Approved:
Date 3-19-03

MINUTES OF THE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE

The meeting was called to order by Chairperson Senator Ruth Teichman at 9:30 a.m. on March 18, 2003 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Ken Wilke, Office of the Revisor of Statutes
Dr. Bill Wolff, Kansas Legislative Research Department
Marlene Putnam, Committee Secretary

Conferees appearing before the committee: Bob Williams, KPHA
Bob Alderson, KPHA
Nancy Corkins, Dillons, KPHA, KFC

Others attending: See attached list

Senator Teichman informed the committee of written testimony from Deena Horst, Representative.(See attachment 1)
She then introduced Bob Williams, KPHA who presented testimony as an proponent for **HB 2233.**
He pointed out that 70% of prescriptions are paid for by insurance companies. Cards are used to pay for prescriptions. In order for the pharmacists to send the proper information over the system, the specific data must be recorded on the card. This bill identifies the data elements we believe should be required on all prescription drug cards. Passage of **HB 2233** will go a long way to eliminating some of the "hassle factor" in processing drug claims, and free up the pharmacist's time to practice pharmacy. (See attachment 2)
Senator Teichman introduced Bob Alderson, KPHA. He appeared on behalf of the Kansas Pharmacists Association in support of **HB 2233.** He related that Pharmacy Benefits Managers ("PBM's") is a company which administers all or a portion of a pharmacy benefit segment of a health benefit plan. (See attachment 3) Brad Smoot presented an amendment to **HB 2233** explaining who receives a prescription card. (See attachment 3a)
Nancy Corkins, regional supervisor for Dillons Pharmacy spoke in support of **HB 2233.** Dillons pharmacies fill in excess of 100000 prescriptions every week. 87% are tied to some type of insurance. A standardized card would help us to achieve administrative efficiencies that benefit consumers. She related that 20% of a pharmacist's time is consumed by insurance issues.
Twenty-four states have passed legislation mandating a standard prescription benefit card since 1999. (See attachment 4)
After discussion among the committee, the hearing was closed. Senator Feleciano moved that **HB 2233** be amended with the suggested amendments, seconded by Senator Brungardt. Motion carried.
Senator Feleciano moved to recommend **HB 2233** as favorable for passage as amended, seconded by Senator Barnett. Motion carried. Bill moved out favorably.
**HB 2071** Having to do with the foreign language of insurance policies. Jarrod Forbes, Ks. Ins. Dept. presented an amendment to **HB 2071**. The amendment is needed to change the date in the Mental Health Parity Provision from December 31, 2002 to December 31, 2003. Senator Teichman explained that the date change will be Section 5 of the bill.
The bill allows insurance companies to print policies in different languages.
Bill Sneed gave his opinion that they must be authorized by statute to print in different languages.
Discussion followed by committee members as to whether the bill was needed or not.
Dr. Wolfe explained that the insurance company must have a filing. So if they are going to have it in different languages, the company must have a filing. Senator Adkins moved that HB 2071 be amended, and passed out favorably. Seconded by Senator Feleciano. .
Minutes were approved
Meeting adjourned

**SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE**
**GUEST LIST**
**DATE:** 3-18-03

| NAME | REPRESENTING |
|---|---|
| Brad Smoot | BCBS |
| BOB ALDERSON | KS PHARMACISTS ASSOC. |
| Cheryl Allard | Coventry Health Care |
| Keith Bradshaw | Budget |
| Bill Sneed | State Farm |
| [illegible] Bunten | KID |
| Chip Wheelen | Assn of Osteo. Med. |
| Melissa Ruggles | Federico Consulting |
| Michael Jones | KFB |
| [illegible] | HCP/ MP/ SBS |
| [illegible] | KU Dept of Adm. |
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TOPEKA

HOUSE OF
REPRESENTATIVES

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JOINT COMMITTEE
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MEMBER: CORRECTIONS AND JUVENILE
JUSTICE
EDUCATION
LOCAL GOVERNMENT

**TESTIMONY OF HB 2233**
**PRESENTED TO THE**
**SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE**

**MARCH 17, 2003**

**Chairman Teichman and members of the Financial Institutions and Insurance Committee, I thank you for allowing me to submit to you written testimony regarding my support of HB 2233 that is similar to HB 2268 which I sponsored.**

**My brother-in-law is a pharmacist in Newton who shared with me his frustrations regarding the time he often spends trying to acquire information required prior to filling a prescription. I have been told by other pharmacists that they often spend several minutes on the phone calling an 800 number, being placed on hold, then waiting while the insurance company employee locates the needed information that isn't included on the card. Meanwhile, several other customers are also waiting for their prescriptions to be filled. In some cases, I'm told this situation occurs several times a day. [The pharmacists also indicate that there are companies who do provide the needed information on their cards and prescriptions are then able to be quickly processed.]**

**In an attempt to relieve the frustration pharmacists are experiencing, I asked that HB 2268 be written to address their concerns. After the hearing in the House Insurance Committee for both HB 2233 and HB 2268, I worked with several individuals to develop amendments to HB 2233 that would specifically address the differences between the two bills. HB 2233, as amended, intends to decrease the amount of time a consumer often must wait to acquire medication. By requiring all prescription drug information cards to specifically identify and display mandatory data elements, the pharmacist can more efficiently serve all customers.**

**Attached to this testimony is a portion of the correspondence received from my brother-in-law that is an example of information he believes should be present on a uniform prescription drug information card.**

**Thank you for your time and your positive consideration of HB 2233. For improved consumer access to prescriptions and improved customer service, I would urge and appreciate your support of this needed piece of legislation.**

Deena Horst

**Deena Horst, Representative 69th District**

Senate F I & I Committee
Meeting Date: 3-18-03
Attachment No.: 1

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FRONT

RxBIN 610014

RxGrp 1234567

Issuer ID 123456789

Name JOHN Q SAMPLE

0003

BACK

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- To locate a participating pharmacy, or for more information about your prescription benefit plan, please visit our website at **www.medcohealth.com**

**Pharmacists:** Submit claims via the TelePAID® System only for the person for whom the prescription was written. Dispense preferred cobranded and generic drug products where applicable in accordance with prevailing pharmacy laws and regulations. For more information contact the Pharmacy Services Help Desk at 1 800 922-1557 or visit the Pharmacist Resource Center at www.medcohealth.com/rph.

1-2

**Kansas Pharmacists Association**
Kansas Society of Health-System Pharmacists
Kansas Employee Pharmacists Council
1020 SW Fairlawn Rd.
Topeka KS 66604
Phone 785-228-2327 ✦ Fax 785-228-9147 ✦ www.kansaspharmacy.org
Robert (Bob) R. Williams, MS, CAE, Executive Director

**TESTIMONY**
Tuesday, March 18, 2003
Senate Financial Institutions and Insurance Committee

**HB 2233**

My name is Bob Williams, I am the Executive Director of the Kansas Pharmacists Association. Thank you for allowing me the opportunity to address the committee on HB 2233.

Currently, more than 70% of prescriptions are paid for by one of many insurance programs, each of which issues its own unique drug benefits card. Frequently, these individual cards lack sufficient data for pharmacists to efficiently process claims for prescriptions, or to verify that the individual is a member of a particular health plan. According to a "Pharmacy Activity Cost and Productivity Study" by Arthur Anderson for the National Association of Chain Drug Stores, 68% of a pharmacists's time is spent dealing with issues unrelated to patient care. Twenty percent of a pharmacist's time is spent acting as an intermediary between the patient and their insurance company. Dealing with the administrative burdens created by inconsistent and confusing information on prescription cards creates unnecessary barriers to pharmacists providing care to their patients. With the dramatic increase in the use of prescription medication, the problem will only get worse.

**Senate F I & I Committee**
**Meeting Date:** 3-18-03
**Attachment No.:** 2

In the contemporary pharmacy practice, prescription claims are processed via electronic transmission whereby the pharmacist enters the appropriate data regarding the patient/prescription and the claim is approved or denied. This is often referred to as "Point of Sale" (POS) or sometimes "Point of Service." This is very similar to the way transactions are processed when one purchases an item with his/her credit card. When the system works, the pharmacist is notified if the drug is covered, any co-payments and the amount of reimbursement. This usually takes only a few moments and is done while the patient waits. Unfortunately, Kansas pharmacists have reported that increasingly, information contained on prescription cards is inadequate for them to provide the very information the issuer of the card requires in order for them to process the claim. This results in the pharmacist having to call an 800 number (if there is an 800 number on the card) to get the required information (while patients are waiting). They refer to this as "1-800-HOLD" because they are frequently placed on hold for 20 to 45 minutes. Often times the pharmacist is forced to submit the claim several times guessing at the missing information until they get "lucky." It should be noted that every time the pharmacist transmits a claim or backs out a claim he/she is charged a fee. Imagine how frustrating it would be if the same situation existed with credit cards used for retail purchases. Twenty-four states have passed similar legislation (NC, TX, AL, GA, IL, TN, VA, AR, CA, IA, IN, MD, NM, ND, NJ, NV, OR, SD, VA, WA, CO, FL, MI, MS, OK.) As you can see, it is a priority issue for pharmacists in many states.

Lines 33--41 on the first page of the bill identifies the data elements we believe should be required on all prescription drug cards. Committee members will note that we are not asking for any information which is not necessary for processing the claim. It is our understanding that some insurance companies are moving in the direction of issuing just one card for medical and

prescription benefits. Section 5 of the bill clearly states that nothing in the "act shall be construed as requiring any person issuing a card for processing of claims under a health benefit plan to issue a separate card for prescription drug coverage..." Additionally we are not asking for new cards to be issued immediately but "...when the plan is amended, delivered, issued or renewed...".

The cost of prescription drugs has been a focus of the Kansas Legislature for several years. As some of you are aware, reports indicate that better management of drug therapy would help control costs. There are a number of issues facing the pharmacy profession which greatly impacts the profession's ability to assist with the management of drug therapy. Managed care has forced pharmacists to increase patient volume in exchange for lower rates. Prescription volume is also increasing (and will continue to do so) as more and more drugs are used to treat diseases. Additionally, the profession is experiencing a shortage of pharmacists. Passage of HB 2233 will go a long way to eliminating some of the "hassle factor" in processing prescription drug claims and free up the pharmacist's time to practice pharmacy. Once again, we are only asking the insurance and managed care industry to provide information **they** require from pharmacists in order for pharmacists to process the prescription claim.

Thank you.

ALDERSON, ALDERSON, WEILER,
CONKLIN, BURGHART & CROW, L.L.C.
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*LL.M., TAXATION
**LICENSED TO PRACTICE IN KANSAS AND MISSOURI

TESTIMONY OF BOB ALDERSON

ON BEHALF OF THE

KANSAS PHARMACISTS ASSOCIATION

BEFORE THE SENATE COMMITTEE ON

FINANCIAL INSTITUTIONS AND INSURANCE

March 18, 2003

Chair Teichman 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. 2233 (HB 2233), which would enact a Uniform Prescription Drug Information Card Act. HB 2233 is patterned substantially after 2001 Senate Bill No. 182 (SB 182), which was considered during the 2001 session by the Senate Committee on Financial Institutions and Insurance and, subsequently, during the 2001 interim, by the Special Committee on Commercial and Financial Institutions/Insurance. The testimony received by these legislative committees highlighted the fact that Pharmacy Benefits Managers ("PBM's") present important considerations in the enactment of a uniform prescription drug information card bill. That prior testimony suggested that PBM's are the "real offenders" with respect to furnishing cards which do not provide information sufficient for the adjudication of prescription drug claims.

At the same time, testimony also was received by these committees indicating that, even though SB 182 would have brought PBM's within its purview, any effort to do so might be preempted by ERISA (acronym for the Employee Retirement Income Security Act of 1974). Because PBM's in many instances administer the pharmacy benefits portion of a self-insured health benefit plan, some conferees on SB 182 advised the committees that considered this bill that ERISA probably would preempt a

attempting to extend its reach to self-insured plans. Since HB 2233 is patterned after SB 182, the primary purpose of my testimony is to address the issue of the bill's application to PBM's.

Initially, it might be helpful to note that a PBM is a company which administers all or a designated portion of a pharmacy benefits segment of a health benefit plan. A PBM is a third-party administrator which may limit its administrative services to the processing and adjudication of claims for prescription drug or device benefits, including making payments to pharmacies, or a PBM also may provide other services, directly or indirectly and either in connection with or separate from claims processing services. These additional services may include negotiating rebates, discounts or other financial incentives and arrangements with pharmaceutical companies; disbursing or distributing such rebates; managing or participating in incentive programs or arrangements for drug therapy and other patient care services provided by a pharmacist that are intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms or arresting or slowing a disease process; negotiating or entering into contractual arrangements with health benefit plans and pharmacists or pharmacies; developing formularies; designing prescription benefit programs; or engaging in other matters relating to the provision of or payment for prescription benefit programs.

There are a variety of arrangements by which a PBM may provide its services. It may do so under contract with an insurer, an HMO or a self-insured employer, or it may subcontract with a third-party administrator which has a contract with one of these entities. Where the PBM provides its pharmacy benefits management services either directly or indirectly through a self-insured employer, the issue of ERISA preemption must be considered. I believe that one of the principal reasons SB 182 was not enacted in the 2001 or 2002 legislative session was the concern that, as long as PBM's (as well as third-party administrators of self-insured plans) were included within the scope of the bill, there was a risk that the bill would be preempted by ERISA. Upon the other prong of this "Catch 22" was the concern that, absent regulation of PBM's, the legislation would not accomplish its objectives.

Accordingly, my law clerks and I researched the provisions of ERISA and the recent case law concerning its preemptive provisions with respect to a variety of state laws. My research prompted the conclusion that the Uniform Prescription Drug Information Card Act (as embodied by SB 182 or HB 2233) would not be preempted by ERISA. However, for two reasons, I did not believe my legal opinion should be used to support KPhA's request

that this legislation be enacted. First, my opinion might be viewed as somewhat self-serving, since I represent KPhA. More importantly, though, I am not an expert on ERISA, which is an extremely complicated statutory/regulatory system for which there is a substantial body of case law construing its provisions.

Accordingly, KPhA agreed with my recommendation to engage an attorney experienced in ERISA to provide KPhA with an opinion as to whether the proposed legislation, if enacted, would be preempted by ERISA. After my interview of several attorneys having expertise in ERISA, KPhA agreed with my recommendation that Charles R. Hay, a partner in the Topeka firm of Goodell, Stratton, Edmonds and Palmer, be engaged to provide such an opinion. Mr. Hay has more than 20 years of practice with ERISA. He has designed and prepared a variety of ERISA plans, both retirement and welfare, including the drafting of self-insured health plans. In addition, he has provided advice and counsel to clients with regard to particular claims issues, including claims arising under self-insured plans. Mr. Hay also has participated in ERISA litigation in the U.S. District Court, primarily with reference to disability claims, which in some instances has included ERISA preemption issues. I also should note that Mr. Hay is an Adjunct Assistant Professor of Law at Washburn University School of Law, teaching courses in both insurance law and employee benefits, having last taught employee benefits law in the fall semester of 2002. Attached to this testimony is a copy of Mr. Hay's Curriculum Vitae.

Also attached to this testimony is a copy of Mr. Hay's Opinion on the issue of whether SB 182, or a bill substantially patterned after SB 182, would be preempted by ERISA. I will not burden this testimony by unnecessarily reiterating the conclusions reached by Mr. Hay. Suffice it to state that, in his opinion, "the bill would not be preempted by ERISA as construed by current case law." The concluding paragraph of Mr. Hay's opinion expands upon that conclusion, as follows:

> "Unquestionably, the health care reimbursement system means that regulation of insurance and regulation of health care may be closely related. The Supreme Court has three times recognized that ERISA does not preclude state law that impacts regulation of both. . . . The Court itself has stated that . . . 'in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose.' [Citation omitted] There is no clear manifestation of congressional purpose that would suggest that regulation of the health care reimbursement structure contemplated by the proposed bill in this instance would be preempted."

I would encourage you to read Mr. Hay's opinion. It contains a minimum of "legalese." I am confident that, should you have any questions or concerns regarding his opinion, Mr. Hay would be happy to appear before you and address those issues.

My concluding remarks concern the differences between HB 2233 and SB 182. One of the differences was prompted by discussions with Mr. Hay regarding his opinion. As noted above, Mr. Hay concluded that, in his opinion, current case law construing the provisions of ERISA would dictate that the provisions of the Uniform Prescription Drug Information Card Act would not implicate the preemptive provisions of ERISA. However, he indicated that the provision of SB 182 which prompted some of the issues he considered was the provision which referenced "self-insured plans." His opinion notes several cases which found a state law to be preempted because of the mere mention of ERISA or self-insured plans. Based on that consideration, the reference to self-insured plans has been eliminated in HB 2233.

Another difference is in Section 3(a)(1), where "Bank identification number (BIN)," as the language appeared in SB 182, has been replaced by "ANSI-BIN number."

An additional difference effected in HB 2233 occurs in the first sentence of Section 4. SB 182 indicated that the uniform prescription drug information card could be used for any and all "health insurance coverage," whereas HB 2233 provides that the card may be used "for any and all coverage under a health benefit plan," which is a defined term in the bill.

Finally, HB 2233 differs from SB 182 by virtue of the amendments made to the bill by the House Committee on Insurance. I trust these changes are self-evident.

I appreciate your attention to these remarks. I will try to answer any questions you may have.

# CURRICULUM VITAE

**PERSONAL:**

Charles R. Hay
3605 Blue Inn Road
Topeka, Kansas 66614
(785) 233-0593
Age: 52 Married/One Child

**EDUCATION:**

B.S.J., with honors, 1972 -- University of Kansas; associate editor, university newspaper

J.D., Order of the Coif, 1974 -- University of Kansas; staff member, University of Kansas Law Review

**PROFESSIONAL:**

Admitted to practice in Kansas, 10th Circuit and Western District of Missouri

Partner, Goodell, Stratton, Edmonds and Palmer (Topeka, Kansas) since 1979; associate attorney 1974-79; general practice with emphasis as follows:

Substantial involvement with most aspects of health law, including litigation, as to hospital and physician regulation and reimbursement, managed care and non-profit organizations, fraud and abuse, Stark and related tax issues including:

- Government investigations
- Compliance plans
- Reimbursement litigation and appeals
- Medical staff privileges hearings and litigation
- Managed care contracts and organization of companies
- Federal and state tax exemptions

Preparation and counseling regarding retirement plans and obligations under ERISA and ERISA litigation

Extensive experience in bankruptcy matters

Insurance litigation

Listed in "The Best Lawyers In America"
(Health Law)

**TEACHING:**

Adjunct assistant professor of law, Washburn University School of Law (Topeka, Kansas), 1980-1983, 1987 (insurance law), 2001, 2002 (employee benefits law)

Adjunct instructor, Washburn University School of Business, 1984, 1989 (law for insurance agents)

Adjunct instructor, Washburn University School of Applied Education, 1985, (civil procedure for paralegals)

**PRESENTATIONS AND PUBLICATIONS:**

Presenter, Kansas Hospital Association HIPAA Privacy Regulation Compliance, 2001

Presenter, Kansas Medical Society Stark Seminar, 1998

Presenter, Kansas Association of Risk and Quality Management Annual Conference, 1998

Presenter, Peer Review Issues, Health Care Stabilization Fund Seminar, 1998

Presenter, The Kansas Hospital Association: Responding to a Sentinel Event, 1998

Presenter, Kansas Bar Association Seminar: Actionable Ethics? Or Ethics In Action, 1995

Presenter, ALPS and The Kansas Bar Association Seminar: Ethical Issues In Corporate Representation, 1995

Presenter, Kansas Hospital Association Health Information Management: Law and Practice Seminar, 1994

Presenter, Kansas Hospital Association Physician Recruitment and Corporate Practice Considerations, 1994

Co-Presenter, Kansas Bar Association, Professional Ethics

Conferences, 1994 (2), 1995

Presenter, Kansas Hospital Association Regulatory Update, 1993

Presenter, Kansas Claims Association, Ethical Obligations of Insurance Defense Counsel, 1992

Presenter, Kansas Bar Association, Survey of Law, 1990, 1991, 1992, 1994, 1995, 1996, 1997, 1999, 2000 and 2001

Presenter, Medical Educational Services Seminar on Confidentiality of Medical Records in Kansas, 1989 and 1993

Presenter, Kansas Hospital Association Medicaid Appeals Workshop, 1988

Presenter, Kansas Hospital Association Seminar on Third Party Review, 1987

Presenter, Kansas Hospital Association Seminar on Risk Management, 1986

Presenter, Kansas Bar Association, Kansas Medical Malpractice Act, 1986

Co-author of health law chapter, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001 and 2002 Kansas Handbooks on Legal Developments

Co-editor, Kansas Bar Association Ethics Handbook, 1996

**MEMBERSHIPS:**

American, Kansas and Topeka Bar Associations

Held all offices in Young Lawyers Section of Kansas Bar Association, including President (1983-84) and member of KBA Executive Council (1983-84)

Outstanding Service Award, Kansas Bar Association, 1984

Member, Board of Editors of Journal of Kansas Bar Association (1982-96), KBA Professional Ethics Advisory

Committee (Chairman 1988 - 1992), Awards Committee (1984-86), and Planning Committee (1987)

Chairman, General Contributions Committee (1984-86), Kansas Bar Foundation

Kansas Association of Defense Counsel (to 1992)

Kansas Association of Hospital Attorneys (President 1987-88)

Advisory Council on Paralegal Education, Washburn University (1986-88)

American Bankruptcy Institute

American Health Lawyers' Association

IRS Employee Plans/Exempt Organizations Advisory Council

Topeka Area Bankruptcy Council

**CIVIC:**

Charter board member (1977-88) and President (1985-87) Topeka Hospice (care for terminally ill and families)

Board of Directors, American Cancer Society, Shawnee County, (1977-80); residential crusade chairman (1977, 1978)

Topeka Lions Club, President (1994-95)

U.S.D. 437 Retirement Benefits Committee, 1993

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February 7, 2003

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RE: Kansas Pharmacists Association
Uniform Prescription Drug Information Card

Dear Mr. Alderson:

You have requested my opinion as to whether ERISA would preempt a proposed bill that, if enacted into law by the Kansas legislature, would generally mandate that a health benefit plan that provides coverage for prescription drugs issue a card containing uniform prescription drug information as defined in the bill.

In my opinion, the bill would not be preempted by ERISA as construed by current case law.

My understanding is that a common practice for group health plans is to issue a card to individuals covered under the plan that may be presented to health care providers at the time of receiving treatment. The proposed Uniform Prescription Drug Information Card Act would mandate that a health benefit plan that provides coverage for prescription drugs or devices "and issues a card for claims processing" shall issue a card containing uniform prescription drug information, as detailed in the proposed act. Section 5 of the proposed act specifically states that a separate card is not required so long as the general card is able to accommodate the prescribed information. Alternatively, "other technology" may be utilized if it contains all of the information required by the act. Any administrator of a plan that provides prescription drug coverage and that issues a card for claims processing is to issue a card containing the information to each insured. The term "health benefit plan" is defined by §3(c) of the proposed act by reference to K.S.A. 40-2209d(l), which references "any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization

contract offered by an employer or any certificate issued under such policies, contracts or plans." K.S.A. 40-2209(d) is an integral part of the Kansas Insurance Code as it relates to group health insurance, particularly with regard to small employers.

The federal enactment referenced as ERISA (an acronym for the Employee Retirement Income Security Act of 1974) is marked by a mass of detail and terminology that creates a high level of complexity. But the complexity and confusion that surrounds the issue of ERISA preemption is created by the generality of the applicable statutory language. The basic rule is that ERISA supersedes any state law that may "relate to" an employee benefit plan to which ERISA applies. ERISA §514(a), 29 U.S.C. §1144(a). An exception is provided to this general rule such that a state law that regulates insurance is not preempted. ERISA §514(b)(2)(A). However, a self-insured health plan may not be treated as an insurance company under state law merely because its functions and operations involve shifting of risk and thus resemble insurance. A self-insured plan, in other words, may not be "deemed" to be an insurance company simply because it exhibits characteristics normally associated with an insurance company. ERISA §514(b)(2)(B). This distinction was recognized by the U.S. Supreme Court in an early ERISA preemption case. In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985), the Court held that a state mandated-benefits law was a law that regulates insurance and was therefore not preempted by ERISA as applied to insurance companies. The Court also recognized that its decision would result in a difference in treatment between an insured plan and a self-insured plan; an insured plan could be regulated by the state but state regulation that could be said to "relate to" a self-insured plan would be preempted.

The language of the proposed bill is susceptible to an interpretation that it is limited to a health benefit plan that is specifically regulated by the Kansas Commissioner of Insurance. While §4 references various types of administrators, this reference is qualified by the requirement that the individual or entity be an administrator "of any such plan," which in turn references back to "health benefit plan," a term defined by reference to the insurance code. To the extent that this constitutes insurance regulation, it should withstand a preemption attack even if a court construes the law as "relating" to an employee benefit plan.

In *Metropolitan Life Insurance Co. v. Massachusetts*, *supra*, the U.S. Supreme Court specifically upheld a Massachusetts statute that required minimum mental health care benefits under a general insurance policy. The reason was ERISA §514(b)(2)(A), which provides that a state law that regulates insurance is not preempted. The test enunciated in that case involves consideration of two factors. The first is whether, from a "common sense view" the state law in question regulates insurance. The second involves consideration of three factors utilized to determine whether a requirement or regulation fits within the "business of insurance" as that phrase is used in the federal McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* [1] These considerations were applied in *Unum Life*

[1] The McCarran-Ferguson Act was generally intended to preserve state regulation of the business of insurance, in particular with reference to federal enforcement efforts under the federal antitrust

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*Insurance Co. of America v. Ward*, 526 U.S. 358, 119 S.Ct. 1380 (1999), to find that a California "notice-prejudice rule" developed through case law was not preempted. The rule generally was to the effect that an insurance company defense based on failure of insured to give timely notice of a claim would require that the insurance company prove that it suffered actual prejudice and the insurer could not simply rely upon the delayed notice to avoid the claim. The Court agreed that the rule regulates insurance as a matter of common sense and thus satisfied the first portion of the test. The Court also concluded that the state rule was sufficiently consistent with McCarran-Ferguson Act criteria. More recently, in *Rush Prudential HMO v. Moran*, 536 U.S. 355, 122 S.Ct. 2151 (2002), an HMO challenged an Illinois law that required an independent medical review of any claim that had been denied on the grounds it was not medically necessary. A key element in the attack of the HMO on the statute was that the HMO should not be considered an insurance company but rather a health care provider, meaning that the ERISA preemption exception for insurance regulation would be inapplicable. The Court rejected this contention and found that the Illinois independent review statute was directed toward the insurance industry and thus was an insurance regulation under a "common sense" view. It then utilized the McCarran-Ferguson factors to "confirm our conclusion."

The proposed statute appears to contemplate that it would supplement the portion of the Kansas insurance code that regulates unfair methods of competition and unfair or deceptive acts or practices. Requiring that an insurer provide basic information necessary for effective processing of claims, particularly in light of the increasing reliance upon electronic transactions, seems consistent with a common sense view of insurance regulation. Section 7 of the proposed bill specifically states that it should be administered and enforced by the commissioner in the same manner as a list of statutes that regulate such unfair and deceptive practices and define the commissioner's authority to issue orders and impose penalties for violations. As originally enacted, the Kansas statutes referenced in proposed §7 were intended to mesh with the requirements of the McCarran-Ferguson Act. *See* K.S.A. 40-2401. So long as the proposed bill is limited in scope to the insurance industry, the McCarran-Ferguson Act component of the test enunciated by the U.S. Supreme Court also should be satisfied. Thus, the proposed bill should be considered permissible to the extent that it is regarded as a state law that regulates insurance.

The conclusion that the proposed bill would be considered insurance regulation and saved from preemption would ordinarily eliminate the need for additional analysis. Nonetheless, the traditional approach to a question of ERISA preemption is to analyze the issue in the order in which the pertinent considerations are defined in ERISA §514 and the first issue presented by that statutory section is whether a state law may "relate to" an ERISA employee benefit plan. Because of the

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laws. The three factors are whether the practice in question has the effect of transferring or spreading policyholder risk, whether the practice is an integral part of the policy relationship between the insurer and the insured and whether the practice is limited to entities within the insurance industry.

potential of amendment to the bill,[2] or a more expansive interpretation by a court, additional analysis is therefore in order.

The language of the statute that defines the test of ERISA preemption – whether a state law "relates to" an employee benefit plan – provides virtually no direction in determining what is or is not preempted. The problem is that "if 'relate to' were taken to extend to the furthest stretch of its indeterminacy then for all practical purposes preemption would never run its course. . . ." *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 115 S.Ct. 1671, 1677 (1995). The U.S. Supreme Court initially interpreted ERISA as preempting "even indirect state action bearing on private pensions" *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525, 101 S.Ct. 1895, 1907 (1981). This meant that preemption of state statutes became almost automatic. However, even then, the Court said that state actions that affected an employee benefit plan in a tenuous, remote or peripheral manner might not be preempted. *Shaw v. Delta Airlines*, 463 U.S. 85, 103 S.Ct. 2890 (1983).

The U.S. Supreme Court also has held that a state statute that by its language refers to an ERISA plan will be preempted. The view of the Court has been that a state law that specifically refers to an ERISA plan must be said to "relate to" an ERISA plan. *Mackey v. Lanier Collection Agency and Service, Inc.*, 46 U.S. 825, 108 S.Ct. 2182 (1988). This means that a state statute that expressly refers to an ERISA plan may be preempted even if it is consistent with ERISA because of its direct reference to an ERISA plan. *Mackey, supra* (statute that singled out ERISA welfare benefit for protective treatment under state garnishment procedure was preempted). This type of analysis may lead to rather odd results. For example, in *Prudential Insurance Co. of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998), the court found that an Arkansas any-willing provider statute was preempted in part because it expressly provided that it would not be applicable to self-funded or other health benefit plans exempt from state regulation by ERISA.

The basic test of ERISA preemption has thus been whether it has a "connection with or reference to" an ERISA plan. *Shaw v. Delta Airlines*, *supra*, 463 U.S. at 96. Under this formulation of the test, when "a State's law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation . . . that 'reference' will result in preemption." *California Division of Labor Standards v. Dillingham Construction*, 519 U.S. 316, 117 S.Ct. 832, 838 (1997). A state statute is often not structured in this manner and the uncertainty has generally focused on when state regulation has a "connection with" an ERISA plan. As noted previously, this was initially characterized such that action that "bears on" an ERISA plan would be

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[2] At present, the application of §4 is limited to an administrator of a health benefit plan, which is generally defined in the proposed bill by reference to insurance regulation. The additional reference in §4 to an administrator "of any such plan" would thus seem to be limited by the overriding definition of the scope of the bill limiting it to a health benefit plan. This would obviously change if an attempt were made to make the bill applicable to all PBMs or TPAs or some other expansion.

preempted. *Alessi, supra*, 451 U.S. at 526. However, in *Travelers Ins. Co., supra*, the Court recognized that prior precedent provided little assistance in defining the statutory term and stated that the analysis "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656. The Court emphasized its traditional presumption that Congress did not intend to supplant state law, particularly in areas of traditional state regulation, and determined that the meaning of "relate to" must be gauged by the objectives of ERISA to determine whether a particular law was intended to be preempted. The *Travelers* decision has been termed a "sea change." *Whitt v. Sherman Int'l Corp.*, 147 F.3d 1325, 1333 (11th Cir. 1998).

The lower courts have continued to struggle with the exact parameters of this and have generally focused upon the impact of a challenged state law on relations among the principal ERISA entities – the employer, the plan, the plan fiduciaries, and the beneficiaries – or whether the state law involves an exercise of traditional state authority, or both. Employee Benefits Law at 795-96 (BNA 2000). The Tenth Circuit has identified four causes of action that might relate to a benefit plan for purposes of ERISA preemption. [3] But it has also stated the following:

> At the same time, this circuit recognizes that ERISA does not preempt all state law claims. It has no bearing on those "which do[] not affect the 'relations among the principal ERISA entities, the employer, the plan, the plan fiduciaries and the beneficiaries' as such." *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla. Inc.*, 944 F.2d 752, 756 (10th Cir. 1991) (quoting *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 249 (5th Cir. 1990)). "As a corollary, actions that affect the relations between one or more of these plan entities and an outside party similarly escape preemption." *Airparts Co.*, 28 F.3d at 1065. While the scope of ERISA preemption may be broad, it is certainly not boundless. *See Monarch Cement Co. v. Lone Star Indus. Inc.*, 982 F.2d 1448, 1452, (10th Cir. 1992).

*Woodworker's Supply, Inc. v. Principal Mut. Life*, 170 F.3d 985, 990 (10th Cir. 1999).

The possibility of ERISA preemption thus increases if the language of the proposed bill were changed so that it has a more direct impact on, and potentially direct reference to, self-insured ERISA plans or if the language is interpreted to this effect. The references to pharmacy benefit managers and third-party administrators are likely to be the focus of this. While my opinion is that the available precedent still suggests that this would not be preempted, the issue is debatable. "While a mere reference to an ERISA plan, without more, may not be enough to cause preemption, Supreme Court

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[3] These are (1) laws regulating the type of benefits or terms of ERISA plans; (2) laws creating reporting, disclosure, funding or vesting requirements for such plans; (3) laws providing rules for calculating the amount of benefits to be paid; and (4) laws or rules providing remedies for misconduct growing out of plan administration.

precedent shows that if such a reference is combined with some effect on those plans, such as singling them out for different treatment, preemption will result." *Kentucky Ass'n. of Health Plans, Inc. v. Nichols*, 227 F.3d 352 (6th Cir. 2000), *cert. granted, sub nom, Kentucky Ass'n. Of Health Plans, Inc. v. Miller*, 122 S.Ct. 2657 (2002). (Kentucky any-willing provider statute that included ERISA plans "to the extent permitted by ERISA" brings the statute within the "refer to" prong of the "relate to" analysis).

The conclusion that the bill should nonetheless escape ERISA preemption is based upon case law involving other, related issues. One of these involves state attempts to license third-party administrators whose primary client base is ERISA health plans. In *Benefax Corp. v. Wright*, 757 F. Supp. 800 (W.D. Ky 1990) a TPA that acted solely on behalf of self-funded health plans challenged a statute that required licensure as an administrator. The Kentucky statute generally established various standards for licensure, such as financial responsibility, reliability, and other similar factors and provided for revocation or suspension of the license for such conduct as misappropriation or misrepresentation. The court found that the Kentucky statute did not single out individuals that provided services exclusively to ERISA plans and did not therefore relate to an employee benefit plan; the statute was thus not preempted. In contrast, a Texas statute that permitted the insurance commissioner to review a TPA's financial statements and all of its client contracts along with other requirements was held to be preempted because it imposed significant burdens on administrators of ERISA plans. *NGS American, Inc. v. Barnes*, 998 F.2d 296 (5th Cir. 1993). The court in that case specifically expressed concern that the ERISA goal of reducing conflicting or inconsistent state regulation was implicated by this level of state involvement. To much the same effect see also *Self-Insurance Institute of America v. Gallagher*, 1989 U.S. Dist. LEXIS 13942 (N.D. Fla. 1989), *aff'd*, 904 F.2d 1491 (11th Cir. 1990).

Case law addressing claims by health care providers against plans also supports the conclusion that a drug card requirement should not be preempted. In a number of reported cases, health care providers have contacted employee benefit plans or plan administrators to confirm coverage before providing particular care or undertaking a particular procedure or treatment regimen. When the plans have subsequently attempted to disavow coverage, health care providers have brought state law claims under various theories including negligent misrepresentation. Several courts, including the 10th Circuit, have permitted these claims and have concluded that they are not preempted by ERISA. *Hospice of Metro Denver, Inc. v. Group Health Ins. of Okla., Inc.*, 944 F.2d 752 (10th Cir. 1991). *See also* Employee Benefits Law, supra, at 841-43.

A major consideration driving the proposed bill involves regulation of the relationship between plan administrators and commercial pharmacies. If this relationship can be in effect regulated pursuant to state law in the form of negligent misrepresentation or promissory estoppel claims, it would seem not to be a great stretch to allow it likewise to be regulated through a requirement of affirmative representation in the first instance. This also would appear to be supported by the Supreme Court decision in the *Travelers* case, which upheld a state surcharge on hospital rates that

was calculated on a sliding scale basis and that had a significant impact upon ERISA plans. Of significance to the Court in *Travelers* was that the tax involved health care, traditionally an area of state concern. The same is true in this case.

The proposed bill also does not appear to be greatly removed from TPA licensure. While it perhaps could be said to impact the relations between a plan and its participants by mandating particular information to be provided in card or other form for the use by participants, this would seem to be peripheral to a major point of the bill – to streamline the dispensing of prescription drugs. It is not, in other words, intended to significantly impact the relations among the principal ERISA entities. Uniform prescription drug information must only be included on a card if the plan provides coverage for prescription drugs and if it issues a card for claims processing. The proposed bill would not force an ERISA plan to adopt a particular scheme of substantive coverage or otherwise restrict the flexibility of benefits with regard to benefits afforded to health plans under ERISA. Given the presumption against preemption highlighted in *Travelers* and its conclusion that Congress did not intend to displace state health care regulation, the conclusion that follows is that a uniform prescription drug information card as described in the proposed bill should not be preempted by ERISA.

Unquestionably, the health care reimbursement system means that regulation of insurance and regulation of health care may be closely related. The Supreme Court has three times recognized that ERISA does not preclude state law that impacts regulation of both. *Rush, supra.; Travelers, supra.*; *Metropolitan Life, supra.* The Court itself has stated that its holding in *Travelers* means that "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." *Pegram v. Herdrich*, 530 U.S. 211, 237, 120 S.Ct. 2143 (2000). There is no clear manifestation of congressional purpose that would suggest that regulation of the health care reimbursement structure contemplated by the proposed bill in this instance would be preempted.

Sincerely,

Charles R. Hay

CRH:eo

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**As Amended by House Committee**

*Session of 2003*

# HOUSE BILL No. 2233

By Committee on Insurance

2-7

AN ACT enacting the uniform prescription drug information card act.

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

Section 1. This act shall be known and may be cited as the uniform prescription drug information card act.

~~Sec. 2. It is the intent and purpose of the legislature to lessen patients' waiting times, decrease administrative burdens for pharmacies and improve care to patients by minimizing confusion, eliminating unnecessary paperwork and streamlining the dispensing of prescription products paid for by third-party payors. This act shall be broadly applied and construed to effectuate this purpose.~~

Sec. ~~3.~~ 2. As used in this act:

(a) "Commissioner" means the Kansas commissioner of insurance;

(b) "department" means the Kansas department of insurance; and

(c) "health benefit plan" shall have the meaning ascribed to such term by subsection (1) of K.S.A. 40-2209d, and amendments thereto.

Sec. ~~4.~~ 3. (a) A health benefit plan that provides coverage for prescription drugs or devices and issues a card for claims processing and an administrator of any such plan, including, but not limited to, a pharmacy benefits manager and a third-party administrator shall issue ~~to each insured~~ a card containing uniform prescription drug information[ ~~The~~ **If required for claims adjudication, the** uniform prescription drug information card shall specifically identify and display ~~such information as is necessary for adjudication of prescription drug claims, including~~ **the following information**:

to each person entitled to such card under the health benefit plan

(1) ANSI-BIN number;

(2) processor control number or group number or both~~, if required for claims adjudication~~;

(3) card issuer identifier;

(4) prescription claims processor, if different from card issuer;

(5) cardholder identification number;

or

(6) cardholder[**insured** ~~or~~ name;

(7) claims submission names and addresses; and

(8) help desk telephone numbers.

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(b) A uniform prescription drug information card shall be issued by a health benefit plan to each ~~insured~~ upon enrollment and reissued upon any change in ~~the insured's~~ coverage that affects one or more mandatory data elements contained on the card.

(c) Notwithstanding the foregoing provision, any health benefit plan or ~~other person required by this section to issue a uniform prescription drug information card may provide, in lieu of such card, to participants in the health benefit plan other~~ **administrator of such plan may utilize, in lieu of such card, electronic** technology which contains all of the information required ~~by this section.~~ **for claims adjudication, as long as such electronic technology is provided by the health benefit plan or administrator of such plan to the pharmacies which will adjudicate the prescription drug claims.**

**Sec.** ~~5.~~ **4.** The uniform prescription drug information card may be used for any and all coverage under a health benefit plan. Nothing in this act shall be construed as requiring any person issuing a card for processing of claims under a health benefit plan to issue a separate card for prescription drug coverage, as long as the card is able to accommodate the information necessary to process a prescription drug claim, as required by section ~~4~~ **3**, and amendments thereto.

Sec. ~~6.~~ **5.** (a) This act shall apply to any health benefit plan that is amended, delivered, issued or renewed on or after the effective date of this act.

(b) The commissioner may adopt rules and regulations that are necessary to implement the provisions of this act.

Sec. ~~7.~~ **6.** This act shall be administered and enforced by the commissioner in the same manner as is provided for administering and enforcing the statutes regarding insurers' unfair methods of competition and unfair or deceptive acts or practices, as provided by K.S.A. 40-2405, 40-2406, 40-2407, 40-2408 and 40-2411, and amendments thereto, and the commissioner shall have and may exercise the powers granted by K.S.A. 40-2405, 40-2406, 40-2407, 40-2408 and 40-2411, and amendments thereto, in administering and enforcing the provisions of this act.

Sec. ~~8.~~ **7.** This act shall take effect and be in force from and after its publication in the statute book.

person entitled to such card under the health benefit plan

such person's

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DILLON STORES
2700 EAST FOURTH P.O. BOX 1608
HUTCHINSON, KANSAS 67504-1608 (620)665-5511

Testimony
HB 2233 Uniform Prescription Drug Card
Senate Financial Institutions and Insurance
March 18, 2003

My name is Nancy Corkins. I am a regional supervisor for Dillons Pharmacy. I am also a licensed pharmacist in the State of Kansas. Additionally, I am on the Board of Trustees for the Kansas Pharmacists Association (KPhA), and am a member of the Kansas Federation of Chain Pharmacies (KFCP). I am here today to speak in support of HB 2233.

Dillons operates 58 community retail pharmacies within our supermarkets throughout the state and fill in excess of 100,000 prescriptions every week. Of these prescriptions, 87% are tied to some type of insurance. You can see that the sheer volume (over 12,000 insurance claims in an average day) has the potential to cause problems in the day-to-day operation of our pharmacies. A standardized card would help us to achieve administrative efficiencies that benefit consumers and streamline prescription delivery. The lack of a standard card creates delays in prescription delivery and limits pharmacist interaction with their patients. The passage of HB 2233 would save a lot of time and money, not only for Dillon Pharmacies, but for all the pharmacies across the state—chain and independent alike.

The Anderson study that was conducted by NACDS (National Association of Chain Drug Stores) confirmed that a full 20% of a pharmacist's time is

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insurance issues. These issues can be numerous:

- Insurance carrier vs. pharmacy administrator
  Oftentimes, claims are sent through to a pharmacy administrator

- BIN and/or Processor number to allow electronic transmission
  If there are no indications on the card of the administrator of the plan, a BIN or processor number would identify them
- Group numbers
  Some plans require group numbers to transmit a claim—not all cards have group number indicated
- Coverage eligibility
  Many cards have no indication of pharmacy coverage (be it for cardholder, spouse, or dependents)

Items compounding these issues are:

- Pharmacist shortage (by 2004 a 6% increase in number of pharmacists)
- Increased prescription volume (by 2004 a 47% increase in number of prescriptions)
- Total number of insurance carriers—Dillons currently has over 250 insurance carriers in our computer system—the expectation of the patient is that the pharmacist knows all about their prescription coverage.
- Financial issues—each time a pharmacy transmits a claim, it costs the pharmacy a fee (regardless of the claims fate, such as "Dependent Code Invalid")

Our professional goal as pharmacists is to ensure that the patient obtains the correct medication and understands completely how to administer the medication, including the potential problems associated with their therapy, so that their therapeutic outcome is maximized. This is becoming more challenging with the advent of many new medications, and the subsequent potential for drug interactions. I, as a pharmacist, would much rather spend my workday attempting to locate potential drug misadventures, than spending it stumbling through insurance misadventures.

Twenty-four states have passed legislation mandating a standard prescription benefit card since 1999. I urge you to pass HB 2233 and do your part to help curb the high cost of medications for all the citizens of Kansas. Thank you for your time and consideration.