding any pharmacy provider, regardless of the quality of care delivered by the pharmacies or their record with respect to fraud waste and abuse, this bill impairs both PBM and health plans' efforts to improve the quality of care Hawai`i members receive. With over 200 pharmacies in the State of varying sizes and business practices, 'Ohana Health Plan in partnership with our PBM, Catamaran, provides quality oversight of our pharmacy providers to insure our members get the standard of care they require. This bill would allow a poor performing pharmacy to continue to see 'Ohana members.

Additionally, PBMs are an integral part of assuring that pharmacy costs are appropriately held to reasonable levels. Pharmacy costs account for approximately 20% of health care costs and therefore represent an area of health spending 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 unnecessary increased health care costs.

In summary, `Ohana Health Plan opposes HB62, HD2 because:

1. The measure interferes with the ability of a health plan or purchaser to utilize pharmacy contracting to improve the quality of care delivered to our members
2. The measure prevents Pharmacy Benefit Managers from controlling network participation and utilizing mail order pharmacies to improve access and control costs.
3. The measure interferes with the competitive marketplace and will increase the cost of Hawaii Medicaid.

We respectfully request that you hold House Bill 62, HD2- Relating to Pharmacy Benefit Managers. Thank you for the opportunity to provide these comments on this measure.

HMSA Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 11, 2013

The Honorable Josh Green, M.D., Chair
The Honorable Rosalyn H. Baker, Vice Chair

Senate Committee on Health

Re: HB 62, HD2 – Relating to Pharmacy Benefits Managers

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 62, HD2, which prohibits a pharmacy benefits manager (PBM) from using a patient's benefits claim information to promote the services of a preferred pharmacy network owned by the PBM. HMSA opposes this Bill.

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.

There seems to be a misconception that PBMs dictate pharmacy benefits such as restrictive network, mandatory mail order and copayments. This is not the case. The employer groups or other payers are the entities that make these benefit design decisions. We believe that allowing the purchaser of the benefit to have that decision-making authority is imperative to balancing the needs of the employees with the cost to the health care system. This Bill may restrict that goal.

Thank you for the opportunity to testify on this measure.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

HAWAII FOOD INDUSTRY ASSOCIATION (HFIA)
1050 Bishop St. PMB 235
Honolulu, HI 96813
Fax: 808-791-0702
Telephone : 808-533-1292

DATE: Monday, March 11, 2013 TIME: 4:00 PM PLACE: CR 229

TO: COMMITTEE ON HEALTH

Sen. Josh Green, Chair
Sen. Rosalyn H. Baker, Vice Chair

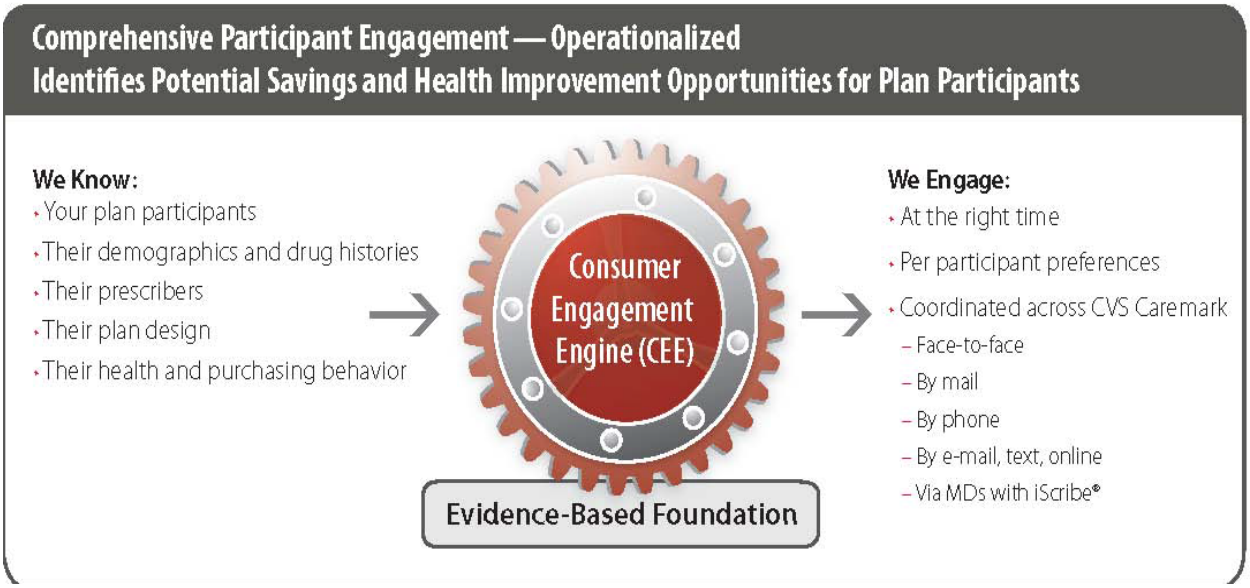
FROM: Hawaii Food Industry Association - Lauren Zirbel, Executive Director

Re: HB 62- Relating to Pharmacy Benefit Managers **Strong Support**

The Hawaii Food Industry Association is comprised of two hundred member companies representing retailers, suppliers, producers and distributors of food and beverage related products in the State of Hawaii.

I am writing on behalf of HFIA members across the State of Hawaii regarding Pharmacy Benefit Managers, (PBM's) and the importance of increasing oversight as it relates to their use of prescription claims information to directly market the services of an affiliated of wholly owned pharmacy provider.

CVS/Caremark as of January 2013 has become the dominate PBM/Pharmacy/Mail order business in the State of Hawaii. HFIA has calculated that CVS/Caremark either fills, or adjudicates over 80% of the pharmacy claims in the state. Across the United States CVS Caremark fills or manages more than 1.2 billion prescriptions annually. The information from these prescriptions is not simply used to process prescription claims. It is compiled by CVS Caremark to form a complete medical picture of the patient. As described in a CVS Caremark publication, CVS Caremark then utilizes these complete medical pictures for its own financial gain to market products and services to (or "engage") the patients. The engagement engine shown below is a graphic example of how this information is processed.



CVS Caremark collects proprietary patient information it receives from non-CVS pharmacies and transfers that same information to its own CVS pharmacies and other business
segments and otherwise uses the information for CVS Caremark's own financial benefit. CVS
Caremark accepts payments from drug companies for directly marketing to those patients who are likely candidates for a drug because of their prescription history. CVS Caremark also directly
targets non-CVS patients and solicits their business to CVS-owned retail stores and their purchase of CVS-branded over-the-counter products.

The importance of this act HB62 can not be over stated. By preventing CVS from using patients claims information to manipulate their choice of pharmacy provider we protect the most vulnerable in our society. This act would prevent call centers from repeatedly calling patients with offers of 20% discounts on other goods if they will only fill their prescriptions at a CVS/Longs store. By implying that the member must purchase their pharmacy services from a CVS store during a series of calls is not in the best interest of our patients and is oriented toward bigger profits not better care. For these reason

HFIA respectfully asks that HB-62 be passed intact from this committee with the blessings of its members.

Thank you for the opportunity to provide this testimony.

Testimony of
Gary M. Slovin / Mihoko E. Ito
on behalf of
Walgreens

DATE: March 10, 2013

TO: Senator Josh Green
Chair, Committee on Health
Submitted Via HTHtestimony@capitol.hawaii.gov

RE: **H.B. 62 HD2 – Relating to Pharmacy Benefits Managers**
Hearing Date: Monday, March 11, 2013 at 4:00 pm
Conference Room 229

Dear Chair Green and Members of the Committee on Consumer Protection & Commerce:

We submit this testimony on behalf of Walgreen Co. ("Walgreens").

Walgreens operates more than 8,200 locations in all 50 states, the District of Columbia and Puerto Rico. In Hawai`i, Walgreens now has 11 stores on the islands of Oahu, Maui and Hawai`i.

Walgreens **supports** H.B. 62 HD2, which prohibits a pharmacy benefits manager from using a patient's prescription drug benefits claim information to market to that patient the services of a preferred pharmacy network that is owned by the pharmacy benefits manager.

Walgreens believes that transparency is an important part of the pharmacy industry, and that patients should be in control of their choices when filling their prescriptions. PBMs that own preferred pharmacy networks can seek to limit patients from accessing their pharmacy of choice, by utilizing drug benefits claim information to market to these patients.

Walgreens supports state efforts to regulate pharmacy benefits managers, and believes this parity in the industry is important. For these reasons, Walgreens supports H.B. 62 HD2 and respectfully requests that you pass this measure.

Mahalo for the opportunity to testify on this measure.

Gary M. Slovin
Mihoko E. Ito
Tiffany N. Yajima
Nicole A. Velasco

1099 Alakea Street, Suite 1400
Honolulu, HI 96813
(808) 539-0840

Testimony Presented Before the
Senate Committee on Health
Monday, March 11, 2013 at 4:00 p.m.
By
John Pezzuto, Ph.D.
Dean, College of Pharmacy, UH Hilo

HB62 HD2 RELATING TO PHARMACY BENEFITS MANAGERS

Chair Green, Vice Chair Baker and Members of the Committee:

My name is Dr. John Pezzuto and I am the Dean of the College of the College of Pharmacy at UH Hilo. I am testifying in support of the enactment of HB62 HD2. I am testifying as a private citizen and not as a representative of UH Hilo.

This bill will prohibit pharmacy benefit managers from engaging in exploitive marketing practices. The role of the pharmacy benefit manager is to serve as an intermediate to negotiate services and costs between pharmaceutical companies and third party payers. It is not their function nor within their purview to utilize privileged patient information to manipulate how and where patients receive prescription drug benefits, nor to exploit this information for profit or any other motivation that has little to do with the welfare of the patient.

By using this information to direct business to their chain stores and mail order operations, consumer choice is compromised and competition is eliminated. This bill prohibits such activities, which frankly are unconscionable.

Thank you for considering this testimony.

CVS CAREMARK 1300 I Street, N. W., Suite 525 West| Washington, DC 20005 | T: 202-772-3500

Honorable Josh Green, Chair
Honorable Rosalyn Baker, Vice Chair
Senate Committee on Health

Monday, March 11, 2013; 4:00 p.m.
State Capitol, Conference Room 229

RE: HB 62 HD2 – Relating to Pharmacy Benefits Managers – In Opposition

Chair Green, Vice Chair Baker and Members of the Committee:

My name is Lauren Rowley, Vice-President of Government Affairs for CVS Caremark Corporation ("CVS Caremark"), testifying in opposition to HB 62 HD2, Relating to Pharmacy Benefits Managers ("PBM").

All group health plans, whether insured or self-insured, are subject to ERISA and its extensive regulations (from the Federal Department of Labor). PBMs are exclusively regulated by ERISA when they perform plan administrative functions. Those functions include determining eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds, and keeping appropriate records.

HIPAA has regulations on privacy which dictates how patient information may be used. HIPAA does NOT require individual consent for a PBM to use a member's prescription information for plan administration. A PBM has to use a patient's prescription drug information to process claims efficiently, prevent fraud and abuse, and assure that the PBM can accomplish safety and quality functions like drug utilization review. If a PBM were forbidden to use that information, it would place patients at risk.

As part of our effort to continually improve our clinical offerings, CVS Caremark launched the Consumer Engagement Engine (CEE), a set of new, proprietary technologies that is used to identify clinical improvement and cost reduction opportunities for a given plan member.

The CEE identifies and prioritizes opportunities to deliver the right message to the right member by the most effective method, while taking into account the value of the opportunity and client and member preferences. All members are eligible and receive opportunity interventions through various CVS Caremark communication methods, such as letters, call center conversations etc. Those who choose to fill prescriptions at other network retail pharmacies or CVS Caremark Mail Service Pharmacy receive interventions through letters, outbound phone calls and other communication vehicles. Members who choose to fill prescriptions at a CVS or Longs Drugs pharmacy may also receive some interventions face-to-face at the pharmacy counter. The CEE records the outcome of all interventions, regardless of prescription channel, and prepares to deliver the next opportunity to the member using the most appropriate method.

- The CEE is **not** a database that can be accessed by either retail or PBM employees, but rather, it is a set of technologies or software that helps to identify appropriate opportunities to deliver targeted information.

- The CEE **cannot** be used to share information subject to the firewall across the enterprise (e.g. does not give CVS or Longs Drugs/pharmacy contracting employees access to PBM network proprietary information or vice versa).

In summary, this legislation will prohibit CVS Caremark from administering the terms of its contract with plan sponsors to provide their desired pharmacy benefit plan for their beneficiaries and employees. For the reasons stated above, CVS Caremark respectfully requests this bill be held.

Thank you for the opportunity to testify.

Lauren Rowley
Vice-President, Government Affairs
CVS Caremark
Telephone (202) 772-3516
Email – lauren.rowley@cvscaremark.com

From: mailinglist@capitol.hawaii.gov
To: HTHTestimony
Cc: rontthi@gmail.com
Subject: *Submitted testimony for HB62 on Mar 11, 2013 16:00PM*
Date: Friday, March 08, 2013 5:11:49 PM

HB62
Submitted on: 3/8/2013
Testimony for HTH on Mar 11, 2013 16:00PM in Conference Room 229

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

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov