DAVID Y. IGE
GOVERNOR

JOSH GREEN
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
335 MERCHANT STREET, ROOM 310
P.O. BOX 541
HONOLULU, HAWAII 96809
Phone Number: 586-2850
Fax Number: 586-2856
cca.hawaii.gov

CATHERINE P. AWAKUNI COLÓN
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Health
Wednesday, February 10, 2021
1:00 p.m.
Via Videoconference

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

Chair Keohokalole and Members of the Committee:

My name is Colin M. Hayashida, and I am the Insurance Commissioner of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purposes of this bill are to: (1) prohibit certain contracts for managed care entered into after June 30, 2021, from containing a provision that authorizes pharmacy benefit managers (PBMs) to reimburse a contracting pharmacy on a maximum allowable cost basis, and void any such provisions in exiting manage care contracts; (2) prohibit PBMs from engaging in self-serving or deceptive business practices; (3) prohibit PBMs from engaging in unfair methods of competition or unfair practices; (4) prohibit PBMs from retaining any portion of spread pricing; (5) prohibit PBMs from reimbursing a 340B pharmacy differently than any other network pharmacy; (6) prohibit PBMs from reimbursing an independent or rural pharmacy an amount less than the rural rate for each prescription drug, under certain circumstances; (7) prohibit PBMs from prohibiting a pharmacist or pharmacy to provide certain information to insureds regarding cost

sharing or more affordable alternative drugs; (8) provide that any information in response to a data call from the Insurance Commissioner or designee shall be treated as confidential and privileged; (9) increase PBMs' annual reporting requirements; (10) require the Insurance Commissioner to file annual reports with the Legislature; (11) increase PBM registration and renewal fees; and (12) make certain violations of PBMs subject to the penalties provided in Hawaii Revised Statutes (HRS) chapter 480 and chapter 481.

Several areas of the bill may require further clarity. The absence of a definition for "rural," which is used throughout S.B. 602, creates vagueness and potential enforcement difficulties. Although the phrase "independent or rural pharmacy" is defined on page 12, lines 12 through 20, this definition also includes the undefined term "rural."

On page 14, lines 4 through 21, the phrase "or health maintenance organization regulated under chapter 432D[;]" is deleted from the definition of "covered entity." This deletion will remove health maintenance organizations from the scope of "covered entity," and it is unclear whether this exclusion was intentional.

On page 15, lines 1 through 16, the definition of "pharmacy benefit manager" is amended to read similarly to the definition in HRS chapter 431R, including omitting the term "covered entity," which is defined in HRS section 431S-1. This bill also adds terms such as "managed care company," which are not defined in either HRS chapters 431R or 431S. This may lead to unnecessary confusion, as "covered entity" is used throughout HRS chapter 431S. If the intent is to create similar definitions of "pharmacy benefit manager" in both chapters, the Department prefers the less vague definition in HRS chapter 431S and respectfully suggests striking the amendments to the definition of "pharmacy benefit manager" in section 4 of this bill.

On page 10, lines 16 through 20, the Insurance Commissioner is tasked with performing an annual examination covering "[t]he negative impacts on independent or rural pharmacies caused by [PBMs]; and . . . [t]he effects of transactions between health plan insurers and [PBMs] on health plan premiums." The Insurance Division does not

have the expertise to perform these analyses and would need to hire a consultant to fulfill these tasks.

Section 5 greatly increases the registration requirements of PBMs. Implementation of section 5 will be difficult, as the Insurance Division lacks expertise to assess the qualifications of PBMs for licensure. Page 16, lines 3 through 11, provide only broad criteria for the Insurance Commissioner to consider in determining whether to grant a registration. To prove that this criteria has been met, the bill provides on page 17, lines 8 through 12, that applicants provide "[a]ny other information the commissioner deems necessary or helpful to determine whether the applicant has the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered pursuant to this chapter." However, the Insurance Division lacks expertise to determine what documents would be sufficient or should be requested.

Further, while section 5 authorizes the issuance of a restricted or limited registration on page 16, lines 8 through 11, the penalty provisions do not give the Insurance Commissioner those same remedies as disciplinary sanctions for HRS chapter 431S violations.

Finally, the issuance, renewal, and penalty fees in section 5, page 17, line 7, section 6, page 18, line 13, and section 6, page 18, lines 14 through 18, are inconsistent with the terms and penalty amounts proposed in S.B. 1096, on page 40, lines 3 through 5 and lines 15 through 22, and S.B. 1098, on page 8, lines 12 through 17. The Department respectfully requests that any changes to the terms and fees be consistent with the proposed language in S.B. 1096 and S.B. 1098.

Thank you for the opportunity to testify on this bill.

DAVID Y. IGE
GOVERNOR OF HAWAII

ELIZABETH A. CHAR, M.D.
DIRECTOR OF HEALTH

LATE

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony COMMENTING on SB602
RELATING TO PHARMACY BENEFIT MANAGERS.

SENATOR JARRETT KEOHOKALOLE, CHAIR
SENATE COMMITTEE ON HEALTH

Hearing Date: February 9, 2021 Room Number: N/A

Department Testimony: The Department of Health (DOH) shares the concern of the Legislature and community stakeholders regarding the viability of independent and rural pharmacies, but takes no position on the mertis of the amendments proposed by SB602. DOH concurs that rural and independent pharmacies are critical health care infrastructure in areas that may not yield enough revenue potential for "big box" pharmacies. Moreover, these smaller pharmacies have deep roots in their communities that enhance their value to kupuna and other vulnerable residents.

DOH supports the larger conversation that examines the role of pharmacy benefit managers (PBM) but recommends that regulatory authority does not span multiple agencies. In the case of the Department of Health, section 328-106 was enacted in 2015 and authorizes DOH to enforce contract provisions between private, often for-profit entities, with regard to maximum allowable charge (MAC). There is no threat to human or environmental health for which this section provides oversight and assurance, and it thus inappropriate for public health statutes. As a result, DOH respectfully requests this section be repealed outright.

<u>Lack of Enforcement Authority</u>

Section 328-106 amendmend the Hawaii Food, Drug, and Cosmetic Act, the purpose of which is to protect consumers and patients from counterfeit or substandard products that are commonly ingested or applied. Enforement authority in this chapter permits DOH to inspect products, inventories, manifests, and related artifacts of distribution and retail. DOH submits that this

authority is inappropriate and insufficient to conduct forensic financial review of business transactions between private entities.

Lack of Expertise

The mission of the Department of Health pursuant to section 321-1, HRS, is to "have general charge charge, oversight, and care of the health and lives of the people of the State." Programs and activities, especially enforcement actions, are based on risks to human and environmental health and not the financial viability of the private sector. This is an inappropriate use of public health resources and ineffective public policy due to the lack of expertise in enforcing contracts, calculating insurance risk, etc.

The Department of Health is unable to implement section 328-106 and respectfully requests repeal.

Thank you for the opportunity to testify.

Offered Amendments:

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

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

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

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

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

(c) The pharmacy benefit manager shall make available to a contracting pharmacy, upon request, the most up-to-date maximum allowable cost price or prices used by the pharmacy benefit manager for patients served by the pharmacy in a readily accessible, secure, and usable web-based or other comparable format.

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

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

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

(3) The drug is not obsolete.

(e) The pharmacy benefit manager shall review and make necessary adjustments to the maximum allowable cost of each drug on a maximum allowable cost list at least once every seven days using the most recent data sources available, and shall apply the updated maximum allowable cost list beginning that same day to reimburse the contracted pharmacy until the pharmacy benefit manager next updates the maximum allowable cost list in accordance with this section.

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

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

(A) The maximum allowable cost for a drug is below the cost at which the drug is available for purchase by similarly situated

pharmacies in this State from a national or regional wholesaler; or

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

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

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

(4) If the maximum allowable cost is upheld on appeal, the pharmacy benefit manager shall provide to the contracting pharmacy the reason therefor and the national drug code of an equivalent drug that may be purchased by a similarly situated pharmacy at a price that is equal to or less than the maximum allowable cost of the drug that is the subject of the appeal; and

(5) If the maximum allowable cost is not upheld on appeal, the pharmacy benefit manager shall adjust, for the appealing contracting pharmacy, the maximum allowable cost of the drug that is the subject of the appeal, within one calendar day of the date of the decision on the appeal and allow the contracting pharmacy to reverse and rebill the appealed claim.

(g) A contracting pharmacy shall not disclose to any third party the maximum allowable cost list and any related information it receives, either directly from a pharmacy benefit manager or through a pharmacy services administrative organization or similar entity with which the pharmacy has a contract to provide administrative services for that pharmacy."]

DAVID Y. IGE
GOVERNOR

LATE

STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
201 MERCHANT STREET, SUITE 1700
HONOLULU, HAWAII 96813
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE SENATE COMMITTEE ON HEALTH
ON SENATE BILL NO. 602

February 10, 2021
1:00 p.m.
Via Videoconference

RELATING TO PHARMACY BENEFIT MANAGERS

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

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees has not been able to take a position on this bill. Their next meeting is scheduled for February 16, 2021. EUTF staff would like to provide information and comments.

The EUTF is concerned with the proposed section "Pharmacy benefit managers; contracting pharmacies; reimbursements; maximum allowable cost basis; prohibition" and its prohibiton of pharmacy benefit manager use of maximum allowable costs in reimbursing pharmacies for common prescription drugs (e.g. generics). The current practice helps to limit EUTF plan costs as actual amounts paid to the pharmacies by the pharmacy benefit managers are paid by the EUTF, pass-through pricing. The EUTF's pharmacy benefit manager does not earn a spread (i.e. spread pricing) between the reimbursement to the pharmacy and the amount charged to the EUTF. Since 2012, the

EUTF has hired a third-party auditor to ensure that the pharmacy benefit manager is adhering to EUTF's contract pass-through pricing provisions. Therefore, any increase in pharmacy reimbursement will likely result in an increase in EUTF plan costs resulting in higher premiums for the State and counties, employees and retirees.

The EUTF also is concerned with the proposed section "Pharmacy benefit manager business practices; prohibitions; independent or rural pharmacy reimbursement rate" that prohibits financial copayment incentives to use mail order facilities or pharmacies with an ownership relationship to the pharmacy benefit manager. For the EUTF prescription drug plans, if a 90-day prescription is filled at a CVS Retail 90 network pharmacy or through mail order the member's copayment is two times the 30-day copayment. If the 90-day prescription is filled at a non-Retail 90 network pharmacy the copayment is three times the 30-day copayment. The CVS Retail 90 network is a sub-network of the CVS national network which includes major chains such as CVS (Longs), Walgreens, Safeway, and Costco as well as local pharmacies. The CVS national network is open to all pharmacies that meet the requirements (e.g. proper licensing) and the CVS Retail 90 network is open to all CVS national network pharmacies. Over 90% of CVS national network Hawaii based pharmacies are also members of the CVS Retail 90 network.

The prescription drug costs charged under pass-through pricing to the EUTF plan are lower for prescriptions filled at Retail 90 pharmacies and mail order than at non-Retail 90 pharmacies. The Retail 90 pharmacies benefit through higher volume as copayments for members are less, in some cases by $50 per prescription. It has been estimated that the EUTF active employee and non-Medicare plans will experience higher annual drug

costs of $3.1 million and $2.5 million, respectively, which will be passed on to the State and counties, employees and retirees through higher premiums. The increase in retiree prescription drug costs is estimated to increase the OPEB unfunded liability by $44 million.

The EUTF staff would like to propose the following change to language in the bill:

"§431S- Pharmacy benefit manager business practices; prohibitions; independent or rural pharmacy reimbursement rate. (a) A pharmacy benefit manager shall be prohibited from penalizing, requiring, or providing financial incentives, including variations in premiums, deductibles, copayments, or coinsurance, to covered persons as incentives to use a specific retail pharmacy, ~~mail service pharmacy,~~ or other network pharmacy provider in which a pharmacy benefit manager has an ownership interest or that has an ownership interest in a pharmacy benefit manager. However, financial incentives are allowed if such financial incentives are also available to other network pharmacies."

Thank you for the opportunity to testify.

KAISER PERMANENTE®

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
Senate Committee on Judiciary
The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair

February 10, 2021
1:00 pm
Via Videoconference

Re: SB 602 Relating to Pharmacy Benefit Managers

Chair, Vice Chair, and committee members thank you for this opportunity to provide testimony on SB 602 regulating pharmacy benefit managers in Hawaii.

Kaiser Permanente Hawaii requests an amendment.

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

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

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5224
Facsimile: 808-432-5906
Mobile: 808-282-6642
E-mail: John.M.Kirimitsu@kp.org

Because these services are already built into our system, Kaiser Permanente generally has no need to engage others to perform its in-house pharmacy services. More importantly, relevant information about these functions is already available to the Insurance Commissioner. This is not the case for industry standard third-party PBMs who are the subject of this bill. Therefore, since we believe the purpose of this bill is to regulate third-party PBMs, and not internally owned in-house pharmacies, we ask for the following exemption excluding an integrated health system that owns and/or manages its own pharmacies. Therefore, on Page 15, lines 1-16, the definition of "Pharmacy Benefit Manager" should read as follows:

3. By amending the definition of "pharmacy benefit manager" to read:

""Pharmacy benefit manager" means any person, business, or entity that performs pharmacy benefit management, including but not limited to a person or entity [~~in a contractual or employment relationship with~~] under contract with a pharmacy benefit manager to perform pharmacy benefit management [~~for a covered entity.~~] as defined in this section, on behalf of a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, or health program administered by the State that is duly licensed pursuant to this chapter. "Pharmacy benefit manager" does not include any health care facility licensed in this State, a health care provider licensed in this State, [a health maintenance organization (HMO) regulated under chapter 432D that owns and/or manages its own pharmacies] or a consultant who only provides advice as to the selection or performance of a pharmacy benefit manager."

[Red bracketed language is added]

Thank you for your consideration.

1275 Pennsylvania Avenue, NW
Suite 700
Washington, DC 20004

February 5, 2021

Senator Jarrett Keohokalole, Chair
Senator Rosalyn Baker, Vice Chair
Senate Committee on Health
415 South Beretania Street
Honolulu, Hawaii 96813

RE: SB 602 Relating to Pharmacy Benefit Managers

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

CVS Health has a number of concerns regarding Senate Bill 602 ("SB 602"), relating to pharmacy benefit managers (PBMs) as it is currently drafted and would be happy to work with legislators and stakeholders as discussion on this bill continues. SB 602 seeks to regulate private business contracts between PBMs, their clients, including employers and health plans, and pharmacies. We believe that provisions in this bill would interfere in private contracting and greatly increase costs for Hawaii employers and health plans.

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

As noted above, we have a number of concerns with SB 602, including the ban on spread pricing arrangements, the rural reimbursement rate mandate, and the disclosure of competitively sensitive information. We believe these provisions will take away contract flexibility for employers and plan sponsors and could lead to higher health care costs.

Spread Pricing Ban

SB 602 seeks to prohibit the use of spread pricing arrangements. CVS Health offers PBM clients a variety of contractual options to pay for our PBM services and they choose the one that is best for them based on the services they need and their plan membership. Each employer and plan sponsor evaluates and determines the financial arrangement that meets its needs for PBM services.

Many clients choose a spread pricing arrangement because it provides clients with more certainty in their pharmacy costs and allows them to budget in a more predictable manner. Reducing options in the marketplace that employer and plan sponsors are currently choosing takes away flexibility in contracting that may lower health care costs for them and their employees and members.

Rural Reimbursement Rate

SB 602 seeks to prohibit a PBM from reimbursing an independent or rural pharmacy an amount less than the rural rate for prescription drugs. It should be noted that typically, rural pharmacies get paid

higher reimbursement rates because they have lesser patient volume but are important for patient access. Not all independent pharmacies are rural pharmacies and should not be reimbursed at the same rates as rural pharmacies – independent pharmacies in urban and suburban areas have greater volume and therefore their reimbursement rates account for this. If all independent pharmacies must be reimbursed at a rural rate, this rate is likely to be inflated and may create a windfall to those pharmacies at the expense of Hawaii plan sponsors and consumers.

This bill also seeks to prohibit PBMs from making changes to the rate without providing 30 days' notice to pharmacies. Given the complex and dynamic nature of the generic drug marketplace, prices change throughout the year. This bill would cause reimbursement rates to be based on information from 30 days prior, no longer reflecting the actual market price of a drug product when it goes into effect. If there's a fluctuation in the marketplace that would entitle a pharmacy to a greater reimbursement, they would not be able to receive such reimbursement because the rate would be frozen at the rural rate. For example, if the market price of a drug quickly increases (due to a drug shortage or if a manufacturer drastically increases its price), pharmacies would be under-reimbursed for that drug because the PBM would not be able to adjust the reimbursement rate for 30 days. We also believe the proposed provision may conflict with the existing maximum allowable cost (MAC) law that requires that MAC lists be updated every 7 days.

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

Transparency Report

SB 602 would also require the disclosure of competitively sensitive information with no confidentiality protections. CVS Health believes that it is important to keep the competitive marketplace among drug manufacturers in place in order to drive down the cost of prescription medications. Any public disclosure of rebate information could allow manufacturers to learn what type of price concessions other manufacturers are giving and could disincentivize them from offering deeper discounts, which benefit plan sponsors and their beneficiaries.

The FTC has reviewed a number of state legislative proposals that would have required the public disclosure of competitive rebate information and opined that, "[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors, then tacit collusion among them is more feasible" and that such knowledge of competitors' pricing information would dilute incentives for manufacturers to bid aggressively "which leads to higher prices."[1] The FTC also concluded that "[a]ny such cost increases are likely to undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford."[2]

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

On behalf of CVS Health, thank you for allowing us to express our concerns and we welcome the opportunity to work with you on these important issues.

Respectfully,

Shannon Butler
Executive Director of Government Affairs
CVS Health

PCMA

February 9, 2021

Senator Jarrett Keohokalole, Chiar
Senator Rosalyn Baker, Vice Chair
Committee on Health

RE: S.B. 602 Relating to Pharmacy Benefit Managers
February 10, 2021, 1:00 p.m.
Submitted electronically

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

On behalf of the Pharmaceutical Care Management Association (PCMA), we greatly appreciate the opportunity to testify on S.B. 602 relating to Pharmacy Benefit Managers. We respectfully request the committee to consider our comments in the interest of payers and patients.

PCMA is the national trade association representing America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D. PBMs are engaged by clients including health insurers, government agencies, unions, school districts, and large and small employers, to manage pharmacy benefits pursuant to health insurance benefits and contracts. PBMs are projected to save payers over $30 billion through the next decade thanks to tools such as negotiating price discounts with drug manufacturers, establishing pharmacy networks and disease management and adherence programs.

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

§431S- Pharmacy benefit manager business practices; prohibitions; independent or rural pharmacy reimbursement rate
PBMs do not establish premiums, copayments, deductibles, or mail order benefits. Those are all plan benefit designs established by the health plan sponsor. PBMs merely administer the benefits on behalf of the plan sponsor.

Further, the use of spread pricing is a risk management tool for purchasers to use to limit their financial exposure. Eliminating the use of spread pricing takes away an important option for health plan sponsors. Many PBM clients choose a spread pricing arrangement because it provides them with greater certainty in their pharmacy costs and allows them to budget in a more predictable manner. Reducing options in the marketplace that employer and plan

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

PCMA

sponsors are currently choosing takes away flexibility in contracting that may lower health care costs for them and their employees and members.

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

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

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

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

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

§431S3- Registration required
This section imposes several new PBM registration requirements. However, these provisions are much more akin to licensing requirements under the guise of the registration nomenclature. The Insurance Commissioner has jurisdiction over the pharmacy benefits of insured plans and the ability to enforce those requirements on plans providing those benefits within the state. PBMs, through their contracts with health plans, cannot do anything that would bring their clients out of compliance with state law. PBMs are required to comply with the same consumer

PCMA

protections governing utilization review, prior approval, and dispute resolution systems, among others. As a condition of registration, the language states that a PBM demonstrate "background expertise" and "financial integrity" and it is unclear as to what these standards are. This enhanced registration to more of a licensing requirement is unnecessary.

Again, thank you for the opportunity to testify on S.B. 602 and we look forward to working with the Committee to develop solutions that will demonstrably benefit Hawaii's residents.

Sincerely,

Bill Head
Assistant Vice President
State Affairs

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

THE QUEEN'S HEALTH SYSTEMS

LATE

To: The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn Baker, Vice Chair
Members, Senate Committee on Health

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

Date: February 10, 2021

Re: Support for SB602: Relating to Pharmacy Benefits Managers

The Queen's Health Systems (Queen's) is a nonprofit corporation that provides expanded health care capabilities to the people of Hawai'i and the Pacific Basin. Since the founding of the first Queen's hospital in 1859 by Queen Emma and King Kamehameha IV, it has been our mission to provide quality health care services in perpetuity for Native Hawaiians and all of the people of Hawai'i. Over the years, the organization has grown to four hospitals, and more than 1,500 affiliated physicians and providers statewide. As the preeminent health care system in Hawai'i, Queen's strives to provide superior patient care that is constantly advancing through education and research.

Queen's appreciates the opportunity to provide testimony in support of SB602, relating to pharmacy benefits managers, which prohibits pharmacy benefit managers (PBM) from engaging in self-serving business practices, allow pharmacies to provide an insured individual with information about the amount of the insured's cost share for their prescription drug and if a more affordable alternative is available, increases annual reporting for PBMs, and provides the Insurance Commissioner with oversight of PBMs – including the ability to levy fines of up to $5000 for violations.

Queen's contracts with over 15 PBMs, with each PBM having their own way of doing business and some with little to no transparency. PBMs control the formularies for prices and have the ability create pricing uncertainty for pharmacies. Queen's outpatient pharmacies take on the responsibility of due diligence in working to find the lowest costs possible for our patients. However, when PBMs reimburse our pharmacies for half of what the costs are to acquire a drug, there is no process for us to know where that drug is being purchased, in what market, and/or if it is even available at that price in Hawaii.

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

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

Thank you for the opportunity to testify on this measure.

Hawaii Association of Health Plans

February 10, 2020

The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair
Senate Committee on Health

Senate Bill 602 – Relating to Pharmacy Benefit Managers

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

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

Pharmacy Benefit Managers help health plans to control drug costs. We believe that this bill will create more administrative burden and increase costs for Pharmacy Benefit Managers and health plans, which in turn will affect premiums for consumers. As this bill will increase costs to our members, we ask that it be deferred.

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

Sincerely,

HAHP Public Policy Committee

cc: HAHP Board Members

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the Senate Committee on Health
Wednesday, February 10, 2020; 1:00 p.m.
Via Videoconference

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

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS THE INTENT** of Senate Bill No. 0602, RELATING TO PHARMACY BENEFIT MANAGERS.

The bill, as received by your Committee, would, among other things:

(1) Establish a five-year moratorium on the use of contract Pharmacy Benefit Managers (PBMs) in managed care programs overseen by the Hawaii State Department of Human Services, including Medicaid;

(2) Prohibit PBMs from engaging in unfair methods of competition in the conduct of pharmacy benefit management;

(3) Ensures that PBMs reimburse independent or rural pharmacies an amount not less than the rural rate for each prescription drug;

(4) Prohibit PBMs from stopping a pharmacist or pharmacy from providing an insured with information on the amount of the insured's cost share for the prescription drug, and the clinical efficacy of a more affordable alternative drug if one is available;

(5) Establish annual reporting requirements to the Insurance Commissioner, and clarifying the confidentiality of such information and data;

(6) Increase the registration fees for PBMs with the Insurance Division;

(7) Empower the insurance Commissioner to suspend, revoke, or place a probation on a PBMs registration under certain circumstances; and

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

(8) Take effect on July 1, 2020.

This bill is substantively similar to Senate Bill No. 2280, Senate Draft 1, Regular Session of 2020.

By way of background, the HPCA represents Hawaii Federally-Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

The federal 340B Drug Pricing Program (340B Program) provides eligible health care providers, such as FQHCs, the ability to purchase outpatient drugs for patients at significantly reduced costs. By purchasing medications at a much lower cost, FQHCs are able to pass the savings on to their patients through reduced drug prices and the expansion of access and service to underserved populations. The discounts provided in the Program are financed by the drug manufacturers, not the government.

In recent years, a growing number of outside organizations called PBMs have determined how to access the 340B savings intended to accrue to FQHCs and other 340B providers. Among other things, PBMs have structured their contracts with FQHCs to retain part or all of the 340B savings. Examples of this include:

- A third party insurer determines that the FQHC is 340B eligible, but reduces reimbursement to the estimated 340B ceiling price;

- A retail pharmacy requests a sizeable percentage of the "spread" between the 340B purchase price and the insurance reimbursement of a higher dispensing fee than they charge for non-340B drugs; and

- A claims processor charges a higher fee for the 340B drugs (more than is justified by higher administrative costs) on the grounds that the health center is paying less for these drugs.

At this time, the federal 340B statute does not prohibit outside groups from accessing 340B savings intended for safety net providers and their patients. While the Congressional Record is clear that the 340B Program was intended to assist safety net providers to "stretch scarce federal resources", the statute does not explicitly prohibit the types of contracting arrangements described above. As such, FQHCs cannot reject these contracts on the grounds that they are illegal under law.

The practices of PBMs have had an enormous impact on limited State resources as well. In late 2018, the Ohio State Department of Medicaid required its five managed care plans to terminate contracts with PBMs after the State Auditor found that PBMs had been skimming hundreds of millions of dollars from the Ohio Medicaid Program through previously-hidden spread pricing tactics.

The HPCA notes that many of the concepts in this bill mirror laws enacted in Ohio. However, other states have specifically included statutory protections for the 340B Program, which this bill, in its current form, does not have. These states include Oregon, Montana, West Virginia, and South Dakota.

Because of this, the HPCA supports any and all legislative efforts to protect the 340B Program, including Senate Bill No. 2226, Senate Draft 1.

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

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

SB-602
Submitted on: 2/8/2021 4:37:47 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Byron N Yoshino	Testifying for Pharmacare Hawaii	Support	No

Comments:

The large Pharmacy Benefits Management (PBM) companies have been taking advantage of unfair reimbursement for independent pharmacies and benefitting their own companies without improving healthcare outcomes. All of the top 3 largest PBM's are owned by a Health Plan, and together they control over 80% of the market. They use their size to unfairly reimburse pharmacies to the detriment of patients who are often told their prescriptions can not be filled.

PBM's need to be regulated at the state and federal level. The Supreme Court recently ruled in favor of regulating PBM's. The Insurance Commissioner's Office needs to get funding to be able to regulate PBMs. Fair reimbursement will all pharmacies to provide the services needed to help patients with their increasingly complex drug therapies instead of only getting their pills>

An Independent Licensee of the Blue Cross and Blue Shield Association

February 10, 2021

The Honorable Jarrett Keohokalole, Chair
The Honorable Rosalyn H. Baker, Vice Chair
Senate Committee on Health

Re: SB 602 – Relating to Pharmacy Benefit Managers

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

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

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

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

Sincerely,

Matthew W. Sasaki
Director, Government Relations

Times Supermarket and Times Pharmacy Strongly Support SB602

Aloha Chair Keohokalole, Vice Chair Baker, and Members of the Committee on Health,

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

Three PBMs-Optum Rx, Express Scripts, and CVS Caremark-control 85% of the PBM market according to the President's Council of Economic Advisors. The Council also observed "Over 20% of spending on prescription drugs was taken in as profit by the pharmaceutical distribution system. The size of manufacturer rebates and the percentage of the rebate passed on to health plans and patients are secret." There are also numerous conflicts of interest, the most significant are rebates - when PBMs can share in rebates they want higher not lower drug prices. PBMs have their own pharmacies and drive consumers from their community pharmacy to the PBM owned pharmacy.

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

PBMs overcharge states and fail to pass along discounts. Ohio State Auditor found that the PBM OptumRx earned over $223 million between April 2017 and March 2018. Kentucky found that hidden PBM fees accounted for $125 million in costs to taxpayers. And between April 2017 and April 2018, PBMs overcharged New York taxpayers by over $200 million. Innovative new therapies are also sent to the back of the line for consumer access.

PBMs use hidden fees (among other tactics) to increase their revenue. According to Pew Charitable Trust, PBMs nearly quadrupled fees they charged biopharmaceutical companies between 2014 and 2016. Growth in alternate PBM revenue streams, such as spread pricing and administrative fees, increased from $5.9 billion in 2012 to $16.6 billion in 2016.

PBMs aggressively fight transparency which is the main reason why there is no meaningful regulation of PBMs. There are at most 5-6 states that require PBMs to register, but there is no regulation of rebates, transparency, or conflicts of interest.

Local residents and local businesses, your constituents, are being ripped off due to these unethical business practices. I would not be surprised if the state's EUTF program is getting ripped off as well. Just look at the hundreds of millions of taxpayer dollars that other states have found going straight into the PBM's pocket. Please look into the PBM issues, get educated, and help protect Hawaii. Thank you for the opportunity to provide testimony on SB602.

Crystal Jack
State Government Affairs

1215 K Street, Suite 1700
Sacramento, CA 95814
Tel (925) 906-8216
Cell (916) 605-6736
Crystal.Jack@cigna.com

February 9, 2021

To: Senator Jarrett Keohokalole, Chair
Senator Rosalyn H. Baker, Vice Chair
Members of the Senate Committee on Judiciary

From: Crystal Jack, State Government Affairs

Re: SB 602 – Relating to Pharmacy Benefit Managers
Hearing Date: February 10, 2021 at 1:00 p.m.

Thank you for the opportunity to provide testimony in OPPOSITION to SB 602. Express Scripts, a Cigna company, is one of the leading pharmacy benefit managers ("PBM") in the nation. PBMs are an important part of the delivery of pharmaceuticals in addition to supporting healthcare broadly. Express Scripts is engaged by clients to manage pharmacy benefits pursuant to health insurance contracts. Unfortunately, the contract and pricing restrictions proposed in SB 602 limit a PBM's ability to provide flexibility to clients, price savings to our members, and are unworkable for Cigna's customer-focused operations.

SB 602 seeks to regulate business contracts PBMs have with both their clients, such as employers and health plans, and pharmacies by prohibiting the use of spread pricing arrangements. Spread pricing arrangements are important because they provide health plans with more certainty in their pharmacy expenses and allows them to have a predictable budget. Employers that choose this pricing arrangement do so because it ultimately saves them costs. Taking away this option reduces the flexibility for a plan and ultimately may increase the costs of pharmaceuticals to plan members and employees. Whether or not a health plan chooses to engage in a spread pricing arrangement is the choice of the health plan.

The bill also imposes stringent reporting requirements which includes quarterly reporting of proprietary and confidential information, compromising competition in the future. Public disclosure of rebate information, for example, would likely allow manufacturers to learn the pricing from other manufacturers' products, and allow them to limit pricing concessions, rather than reducing prices. As we have seen repeatedly in the drug pricing market, manufacturers do not "race to the bottom" when setting new pricing but rather it is often a "race to the top" where other drugs follow the newer and higher-priced drug in a particular class upon market entry. Not knowing the rebate information forces manufacturers to provide their best prices or risk losing product market share. In addition, although the bill seeks to protect confidential information under existing Hawaii law, if the information is somehow disclosed it is impossible to "unring" the bell. Contrary to the goals of this bill, the result will be increased costs to consumers. For these reasons we urge the committee to defer SB 602.

Finally, SB 602 imposes several additional "registration" requirements more akin to "licensing" requirements. Under current law, the Insurance Commissioner has jurisdiction and enforcement ability over the pharmacy benefits of insured plans. PBMs are required to comply with the same consumer protections governing utilization review, prior approval, and dispute resolution systems, among others.

Over the past few years, Cigna been working with Hawaii's health insurance plans, PBMs and local pharmacies to address some issues raised about PBMs. We continue to be willing to work together with stakeholders to address these concerns. Thank you for your consideration.

Sincerely,

Crystal Jack
Director, State Government Affairs

SB-602
Submitted on: 2/8/2021 3:22:39 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

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

Comments:

Honorable Senator Keohokalole Chair

Honorable Senator Baker Co-Chair

SB 602

I have been a practiciing Pharmacist in Hawaii more than 30 years. When reading this bill I see many of the methods that pharmacy benefit managers (PBM) use to profit off the community pharmacies in Hawaii and across the nation. The standard approach is to offer a take it or leave it contract with brand medication pricing at or below my cost, (the PBM's know what the community pharmacy pays) and generic drugs paid according to their own MAC, (maximum allowable cost) price. The PBM has complete control over the MAC and can change the MAC price at will. I was being underpaid on over 300 claims per month for the past 5 years. They refuse to play by the rules. PBM's have the power to price pharmacies out of the market and have decreased the number of commuity in Hawaii **BY 50%** in the past 10 years. PBM's use competing pharmacies as a conduit to funnel Hawaii health care dollars to themselves. Community pharmacists in Hawaii beg you to level the playing field so we can remain a resource for our patients.

Aloha and Mahalo,

Kevin Glick, R.Ph.

I, Megan Arbles, Pharmacy Manager at KTA Puainako Pharmacy Hilo, HI strongly Support SB602

Aloha Chair Keohokalole, Chair Baker, and Respected Members of the Committees

A number of local independent pharmacies have been forced to close down or sell to large mainland corporations. The few local independent pharmacies that remain are struggling to survive due to the predatory practices employed by pharmacy benefit managers (PBMs). Pharmacies are being reimbursed below the cost of acquiring certain medications, sometimes losing up to hundreds of dollars per prescription. PBMs determine how much a pharmacy is reimbursed through a Maximum Allowable Cost (MAC) formula and claim that local pharmacies are being reimbursed at a fair price yet they have no way or are not willing to justify the reimbursement rate when questioned. The only recourse a pharmacy has when met with a below cost reimbursement is to submit a MAC appeal to the PBM to request a higher reimbursement or for them to inform us where the medication can be purchased so that a profit can be made. Hundreds of MAC appeals have been submitted with no response from the PBMs or them stating that the reimbursement rate is fair and no adjustments need to be made. Meeting with the PBMs has not done anything to solve this problem and yet local independent pharmacies continue to do everything they can to do the right thing for patients in their communities including dispensing medications at a loss. If the current pharmacy reimbursement model remains the same and the PBMs are not regulated or held accountable, it will only be a matter of time until all local independent pharmacies are forced to close or sell.

The intent of this bill was and still is, to increase transparency and regulation of PBMs for all pharmacies in the State of Hawaii.

I hope the legislature recognizes that independent pharmacy owners and employees are residents of the State of Hawaii and that an independent pharmacy is a local business. By not supporting some form of regulation or accountability for PBMs, you are letting billion dollar national corporations take advantage and shut down local businesses. I humbly request that as legislatures you consider the larger picture and how this affects our state as a whole. PBMs are profiting from local plans, pharmacies, and consumers, where does that revenue go? Does it stay in Hawaii? Do PBMs help our local economy? Or communities? Or residents? Now think about local independent pharmacies that have been here for generations. Do they help our local economy? Our communities? Our residents?

Thank you for the opportunity to provide testimony on SB1521 SD1 HD1.

LATE

Testimony in Support for SB 602

Dear Chair Keohokalole, Vice Chair Baker, and Health Committee Members,

My name is Keri Oyadomari and I am a community pharmacist here in Honolulu. I am testifying my support for SB 602. Pharmacy Benefit Managers currently affect every aspect of a pharmacy's business operations. They work with both pharmacies and insurance providers in determining reimbursements for drugs that are dispensed. Many times, pharmacies are reimbursed below the cost of the drug. The pharmacy may appeal, but most of the time it is denied or ignored. This type of financial strain on pharmacies makes it very difficult to continue to provide free services to the community and in turn impacts access to care in the state of Hawaii. This bill will improve access to consumers, as well as allow retail pharmacies to better care for their patients.

We are asking for your support of SB 602 to create a fair business environment for all Hawaii pharmacies and to help keep our community healthy.

Thank you for the opportunity to testify.

LATE

SB-602
Submitted on: 2/9/2021 11:11:52 PM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
magdi latif	Testifying for bb inc	Support	No

Comments:

Testimony in Support for SB 602 – Relating to Pharmacy Benefit Managers – SAMPLE #1

Dear Chair Keohokalole, Vice Chair Baker, and Health Committee Members:

My name is Magdi Latif and I am a community pharmacy owner in Kilauea, north shore of Kauai. We have been serving the great community in the north shore of Kauai since 1988. We are a family run retail compounding pharmacy.

I am submitting virtual testimony in support for SB 602 – Relating to Pharmacy Benefit Managers.

SB 602 will protect the health of our community by creating safeguards for fair business practices. Pharmacy Benefit Managers (PBMs) are the middle men between insurance plans and community pharmacies. PBMs determine how much an independent pharmacy is reimbursed for dispensing a prescription drugs. Some PBMs also run their own chain and mail order pharmacies, which provides an unfair advantage of knowing how much a plan pays and how much the PBM can reimburse for a drug. Two pharmacies can be right next to each other. One can make a profit and the other may be reimbursed at below cost because the PBMs know what the community pharmacies pay for their drugs. The PBMs also tell the community pharmacies what is the maximum allowable cost (MAC) price for generics. PBMs have full control over MAC drug pricing and can change the MAC drug list anytime without notice.

In 2020, my pharmacy was underpaid on over 300 claims. We are mandated by our unfair contracts that requires us to dispense at a loss and ask for a review that never gets resolved.

SB 602 will also manage PBMs from engaging in self-serving or deceptive business practices; unfair methods of competition; unfair practices; retaining any portion of spread pricing; and reimbursing a 340B pharmacy differently than any other network pharmacy.

Finally, SB 602 will also require mainland-headquartered pharmacy benefit managers (PBMs) to register in the State of Hawaii to manage its business in Hawaii. This bill will also require reporting to the Legislature. Currently, these Fortune 1000 companies are allowed to run their businesses with very little oversight.

We are asking for your support of SB 602 to create a fair business environment for all Hawaii pharmacies and to help keep our community healthy. Without small businesses such as Hawaii's community pharmacies in business, Hawaii will continue to syphon profits and taxes to mainland corporations rather than keep the funds in Hawaii. We employ 15 people at our store, they depend on us succeeding to maintain their livelihood and we are depending on you to help level the playing field so we can stay in active in our community and provide the personal service our community deserves to have

Sincerely,

Magdi Latif

NorthShore Pharmacy

2460 Oka st #100, Kilauea, HI 96754

808-828-1844

LATE

February 10, 2021

The Honorable Jarrett Keohokalole
Chair, Senate Committee on Health
415 South Beretania Street
Honolulu, HI 96813

RE: NATIONAL COMMUNITY PHARMACISTS ASSOCIATION SUPPORT OF SB 602

Dear Chair Keohokalole and members Senate Health Committee:

I am writing on behalf of the National Community Pharmacists Association in support of SB 602, which will bring transparency to prescriptions drug costs and protect patient access to community pharmacy services in Hawaii.

NCPA represents the interest of America's community pharmacists, including the owners of more than 21,000 independent community pharmacies across the United States and 61 independent community pharmacies in Hawaii. These Hawaii pharmacies filled over 3.5 million prescriptions last year, impacting the lives of thousands of patients in your state.

SB 602 would help to bring transparency to the factors that have been driving up prescription drug costs. Pharmacy benefit managers (PBMs) engage in opaque, anticompetitive practices that raise costs for patients and threaten access to community pharmacy services. As a state-commissioned study from New York found, "PBMs often employ controversial utilization and management tools to generate revenue for themselves in a way that is detrimental to health plan sponsors, patients, and pharmacies."[1]

One practice that generates revenue for PBMs to the detriment of patients and plan sponsors is known as "patient steering." Patients are often forced, either through mandates or coercive copays, to use a particular PBM-owned pharmacy. Not only does this practice remove the patient's authority to choose a provider he or she trusts, but the PBM-owned pharmacies often cost more than non-affiliated pharmacies. An audit of Florida's Medicaid program found that PBMs steered patients to PBM/MCO-owned pharmacies that charged more, on average, to fill generic specialty prescriptions than non-affiliated pharmacies, leading to increased costs for the state as the plan sponsor.[2] SB 602 would help put an end to this costly practice and give Hawaii residents greater authority over their healthcare decisions.

SB 602 would also put an end to spread pricing, in which a PBM reimburses a pharmacy at one rate for filling a prescription and charges the plan sponsor a higher rate for administering the claim. States that have looked into their own prescription drug benefit plans have found

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

[2] Milliman, *Florida Agency for Health Care Administration: Pharmacy Benefit Manager Pricing Practices in Statewide Medicaid Managed Care Program* (Dec. 2020).

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

tremendous amounts of money going to PBMs through this practice: $224 million in Ohio, $123.5 million in Kentucky, and $90 million in Florida.[3] By prohibiting this practice, SB 602 would help patients and plan sponsors save money on their prescription drug benefit programs.

SB 602 would also require PBMs to file annual transparency reports, which will help the state identify additional practices that threaten patient access to community pharmacy services. Opaque PBM practices are currently working to severely limit access to community pharmacies. A study by the Rural Policy Research Institute found that under-reimbursements led to the closure of 1,231 independent pharmacies in rural areas between 2003 and 2018. As a result, 630 rural communities nationwide that had at least one retail pharmacy in 2003 had **zero** retail pharmacies in 2018.[4] The situation is no better in urban areas; between 2009 and 2015, 1 in 8 pharmacies closed as a result of under reimbursements, disproportionately affecting independent pharmacies and low-income neighborhoods. Hawaii has lost more than 35% of its independent pharmacies since 2010. These pharmacy closures "are associated with nonadherence to prescription medications, and declines in adherence are worse in patients using independent pharmacies that subsequently closed."[5] PBM transparency is necessary to end the games that lead to pharmacy closures and threaten patient health in Hawaii.

For these reasons, NCPA respectfully requests your support of SB 602. If you have any questions about the information contained in this letter or wish to discuss the issue in greater detail, please do not hesitate to contact me at matthew.magner@ncpa.org or (703) 600-1186.

Sincerely,

Matthew Magner
Director, State Government Affairs

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[3] Auditor of State of Ohio, *Auditor's Report: Pharmacy Benefit Managers Take Fees of 31% on Generic Drugs Worth $208M in One-Year Period*, (Aug. 16, 2018) https://ohioauditor.gov/news/pressreleases/Details/5042. Kentucky Department for Medicaid Services, *Medicaid Pharmacy Pricing: Opening the Black Box* 5, 8 (Feb. 19, 2019), https://chfs.ky.gov/agencies/ohda/Documents1/CHFS_Medicaid_Pharmacy_Pricing.pdf. Kentucky Attorney General, *Beshear Launches Investigation into Inflated Prescription Drug Prices*, (Mar. 21, 2019), https://kentucky.gov/Pages/Activity-stream.aspx?n=AttorneyGeneral&prId=739. Milliman, *supra* note 2.

[4] Abiodun Salako, Fred Ullrich & Keith Mueller, *Update: Independently Owned Pharmacy Closures in Rural America, 2003-2018*, RUPRI Center for Rural Health Policy Analysis, July 2018, Rural Policy Brief No. 2018-2, *available at* https://rupri.public-health.uiowa.edu/publications/policybriefs/2018/2018%20Pharmacy%20Closures.pdf.

[5] Jenny S. Guadamuz, G. Caleb Alexander, Shannon N. Zenk & Dima M. Qato, *Assessment of Pharmacy Closures in the United States From 2009 Through 2015*, JAMA Internal Medicine, Oct. 21, 2019, www.jamainternalmedicine.com.

LATE

February 10, 2021

Testimony in Support for SB 602 – Relating to Pharmacy Benefit Managers

Dear Chair Keohokalole, Vice-Chair Baker, and Health Committee Members:

My name is Judith Mikami, and I am a life-long resident of Molokai and have grown up with our community independent pharmacy, Molokai Drugs, Inc. It is a family-run business in its third generation; Molokai Drugs celebrated its 85th year as a community pharmacy last year, 2020.

I am in support of SB 602 that will manage PBMs from engaging in self-serving or deceptive business practices; unfair methods of competition; unfair practices; retaining any portion of spread pricing; and reimbursing a 340B pharmacy differently than any other network pharmacy.

Every year, our independent pharmacy is required to file an annual report with the State of Hawaii to do business in our state. SB 602 will also require the same—mainland-headquartered pharmacy benefit managers (PBMs) to register in the State of Hawaii to manage its business in Hawaii. This bill will also require reporting to the Legislature. Currently, these Fortune 1000 companies are allowed to run their businesses with very little oversight.

We are asking for your support of SB 602 to create a fair business environment for all Hawaii pharmacies and to help keep our community healthy. Without small businesses such as Hawaii's community pharmacies in business, Hawaii will continue to syphon profits and taxes to mainland corporations rather than keep the funds in Hawaii.

With much aloha,

Judith Mikami
Testifying for Molokai Drugs, Inc.
P. O. Box 558
28 Kamoi Street
Kaunakakai, HI 96748-0558
(808) 658-0710

LATE

Testimony in Support for SB 602 – Relating to Pharmacy Benefit Managers

Dear Chair Keohokalole, Vice Chair Baker, and Health Committee Members:

My name is Larry Tong and I am a Pharmacist in Oahu. I have been practicing pharmacy in Hawaii since 1982.

I am submitting virtual testimony in support for SB 602 – Relating to Pharmacy Benefit Managers.

I am writing in support of SB 602 that will protect the health of our community pharmacies and help bring transparency to prescription drug cost via the PBM's. The PBM's have utilized and masterly made it to generate revenue.

In 2020, one of my pharmacies was underpaid on 5481 claims.

This will be a slow death to the small community pharmacies. We are aware of the present day situation. I am asking for fairness.

Sincerely,
Larry Tong
Pharmacy Director
Don Quijote Drugs
801 Kaheka St
Honolulu, Hawaii 96814
808 973-6663

LATE

SB-602
Submitted on: 2/10/2021 11:21:56 AM
Testimony for HTH on 2/10/2021 1:00:00 PM

Submitted By	Organization	Testifier Position	Present at Hearing
Ashok Kota	Testifying for Foodland Pharmacies	Support	No

Comments:

I am writing to you on behalf of Foodland Pharmacies in support of SB602, which would help control drug costs in Hawaii, provide greater protections for patients regarding their prescription drug benefits programs, and provide greater oversight over the pharmacy benefit managers (PBMs) that administer those benefits.

Community pharmacies have long been concerned with PBMs operating as largely unregulated middlemen in the drug supply chain. While PBMs claim to keep drug costs low, we believe PBM practices are often anti-competitive and ultimately drive up healthcare costs for consumers and plan sponsors while reducing payments to pharmacies. PBMs determine which pharmacies patients may choose by creating provider networks, determine which drugs patients can be prescribed by creating drug formularies, and determine how much patients pay at the pharmacy counter for their medications. The patient's choice of pharmacy should be left to the patient and is informed by what's in the patient's best interest, instead of what's in the PBM's best interest. Despite their authority over patients' health care options, PBMs enjoy little regulatory oversight by the state.

There is little to no standardization in the industry for the criteria or the methodology used by PBMs to determine prescription drug reimbursement rates. This gives PBMs the ability to gain significant revenues through questionable business practices at the expense of patients, pharmacies, and plan sponsors.

To protect local businesses and patient access to vital Pharmacy services, we respectfully request your support SB602