Approved: February 28, 2007
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on February 14, 2007 in Room 234-N of the Capitol.

All members were present except:
Dennis Wilson- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Office of Revisor of Statutes
Bev Beam, Committee Secretary

Conferees appearing before the committee:
Gary Haulmark, CCPA; Brian Caswell, KPHA; Sam Boyajian, Independent Pharmacist; Jeff Denton, Independent Pharmacist; John Kollhoff, Independent Pharmacist; Bob Tomlinson, KID; Cindy Laubacher, Medco; Alan Horne, Caremark; Michael Harrold, Express Scripts; and Bill Sneed, AHIP

Others attending:
See attached list.

The Chair called the meeting to order and welcomed everyone to the meeting.

Hearing on:

SB 272 - concerning the Kansas Pharmacy Benefits Managers Act; establishing duties for pharmacy benefit managers; establishing penalties for violations of the act; amending K.S.A. 2006 Supp. 40-3821, 40-3822, 40-3824 and 40-3826 repealing the existing sections.

Gary Haulmark, CCPA, testified in support of SB 272. Mr. Haulmark testified that pharmacy benefit managers are the largely unregulated drug middlemen who administer the prescription drug benefit portion of health insurance plans for private companies, unions and governments. He stated further that PBMs manage all aspects of the prescription drug benefit plan, including creating formularies of preferred medicines, negotiating with drug manufacturers for discounts on rebates, and negotiating with pharmacies to establish retail networks for dispensing drugs. The proposed legislation is based on the Unfair Prescription Drug Practices Act. At its heart, the proposed legislation will allow employers and consumers the opportunity to make better decisions about the purchase of prescription drugs, he said. (Attachment 1)

Brian Caswell, on behalf of Kansas Pharmacists Association testified in support of SB 272. Mr. Caswell testified that as a plan sponsor, one should have access to the true overall cost of a plan benefit. He further testified that all rebates that are derived from drug management should be transparent to that plan sponsor. Any means to try and hide or misrepresent those rebates would be doing harm to the plan sponsor. Any plan sponsor who would contract with a PBM probably does so with the intent that the PBM is working in the plan sponsors best interest. Therefore, one would expect that a PBM has a fiduciary duty to that plan sponsor. SB 272 does just that. It requires any PBM to disclose to its client, financial gains that it has secured through its relationship with the plan sponsor, especially that of formulary rebates and "Spread Pricing" with generics, he said. He also stated that it protects the PBM industry's proprietary information, he said.. It would not and should not increase healthcare or prescription management costs, unless the PBM industry chooses to do so. SB 272 increases honesty. (Attachment 2)

Sam Boyajian, RPH, testified in support of SB 272 stating that pharmacies have been dealing with PBM abuses for years. PBMs have hidden the different ways of procuring monies that should have either been passed to the consumer or never should have been available in the first place. He said lack of transparency in their business dealings has given PBMs carte blanche to fleece the prescription drug side of the healthcare system of hundreds of millions of dollars and led to countless lawsuits across the country. He said PBMs claim they contain costs and keep prescription drugs affordable. Where then are all the savings they claim to have made for employers and patients, he asked? (Attachment 3)

John Kollhoff, Pharmacist, testified in support of SB 272. Mr. Kollhoff started his testimony citing some recent high profile court cases involving PBMs. Mr. Kollhoff stated that the PBM industry has proven that they are not able to conduct business in a responsible manner without close oversight. He continued by stating that the big PBMs have shown repeatedly that they are unwilling to transact business openly and honestly with anyone, including the United States government, the states, my patients and your constituents. (Attachment 4)

Bob Tomlinson, Assistant Insurance Commissioner, testified as a neutral party. Mr. Tomlinson testified that a few states, including Maine, have enacted legislation regarding PBMs. Mr. Tomlinson said the National Association of Insurance Commissioners and National Conference of Insurance Legislators are presently studying the PBM issue. The 2006 Kansas legislation required PBMs to register with the Kansas Insurance Department. In order to make sure this legislation could be implemented, the pharmacists worked closely with the Department. Currently, the Insurance Department can administer the program, he said. He further stated the Insurance Department's main concern is with the transparency in the business relationships. (Attachment 5)

Cindy Laubacher, Senior Director, State Government Affairs, Medco Health Solutions, Inc., testified in opposition to SB 272. Ms. Laubacher testified that SB 272 mandates that PBMs transfer any benefit or payment for certain transactions to the "covered entity." If PBMs are going to be required by law to disgorge any profit that they might make in certain transactions such as substituting a less expensive generic drug for a more expensive brand-name prescription, then shouldn't all for-profit entities in the pharmaceutical distribution and reimbursement systems be required to do the same? She stated that at a time when both public and private health plans are struggling to stretch limited resources into meaningful health benefits, state and national policymakers should be focused on encouraging the use of innovative and effective cost control techniques. There is also evidence that proposals such as SB 272 will result in added costs for both public and private plans. Given documented evidence of the value that PBMs provide to their customers, and the significant costs associated with SB 272, Ms. Laubacher said Medco opposes this bill. (Attachment 6)

Allen Horne, Vice President, Government Relations, Caremark Rx, testified in opposition to SB 272. He stated that Caremark opposes SB 272 because the legislation mandates a fiduciary duty to the covered entity. The legislation requires the PBM to transfer any benefit or payment in full that it receives if a generic or lower cost drug is substituted for a higher cost drug. Also, the Federal Trade Commission has stated that disclosure of PBMs cost structure and revenues would hold PBMs to a standard that does not apply to other industries, he said. (Attachment 7)

Michael Harrold, Express Scripts, testified in opposition to SB 272. Mr. Harrold testified that the benefits PBMs bring to the health care system have been studied and documented by the Federal Trade Commission, U. S. General Accounting Office, Congressional Budget Office and the Centers for Medicare and Medicaid Services. He stated that Express Scripts opposes SB 272 as an unnecessary and costly level of regulation of PBMs. PBM activities already are regulated at both the state and federal level and this bill would impose an inappropriate regulatory standard that will prove unworkable and drive up the cost of prescription drug benefits. Mr. Harrold said PBMs administer prescription drug benefits for employers and health plans. Mr. Harrold said PBMs play an integral part in providing affordable prescription drug benefits to patients in Kansas. They also promote better patient care by using sophisticated management systems to identify and reduce medical errors, he said. (Attachment 8)

William Sneed, Legislative Counsel for America's Health Insurance Plans (AHIP), testified in opposition to SB 272. Mr. Sneed said that based on review of SB 272, AHIP believes it will not be in the best interest of Kansas citizens and will have the potential to dramatically increase the cost of drugs, thus increasing health insurance premiums. (Attachment 9)

Q & A followed testimony. The Chair closed the hearing on SB 272.

The meeting adjourned at 10:30 a.m.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: 2-14-07

NAME	REPRESENTING
Alex Kotoyantz	P.I.A.
John Meetz	KIO
BRIAN CASWELL	KPhA
Jeff Deaton	Me
Natalie Hogg	Security Benefit
Gary Haulmark	NCPA
Lindy Laubacher	Medco
John C. Sottnik	CAREMARK
Allen Hayne	Caremark
Michael Fewell	Express Scripts
MIKE LARKIN	KPhA
LaneAnn Rowen	Medco
Bill Sneed	NHP / ExpressScripts

Senate Financial Institutions and Insurance Committee
Testimony Re: SB 272
Presented by Gary Haulmark
on behalf of the
National Community Pharmacists Association (NCPA)
February 14, 2007

Madam Chair, Members of the Committee:

Pharmacy benefit managers are the largely unregulated drug middlemen that administer the prescription drug benefit portion of health insurance plans for private companies, unions and governments. PBM's manage all aspects of the prescription drug benefit plan, including creating formularies of preferred medicines, negotiating with drug manufacturers for discounts on rebates, and negotiating with pharmacies to establish retail networks for dispensing drugs.

The proposed legislation is based on the Unfair Prescription Drug Practices Act, passed by the Maine legislature and signed by the governor in 2003.

At its heart we believe the proposed legislation will allow employers and consumers the opportunity to make better decisions about the purchase of prescription drugs.

The following are key provisions in the proposed legislation:

1. The PBM owes a fiduciary duty to the covered entity (employer, health plan, insurer, union, governmental unit).

A fiduciary is expected to be extremely loyal to the person to whom they owe the duty they must not put their personal interests before the duty, and must not profit from their position as a fiduciary, unless the principal consents.

2. The PBM shall notify the covered entity of any conflicts of interest, such as rebates from pharmaceutical companies and drug switching practices.

On "rebates" from pharmaceutical companies. The Federal Trade Commission has said:

Pharmaceutical manufacturers recognize that having their drugs listed on the formulary or in a preferred spot on the formulary (as compared to competing drug products) will likely increase the drug products' sales. . . . [P]harmaceutical manufacturers use "formulary payments" to obtain formulary status, and/or they use "market share payments" to encourage PBMs to dispense their drugs most industry members refer to these payments as "rebates". PBMs profit from rebates by retaining some or all of them instead of passing the savings on to plans and consumers.

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Attachment 1

The U.S. Government sued Caremark in 2002 under the Federal False Claims Act, claiming that Caremark solicited and received kickbacks from pharmaceutical manufactures in exchange for favorable treatment of their products under contract with the government. In September of 2005 Caremark settled for $137.5 million dollars.

PBMs also have conflicts by favoring higher priced drugs through drug switching. Drug switching, or "therapeutic substitution," occurs when a doctor prescribes one drug and the PBM requests to change the prescription to a different drug of similar therapeutic value. The PBM can profit off of the switch if the second drug has a higher rebate value or mark up than the initially prescribed drug.

In another case brought by the federal government in 2004, Medco agreed to pay $2.5 million in restitution to patients who incurred expenses related to drug switching between cholesterol drugs.

3. The PBM shall provide the covered entity all financial and utilization information requested by the covered entity relating to the provision of benefits for plan participants. This information can be designated confidential by the PBM.

PBMs increase their profits by "playing the spread" between the amount that is reimbursed by the PBM to a pharmacy for a prescription and the amount reimbursed to the PBM from a plan for the same prescription. Because each amount is independently negotiated and is normally kept secret from the other, the PBM can negotiate a higher reimbursement amount for itself than it pays to a participating pharmacy to dispense the prescription. For example, in one reported case a PBM billed an employer $215 for a generic stomach medicine, Ranitidine, but paid the pharmacy only $15 for the drug, pocketing the difference.

4. The PBM will notify the covered entity if they substitute a higher priced medication for the one prescribed by the doctor. If they do so any benefit gained will transfer to the covered entity.

If a benefit is gained from "drug switching" the benefit should go to the employer or covered entity and ultimately the consumer.

5. The PBM will pass to the covered entity all benefits gained for the dispensation of drugs within the state based on volume.

This is the market share rebate and again this is a benefit that should go to the employer or covered entity and ultimately the consumer.

6. The PBM will disclose all pharmaceutical manufacturer rebates to the covered entity. This information can be designated confidential by the PBM.

The employer or covered entity and ultimately the consumer deserve this full disclosure in order to make the best decisions about the purchase of prescription drugs.

Since the Maine law was enacted, the states of North Dakota, South Dakota, and the District of Columbia have enacted comprehensive legislation establishing PBM disclosure requirements. The D.C. statute also addresses fiduciary duty standards. Mississippi has enacted a law setting some financial standards for PBMs.

Thank you for your time today and will be glad to stand for any questions the committee may have.

Senate Financial Institutions and Insurance Committee
Testimony Re: SB 272
Presented by Brian Caswell
on behalf of
Kansas Pharmacists Association
February 14, 2007

Madam Chairman, Members of the Committee:

My name is Brian Caswell. I am Chairman of the Governmental Affairs Committee with the Kansas Pharmacists Association (KPhA), former President of KPhA, and a representative of the Kansas Pharmacy Coalition (KPC). I come today in full support of SB 272.

In practicing pharmacy over the past 20 years, I have witnessed an unfortunate revolution within the healthcare arena. I have watched as prescription prices have soared to unbelievable amounts, a subsequent increase in insurance covered medications, and an outgrowth of the insurance industry that manages that prescription benefit. That initial benign outgrowth of the insurance industry, which now oversees the prescription benefit of over 200 Million Americans, is called a prescription benefit manager, PBM. Initially PBM's managed the prescription coverage for Third Party Administrators (TPA), Insurance carriers, or self-funded employee benefit plans. The purpose was to eliminate the tedious and expensive overhead costs of processing prescription claims.

The PBM's would contract with pharmacy providers in order to streamline and centralize the payment process. With computerization of the pharmacy industry, the PBM's were quite pleased in partnering with pharmacy in order to further improve efficiency. That model lasted for only a few years until the PBM industry realigned its focus in order to "create more savings" by implementing preferred formularies. The impetus for this was to drive down costs to the client. In fact, what we have seen is a rather subsequent and dramatic increase in medication costs.

In order to place a medication on a preferred status with the drug plan, a drug manufacturer would need to pay a rebate back to the PBM. It is of my opinion that one of the reasons for increased medication costs in this country is due to the proliferation of formulary management that uses rebates as its primary focus of placement on a particular plans preferred formulary list. I would speculate that many manufacturers offset the cost of this rebate with an increase in cost of the drug. My basis for this reasoning is that over the past decade the use of formularies have increased dramatically. As formularies have expanded, manufacturers are forced to pay rebates on more drugs and pay higher rebates on some drug classes in order to stay competitive in the marketplace. As you can imagine, this has a cumulative financial impact on pharmaceutical care.

The dollar figures from formulary rebates to the PBM industry is a very closely guarded secret. The PBM's claim that it is proprietary information and it should be, but only to its

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Attachment 2

competitors. As a plan sponsor you should have access to the true overall cost of a plan benefit. All rebates that are derived from drug management should be transparent to that plan sponsor. Any means to try and hide or misrepresent those rebates would be doing harm to the plan sponsor.

Any plan sponsor that would contract with a PBM, probably does so with the intent that the PBM is working in the plan sponsors best interest. Therefore one would expect that a PBM has a fiduciary duty to that plan sponsor. SB 272 does just that. It requires any PBM to disclose to its client, financial gains that it has secured through its relationship with the plan sponsor, especially that of formulary rebates and "Spread Pricing" with generics. It protects the PBM industry's proprietary information. It would not and should not increase healthcare or prescription management costs, unless the PBM industry chooses to do so. SB 272 increases honesty. Why should honesty cost us more? It's time for more honesty. It's time for SB 272.

Thank you for allowing me to address the committee today on such an important issue. I will be glad to answer any questions the committee may have.

Brian Caswell R.Ph.

Kansas Pharmacists Association
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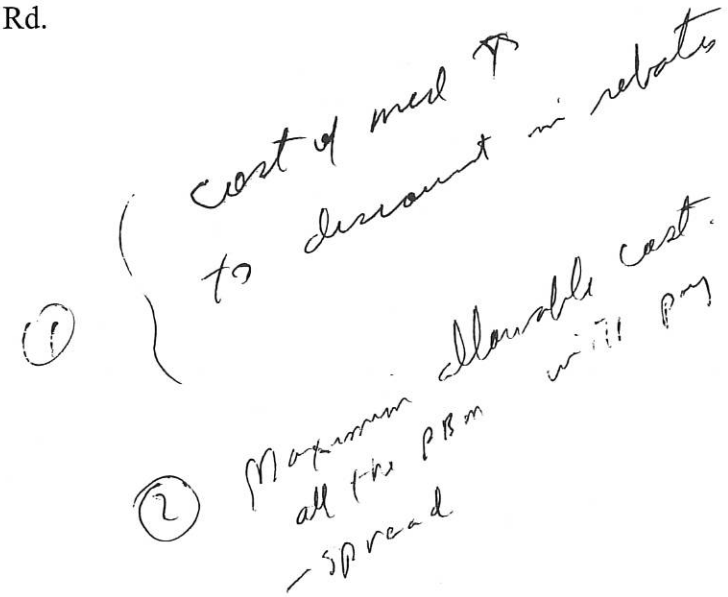
Topeka, KS 66604



Senate Financial Institutions and Insurance Committee
Testimony Re: SB 272
Presented by Sam H. Boyajian RPH
2/14/2007

Madam Chairman, Members of the Committee:

I come to you in support of SB 272.
Pharmacy Benefit Managers have unscrupulously manipulated our healthcare system to the extent of millions of dollars that should have stayed with the employer or covered group and ultimately should have been realized by the consumer. The real question is not "should this bill be passed", but, "what took so long".

Many years ago in the 80's, PBMs started to emerge, but only as pharmacy claim adjudicators. They served a valuable purpose as claims processors, at that time, but since then have figured out that there are billions of dollars to be had, at the expense of employers, pharmacies, and consumers. They have been relentless in their ability to siphon money out of a system that has local community pharmacies on the verge of closure, employers unable to offer healthcare to their employees and employees having to chose jobs based solely on healthcare insurance.

Pharmacies have been dealing with PBM abuses for years. We have watched as they have hidden the different ways of procuring monies that should have either been passed to the consumer or never should have been available in the first place. This lack of transparency in their business dealings has given PBMs carte blanche to fleece the prescription drug side of the healthcare system of hundreds of millions of dollars, and led to countless lawsuits across the country. We have watched as they have forced our patients into mail order only plans, only to find out that they not only may own the mail order pharmacies, but have found out through studies, that it is more expensive for the employer or covered entity, and eventually the patient, to use these mail order pharmacies. The difference of course goes right into the PBM's pockets. We have watched as they have forced "take it or leave it" contracts upon pharmacies, as they have continuously decreased reimbursement yet all the while manipulating formularies for drugs that have the highest rebate level for themselves. Rebates that should flow through to the employers and consumers. I believe that the right drug for a patient is the decision of the Doctor, patient, and pharmacist not the PBMs. However, lack of transparency allows these dealings to continue unchecked. The PBMs claim they contain costs and keep prescription drugs affordable. Have you noticed any decrease in prescription drugs in the last 20 years? Where then are all the savings they claim to have made for employers and patients?

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Attachment 3

While there may be, I cannot think of one industry that receives money for a service, that has no obligation or fiduciary duty to the entity that pays them, except PBMs. This is truly the "fox in charge of the hen house" metaphor at work. I ask that you make these PBMs accountable and start answering for their actions. Obviously, they will not do it on their own, which is why SB 272 is so necessary at this time.

Thank you for your time. I would be happy to stand for any questions you may have of me.

Senate Financial Institutions and Insurance Committee

Testimony in Support of SB 272

Presented by John Kollhoff, Pharmacist

February 14, 2007

Madam Chair and distinguished Senators:

It is my honor to be here today to speak in support of SB 272. I believe that requiring PBMs to act as a fiduciary to covered entities and disclosing their financial relationships with pharmaceutical manufacturers will allow Kansas employers to better assess their options when purchasing drug benefits. This should lead to a slowing of growth in drug spending for Kansas employers and consumers.

I would like to share with you some recent court cases involving PBMs. In addition, I will share with you some questionable practices I have discovered in my own personal experience and how they are affecting Kansans.

October 2006 – Medco pays $155M to settle allegations of kickbacks and Medicare fraud with the federal government and several former employees.

March 2006 – Jury finds Medco should pay $7.8M to Ohio STRS for fraud and breaching fiduciary duty.

April 2004 – Medco pays $5.5M to settle charges that it did not pass rebates to State of Massachusetts.

These are simply a few of the high profile cases. Dozens more lawsuits with similar allegations have been settled while others are pending in courts across the nation. The PBM industry has proven that they are not able to conduct business in a responsible manner without close oversight.

One of the changes that occurred when the Medicare Modernization Act was signed into law included issuing a monthly statement to every beneficiary accounting for his or her drug spending. Many patients brought these statements to their pharmacists for various reasons. As I looked at a one of them, I noticed that the amount the insurance company said they paid was significantly higher than the pharmacy was likely reimbursed for a particular generic drug. Further research found that this particular company was using this "spread pricing" tactic on many of the beneficiaries with whose Medicare drug plan they had been entrusted. Of the patients who shared their monthly statements with me, about one-third showed nothing significant. The remaining two-thirds showed price differences ranging from $0.03 per statement to over $120.00 on a single statement. One patient, who ended up in the "donut hole" or coverage gap in early October, was over-billed approximately $20 in one statement period, which would amount to almost $200 if the same practices took place from the beginning of the year until the time he reached the "donut hole" in October. Had this abuse not occurred, he would have likely enjoyed uninterrupted drug coverage until early November. I know you are aware of what $200 can mean to a senior on a fixed income.

The big PBMs have shown us repeatedly that they are unwilling to transact business openly and honestly with anyone, including the United States government, the States, my patients and your constituents. When a company will act in such a manner when the information is readily discoverable, imagine the liberties they will take when they are allowed to hide rebates and financial incentives they receive from pharmaceutical manufacturers from the many small and medium-sized Kansas businesses that purchase prescription plans for their employees.

I thank each of you for your time and for your service to the people of Kansas, and I will be happy to answer any questions.

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Attachment 4

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON
SB 272 – Kansas pharmacy benefits managers act
SENATE FINANCIAL INSTITUTIONS AND INSURANCE
February 14, 2007

Madam Chair and Members of the Committee:

Thank you for the opportunity to speak to the concepts contained in SB 272 which would enact the Kansas PBM act. A few states, including Maine, have enacted legislation regarding PBMs. The National Association of Insurance Commissioners and National Conference of Insurance Legislators are presently studying this issue.

2006 Kansas legislation required PBMs to register with the Kansas Insurance Department and to date most have registered.

In order to make sure this legislation could be implemented, the pharmacists worked closely with the Department. Currently, the Department could administer the program.

However, our main concern is with the transparency in the business relationships.

The Department would suggest some changes to make this bill even more functional.

- By eliminating Section 1 of the bill, the concern of transparency in the business relationships would be emphasized.
- Second, consider removing insurance companies with self contained PBMS from legislation. Currently, the insurance company itself is under fiduciary and regulatory examination therefore, the PBM would be included.
- Third, work with the industry to see if we can come to more suitable PBM language for the State of Kansas.

Thank you for the opportunity to speak and I would be happy to stand for any questions you may have.

Bob Tomlinson
Assistant Insurance Commissioner

F I & I
2-14-07
Attachment 5

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TESTIMONY SUBMITTED IN OPPOSITION TO KS SB 272

SENATE COMMITTEE on FINANCIAL INSTITUTIONS and INSURANCE

Submitted by:

Cindy Laubacher
Senior Director, State Government Affairs
Medco Health Solutions, Inc.

February 14, 2007

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Attachment 6

Madame Chairwoman, and members of the Committee, my name is Cindy Laubacher and I am Senior Director of State Government Affairs for Medco Health Solutions, Inc., which is a pharmacy benefits management company, or "PBM." Thank you for this opportunity to testify today regarding our opposition to Senate Bill 272. We believe that the private marketplace is working, and there is no need for additional regulation in this area.

Medco is a leading provider of comprehensive, high-quality, affordable prescription drug care in the United States. We manage prescription drug benefit for approximately 400,000 Kansas residents – or about 14% of the state's population. As such, we are registered in the state both as a non-resident pharmacy and as a third party administrator.

We work with employers, health plan sponsors, patients, pharmacists and physicians to improve the quality of pharmaceutical care provided to patients while helping to control the growth in drug costs. We work under contract with health plan clients throughout the country that are providing prescription drug benefits for their members and employees, totaling more than 60 million covered lives. Our clients are very sophisticated health care purchasers, including:

- Fortune 500 corporations and smaller employers
- local, state and federal employee and retiree groups
- Blue Cross/Blue Shield plans
- unions, and
- insurance carriers and managed care plans.

Usually assisted by benefits consulting firms, our customers – "covered entities" as defined in this bill – design the voluntary benefit that they want to offer to their employees and/or members. That plan design includes such factors as members' cost-sharing in the form of deductibles and co-payments, use of mail service or retail pharmacies, the list of drugs to be

covered under the plan, and the conditions under which drug substitution programs will be permitted.

In a competitive bidding process, and again often with the assistance of consultants, the customers issue lengthy Requests for Proposals (RFPs) outlining their plan design requirements. An RFP includes any other factors that the customer (or potential customer) deems to be important, which can – but does not always – include such issues as fiduciary responsibilities, disclosure of financial information, allocation of manufacturer rebates that the PBM receives from pharmaceutical manufacturers, and other financial terms between the parties.

This process takes place in a very competitive environment. In fact, the Federal Trade Commission determined that there is "vigorous" competition within the marketplace for PBM services. [1] The agency has noted that there are approximately 40-60 PBMs – some standalone such as Medco, some owned by health plans such as Anthem/Wellpoint, some owned by chain drugstores such as CVS or Walgreens, some national, and some regional. Given this crowded marketplace and the growing application of benefit consultants who have specific knowledge about the discount that payors can achieve, the "covered entity" has significant leverage over the PBMs that compete for their business.

That leverage has resulted in "covered entities" driving the terms of their pharmacy benefit plan in a manner that best suits their unique individual needs. Case in point: every deal is different; there is no such thing as a typical or "form" contract for PBM services. Given the fact that the marketplace has requested and received such a wide variety of solutions, it would be against the best interests of "covered entities to limit what they can have by imposing on them a one-size-fits-all solution as is the case with SB 272. There is no need for the state to mandate

[1]Federal Trade Commission, *In re* Caremark Rx, Inc. / AdvancePCS, February 11, 2004

specific approaches to issues such as disclosure and a fiduciary obligation when the marketplace already can and does address those issues every day.

The fiduciary role in health care is clearly defined under the federal ERISA statute as an entity that exercises discretionary authority over plan assets or the administration of the plan. As a general rule, PBMs do not exercise such authority, and have no control of plan assets. Since the health plan determines the formulary, cost-sharing, and other discretionary aspects of the drug benefit, it is the health plan, not the PBM that occupies the role of the ERISA fiduciary.

Furthermore, after reviewing the role of a PBM, the U.S. First Circuit concluded that "such duties are purely ministerial and simply not sufficient for us to find that the PBMs are acting as fiduciaries under ERISA."[2] In Bickley v. Caremark RX, Inc. & Caremark, Inc., the court found that "making an advantageous contractual agreement with an ERISA plan does not make one an ERISA fiduciary."[3]

While there are some customers that do include in their RFP a request for the winning PBM to assume fiduciary responsibility for some discrete functions (*e.g.,* handling grievances and appeals, which can entail the exercise of some discretionary authority), those requirements are nothing like the broad requirements in SB 272, which would declare a PBM to be a fiduciary for *all* functions. Those PBMs that are interested in bidding on the terms established by the purchaser in the RFP submit bids and the parties negotiate the terms, with the advice and counsel of their respective attorneys and the purchaser's consultant.

In addition, there is no movement among PBM-clients to establish a universal fiduciary role for PBMs. This is largely because the payor is concerned about the bottom line: what are

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[2] PCMA v. Rowe; U.S. First Circuit Court of Appeal case No.:05-1606, 11/8/2005 (p.45): (opinion available at : http://www.ca1.uscourts.gov/ last accessed 11/2005).

[3] *Bickley v. Caremark RX, Inc. & Caremark, Inc., 361 F. Supp. 2d 1317 (N.D. AL 2004)*:

my drug costs and how are they changing? As a result, most payors are focused on obtaining guarantees for the lowest possible price -- frequently eschewing rebates and opting instead to leave the PBM "at risk" to obtain the guaranteed discounts.

Requiring PBMs to disclose confidential elements of their cost structure and revenue streams would be a drastic departure from the free-market principles that provide the basis for our economy. What other private sector business has a statutory obligation to disclose its proprietary financial information to its customers as this bill would mandate? As the Federal Trade Commission (FTC) has concluded, state laws mandating disclosure of PBMs' cost structure and revenues would "hold PBMs to a standard that does not apply to other industries."[4] No other industry is subjected to such disclosure requirements – and for good reason, as such requirements would hinder price competition. The FTC further concluded that "[v]igorous competition in the marketplace for PBMs is more likely to arrive at an economically efficient level of transparency than regulation of those terms."[5]

Finally, the bill mandates that PBMs transfer any benefit or payment for certain transactions to the "covered entity." If PBMs are going to be required by law to disgorge any profit that they might make in certain transactions (*e.g.,* substituting a less expensive generic drug for a more expensive brand-name prescription, then shouldn't *all* for-profit entities in the pharmaceutical distribution and reimbursement systems – from independent pharmacies to chain drugstores to supermarkets and other mass merchandisers, from manufacturers to wholesalers to insurers – be required to do the same? Why force one player in that sector to give up its profits, but not any of the other players?

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[4] Federal Trade Commission letter to Assembly Member Greg Aghazarian on California's AB1960, September 3, 2004

[5] Federal Trade Commission letter to Assembly Member Greg Aghazarian on California's AB1960, September 3, 2004

At a time when both public and private health plans are struggling to stretch limited resources into meaningful health benefits, state and national policymakers should be focused on encouraging the use of innovative and effective cost control techniques. There is a growing body of objective, nonpartisan evidence documenting the savings that PBMs provide for their customers:

- The federal General Accounting Office (GAO) found that PBM retail prices for brand-name drugs were about 18% lower than the retail prices paid by patients without third-party coverage and generic prices were about 47% lower. At mail, PBMs provide even greater savings - about 27% and 53% for brand and generic drugs, respectively.[6]
- The Congressional Budget Office (CBO) estimated that PBMs could save between 25 and 30 percent if used to administer a Medicare drug benefit.[7]
- The Federal Trade Commission found that consumers with a PBM-administered plan saved "substantially" on their drug costs as compared to cash paying customers.[8]
- PricewaterhouseCoopers estimated that PBMs reduced drug costs by 25% compared to retail prices for patients without coverage, and that total system-wide saving achieved by PBMs will reach $1.3 trillion over ten years.[9]
- An analysis from the Heritage Foundation determined that PBMs provide value for patients by reducing costs and by promoting the better use of prescription drugs.[10]
- And at Medco, we are proud of the fact that drug trend (or the rate of increase in prescription drug costs) for our clients has declined progressively over the past five years from a high of 16.4% in 1999 to 5.4% in 2005. Nationally, the federal Centers for Medicare and Medicaid Services (CMS) has also documented the marked deceleration in prescription drug spending. In fact, they point out that in 2005, prescription drug trend was 5.8% nationally – lower than the rate of spending increases for each of the other health care service sectors. CMS attributes this moderation in prescription drug spending to several factors including the greater use of generics, which they point out has been aided by a continued growth in mail service pharmacy, and a greater reliance on tiered formularies[11], some of the tools that PBMs have brought to the marketplace and offer to their clients.

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[6] GAO Report: Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies (1/2003)

[7] CBO Cost Estimate: H.R. 4680. Medicare Rx 2000 Act (6/28/2000); in testimony one year later (6/8/2001), CBO provided updated savings estimates of 30 percent.

[8] PricewaterhouseCoopers Report: The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation (7/15/2004)

[9] PricewaterhouseCoopers Report: The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation (7/15/2004)

[10] Heritage Foundation Backgrounder: Compromising Quality: The High Cost of Government Drug Purchasing (5/25/2004)

[11] *Health Affairs* article: National Health Spending in 2005: The Slowdown Continues. January/February 2007 edition; volume 26, number 1. Available at: http://content.healthaffairs.org/cgi/content/full/26/1/142Accessed February 7, 2007.

At the same time, there is also evidence that proposals such as SB 272 will result in added costs for both public and private plans. For example, by forcing a fiduciary obligation on every PBM contract and by requiring that PBMs disclose the discounts they negotiate from drug companies, this bill would likely increase prescription drugs costs in Kansas by more than $981 million over a ten-year period.[12]

Given this documented evidence of the value that PBMs provide to their customers, and the significant costs associated with SB 272, we respectfully request that you oppose this bill. Thank you for your consideration of our views. I would be happy to answer any questions that members of the Committee might have.

[12] PricewaterhouseCoopers Report: The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation (7/15/2004)

Allen Horne
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Statement of Allen Horne
Vice President, Government Relations
Caremark Rx
Before the Senate Financial Institutions and Insurance Committee
Regarding SB 272

Madame Chair and Members:

I am Allen Horne, Vice President of Government Relations for Caremark. Caremark is a pharmacy benefit manager (PBM) whose clients include Fortune 500 companies, local, state and federal employee and retiree groups, unions and health insurers.

We work with our clients, their participants and health care providers to improve the quality of pharmaceutical care and services provided to patients while controlling costs. At the end of the day, if we don't improve services and assist in lowering costs to our clients, we will find ourselves out of a contract with that client.

In order to get a client's business, we must go through a highly competitive Request for Proposal (RFP) process. It is in this RFP process and the subsequent contracting process that a client is able to clearly delineate what is expected of their PBM, including the level of "transparency."

Caremark opposes SB 272 for the following reasons:

Fiduciary status – The legislation mandates a fiduciary duty to the covered entity. A fiduciary is one who has authority over plan assets, however this situation generally does not occur in the PBM to covered entity relationship.

Transfer of any benefit or payments – The legislation requires the PBM to transfer any benefit or payment in full that it receives if a generic or lower cost drug is substituted for a higher cost drug. PBMs by their nature are there to help payers and enrollees save on pharmaceutical costs. If PBMs are not able to share in the aligned incentives of their clients, why are other businesses in the pharmacy or health care avenue not being asked to forego any of their potential profits?

Disclosure of drug manufacturer contracts – The Federal Trade Commission has stated that disclosure of PBM's cost structure and revenues would "hold PBMs to a standard that does not apply to other industries." Further, what businesses are mandated to share proprietary financial information to its customers?

Respectfully, Caremark urges the members of this committee to reject SB 272 as legislatures have done across the United States.

Thank you.

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STATEMENT SUBMITTED

BY

EXPRESS SCRIPTS

TO THE

KANSAS SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

IN OPPOSITION TO SENATE BILL 272

FEBRUARY 14, 2007

Express Scripts is one of the largest Pharmacy Benefit Management Companies (PBM) in North America. Express Scripts works with over 10,000 client organizations to help manage costs, assist physicians and pharmacists in improving effectiveness and safety in the use of prescription medications and keep access to quality prescription medications affordable for more than 50 million people. Over 450 million prescriptions a year are written for members of pharmacy benefit plans administered by Express Scripts.

The value, benefits and savings PBMs bring to the health care system have been studied and documented by the Federal Trade Commission (FTC), U.S. General Accounting Office (GAO), Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS).

Express Scripts opposes Senate Bill 272 as an unnecessary and costly level of regulation of PBMs. PBM activities already are regulated at both the state and federal level and this bill would impose an inappropriate regulatory standard that will prove unworkable and drive up the cost of prescription drug benefits.

Senate Bill 272 is based on the incorrect assumptions that the benefits administered by PBMs are not currently protected by state and federal law and that PBMs somehow assume underwriting or financial risk for those benefits and therefore have some fiduciary relationship with health plan members.

PBMs administer prescription drug benefits for employers and health plans. Those benefits are protected under current Kansas law if they are insured plans and under federal ERISA law if they are self-insured plans.

Insured Plans - The drug benefits of these plans are subject to extensive regulatory controls on managed care contracts, including:

- disclosure as to co-payments, deductibles or other out-of-pocket expenses the enrollee must pay,
- the nature of the health care services, benefits or coverage to be furnished, and

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- the use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered.

State law also sets guidelines for network adequacy, prompt payment of claims and appeal rights of members. The Department of Insurance has full jurisdiction over the health plans that offer these benefits. The PBMs are bound by their contracts with the health plans to administer the prescription drug benefits in accordance with state law.

Self-Insured Plans - The Federal Department of Labor regulates ERISA Employer Group Health Benefit Plans, including claim payment and coverage decisions. This includes the benefits administered by PBMs. The Plan sponsors have a fiduciary obligation to the people covered under their plans. Again, PBMs are contractually obligated to administer their programs in a manner consistent with the requirements of ERISA that are applicable to the plan sponsor.

Additional regulation is unnecessary. Its only purposes would be to increase the cost of administration of PBMs, foster unnecessary and costly litigation and interfere with private contractual negotiations in a competitive market.

Specific Concerns with Senate Bill 272

Section 1 of the bill states that a pharmacy benefits manager owes a fiduciary duty to a covered entity in accordance with state and federal law and shall perform its duties with care, skill, prudence and diligence and in accordance with the standards of conduct applicable to a fiduciary in an enterprise of a like character and with like aims.

Since there are no like enterprises, since PBMs are not acting as fiduciaries and since this bill does not state who those duties relate to, this creates an impossible standard for compliance.

PBMs are *not* fiduciaries under the federal ERISA statute, and it would be inappropriate for states to require PBMs to adhere to state fiduciary standards that simply do not apply. In determining whether an entity is acting in a fiduciary capacity under ERISA, the key factor is whether that entity is exercising any discretionary authority in connection with plan assets or the administration of the plan. PBMs do not exercise such authority. PBMs administer the plan design that the health plan clients have decided to offer to their members. The plans choose their formulary, the members' cost-sharing obligations, and other aspects of plan design. PBMs do not have any control over plan assets.

"Fiduciary duty" is a term of art under ERISA with significant regulatory attention and determination and delineation by the federal courts. To misapply it to an entity for which it was never intended is extremely dangerous from a legal perspective and unwarranted based on the nature of the function and obligations of PBMs.

In addition, federal law is very clear that an entity is a fiduciary *only* in connection with the specific functions that involve the use of such discretionary authority. In other words, ERISA deems an entity to be a fiduciary only with regard to a specific function, not with regard to *all* functions. This bill goes well beyond the language, intent and scope of the federal statute.

ERISA was designed to bring a needed level of uniformity across the nation in the administration of employer health plans. Imposing this new application of "fiduciary obligation" where no such obligation arises from the nature of the service provided, and which the Congress has not seen fit to enact, would be in direct conflict with ERISA and extremely disruptive to the administration of employer health plans.

PBMs contract with very sophisticated public and private health plans to administer the prescription drug benefit for the plans' members. If the health plan wants the PBM to act in a fiduciary capacity, the health plan and the PBM can agree on the scope of the fiduciary obligations as part of the contracting process. There is no need for the state to declare all PBMs to be fiduciaries for all purposes.

Health plans have enforceable contracts and do not need to have their rights further protected by deeming their contractual partners, the PBMs, to be fiduciaries as to those health plans.

The health plans have not asked for such protection, federal law has not seen the need for it and the courts have not seen the need for it. Why would the state of Kansas see the need to protect large corporations and health plans which do not need and have not asked for such protection?

There is no need for the state to intrude into this marketplace. The health plan, not the PBM, determines the formulary and other aspects of plan design that it is offering to its enrollees. Prescribing physicians, not the PBMs, write the prescription for the drug that they believe is appropriate for the patient.

It is true that the First Circuit Court of Appeals recently upheld a similar law in Maine but that decision is inconsistent with a pending ruling in the 4th Circuit on a similar DC law. It is also entirely inconsistent with the most recent major US Supreme Court ERISA case, *Aetna v. Davila*, in which the Supreme Court unanimously reaffirmed that the purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. See, 124 S. Ct. 2488 (2004). The High Court observed that ERISA includes expansive preemption provisions which are intended to ensure that employee benefit plan regulation would be exclusively a federal concern. This fiduciary obligation at the state level clearly interferes with the ability of a benefit plan to uniformly administer its program and it clearly interferes with exclusive federal remedies.

Section 1(d)(2) requires the PBM to pass on to the client any benefits from drug substitution or generic substitution and **Section 1(e)** requires the same as to volume of sales.

The issue of which benefits are passed on to the client and which are retained by the PBM are negotiated at the time of contracting, normally specified in the RFP that the health plan customer sends out. Benefits may be left with the PBM to reduce the administrative fees charged and this decision is made by the client.

The state should not be in the business of setting the terms of private contracts between sophisticated corporate entities or tying the negotiating hands of health plan purchasers of administrative services.

Section 1(f)(1) requires disclosure by the PBM of all forms of remuneration that a PBM may receive. Some of these are not directly related to the services provided to individual clients and therefore there should be no statutory obligation to disclose them to the client. Our contracts permit full audits by our clients and the contracts negotiated with clients can specify exactly what information they want us to provide to them. Again, there is no need for the state to interfere with the ability of private parties to contract as they wish. If clients want full disclosure, they can contract for it. They can also seek less disclosure if they are not interested or wish to avoid the administrative expense.

PBMs play an integral part in providing affordable prescription drug benefits to patients in Kansas. They also promote better patient care by using sophisticated management systems to identify and reduce medical errors.

Senate Bill 272 will do nothing to enhance the ability of PBMs to perform these functions. On the contrary, it will inhibit these activities, and drive up the cost of health plans in providing prescription drug benefits. For these reasons, Express Scripts urges members of the Senate Financial Institutions Committee to oppose the passage of Senate Bill 272.

Polsinelli | Shalton
Welte | Suelthaus PC

Memorandum

TO: THE HONORABLE RUTH TEICHMAN, CHAIR
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
AMERICA'S HEALTH INSURANCE PLANS

RE: S.B. 239

DATE: FEBRUARY 13, 2007

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for America's Health Insurance Plans ("AHIP"). AHIP is a trade association representing nearly 1,300 member companies providing health insurance coverage to more than two million Americans. Our member companies offer medical expense insurance; long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers. We appreciate the opportunity to present testimony in support of proposed amendments to S.B. 239, and thereafter, support of the bill.

The Kansas Insurance Department in an effort to expand the prompt pay laws for both dental and long-term care approached my client relative to this proposal. Inasmuch as our member companies that sell long-term care policies do so on a national basis, we requested the Department mirror those statutes already in effect in the country.

To meet that goal, the Department introduced a new statute dealing with long-term care and prompt pay as opposed to simply inserting long-term care in the current law. Long-term care, although sold under the license of an accident and health certificate is truly not accident and health in the traditional sense and as such my clients attempt, whenever possible, to separate long-term care statutes from accident and health statutes.

Secondly, my client requested that the Department change on Page 2, line 15, the number of days from 15 to 30. Again, as we sell throughout the country state laws, which do provide for prompt pay statutes relative to long-term care contracts, have a 30-day timeframe. Although most if not all clean claims are paid well in advance of that, we respectfully request that Kansas mirror those other states for ease of administration and to continue to keep costs down.

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Based on the foregoing and with the amendments we would respectfully request that the committee approve the amendments and pass the bill out as amended, favorably. I'm available for questions at your convenience.

Respectfully submitted,

William W. Sneed

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