Approved: March 20, 2003
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Patricia Barbieri-Lightner at 3:30 on February 25, 2003 in Room 527-S of the Capitol.

All members were present.

Committee staff present: Bill Wolff, Legislative Research
Ken Wilke, Revisor of Statutes
Renae Hansen, Secretary

Conferees appearing before the committee: **Bob Williams**, Executive Director, Kansas Pharmacists Association
Bob Alderson, representing Kansas Pharmacists Association
William Sneed, Legislative Council, PBM coalition Group
Larry Magill, representing Kansas Association of Insurance Agents

Others attending: 22 others including those who signed the register.

Hearing on:

HB 2392- Pharmacy benefit management companies; registration of.

Proponents:

Bob Williams, Executive Director, Kansas Pharmacists Association, (Attachment #1), presented testimony to describe why Kansans need **HB 2392.** Currently there are no repercussions for pharmacy benefit management companies for not registering with the state, even though they are required to do so. Only four of the thirty plus doing business in the state are registered.

Questions were posed by: Representatives Mario Goico and Stanley Dreher.

Bob Alderson, representing Kansas Pharmacists Association, (Attachment #2), explained point by point the language of **HB 2392.** Believes this is a good first step towards regulating Pharmacy Benefit Management Companies.

Questions were posed by: Representatives Scott Schwab, Patricia Barbieri-Lightner, and Ray Cox.

Opponents:

William Sneed, Legislative Council, PBM coalition Group, (Attachment #3), presented testimony that explains why this bill is just adding more regulation to business and is not needed.

Questions were posed by: Representatives Mario Goico, Scott Schwab, Patricia Barbieri-Lightner, and Nancy Kirk.

The hearing was closed.

The committee then chose to work:

HB 2233 - Enacting the Uniform Prescription Drug Information Card Act.

An amendment was presented by Brad Smoot, and explained by Ken Wilke and it was explained by Bob Alderson that Representative Deena Horst saw this amendment and was in favor of the changes that helped to combine **HB2268** and **HB 2233.**

Representative Bob Grant moved to adopt the amendments to **HB2233** , seconded by Representative Ray Cox, passed unanimously.

A question was posed by Representative David Huff.

Representative Scott Schwab moved to pass **HB 2233** favorably out of committee as amended, seconded by Representative Cindy Neighbor, passed unanimously.

It was recommended that Representative Scott Schwab carry this bill to the floor of the Kansas House of Representatives.

HB 2232 - Insurance; informal deductible for certain medical claims under workers compensation.

An amendment was presented by Larry Magill, representing Kansas Association of Insurance Agents, (Attachment #4). Also reminded everyone that a fiscal note was passed out on this bill.

Concerns were expressed by: Representative Nancy Kirk, and Ray Cox.

Representative Bob Grant moved to table the bill and that it be looked at by the Workers Compensation Advisory Board, seconded by Representative Ray Cox, passed unanimously.

HB 2392 - Pharmacy benefit management companies; registration of.

Representative Nile Dillmore moved to recommend **HB2392** favorably out of committee, seconded by Representative Nancy Kirk.

Discussion was posed by: Representative Scott Schwab, Ray Cox, and Mario Goico.

Representative Nancy Kirk moved to table **HB 2392**, seconded by Representative Scott Schwab, passed unanimously.

HB 2069 - Insurance coverage for expense of participating in clinical trials.

Representative Nancy Kirk presented some amendments for **HB 2069.**

Representative Cindy Neighbors moved to adopt the amendments presented, seconded by Representative Eber Phelps.

Discussion was offered by: Representatives Stephanie Sharp, Mario Goico, and Nile Dilmore.

Motion passed unanimously.

It was noted that the bill would be asked to be looked at in an interim committee, if funding allowed.

Representative Bob Grant moved to approve the minutes from January 30, February 4, and February 6, 2003, seconded by Representative Stephanie Sharp, passed unanimously.

Meeting Adjourned.

Next Meeting after turn around yet to be scheduled.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: February 25, 2003

NAME	REPRESENTING
Michelle Hamilton	Intern - Rep. B. Sharp
John Koelliff	Intern - Rep. Yoder
John Woods	Intern - Schodorf
Vickie Thomas, RN	National Patient Advocate Foundation
Sharon Roeder, CPC	National Patient Advocate Foundation
Bill Sneed	PBM Coalition
Rebecca Tepick	Federico Consulting
Celia Boyne-Schuh LMSW	Natl. Patient Advocate Foundation
John Federico	Humana
BOB Kuhn	Natl Patient Advocate Foundation
Ryan Schenk	KPhA

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Attachment # 1

TESTIMONY

House Committee on Insurance
February 25, 2003

HB 2392

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for this opportunity to address the Committee regarding HB 2392.

HB 2392 will require the registration of pharmacy benefits management companies (PBMs) with the Kansas Insurance Department. The definition of a PBM is identified on page one, lines 39-43 and line one of page two. The first operating plan filed by a PBM with the Antitrust Division of the Department of Justice was the Pharmaceutical Card System, Inc. (PCS) in 1969. At that time PBMs simply served as information clearing houses for health plan payors and pharmacy providers. The average prescription price was $5 and insurance played a small part of a pharmacies business. Back then, with PBMs nothing more than subcontractors of third parties, oversight of PBMs by insurance departments was provided via oversight of the third party with whom they contract.

Over the years, PBMs have grown into a multi-billion dollar business with insurance companies, HMOs and other third parties contracting with them to manage their drug benefit plans. More recently, PBMs have begun to contract directly with employer groups, bypassing the third party "middle man". (For example, the State of Kansas contracts directly with a PBM to administer the state's drug benefit program.) The shift to direct contracting has resulted in the need to provide direct oversight of PBMs by

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the Kansas Insurance Department. Kansas does have a statute which requires Third Party Administrators (TPAs) which includes PBMs to register with the Insurance Department. Unfortunately, there is no penalty provision for not registering. There are at least thirty PBMs doing business in Kansas and we are not aware of any who have registered with the Insurance Department.

Today's PBMs perform a variety of cost-cutting services for health plans. They operate mail-order pharmacies and they develop pharmacy networks. However, their most important function is to decide which drugs a health plan will pay for and which it will not. These lists of approved drugs–known as formularies – are highly controversial. Many formularies are now "closed" meaning that a doctor must prescribe from a narrow range of medications selected by the PBM. Formularies are not new, hospitals have been using them for years. However, in the hospital, drugs are selected based on sound therapeutic decisions. Increasingly, according to an article in the September, 1997 issue of *U.S. News and World Report*, with PBMs "...what drug ends up on what formulary-- and at what price-- frequently depends on how lucrative a deal the PBM has struck with a drug company."

In 1998 a 73 page report was filed by the Public Advocate for the City of New York. According to the report, therapeutic substitutions by PBMs were driven by cost, not care, and were endangering patients. West Virginia's attorney general has sued Merck & Co. and its Medco Health Solutions PBM subsidiary, charging that Merck and Medco steered state employees to higher-priced drugs, including Merck products and kept rebates from drug companies that should have been passed on to the state. In December, 2002, Merck- Medco agreed to pay $42.5 million to settle a long-running class-action lawsuits brought by several former clients. Apparently, Medco held back from certain clients for which it served as the PBM, $2.85 billion in incentive rebates from 1995 to 1999 and $1.29 billion more in other rebates and various fees.

AARP is suing Advance PCS because it claims that Advance PCS illegitimately kept their Cash Discount Card (100 per cent copay) business after AARP moved to Express Scripts as their claims processor.

In the summer of 1997 Blue Cross Blue Shield of Kansas changed PBMs to PAID Prescriptions, a division of Merck-Medco Managed Care. For several months thereafter, PAID failed to download into its computer system maximum allowable cost (MAC) pricing for generic drugs. Consequently, in those months the PBM offered pharmacists a slightly better reimbursement for those drugs. When PAID discovered its error it subtracted the overpaid amounts, up to $15,000 for one pharmacy, from each pharmacy's reimbursement checks. Even though the mistake was made by PAID.

The Philadelphia U.S. Attorney's office has been involved in an investigation of PBM practices for the past four years. According to court documents, the U.S. Attorney's office declared an interest in "...investigating AdvancePCS's drug switching programs and its financial relationships with drug manufacturers, including its solicitation and receipt of rebates and secret payments for putting certain brand name drugs on AdvancePCS' preferred drug formularies."

These are but a few of the problems involving PBMs. KPhA does not want to give the impression that all PBMs are bad or that PBMs do not provide a valuable service. Indeed they do. However, given the increased reliance on PBMs to provide drug benefits to the citizens of Kansas, KPhA believes it is only reasonable to provide those citizens the same protection as is provided by the Insurance Department for health insurance companies, HMOs and other managed care entities.

Thank you.

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OF COUNSEL:
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THOMAS C. HENDERSON

*LL.M., TAXATION
**LICENSED TO PRACTICE IN KANSAS AND MISSOURI

TESTIMONY OF BOB ALDERSON

ON BEHALF OF THE

KANSAS PHARMACISTS ASSOCIATION

BEFORE THE HOUSE COMMITTEE ON INSURANCE

February 25, 2003

Chair Barbieri-Lightner and Members of the Committee:

I am Bob Alderson, an attorney in private practice in Topeka. I am appearing today on behalf of the Kansas Pharmacists Association (KPhA) in support of House Bill No. 2392. The purpose of HB 2392 is to provide regulatory oversight of Pharmacy Benefits Managers ("PBM's").

Last week, I testified before you in support of HB 2233, the bill that would provide for a uniform prescription drug card. My testimony focused primarily on that bill's application to PBM's. I included with my written testimony a copy of the letter to me from Topeka attorney, Dick Hay, advising of his opinion that ERISA (Employee Retirement Income Security Act of 1974) would not be implicated by extending the reach of HB 2233 to PBM's. In some respects, HB 2392 complements HB 2233. By providing regulatory oversight of PBM's, implementation of HB 2233 will be facilitated.

Although there are statutes currently in place (K.S.A. 40-3801 *et seq.*) requiring the registration of third-party administrators (TPA's) with the Commissioner of Insurance, they are not broad enough in scope to have application to all PBM's, and they do not provide the Commissioner with sufficient authority to enforce compliance with the

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registration requirements and the other substantive provisions of these statutes. Thus, absent additional statutory provisions enabling regulatory oversight of PBM's, the provisions of HB 2233 may not be as effective as they should be.

I should note that, in the summer of 2001, the National Community Pharmacists Association (NCPA) published its PBM Model Regulation Act. Subsequently, the National Association of Chain Drug Stores (NACDS) and other national organizations published their versions of the model bill to regulate PBM's. In addition, several states, including Georgia and Arkansas, have enacted laws regulating PBM's. These legislative proposals and enactments clearly indicate a nationwide interest in regulating PBM's.

Bob Williams, KPhA's Executive Director, and I reviewed these various model bills and enactments as potential models to use for developing legislation in Kansas. However, for the most part, KPhA believes that these other measures are too broad for our purposes at this point in time. KPhA believes that attempting to enact a very complicated, comprehensive legislative measure to regulate PBM's is too ambitious an undertaking at this point. While expanded regulation of PBM's might be warranted in future years, KPhA believes that there are certain essential legislative measures which need to be enacted first before considering comprehensive regulation.

Initially, I would note that we believe the legislation should vest regulatory oversight with the Commissioner of Insurance. This conclusion is prompted in part by the fact that the current statutes regulating TPA's are administered by the Commissioner. PBM's are, for the most part, TPA's within the meaning of those statutes. In many instances, PBM's contract with health insurers and HMO's, and both of these groups are regulated by the Commissioner. For these reasons, it seems appropriate to charge the Commissioner of Insurance with the regulatory oversight of PBM's. That is accomplished by HB 2392.

As far as the scope of regulation to be effected, we believe the bill should focus principally on two areas: Enforceable registration of all PBM's and consumer protection. As noted previously, the existing law pertaining to TPA's would include many PBM's, but probably not all. It requires registration of TPA's, but we are aware that very few PBM's have registered. In prior years, we have visited with personnel in the Kansas Insurance Department regarding the obvious noncompliance with this law, and on one occasion we provided them with the names and addresses of PBM's we knew were doing business in this state but had not registered. I

know that the Department contacted most (if not all) of the PBM's on that list, to advise of their need to register pursuant to the current law, but those efforts bore little fruit. The current law does not impose penalties for a PBM doing business in Kansas without registering and does not otherwise provide any enforcement mechanism; thus, absent any statutory sanctions or enforcement tools, it is unlikely that significant compliance with registration requirements will be achieved.

Therefore, first and foremost, we believe that PBM regulatory oversight legislation should contain enforceable registration requirements. Registration should be a condition precedent to a PBM doing business or continuing to do business in Kansas. Sections 2 through 5, collectively, of HB 2392 provide for the enforceable registration of PBM's, to satisfy our primary objective in proposing this legislation.

Pursuant to Section 2, a PBM doing business in Kansas must obtain a certificate of authority. That section sets forth the requirements for an application for such certificate of authority. It also provides for annual renewal of the certificate of authority, and both the original application and renewal application must be accompanied by a non-refundable fee of $500. The language in Section 2 is derived from provisions of the various model acts and legislation in other states.

Notice of the Insurance Commissioner's action with respect to an application or renewal application must be provided within 60 days of the filing of the application, as provided in Section 3. The language of this section was patterned after the provisions of K.S.A. 40-3204, a section of the Health Maintenance Organization Act.

Section 4 relates to the suspension or revocation of a certificate of authority. The provisions of subsection (a) of this section, itemizing the findings necessary for the Commissioner to suspend or revoke a certificate of authority, also were derived from provisions of various model acts and state legislation. However, subsections (b) and (c) are patterned after comparable provisions in the Insurance Code (K.S.A. 40-2,125), and authorize the Commissioner to impose monetary penalties for various violations.

Subsection (a) of Section 5 sets forth the procedure for the suspension or revocation of a certificate of authority, and subsection (b) concerns the procedure to be followed by a PBM whose certificate of authority is revoked pursuant to this section. It should be noted that subsection (b) also provides that, after one year following the revocation, a PBM may apply

for reinstatement and issuance of a new certificate of authority. This section is patterned after another section of the HMO Act (K.S.A. 40-3207).

We believe the other important area to address in any PBM regulatory oversight legislation at this time is consumer protection. To that end, Section 6 requires a PBM to have a grievance procedure whereby enrollees of a health benefit plan will have a method for resolving their grievances. The provisions of this section were patterned substantially after the grievance procedure set forth in the HMO Act (K.S.A. 40-3228).

KPhA believes that HB 2392 is a good first step in providing regulatory oversight of PBM's. It will provide for the enforceable registration of PBM's, and it will afford enrollees of health plans a procedure for pursuing their grievances. KPhA respectfully requests that the Committee recommend HB 2392 favorable for passage.

I appreciate the opportunity to present this matter to the Committee, and I will try to answer any questions members of the Committee may have.

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Memorandum

House Insurance
Date: 2/25/03
Attachment # 3

TO: THE HONORABLE PATRICIA BARBIERI- LIGHTNER, CHAIR
HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
PBM COALITION GROUP

RE: HOUSE BILL 2392

DATE: FEBRUARY 25, 2003

Madame Chair, Members of the Committee: My name is Bill Sneed and I represent the PBM Coalition Group ("PBM Coalition"). We appreciate the opportunity to appear in opposition of HB 2392. Our Coalition is comprised of four of the major pharmacy benefits management companies in the United States. They are AdvancePCS, Caremark RX, Medco Health Solutions, Inc., and Express-Scripts. All of these companies have been actively involved working with a variety of groups and governments relative to the regulation of PBM's. We appreciate the opportunity to present information regarding our business to the House Insurance Committee as reflected in HB 2392.

Pharmacy benefit management companies or PBM's are entities who, on behalf of health benefit plans employers, unions and governmental entities, provide a variety of services for those plans.

The first important detail to point out is that my clients simply provide services to these health plans. These are health plans designed by employers, unions and governmental entities, and my clients simply implement those plans and thus are not "PBM" plans but simply plans by the underlying entity that we help service. There are a variety of reasons why PBM's are utilized.

In a January 2003 GAO Report on Federal Employees Health Benefits: affects of using pharmacy benefits managers on health plans, enrollees and pharmacies, the GAO conclusions were "PBM's are central to most FEHBP plan efforts to manage their prescription drugs, and PBM's have helped the FEHBP plans we reviewed reduce what they would likely otherwise pay in prescription drug expenditures while generally maintaining wide excess to most retail pharmacies and drugs". Attached to my testimony is a summary of the GAO conclusions and specific reference to a variety of benefits pointed out in the GAO Report.

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Next, I have attached a white paper that was a part of a report by Kelli Back and Mark S. Joffe, entitled "The Regulation of Pharmacy Benefit Management Companies 2002". As a part of full disclosure, three of my member companies sponsored and funded the report. However, it is our contention that this report coincides with the findings that are enumerated in the GAO Report.

As we have reviewed HB 2392, it is unclear to us what problem the bill seeks to resolve outside creating an additional layer of government regulation. We are unaware of any evidence that there is a consumer protection problem with respect to PBM activities that is not already addressed in existing laws and regulations. In fact, HB 2392 overlooks the fact that PBM activities are already subject to extensive regulation on both the state and federal level.

At a time when employers are struggling to afford the prescription drug benefit, we contend that it is inappropriate to increase the cost of administrating the benefit by adding unnecessary and potentially duplicative regulation. In the absence of specific problems that are not already addressed in current laws and regulations, we do not believe that it is justifiable to impose additional layers of regulation. It is our contention that this will simply increase the cost of prescription drug benefit for employers and consumers.

We appreciate the opportunity to present our testimony to the Committee. Based upon the foregoing, we respectfully request that the Committee not act on HB 2392. We will make ourselves available for any questions in the future.

Respectfully submitted,

William W. Sneed

WWS:pmk

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PBM ACTIVITIES ALREADY APPROPRIATELY REGULATED

Additional State Licensure Requirements Would Be Duplicative, Inappropriate and Costly

PBMs perform an important role in our nation's health care system

Pharmacy benefit management companies (PBMs) play a unique role in uniting health plans, employers, physicians, pharmacists and consumers to help improve the overall quality of health care in America. Since they were established more than 30 years ago, PBMs have continued to demonstrate their value in providing consumers with a single source of information about safe and effective prescription drug use while containing costs of prescription drug benefits for employers and other health plan sponsors, including Medicare and Medicaid. Today, more than 150 million Americans receive coverage for their prescription medications through PBMs, which have evolved into complex entities that provide an array of comprehensive services designed to improve the value of pharmaceutical benefits.

As the number of Americans with prescription drug coverage through PBMs has grown so, too, has the amount of federal and state legislation regulating the industry. However, a narrow segment of the health care marketplace, primarily concerned with protecting its own economic interests, has suggested that additional state licensure and regulation of PBMs is needed to protect consumer interests.

PBMs are already subject to extensive regulation

To assess the wisdom and value of further regulation, a recent comprehensive review of federal and state laws governing how PBMs carry out their activities identified four federal agencies and, typically, at least three agencies in every state that are responsible for regulating the services performed by PBMs, including:

- U.S. Department of Health and Human Services;
- Centers for Medicare & Medicaid Services;
- U.S. Department of Labor;
- Federal Trade Commission;
- State departments of insurance or related agencies;
- State boards of pharmacy; and
- State Medicaid agencies.

In some states, PBM activities also are regulated by such entities as departments of health, consumer protection agencies, and personnel departments if state employees are covered under a PBM. And other federal agencies, including the Department of Justice as well as the Drug Enforcement Agency and Food and Drug Administration, play a role in regulating PBM activities.* The chart on the next page provides more details of these regulations.

Continued

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*Back, Kelli, J.D., and Mark S. Joffe, J.D., of the Law Offices of Mark S. Joffe, *The Regulation of Pharmacy Benefit Management Companies*, 2002. This white paper and issue brief were sponsored and funded by AdvancePCS, Caremark Rx, Inc., and Express Scripts, Inc. Copies of the full report are available through these companies.

PBM Activity	State Regulation	Federal Regulation
Claims processing and payment	Directly through licensure or certification requirements as TPA, PPO and/or URO; indirectly through prompt pay laws and other requirements on insurers or HMOs.	Indirectly through requirements on employer-sponsored ERISA plans; Medicare and Medicaid laws set standards for timely payment by Medicare+Choice organizations and Medicaid programs and managed care organizations.
Coverage decisions, utilization review (UR) and appeals	Directly through licensure or certification requirements as TPA, PPO or URO; indirectly through requirements on insurers or HMOs such as notification timeframes, clinical review documentation, telephone access standards, reviewer qualifications, and independent external review.	Indirectly through Department of Labor regulations governing notification and timeliness of benefit decisions and appeals by employer-sponsored ERISA plans; Medicare law governing UR decision-making including reconsiderations and outside review of appeals for Medicare+Choice organizations, and similar requirements for Medicaid programs and managed care organizations.
Consumer complaint process	Directly if licensed as PPO; indirectly through requirements on HMOs to resolve complaints in a timely manner and consider complaints specifically regarding prescription drug benefits.	Indirectly through Medicare law requirements on Medicare+Choice organizations' procedures for reviewing and resolving member complaints; Medicaid law requires similar process.
Formulary and prescription drug benefit management	Indirectly through requirements on HMOs and Medicaid managed care organizations regarding formulary development, revisions, exceptions and coverage information disclosure.	Indirectly through requirements on employer-sponsored ERISA plans for disclosing information about coverage; Medicare law requiring Medicare+Choice organizations to disclose information about formulary decision-making.
Pharmacy services	Direct regulation through licensure or registration of resident or non-resident mail order pharmacies, governing issues such as prescription drug dispensing and labeling, patient counseling, and generic substitution.	Directly through Drug Enforcement Agency oversight of dispensing of controlled substances and Food and Drug Administration regulations governing prescription drug labeling and patient information; indirectly through federal Medicaid law requiring counseling for patients in Medicaid managed care organizations.
Access to providers and network management	Directly if licensed as PPO; indirectly through requirements for network development and adequacy under HMO or Medicaid managed care organization.	Indirectly through Medicare law requirements on Medicare+Choice organizations to provide timely access and have policies and procedures for selection and evaluation of providers; Medicaid law requirements to maintain timeliness and continuity of care for Medicaid managed care organizations.
Quality assurance and drug utilization review	Directly when licensed as TPA, PPO or URO; directly when PBMs contract with state Medicaid programs, such as requirements to identify inappropriate patterns of drugs use and prescribing; indirectly under licensure requirements for HMOs and other managed care plans, such as evaluating quality of services.	Medicare law requires Medicare+Choice organizations to measure and engage in performance review and improvement projects; Federal Medicaid law requires state Medicaid managed care organizations to develop and implement a quality improvement strategy.
Negotiations with drug manufacturers	Directly through state laws prohibiting kickbacks in exchange for referrals to particular provider or for service.	Indirectly through anti-kickback laws covering Medicare, Medicaid, CHAMPUS, and the State Children's Health Insurance Program as well as Civil False Claims Act provisions.
Fair trade	Directly through consumer protection and fair business practices laws; indirectly through HMO or insurer on whose behalf PBM provides services.	Directly through Federal Trade Commission regulation of mail order pharmacies' advertising, stocking, supply and order filling practices.
Confidentiality and security of health care information	Directly through state laws imposing confidentiality obligations under licensure requirements as TPA, URO and/or pharmacy; indirectly through requirements on HMOs, health insurer or other health care provider.	HIPAA directly sets standards governing protected information handled by mail order pharmacies and indirectly imposes similar requirements on PBMs through their business relationships with HMOs, insurers and employer group health plans; federal law imposes requirements on Medicare+Choice plans and state Medicaid managed care programs.

PBMs are regulated according to activities they perform and populations they serve

PBMs are directly regulated at the state level in their capacity as licensed, certified or registered entities, such as resident or non-resident pharmacies or as third party administrators (TPAs), preferred provider organizations (PPOs), and/or utilization review organizations (UROs). In addition, they are regulated indirectly through their contractual compliance with state and federal requirements imposed on insurers, HMOs and employer-sponsored ERISA plans on whose behalf PBMs provide services.

In pursuing their goal of optimal and cost-effective drug prescribing and use, PBMs perform four defining functions: claims processing; pharmacy network management; formulary development and management; and price negotiations with manufacturers, wholesalers and retail pharmacies. Each of these primary functions—as well as more discrete elements within or across them—is regulated either directly or indirectly under state and federal requirements based on the population served, as indicated in the following table.

Additional state licensure requirements are unnecessary and inappropriate

This complex web of regulations governing PBM activities ensures appropriate and substantial safeguards for consumers. Attempts to protect the economic self-interests of independent retail pharmacies under the guise of additional PBM state licensure would be duplicative, inappropriate and costly both for PBMs working to contain costs and for states struggling with budget constraints. Further, no single regulatory entity has the statutory scope or expertise necessary to effectively and appropriately oversee the array of services provided by PBMs.

- **Cost savings would be eroded.** Given that many PBMs provide services to health plan sponsors operating in more than one state, the complexity of compliance with additional regulations would unnecessarily raise operating costs for PBMs and reduce cost savings for consumers, employers and other purchasers, including state governments providing pharmacy benefit coverage for their employees and Medicaid beneficiaries.

- **Financial risks are already regulated.** PBMs already are licensed as TPAs, PPOs, and/or UROs where required by law. PBMs do not need to meet additional state licensure requirements as insurance companies because they do not accept insurance risk; instead, they administer pharmacy benefits at the direction of insurers and HMOs, which already are licensed by state departments of insurance and carry fiduciary responsibility for any functions they delegate.

- **Additional regulation by state pharmacy boards would exceed their scope of expertise.** Current regulation of PBM mail order pharmacies by state boards of pharmacy already covers critical pharmacy services, including prescription drug dispensing and labeling, patient counseling, generic substitutions and controlled substances. Subjecting PBMs to additional licensure requirements by state boards of pharmacy would be inappropriate because these entities are not qualified to oversee benefits management, which is already regulated by state insurance departments and similar regulatory agencies nationwide.

- **Granting pharmacy boards power to review PBM contracts could lead to anticompetitive behavior.** Granting pharmacy boards the authority to regulate business relationships between PBMs and retail pharmacies would create conflicts of interest that could result in anticompetitive behavior and price fixing, as retail pharmacies would then be in a position to dictate the terms of their contractual negotiations as a matter of law.

Appropriate regulation already exists to ensure that PBMs are accountable to protect consumer interests. No clear case can be made for imposing additional regulations and costs that will ultimately harm consumers while only serving to protect the economic self-interests of competing entities

Kansas Association of Insurance Agents

KAIA

Independent Insurance Agent.

Trusted Choice
We serve you first.

House Insurance
Date: 2/25/03
Attachment # 4

February 24, 2003

Honorable Patricia Barbieri-Lightner, Chair
House Insurance Committee
Kansas House of Representatives
State Capitol Building
Topeka, Kansas 66612

Re: HB 2232 "Informal" Workers Compensation Deductible

Dear Trisha:

Thank you very much for providing a hearing on HB 2232, KAIA's "informal" workers compensation deductible proposal last Thursday, February 20th. I would like to address with you and the members of your Committee some of the concerns raised by other conferees. My members firmly believe that this is an extremely valuable tool for small businesses to manage their workers compensation costs.

Clearly the acting Director of the Division of Workers Compensation's fiscal note is alarming in these tight budget times. **We propose on the attached balloon to strike the requirement that businesses report the amounts paid under the "informal" deductible, which should completely eliminate the fiscal note.** As the Director testified, the way the assessment for the workers compensation division works, they collect paid claim data from insurance companies, self-insureds and pools and then calculate the percentage they must charge to collect enough to cover their budget. Then they bill that amount to these three groups. Businesses who are using an "informal" deductible system now are not reporting and the system is working fine. We don't anticipate that there will be a significant increase in the number of firms using this technique in the future, but the ones that find it helpful will continue. This should also eliminate the Kansas Insurance Department's fiscal note for possible assessments of the second injury fund.

As Acting Director Harness mentioned, most of them would probably owe less than $10 and the Division does not bill for that small an amount anyway.

We are also proposing on the attached balloon that we eliminate the separate requirement that the business report the injury under K.S.A. 44-537. Since the insured will be reporting the injury to their insurance company, the insurer will report the injury to the Director just as they do normally. There really is no need for the language in HB 2232 on this point.

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Date: 2/25/03
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I'm a little confused by the opposition from the Kansas Association of School Boards since the bill does not extend to group self-insurance pools like they have. The new language is intentionally limited to "insurers" on line 12, page 2 to avoid the concerns raised by Mr. Curtis. The language in subparagraph (f) on page 2, lines 6-11 is current law and allows pools to offer "formal" deductibles only.

The NCCI's opposition to employers' efforts to control their workers compensation expense by handling their small claims has been long-standing. They opposed the provision in the current "formal" deductible law that makes Kansas a net-reporting state for purposes of amounts paid by the employer under their deductible. If NCCI had their way, they would make the employer pay the loss under their deductible and then NCCI would charge it back to them again in their experience modification formula as if the insurance company had paid it. How much sense does that make?

I called my counterpart in Missouri, Larry Case, the Executive Vice President of the Missouri Association of Insurance Agents, and he is completely unaware of any problems with their act that was passed in 1993. He offered to check out any concerns if documentation could be provided on specific problems.

The Workers Compensation Advisory Council discussed this issue twice at different meetings but did not have a quorum at either meeting. No opposition was expressed by labor at either meeting and they did not appear on the bill last Thursday. Terry Leatherman appeared as a proponent of HB 2232 representing the Kansas Chamber of Commerce and Industry.

We would be happy to provide additional information or answer any remaining questions. We hope that the Committee will amend the bill as proposed on the attached balloon and pass it out favorably on Tuesday. Thank you very much for giving us the time to discuss this issue with you and the committee.

Sincerely,

Larry W. Magill, Jr.
Executive Vice President

Cc: Members of the House Insurance Committee

Session of 2003

HOUSE BILL No. 2232

By Committee on Insurance

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AN ACT relating to insurance; relating to an informal deductible for certain medical claims under workers compensation; amending K.S.A. 44-559a and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 44-559a is hereby amended to read as follows: 44-559a. (a) Each insurer issuing a policy to assure the payment of compensation under the workers compensation act may offer, as a part of the policy or as an optional endorsement to the policy, deductibles optional to the policyholder for benefits, which may include allocated loss adjustment expenses, payable under the workers compensation act.

(b) The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or medical provider entitled to the benefits conferred by the workers compensation act and seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer shall be treated under the policy insuring the liability for workers compensation in the same manner as payment or nonpayment of premiums. The insurer may require adequate security to provide for reimbursement of the paid deductible from the insured. An employer's failure to reimburse deductible amounts to the insurer shall not cause the deductible amount to be paid from the workers compensation fund under K.S.A. 44-532a and amendments thereto or any other statute. The insurer shall have the right to offset unpaid deductible amounts against unearned premium, if any, in the event of cancellation.

(c) Such deductible shall provide premium credits as approved by the commissioner of insurance, and losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification.

(d) The commissioner of insurance shall not approve any policy form that permits, directly or indirectly, any part of the deductible to be charged to or be passed on to the worker.

(e) The deductible amounts paid by an employer shall be subject to reimbursement as provided for under K.S.A. 44-567 and amendments

thereto when applicable. All compensation benefits paid by the insurer including the deductible amounts shall be subject to assessments under K.S.A. 44-566a and 74-713 and amendments thereto. The Kansas workers compensation plan under K.S.A. 40-2109 and amendments thereto shall not require deductibles under policies issued by the plan.

(f) Group-funded worker compensation pools as defined in K.S.A. 44-581, and amendments thereto, and municipal group-funded pools as defined in K.S.A. 12-2616, and amendments thereto, may offer deductibles as defined herein using deductible rules and premium credits as promulgated by the national council on compensation insurance and approved by the commissioner.

(g) An insurer shall allow an informal workers compensation deductible to an employer for medical expenses only up to $500 per claim. The employer shall pay the medical costs and report the claim to the insurer ~~and the director of the division of workers compensation under K.S.A. 44-557, and amendments thereto~~. If the claim results in any lost time or if the medical expenses exceed $500, the employer shall report the status of the claim to the insurer and the insurer shall take over the claim and reimburse the employer for amounts expended up to $500. ~~Amounts paid by an employer under an informal deductible shall be reported annually and the employer shall be subject to assessments under K.S.A. 44-566a and 74-713, and amendments thereto~~.

Sec. 2. K.S.A. 44-559a is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

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