MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1366

2007 HOUSE HUMAN SERVICES

HB 1366

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1366

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 6, 2007

Recorder Job Number: 2895

Committee Clerk Signature

Minutes:

Chairman Price: We will open the hearing on HB 1366.

Representative George Keiser, District 47: This is an important bill to both parties for providing prescriptions to the residence of the state. It would be a pharmacy manage benefit plan. It would allow them to give 90 days of meds for 1 co pay instead of 30 days, and pay a co pay each time. The pharmacist at times is the only health care in the community.

Representative Jim Kasper, District 46: We had 7 meetings and nothing really came out. Blue Cross Blue Shield does own there own PBM. PBM have a competitive advantage. The current plan now is only 30 supplies and not a 90 day supply.

Senator Nick Hacker, District 42: Just a reminder that the people in the rural areas need our support and this would be an advantage to them.

Dan Churchill, testifying for the ND Pharmacist's association: See attached testimony. PBM forces people to use mail order pharmacies. There is more profit if you own PBM.

Rod St. Aubyn, representing Blue Cross, Blue Shield: See attached I am opposed to the bill. Blue Cross plans are independent. We can sell only to ND. Blue Cross owns 5.2% of their PBM. Blue Cross does not show a profit with their PBM. I dispute this would be helping the consumer. It limits where you can go.

Pat Ward, with MED CO: We learned PBM structure is very complicated. The Statue passed is working. It is an issue of consumer choice. I urge you to leave this alone. PBM always make this more competitive.

Peter Hardy, Vice President of MED CO Health Solutions Inc: the question would be if there is a benefit? It should be up to the payer to make the decision. Some have limited dollars and make most efficient use of their dollars. It is cheaper to use mail service than average pharmacy. It is a large saving to companies to do mail order. Why would some employers want to have an incentive for mail order, because it saves money. Employers encourage employees to use mail order as a savings. It is a consumer benefit as well as the payer. There is nothing in here that says pharmacies take the same rate. Will they all be filled at a higher retail rate or lower mail service rate? Retail pharmacies fill 80% of the prescriptions, but mail order is growing. You can call toll free 24-7 for prescriptions from the privacy of your home. We maintain a data base no matter where you fill. This language was similar in the bill last session. The difference is price (AWP discount). CMS published paper looked at what we spend on drugs. In 2005 data showed 5.5% decrease and that is due to increase of mail service. Do we really want to take away the ability of the payer to have savings on prescriptions drugs? Some of the larger companies showed a tremendous savings after having gone to this type of program. Attached is federal information.

Robert Harms Caremark, RX Inc.: See attached testimony along with letter.

Michael Harrold, with Express Scripts: I am against the bill

Chairman Price: Anyone else in favor of HB 1366? Anyone in opposition of HB 1366? If not we will close the hearing on HB 1366

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1366

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 7, 2007

Recorder Job Number: could not hear minutes

Committee Clerk Signature Judy Schock

Minutes:

Chairman Price: Let's take out HB 1366 and take action on the bill.

Representative Weisz: I move a do not pass**, Representative Schneider** seconded the motion.

Chairman Price: asks for discussion on the bill, not hearing any we will take the vote with 8 yeas, 4 nays, and 0 absent. **Representative Schneider** will carry the bill to the floor.

Date: 2/7
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1366 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Rep. Weisz Seconded By Rep. Schneider

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman		✓	Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor		✓
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad		✓	Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter		✓			
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) "Click here to type Yes Vote" 8 No "Click here to type No Vote" 4

Absent 0

Floor Assignment Rep. Schneider

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1366: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (8 YEAS, 4 NAYS, 0 ABSENT AND NOT VOTING). HB 1366 was placed on the Eleventh order on the calendar.

2007 SENATE HUMAN SERVICES

HB 1366

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1366

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3-14-07

Recorder Job Number: 5051, 5084

Committee Clerk Signature Mary K Monson

Minutes:

JOB # 5051

Roll was taken and all members were present.

Chairman Judy Lee opened the public hearing on HB 1366.

Representative George Keiser from District 47 introduced and testified in support of this bill. From a policy standpoint they need to make a determination to what degree they want to support our local pharmacists. In many rural communities there aren't local pharmacists any more. Even in our more urban areas there are fewer pharmacists. They do provide a very important service to the people of our state. This bill aims to create a level playing field for our local pharmacists. It will not affect people covered by Medicare Part D or ERISA. It deals with people who are not with a large company so they are not able to be self insured. After the bill was heard on the House side, BC/BS said they already allow a 90 day prescription for all providers. This bill just says for those programs we do control make it a level playing field. Our local pharmacists would like to fill as many prescriptions as possible.

Senator Dever asked if Representative Keiser could explain how the PBM's (Pharmacy Benefits Managers) and the whole process works. He wants to know how pharmacists are treated differently. Is it a contractual thing?

Representative Keiser said PBM's provide a very good service. It was a clearinghouse to receive approval. Is this person qualified under this plan? As a control mechanism it was initiated so that the pharmacist would call the PBM and say is this individual covered under BC/BS through the state. The PBM would say yes he is and there might be some limits in the plan that the pharmacist would have to address in filling the prescription, but it was more of a paper management system rather than an electronic management system. You would get prior approval for filling prescriptions. PBM systems have evolved from that. Today they are actually writing formularies, negotiating prices and managing the delivery of pharmaceutical products mail order and in other forms. It has become a principle part of their business line. As a result they are motivated to maximize that part of their business. It does potentially directly or indirectly cut out the activity of the local pharmacist. If everyone in our state goes mail order, there will not be pharmacists and there will not be a need for pharmacists. They could sell some of these items but they certainly wouldn't need to go to school and spend five years getting a degree.

Senator Lee said she always tries to draw a parallel with an industry she is familiar with. In the mortgage lending business a parallel would be, if they would try to limit people from going to website lenders. She finds website lenders to be extremely frustrating and occasionally incompetent. She would love it if all the real estate companies would have to charge the same brokerage fee even though anti-trust laws at the federal level would probably not agree with it. She asked why that would be different.

Representative Keiser said banks get into the real estate business and they have insurance businesses already. They have all of the financial side covered. They get into the real estate, they get into the mortgage, they get into everything. Is it good policy and should we address it.? They could come to him and say, "Look, if you do everything with us we're going to give

you a significantly lower rate." The question is, is that good policy? Maybe it is because if it is they will be happy to do it.

Senator Lee asked if it would be good for the consumer.

Representative Keiser said that is the policy question.

Senator Lee said on the one hand she does her business with local lenders because that is who does business with her. She believes in doing business with her local business people. She has great frustration with the way some of those web based lending institutions do business. There is a generation that believes that if it's on the web it must be true. She agrees with doing business locally but she wonders if we are interfering with the ability of the consumer to make some choices that help their pocketbooks with co-pays and private pays.

Representative Keiser said one concern he has is how you go off the books. How can you treat money? A more direct analogy is they just heard in the House the Walmart banking bill which the Senate had heard. Should retail stores be allowed to own banks and put them in their store and use lost leaders within their store to offset, have a higher interest rate but offset with a loss leader. The Senate has taken a policy decision on that and the House is currently deliberating that. In this case if I own a mail order catalog, if a PBM owns a mail order catalog or an insurance company owns part of a PBM and part of a mail order catalog how do the dollars flow? When I get ready to write premiums do those dollars come in as profits to the health insurance company or are they kept offline so that when he goes to the insurance commissioner he gets a bigger rate increase on his premium because this is a free standing separate corporation over here. Although I own it, how do I move those dollars? How do I account for the profitability or loss of the transactions? That is a concern that we have here.

Senator Lee said if she has two businesses she cannot deduct the loss of one against the profits of another.

Representative Keiser said he thinks you can with good financial expertise. He said he does it all the time. He competes with the state printing shop here in the building. They charge a fee to the state printing shop per square foot. It has no correlation with what the real cost is. They don't have an accounting department. That is up in OMB. They don't have any legal fees. That's going to be administratively handled. They don't have to provide a lunchroom. They don't have to provide parking spaces. They have one but they don't have to pay for it so they can say our cost to operate is $7.00 because they can share the administration cost when you have useful ownership and you don't see it. Again it comes back to the policy. It comes back to this bill. Do we want to protect our local pharmacists and keep them in business or do we want to not protect them? He believes it is good policy to have our pharmacists in the state.

Senator Dever asked if the pharmacists are asking for this bill.

Representative Keiser said they will be testifying and he thinks they support it very strongly. This is the one area dealing with the PBM's that repeatedly surfaced during the interim. Pharmacists did not come to him and ask him to introduce the bill.

Representative Jim Kasper from District 46 said the bottom line of the bill is in prescription drug management the controlling entity is the PBM in almost all cases. The PBM contracts with local pharmacists for reimbursement rate. There are a number of PBM's in North Dakota who contract with pharmacists in North Dakota and the contracting rates could be different for drugs and for the different PBM's. That is good competition. Where we have a problem in the competitive market in North Dakota is in the amount of the prescription the individual can order or purchase from the local pharmacist compared to the mail order. If the consumer buys from the local pharmacist he has to pay three co-pays, whereas through mail order he has to pay only one co-pay. This bill simply says whatever a PBM will offer a consumer on a mail order purchase you have to also allow the local pharmacist to have the same opportunity. It doesn't

get into costs. To compare it to the real estate, if you in the real estate had to compete with other realtors who were able to be 2/3 lower in price than what you are and you would not be able to lower your price or not control your price because it was set by some outside entity, you couldn't stay in business very long.

Senator Lee said they do compete with some people who do charge significantly less than they do.

Dan Churchill testified on behalf of the North Dakota Pharmacist's Association. See attachment # 1.

Senator Dever asked about his comment that he has had a number of patients that have had no choice but to get their prescriptions from their PBM's mail order pharmacy. Are PBM's the supplier and the competitor of local pharmacies?

Mr. Churchill said that is so but they don't think it is right when people are forced, incentivized or economically forced to order from mail order companies. BC/BS of North Dakota doesn't do that. They allow their people to choose where to fill their prescriptions. North Dakota Pharmacists appreciate that. It helps them care for their patients and BC of North Dakota probably has a healthier membership because of that.

Senator Dever asked if some insurance plans require mail order.

Mr. Churchill said that some of them force their beneficiaries to go through mail order. Some plans say for the first two months you can go to your local pharmacy and after that you must go to mail order. Some of them will allow you to continue to go to the local pharmacy but will only allow you to get a one month supply through the local pharmacy and a three month supply through the mail order pharmacy.

John Olson, representing the North Dakota Pharmacy Services Corporation, spoke in full support of the bill. The North Dakota Pharmacy Services Corporation works closely with the Pharmacists Association and is comprised mainly of retail pharmacists.

Kyle Schwandt, a Pharm D student from the NDSU College of Pharmacy, spoke in support of the bill. See attachment # 2.

Senator Erbele asked if Kyle knew why the restriction was put in place.

Kyle said he didn't know.

Senator Warner asked if Kyle knew of any insurance companies that required only mail order.

Kyle said he was not aware of any.

Opposition: -

Pat Ward with Medco Health Solutions spoke in opposition to the bill. See attachment # 3.

Rod St. Aubyn, representing BC/BS of North Dakota, strongly opposed HB 1366. See attachment # 4. He disagreed with prior testimony that it would not affect PERS and Blue Cross. He said it definitely would. He stated that the PBM's are very competitive. When Blue Cross was looking for a PBM they put it out for bids and a number of PBMs bid on it. He addressed some of the previously made comments (audio 55:20). He referred to George Keiser saying the PBM's write formularies. The health plan is what determines the formulary for the health plan. In BCBS of North Dakota the formulary committee is made up of ND pharmacists and ND physicians. A rep from the PBM sits in on it for technical expertise and information but it is the formulary committee that determines which drugs are payable and which drugs are on the formulary and which are not. The PBM doesn't determine that. There was a comment made about how do profits flow to another insurance company if they own their own PBM and/ or mail order. All of their records are reviewed by the insurance commissioner's office. If there are any profits that come back from the PBM it is collected in

their audits so the insurance commissioner has full access to that information. He suggested asking the attorney general's office if the bill will affect Medicare.

Senator Lee asked if Mr. St. Aubin feels there is confusion on the part of the public if they are part of a self funded plan or not.

Mr. St. Aubin said that is the case. Most people don't know. Typically the self funded plans are the larger employers, school districts, city government and large entities that are not part of PERS.

Bob Harms spoke on behalf of Caremark, Rx Inc. in opposition to HB 1366. See attachment # 5.

Senator Lee asked if any states have legislation of this sort.

Mr. Harms said SD, ME, Washington DC, and one other state have looked at PBM legislation and none of them include restrictions on mail order such as what is being considered here.

Todd Kranda spoke on behalf of Express Scripts. He spoke to oppose HB 1366.

Neutral: - none

Michael Mullen, the Assistant Attorney General, was asked to step to the podium to take questions. He wanted to go on record as stating the Attorney General is neutral on this issue. For the record he also stated he does not have any vested interest in this bill.

Senator Lee asked if he would see any conflict between this bill and Medicare Part D.

Mr. Mullen said in his view the federal legislation that established the Medicare Part D contains a provision that he thinks explicitly exempts the Medicare Part D plans from state laws regulating prescription drugs. He cited US Code 42 1395W-26B3 that states Medicare Part D regulations supersede any state law regulating dispensing of prescription drugs.

Senator Lee asked about restraint of trade and federal and state anti-trust issues.

Mr. Mullen said there is a line of decisions of the US Supreme Court which have held that state laws that attempt to restrict the marketplace from out of state competitors violate the commerce clause. If the intent of a law is economic protectionism it is essentially invalid. He stated different cases (audio 70:35) of this law. There is an exception to this law and that is when the state is the consumer of the product. State entities have the first right of refusal on contracts for the state.

Senator Lee commented that her understanding is that it does apply to self funded plans. She asked if there were other legal points that should be considered.

Mr. Mullen said the based on a decision by US Supreme Court and the Eighth Circuit Court of Appeals which covers our area this law could not be applied to self funded plans.

Chairman Lee closed the hearing on HB 1366.

JOB # 5084

Chairman Judy Lee opened discussion on HB 1366. She mentioned that this would be in conflict with Medicare Plan D and that it doesn't apply to self funded plans. The commerce clause states that you cannot restrict out of state competitors. Based on federal court ruling it is economic protectionism. Based on a decision by US Supreme Court and the Eighth Circuit Court of Appeals the self funded plans are preempted. The PBM's wouldn't be able to give different dispensing fees which wouldn't enhance the service for the rural areas.

Senator Erbele moved a do not pass on this bill.

Senator Pomeroy seconded the motion.

Roll Call Vote: Yes 6 No 0 Absent 0

Carrier: Warner

Date: 3-14-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1366

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Not Pass

Motion Made By Sen. Erbele Seconded By Sen. Pomeroy

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair 1	✓		Senator Jim Pomeroy 2	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Warner.

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1366: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1366 was placed on the Fourteenth order on the calendar.

2007 TESTIMONY

HB 1366

Testimony on HB 1366
House Human Services Committee
February 6, 2007

Madam Chair and Committee Members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota. We are opposed to HB 1366. Though it does not directly affect our company, since we already allow participating pharmacies the same 90-day prescription option as mail order pharmacies, the bill does preclude our company from establishing a preferred provider option in the pharmacy area. Because this bill will only affect the fully insured plans, 50% of our business (self-funded plans) could still have this option. In addition, this law will not affect Medicare Part D plans. In fact, the Federal government recognized this option by specifically providing it as an option.

A question was asked during a joint meeting of the Budget Committees on Human Services and Health Care on September 12 & 13, 2006 about the number of prescriptions processed by the different types of payers. Mr. Howard Anderson, Executive Director of the ND Board of Pharmacy responded with the following research:

"I did a quick survey of a few of our pharmacies and can say with reasonable accuracy that the percent of prescriptions filled by North Dakota pharmacies fall close to the following.

Cash 8%
Medicaid 6%
BCBS of ND 25%
Medicare Part D 40%
All other 3rd party 21%

There may be some variances in local areas, but this should hit pretty close to a mean."

As you can see, by passing this bill, you will be unfairly preventing a contracting option on just a minority of health plans, reducing the ability to save members' prescription drug costs. This bill will interfere with the contracting rights of private companies. Because of the potential negative impact on ND citizens, we urge you to defeat HB 1366.

02/06/2006
House Human Services Committee
Testimony in regards to HB 1366

Thank you ladies and gentlemen. My name is Dan Churchill and I am testifying today on behalf of the North Dakota pharmacist's association and as a community pharmacist here in Bismarck.

The intention of bill 1366 is to level the playing field for community pharmacies in the state of North Dakota and also to provide equal access for the citizens of North Dakota that are seeking pharmacy services.

Under current law pharmacy benefits managers, or PBMs, are allowed to force and/or restrict covered individuals use of the pharmacy of their choice, even if the pharmacy is a willing provider. Patients are sometimes charged a higher copay by their insurance at a local community pharmacy than they have to pay at a national mail-order pharmacy (which is often times owned by the PBM). Patients are sometimes restricted to a one month supply of maintenance medications at local pharmacies but allowed by their plan to receive a 3 month supply from mail-order. Often times PBMs will force individuals to receive all their regular medications from mail-order and only allow local pharmacies to fill immediate care and emergency medications. These practices serve to restrict choice for the citizens of North Dakota and also hamper the community pharmacist's ability to properly care for our patients. I personally have had a number of patients that have had no choice but to get their prescriptions from their PBMs mail-order pharmacy even though they were pleased with the care and service that they received from our pharmacy. When patients are forced to get prescriptions from more than one pharmacy it increases risks for drug interactions, allergic reactions, and poorer health outcomes. This is especially true for the medicare population who are more likely to have multiple medications, and quite possibly could have diminished ability to remember and understand all their medications. For these people, having a community pharmacist to rely upon for consultation and information is invaluable and sometimes lifesaving.

Ladies and gentlemen, if you have ever had a prescription filled, or ever sought the advice of a pharmacist, you know that pharmacy services are not a commodity to be bought and sold. A patient's relationship with his or her pharmacist can be very personal and can and does lead to better health outcomes. On behalf of the North Dakota Pharmacist's association I ask you to allow North Dakota citizen's to access the pharmacy of their choice, and allow the willing pharmacies of North Dakota an equal footing with the mail-order pharmacies. I ask you to issue a DO-PASS recommendation on HB 1366.

Thank You
Dan Churchill Pharm.D. R.Ph.

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
Washington, DC 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

March 8, 2005

Senator Richard L. Brown
North Dakota Senate
State Capitol
600 East Boulevard
Bismark, ND 58505-0360

Dear Senator Brown:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] are pleased to respond to your requests for comments on the likely competitive effects of North Dakota House Bill 1332 ("HB 1332" or the "Bill") that would regulate the contractual relationships between pharmacy benefit managers ("PBMs") and "covered entities" – such as health plans and health insurers – and pharmacies.[2]

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1 This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or of any individual Commissioner. The Commission has, however, voted to authorize us to submit these comments.

2 HB 1332 defines a covered entity as a "nonprofit hospital or a medical service corporation; a health insurer; a health benefit plan; a health maintenance organization; a health program administered by the state in a capacity of provider of health coverage; or an employer, a labor union, or other entity organized in the state which provides health coverage to covered individuals who are employed or reside in the state." HB 1332 § 26.1-27.1-01 (1). Covered entities do not include self-funded plans exempt from state regulation pursuant to ERISA, health plans "issued for federal employees," or health plans that provide "coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement, disability income, long-term care, or other limited-benefit health insurance polic[ies] or contract[s]." *Id.*

In your letter dated January 19, 2005, you asked us to analyze the competitive implications of HB 1332 and discuss whether it "will likely result in the increased cost of pharmaceutical care for consumers." We believe that HB 1332, if enacted, may have the unintended consequence of increasing the price of pharmaceuticals and ultimately to decrease the number of North Dakotans with insurance coverage for pharmaceuticals. Specifically, we believe that HB 1332 may limit a PBM's ability to guide consumers to lower-cost pharmacies and would prohibit switching consumers to certain lower-priced drugs.[3]

Interest and Experience of the Federal Trade Commission

The Federal Trade Commission (Commission) is charged by statute with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[4] Pursuant to this statutory mandate, the Commission seeks to identify business practices and regulations that impede competition without offering countervailing benefits to consumers. For several decades, the Commission and its staff have investigated the competitive effects of restrictions on the business practices of health care providers.[5] The Commission has brought numerous enforcement actions against entities involved in the pharmaceutical industry,[6] and the Commission and its staff have issued reports and studies regarding various aspects of the pharmaceutical industry.[7]

The Commission also has extensive recent experience with PBMs. In 2004, Commission staff commented on proposed Rhode Island legislation that would have affected a PBM's ability to contract with pharmacies[8] and on proposed California legislation that would have required

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[3] Although our comment is addressed only to these provisions, the Bill also regulates PBMs in other ways. *See* note 14, *infra*. We note that HB 1332 has been amended once by eliminating a requirement that PBMs act as fiduciaries to covered entities with which they contract and reducing the scope of a PBM's mandatory disclosure of financial information. These amendments eliminated other provisions that likely would have produced adverse competitive effects.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] *See* Federal Trade Commission, *FTC Antitrust Actions in Health Care Services and Products* at http://www.ftc.gov/bc/healthcare031024.pdf.

[6] *See* Federal Trade Commission, *FTC Antitrust Actions in Pharmaceutical Services and Products*, at http://www.ftc.gov/bc/0310rxupdate.pdf.

[7] *See* Federal Trade Commission, GENERIC DRUG ENTRY PRIOR TO PATENT EXPIRATION (July 2002); David Reiffen and Michael R. Ward, GENERIC DRUG INDUSTRY DYNAMICS, Federal Trade Commission Bureau of Economics Working Paper No. 248 (Feb. 2002), *at* http://www.ftc.gov/be/econwork.htm; Roy Levy, THE PHARMACEUTICAL INDUSTRY: COMPETITIVE AND ANTITRUST ISSUES IN AN ENVIRONMENT OF CHANGE, Federal Trade Commission Bureau of Economics Staff Report (Mar. 1999), *at* http://www.ftc.gov/reports/pharmaceutical/drugrep.pdf.

[8] Letter from FTC staff to Patrick C. Lynch, Attorney General and Juan M. Pichardo, Deputy Senate Majority

PBMs to disclose certain information to covered entities and consumers related to a PBM's financial arrangements with pharmaceutical companies.[9] Also in 2004, the Commission investigated the competitive implications of a proposed merger between Caremark and AdvancePCS.[10] On June 26, 2003, the Commission and Department of Justice Antitrust Division (Division) held a half-day of hearings on PBMs, as part of their Hearings on Health Care and Competition Law and Policy (Health Care Hearings).[11] The report jointly issued by the Commission and the Division on July 23, 2004 addressed the issues raised by PBMs as well.[12] Finally, Congress has required the Commission to analyze the prices that plan sponsors and participants pay for pharmaceuticals dispensed through different distribution channels.[13]

Description of HB 1332's Provisions Related to Contracting with Retail Pharmacies and Restrictions on Certain Drug Substitutions

Although HB 1332 would regulate PBMs in several ways, this comment is directed only to certain provisions of the Bill that would restrict PBMs' contracting with pharmacies and that would prohibit certain drug substitutions.[14] Specifically, HB 1332 would prohibit a PBM from discriminating "on the basis copayments or days of supply" when contracting with pharmacies.[15] Further, it requires that "a contract must apply the same coinsurance, copayment, and deductible to covered drug prescriptions" to all pharmacies or pharmacists in a network.[16]

Leader, State of Rhode Island and Providence Plantations (Apr. 8, 2004), *at* http://www.ftc.gov/os/2004/04/ribills.pdf.

9 *See* Letter from FTC staff to Rep. Greg Aghazarian (Sept. 7, 2004), *at* http://www.ftc.gov/be/V040027.pdf.

10 Statement of the Federal Trade Commission, *In re Caremark Rx, Inc./AdvancePCS*, File No. 031 0239 (Feb. 11, 2004), *at* http://www.ftc.gov/os/caselist/0310239/040211ftcstatement0310239.pdf.

11 Health Care Hearings, June 26, 2003, *at* http://www.ftc.gov/opp/healthcarehearings/030626ftcmns.pdf. *See also* http://www.ftc.gov/opp/healthcarehearings/030625260agenda.htm. All subsequent references to the hearings will identify a panelist, affiliation, and transcript page. Affiliations are as of the date of the hearing.

12 Federal Trade Commission and Department of Justice, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Chapter 7 (2004), *at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

13 Federal Trade Commission, *Pharmacy Benefit Manager Conflict of Interest Study Public Notice* (Mar. 26, 2004), *at* http://www.ftc.gov/os/2004/03/040326pbmfnl.pdf.

14 For example, HB 1332 would prohibit a PBM from excluding a pharmacy or pharmacist from one network "solely because the pharmacist or pharmacy declined to participate in another plan or network managed by the [PBM]." HB 1332 § 26.1-27.1.04(2). It also would require a PBM to offer covered entities contracting options that allow the covered entity to keep some, all, or none of the rebates collected by the PBM. *Id.* at § 26.1-27.1-05 (1). Further, any contract between a PBM and a covered entity must allow the covered entity to audit the PBM to "confirm that the benefit of rebates and other retrospective utilization discounts are being shared as required by the contract." *Id.* at § 26.1-27.1-05(2). This letter does not address any of these provisions.

15 HB 1332 § 26.1-27.1.04(3).

16 *Id.*

HB 1332 would allow the PBM to request the substitution of a "lower-priced generic or therapeutically equivalent drug" for a prescribed drug.[17] It is unclear in the Bill whether the term "therapeutically equivalent" drug refers to those drugs that are pharmaceutically equivalent or those that are pharmaceutically distinct, but are within the same therapeutic class.[18] To the extent that the Bill adopts the former, narrower definition, HB 1332 would prohibit a PBM from requesting that the drug referred to in a patient's prescription be substituted for another drug that is designed to have similar therapeutic effects – but that is pharmaceutically distinct – unless the substitution is "for medical reasons that benefit the covered individual" and the prescribing physician approves the substitution.[19]

Background on PBMs

PBMs manage the pharmacy benefits of covered entities. At the Health Care Hearings, one panelist estimated that ninety-five percent of patients with prescription drug insurance coverage receive their benefits through a PBM.[20] There are approximately 60 PBMs operating in the United States today. There are three large, independent, full-service PBMs with national scope: Medco, Express Scripts, and Caremark. Some large insurers manage pharmacy benefits internally. A few PBMs are owned by large retail supermarket/pharmacy chains. In addition, there are many smaller, privately-held PBMs. The relative size and ranking of these companies varies according to the measure used. The three large national PBMs are the major players in many markets, but anywhere from one-third to one-half of the market is made up of the other types of PBMs listed above. In our most recent antitrust investigation in the PBM industry, the FTC found competition among PBMs for contracts with plan sponsors to be "vigorous."[21]

One important tool used by PBMs to manage pharmacy benefits is a formulary, which is a list of PBM-approved drugs for treating various diseases and conditions. Because a formulary affects the mix of drugs used by enrollees in a plan, its design significantly can affect the cost to the covered entity. Two procedures that PBMs use to attain better compliance with their formularies are generic substitution and therapeutic interchange.[22] Because generic drugs are

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17 HB 1332 § 26.1-27.1.04(1)(a).

18 For example, the FDA defines therapeutically equivalent drugs to be those that are pharmaceutically equivalent and have the same therapeutic equivalence codes. *See* http://www.fda.gov/cder/drugsatfda/glossary.htm#T.

19 HB 1332 § 26.1-27.1.04(1)(b).

20 John Richardson, The Health Strategies Consultancy, Health Care Hearings, *supra* note 11, at 2.

21 Commission Statement, *supra* note 10.

22 Therapeutic interchange is the substitution of the drug product referred to on the consumer's prescription with a drug that is designed to have similar therapeutic effects, but is pharmaceutically different (i.e., two brand-name drug products that treat the same ailment). *See* R. Herdman & D. Blumenthal, eds., DESCRIPTION AND

typically substantially less expensive than their brand-name counterparts, generic substitution lowers prescription drug costs. Therapeutic interchange also has the potential of increasing the utilization of less expensive brand name drugs.

Preferential placement on a formulary, accompanied with reduced co-payments, can give a drug product a higher market share within a drug plan. Pharmaceutical companies compete by offering rebates and other financial rewards based on some combination of a percentage of a reference price, achieving certain specified sales or market share targets, and preferred placement of certain drug products on a PBM's formulary. These rebates are either paid to the covered entity, retained by the PBM, or shared between them depending on the specifics of the contract between these parties.[23] Rebates can lead to lower health care costs.[24]

PBMs also enter into contracts with retail pharmacies to create a retail network. The contract generally specifies the amount the PBM will reimburse the pharmacy for dispensing a prescribed pharmaceutical, expressed as a discount from a reference price plus a dispensing fee. By forming an exclusive network, a PBM is able to guide a covered entity's participants to certain pharmacies. The promise of increased customer volume creates an incentive for pharmacies to bid aggressively with lower drug prices in exchange for membership in a network.[25] Pharmacies will be willing to compete more vigorously for inclusion in a network as the exclusivity of the network and the number of pharmacies in the relevant market increases.

Likely Effects of HB 1332

HB 1332 limits PBMs' freedom in contracting with retail pharmacies and prohibits certain drug substitutions. These provisions are likely to lead to higher prices for pharmaceuticals and health insurance, which in turn is likely to increase the number of North Dakotans who go without pharmaceuticals and/or health insurance. As a recent article in *Health*

ANALYSIS OF THE VA NATIONAL FORMULARY (Institute of Medicine June 2000), *at* www.nap.edu/books/0309069866/html.

[23] John Richardson, Health Strategies Consultancy, Health Care Hearings, *supra* note 11, at 23-24 (PBMs "can be paid through administrative fees, share of rebates, or some combination."); Thomas M. Boudreau, Express Scripts, Health Care Hearings, *supra* note 11, at 124.

[24] *See* General Accounting Office, *Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies* at 11 (Jan. 2003) ("GAO Report") (noting that rebates passed through to health plans reduced these plans' annual spending on prescription drugs by three percent to nine percent), *at* http://www.gao.gov/cgi-bin/getrpt?GAO-03-196.

[25] For example, the GAO Report noted that when Blue Cross Blue Shield introduced a plan with a smaller network of retail pharmacies, it included deeper discounts in its retail pharmacy payments. *See* GAO Report at 11. An extensive discussion of these issues is found in the Letter from FTC staff to Patrick C. Lynch, Attorney General and Juan M. Pichardo, Deputy Senate Majority Leader, State of Rhode Island and Providence Plantations, *supra* note 8.

Affairs noted, "when costs are high, people who cannot afford something find substitutes or do without. The higher the cost of health insurance, the more people are uninsured. The higher the cost of pharmaceuticals, the more people skip doses or do not fill their prescriptions."[25] We provide details on our concerns below.

A. Restrictions on Contracting with Pharmacies

HB 1332 would prohibit PBMs from charging different copayments, coinsurance, or deductibles at various pharmacies within a plan's pharmacy network.[27] An important element of the design of pharmacy benefit plans administered by PBMs, however, is the determination of how the price for drugs will be split between the covered entity and its participants. This price sharing is achieved through the copayments, coinsurance, or deductibles that the participant pays to the pharmacy at the time the drug is dispensed.

Both a GAO study and an academic article reported that the prices charged to covered entities can vary substantially across different types of pharmacies.[28] This Bill, however, would prevent covered entities from designing benefit plans to encourage participants to use network pharmacies that provide drugs to the plan at a lower cost than other network pharmacies. Participants ultimately make the decision about where the drugs will be dispensed, but the covered entity bears most of the cost of the purchase. To encourage the participant to make efficient decisions, covered entities must be free to design plans that align its and the participants' interests.

The uniform copayments required by HB 1332, however, will prevent that alignment of interests and will likely generate inefficient decisions and higher drug costs. Under the Bill, participants would be less likely to use low-cost pharmacies than if they had been allowed to share in the cost savings via a lower copayment. Both the participants and the covered entity will miss out on the savings they could have shared from using the low-cost pharmacies. Only the high-cost pharmacies will benefit. A potential secondary effect of this uniform copayment

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[25] William Sage, David A. Hyman & Warren Greenberg, *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFFAIRS 31, 35 (March/April 2003). Although estimates of the elasticity of demand for health insurance coverage vary, the empirical evidence is clear that higher costs result in less coverage. *See* David M. Cutler, HEALTH CARE AND THE PUBLIC SECTOR, NBER Working Paper W8802, Table 5 (Feb. 2002), *at* http://papers.nber.org/papers/W8802.

[27] HB 1332 § 26.1-27.1-04(3).

[28] The study found that the lowest average prices for 30-day supplies were obtained when the drug was purchased through the PBM's mail order pharmacy, and that cash-paying customers at retail pharmacies paid the highest prices. *See* GAO Report. Similar cost savings for PBM clients have been reported in another study. *See* Cindy Parks Thomas et al., *Impact of Health Plan Design And Management On Retirees' Prescription Drug Use And Spending, 2001*, Health Affairs Web Exclusive W2-408 (Dec. 4, 2002), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.408v1.

structure is that low-cost pharmacies may lose the incentive to offer lower prices to covered entities. Pharmacies would not want to offer lower prices because doing so would generate no more sales than offering a high price under the legislation, since the final decision makers – the participants – are shielded from the price differences.

B. Prohibitions on Certain Drug Substitutions

HB 1332 may limit a PBM's ability to effect certain drug substitutions. It is unclear in the Bill whether "therapeutically equivalent" drugs are those that are pharmaceutically equivalent or those that are pharmaceutically distinct, but are within the same therapeutic class. To the extent that the Bill adopts the former narrower definition, HB1332 substantially would impair a PBM's ability to engage in price-reducing therapeutic interchange. Although North Dakota already requires physician approval before one branded drug may be switched for another,[29] HB 1332 further would limit substitutions to those that are "for medical reasons that benefit the covered individual." Consequently, the Bill would prevent a PBM from switching a prescription for one brand-name drug with a less expensive brand-name drug that is designed to have similar therapeutic effects, but that is pharmaceutically distinct, unless the switch was for medical reasons. To the extent HB 1332 makes safe and cost-reducing drug substitutions less common, it is likely to increase the cost of pharmaceuticals, which in turn is likely to increase health insurance premiums and reduce the availability of insurance coverage for pharmaceuticals.[30]

At the same time, it is unclear how the additional requirements in HB 1332 are likely to provide consumers with any additional countervailing benefits, because, as noted above, North Dakota requires prior prescriber authorization before a pharmacist is allowed to substitute one brand-name drug for another. Thus, existing safeguards appear sufficient to protect consumers from inappropriate therapeutic interchange.

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[29] *See* N.D. CENT. CODE § 19-02.1-02(14) (prohibiting "Dispensing or causing to be dispensed a different drug or brand of drug in place of the drug or brand of drug ordered or prescribed without the express permission in each case of the person ordering or prescribing").

[30] Additionally, HB 1332 may reduce the value to a pharmaceutical company of securing a preferred spot on a PBM's formulary. When PBMs can use the formulary to guide consumers from one branded drug to another they can promote competition between pharmaceutical manufacturers, which is likely to result in reduced drug prices and/or insurance premiums. To the extent that HB 1332 reduces a PBM's ability to use therapeutic interchange, pharmaceutical companies may compete less vigorously for inclusion on the formulary, which could lead to higher drug prices.

Conclusion

HB 1332 is likely to limit a PBM's ability to reduce the cost of prescription drugs without providing consumers any additional protections. Any such cost increases are likely to undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford. Accordingly, we would urge the North Dakota legislature not to adopt HB 1332.

Respectfully submitted,

Jean Noonan for

Maureen K. Ohlhausen, Acting Director
Office of Policy Planning

Luke Froeb

Luke M. Froeb, Director
Bureau of Economics

Susan Creighton

Susan A. Creighton, Director
Bureau of Competition

Human Services Committee
House of Representatives
February 6, 2007

HB 1366 (prohibiting different charges for mail order pharmacy services)

Chairman Price and members of the committee, for the record I am Robert W. Harms appearing on behalf of Caremark, Rx Inc., a national pharmaceutical services company that provides PBM services nationwide, which includes mail order services.

-14,000 employees; 1,300 licenses pharmacists in 39 states.

-Contracts with 60,000 pharmacies nationwide

-2,000 health plan sponsors

-Processes 550 million prescriptions annually; 86% of prescriptions in the US are still filled by retail pharmacists. **Caremark Opposes HB 1366.**

The Bill: HB 1366 essentially requires a uniform co-payment system for all providers (such as mail order pharmacies) regardless of their costs, efficiencies, margins of errors etc. The bill forces a "one size fits all" system in spite of overhead differences that a PBM seeks to capitalize on to reduce prescription costs to the health plan. The bill will eliminate choice among North Dakota consumers who wish to use mail order pharmacies through their health plans at substantial savings. ND consumers should be free to lower their prescription costs through the use of mail order pharmacy services.

Health plans will often choose to offer their members with an option of lower co-payments on a 90 day supply of prescriptions, through mail order pharmacies. These

types of practices provide substantial cost savings to the plan and ultimately to the consumer. In 2005 the FTC determined that PBM owned mail order pharmacies offer lower prices than retail pharmacies, and effectively capitalize on opportunities to dispense generic drugs (with cost savings as a result.) Likewise, a Price Waterhouse study in 2004 found that PBM activities (such as the use of mail order pharmacy services) resulted in a 25% savings in the cost of prescription drugs in contrast to retail prices. Finally, to further demonstrate cost savings, the US General Accounting Office (GAO) in 2003 found that the average price of prescription drugs through mail order pharmacies was:

27% below retail for brand name drugs and

53% below retail for generic drugs.

In short, mail order provides significant cost savings that should not be discouraged or prevented through legislation such as HB 1366.

One final point I'd like to make and that is to estimate what this bill would cost the people of North Dakota. In 2006 prescription drug spending was estimated to be $455 million. Approximately $94 million was filled through mail service pharmacies. If the growth in mail order trend continues, the cost savings to ND consumers and employers is estimated at $180 million from 2007 to 2016. Conversely, if HB 1366 is passed, the estimated cost to ND consumers (in higher drug prices) for the same period is $83 million.

During the 2005 Session PBM issues had dozens of hours of hearings resulting in passage of HB 1332. During the interim, the PBM industry was studied at length, with examination of all aspects of the industry, after which the Committee took no further action. (A letter to the interim committee is attached).

The premise of HB 1366 is that some how imposing a uniform system of treatment, ND pharmacies and ND consumers will benefit. The premise is false. As the Price Waterhouse study and the FTC both report, PBMs save consumers money on prescription drugs by employing a host of strategies, including the use of mail order pharmacies. (Price Waterhouse concludes that PBMs saved North Dakota consumers over $100 million in 2005). Requiring "one-size-fits" all policy will simply pay higher prices to those who provide less efficient services to the consumer.

The net effect is likely to increase drug costs for North Dakota consumers.

We believe that it is clearly in the North Dakota consumer's best interest that this bill be rejected and we ask that you recommend a DO NOT PASS on HB 1366.

January 5, 2006

Representative Bill Amerman
Interim IBL Committee Member
Bismarck, North Dakota 58505

Re: PBM study

Dear Representative Vigesaa:

I represent, Caremark, Rx, a leading pharmaceutical services company that testified at the November 8, 2005 hearing. Caremark is a Fortune 100 company, publicly traded and has over 13,000 employees that provide a host of pharmaceutical services to over 2000 plan sponsors in the United States. I am sending you this email as a reminder of the discussion during the past 12 months this issue has had, and to offer some other insights.

First, we should let the bill that passed last Session have some time to work before proceeding with additional legislation. The debate in the 2005 Session, resulted in a diminished HB 1332, and this study. It demonstrated the complexity of the issues and differences of opinion. (During the Session, we provided the initial FTC report, the GAO report and the Price Waterhouse study; all of which spoke well of the PBM industry in their service to their clients and their participants as well as being subject to vigorous competition.) At that time, the FTC was also undergoing an additional study as directed by Congress to assess the costs of mail order practices within the pharmaceutical industry. (That study is now complete and is referenced below.)

During the November, 2005 hearing, a number of themes rang through the pharmacists' presentations. Their testimony demonstrated that:

- New PBMs are entering the market, which heighten the vigorous competition within the industry. (One of the presenters was such a PBM)
- New businesses are evolving to audit and evaluate PBM practices, further enhancing competition. (One of the presenters operated such a business.)
- If a customer is unhappy with its PBM, there is nothing preventing them from obtaining services from another PBM.
- Finally, nothing prevents a customer of Caremark (or any other PBM), from insisting upon as much disclosure at it chooses. Many customers require increased disclosure as a condition of doing business.

Mr. Gary Gustafson offered his opinion that PBMs have caused drug prices to increase. That is simply not true. The presentation by Mr. Michael Saxl on behalf of the pharmacists shows that the drivers on drug costs are: the number of prescriptions per

person are increasing; newer, higher cost prescriptions are replacing older less costly medications, and "prices of prescription drugs are rising". In fact, the GAO report mentioned above indicates that PBMs prices were 18% and 47% lower respectively for brands and generics than retail prices, and PBM mail order prices were 27% and 53% lower for brands and generics. (In fact, the Price Waterhouse study estimated that PBM services will save ND consumers $112 million in 2005. PBMs do not cause high drug prices.)

The FTC was directed by Congress to look further into PBM practices, specifically regarding mail order pharmacies owned by the PBMs. Its report (*FTC Report "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies", Federal Trade Commission, August, 2005)* is very revealing. It concludes:

- PBMs offer lower prices on prescription drugs than retail pharmacies and non-PBM owned mail order pharmacies. (p. 23)
- For the 30 day prescriptions reviewed by the FTC, generic drug prices were 23.9% higher at retail, and single source brands were 13.9% higher (p. 34)
- Cash customers paid 15% more for brand drugs, and 50% more for generics at retail (p.36)
- PBMs drive pricing competition among drug manufacturing companies. (p. 42)
- Nearly all contracts reviewed provide the plan sponsor *(the client)* with audit rights, to verify formulary and market share payments offered by pharmaceutical manufacturers. (p. 58)

These conclusions are consistent with the GAO report and earlier FTC report, which confirm that the PBM industry functions well on behalf of its customers (and the American consumer) and is subject to vigorous competition.

We should refrain from moving forward with additional legislation, until the need is clearly demonstrated and the consequences are fully known. The potential consequence of imposing further regulation is to limit consumer choice, lower competition and increase the price of prescription drugs to North Dakota consumers.

Sincerely,

/s/

Robert W. Harms
On behalf of Caremark, Rx Inc.

PROTECT CONSUMER BENEFITS

SAY "NO" to North Dakota HB 1366 and Keep Prescription Drug Costs Down

Limiting Mail-Service Incentives will Raise Costs and Hurt Health Plans, Employers and Consumers

- Limiting mail-service incentives takes choices away from consumers and would force one-size-fits-all copayments. This approach simply will not work because retail pharmacies often have higher overhead costs than mail-service pharmacies. Why shouldn't consumers have the choice to lower their prescription drug costs through the use of mail-service?
- Health plans and employers frequently chose to provide their members and employees with the option of a lower copayment on a 90-day supply of their medications through use of mail-service pharmacies. This provides significant cost savings, particularly for medications prescribed for chronic conditions.
- Anti-mail legislation, such as HB 1366, that restricts the appropriate use of mail-service for long-term prescriptions amounts to nothing more than special-interest legislation that will raise costs for health plans, employers and consumers.

Mail-Service Pharmacies Make Prescriptions More Affordable for North Dakota Consumers

- In 2006, overall prescription drug spending in North Dakota was estimated to be $455 million. Approximately $94 million of the overall spending was on prescription drugs obtained through mail-service, based on a 2005 study by the Lewin Group (Lewin). [1]
- From 2007-2016, the utilization of mail-service pharmacies is estimated to save North Dakota consumers and employers approximately *$180 million* on the cost of their prescription drugs if the current trends in the growth of mail-service utilization continue, according to a 2006 Lewin study.[2]
- In looking specifically at the economic impact of legislative proposals similar to HB1366 that include restrictions such as uniform cost-sharing and 90-day at retail requirements, Lewin found that the combination of those restrictions would increase prescription drugs costs in North Dakota by $83 million over the next ten years. [3]

Consumers Benefit from Mail-Service Safety and Cost-Savings

- A recent study found a highly automated mail-service pharmacy dispensed prescriptions with 23-times greater accuracy than retail pharmacies. The mail-service error rate was zero in several of the most critical areas, including dispensing the correct drug, dosage, and dosage form. [4]
- In a 2005 report, the Federal Trade Commission determined that PBM-owned mail-order pharmacies (1) offer lower prices on prescription drugs than retail pharmacies and non-PBM owned mail pharmacies; (2) are very effective at capitalizing on opportunities to dispense generic medications; and (3) have incentives closely aligned with their customers: the third-party payers who fund prescription drug care.[5]
- In a July 2004 report, PricewaterhouseCoopers (PwC) concluded that enacting legislation restricting PBM activities would result in increased costs for prescription drugs, higher insurance premiums and an increase in the number of uninsured individuals. PwC determined that PBMs save consumers and plan sponsors, on average, 25 percent on the cost of prescription drugs compared to retail purchases with no pharmacy benefit management support.[6]
- According to a 2003 study by the U.S. General Accounting Office (GAO), the average price of prescriptions through mail-service pharmacies was 27 percent below the average cash price consumers would pay at a retail pharmacy for brand name drugs, and 53 percent below the retail cash price for generic drugs. [7]

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[1] The Lewin Group, "Mail-Service Pharmacy Savings: A Ten-Year Outlook for Public and Private Purchasers," August 2005.
[2] The Lewin Group, "Mail-Service Pharmacy Savings and the Cost of Proposed Limitations in Medicare and the Commercial Sector," September 2006.
[3]
[4] J. Russell Teagarden et al., "Dispensing Error Rate in a Highly Automated Mail-Service Pharmacy Practice," Pharmacotherapy: Official Journal of the American College of Clinical Pharmacy, Volume 25, Issue 11, pgs 1629 – 1635 (2005).
[5] Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005, available at
[6] PricewaterhouseCoopers, "The Value of Pharmacy Benefit Management and National Cost Impact of Proposed PBM Legislation," July 2004.
[7] US General Accounting Office, "Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees and Pharmacies," GAO-03-196, January 2003.

FTC Study: Mail Pharmacies Offer Lower Prices than Retail

Congress asked the Federal Trade Commission (FTC) to determine whether Pharmacy Benefit Managers (PBMs) are engaged in "self-dealing" when they both administer a drug benefit and dispense prescriptions through a mail service pharmacy that they own. After a year-and-a-half study, the FTC flatly determined that any such "self-dealing" allegations are ***"without merit."***

Background on the study

During the debate leading up to the passage of the Medicare Modernization Act of 2003, the retail pharmacy lobby sought to convince Congress that mail pharmacies – when owned by a PBM – can result in higher costs. In response to these allegations, the FTC was charged with answering a number of very specific questions about the effects that PBM ownership of a mail service pharmacy can have on overall costs.

The FTC used its subpoena power to collect financial, volume, and claims data from several PBMs, insurers and retail pharmacies. The agency also looked at contracts between plan sponsors and PBMs as well as agreements between the PBMs and a group of 11 pharmaceutical manufacturers. The agency adjusted the data received so that its findings would present an "apples to apples" comparison of pharmacy performance and value. *(For example, mail pharmacies dispense a longer days-supply; retail pharmacies dispense more acute medications; and different pharmacies use a variety of pricing benchmarks to establish discounts.)*

What the FTC Found

The results of the study were unambiguous. PBM-owned mail service pharmacies:

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

Below is a summary of some specific findings included in the 100-page FTC report:

Pricing:

- Retail prices were higher than mail prices for a common basket of drugs studied by the FTC (p.23).
- "Plan sponsors often secured more favorable pricing for mail dispensing than for retail" (p.25).
- For 30-day scripts reviewed by the FTC, generic drug prices were 23.9% higher at retail than at the PBM-owned mail pharmacy and single-source brands were 13.9% higher (p.34).
- Plans requiring their PBM to fill scripts at non PBM-owned mail pharmacies paid about 3% more (p.35).
- The most vulnerable customer -- the cash-paying customer -- gets a raw deal at retail. Cash-paying customers paid 15% more for brand drugs and 50% more for generics at retail (p.36). In addition, the FTC learned that the spreads that retailers earn off the cash-paying customer for branded drugs are nearly twice what the pharmacy earns from the patient with third-party insurance (p.74).
- Most plans paid no dispensing or shipping fees to the PBM-owned mail service pharmacy (p.37).

Generics:

- Retail and PBM-owned mail pharmacies substitute generics at similar rates (p. 62).
- The generic substitution rates (GSR) observed "show that (PBM-owned) mail order pharmacies were generally more, rather than less, aggressive in dispensing generic drugs than were other pharmacies, despite the payments PBMs receive from pharmaceutical manufactures for some brand drugs."
- The agency also found that "generic dispensing at (PBM) owned mail-order pharmacies generally is more profitable than brand dispensing" (p.74). Therefore, the FTC determined that "the PBM-owned mail-order pharmacies' incentives, on average, were consistent with those of their clients" (p. 62).

- Retail pharmacists frequently point to generic dispensing rates (GDR -- the share of generics as a percent of all drugs dispensed) as their favored metric to measure pharmacy performance. GDRs are higher at retail because of the volume of acute drugs dispensed (many of which are generically available). However, the FTC determined that the GDRs are an "unreliable" measure if it does not take into account the different mix of drugs dispensed through the two types of pharmacies as well as benefit design features and formulary decisions that affect the patient's pharmacy selection (p. 63).
- The FTC also found that some plans require their PBM to guarantee a GSR or GDR (p.75).

Payments from Manufacturers:

- The FTC found that PBMs drive pricing competition among drug companies. In evaluating PBM agreements with pharmaceutical manufacturers, the Commission revealed that "manufacturers readily raised and lowered allowance levels for each of their drug products as competition developed in the drug's therapeutic class" (p.42).
- The FTC also determined that in recent years, the contracts between PBMs and plan sponsors "generally have increased the pass-through percentages *(of pharmaceutical manufacturer payments)* received by the plan sponsor above the percentage or level specified in the older contracts" (p. 58).
- The FTC also determined that pass-through arrangements alone do not reveal the true value of a plan's arrangement with their PBM. In the report, the FTC found that "manufacturer payments to PBMs can be passed on to plan sponsor clients through a complex array of adjustments in the prices for the services that PBMs provide." Further, the FTC stated that "a sole focus on the explicit contract terms governing sharing of manufacturer payments with plan sponsors ... does not provide a basis for valid inferences regarding prescription drug competition or an alleged conflict of interest" (p.43).
- Nearly all contracts reviewed by the FTC grant audit rights to plan sponsors to help verify the sharing of formulary and market-share payments that are made by the pharmaceutical manufacturers (p. 58).

Therapeutic Interchange (TI):

- FTC found that therapeutic interchange (TI) programs could reduce plan costs in most cases (p.81).
- The FTC found that many plans have negotiated various safeguards to ensure that PBM-initiated TIs have a neutral or beneficial effect on the plan and its members (p.90-92).
- Despite their savings potential, the FTC found therapeutic interchange programs to be very rare (p.81).

FTC Credibility:

- PBMs and mail service pharmacies did not ask to be investigated by the FTC. The retail pharmacy lobby urged Congress to request an inquiry by the agency.
- In fact, after passage of the MMA, the April 2004 "*Notes from Capitol Hill*" from National Community Pharmacists Association (NCPA) celebrated the study by reminding members that it was the product of a campaign "spearheaded" by Wal-Mart, Walgreen and NCPA.
- After the FTC released findings that validate the value of PBMs and PBM-owned mail pharmacies, the retail lobby responded by calling into question the agency's objectiveness and credibility.
- *"It is reasonable to question the objectivity and results of the FTC study"* - Bruce Roberts, CEO of NCPA.
- After acknowledging the report as a *"real disappointment"* for his industry, John Rector, General Counsel of NCPA, said that PBMs and the FTC seem to have *"a mutual admiration society."*
- The FTC is an independent regulatory agency that is headed by five Commissioners -- nominated by the President and confirmed by the Senate -- that serve seven-year terms. No more than three Commissioners can be of the same political party.
- The FTC report on PBMs was unanimously approved by the Commissioners. Because the FTC is currently comprised of Commissioners appointed by both Presidents Bush and Clinton, the unanimous approval underscores the objectivity of the report.

NDPhA
NORTH DAKOTA
PHARMACISTS
ASSOCIATION

Madam Chairman Price and members of the House Human Services Committee, for the record my name is Mark Hardy. I am here to speak on behalf of the North Dakota Pharmacist Association (NDPhA). The NDPhA recommends a DO PASS on HB 1366.

The NDPhA supports any legislation that would strengthen our position against any PBM. I believe patients across the state would benefit from this legislation. It would also help the retail pharmacists that are being hurt by patients being pushed to mail out pharmacies due to lower co-pays or increased supply than they can get at their local pharmacy. I would be happy to answer any questions that I can.

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#1

03/14/2007
Senate Human Services Committee
Testimony in regards to HB 1366

Madam Chairman Lee, members of the commitee. My name is Dan Churchill and I am testifying today on behalf of the North Dakota Pharmacist's Association and as a community pharmacist here in Bismarck.

The intention of house bill 1366 is to level the playing field for community pharmacies in the state of North Dakota and also to provide equal access for the citizens of North Dakota that are seeking pharmacy services.

Under current law pharmacy benefits managers, or PBMs, are allowed to force and/or restrict covered individuals use of the pharmacy of their choice, even if the pharmacy is a willing provider. Patients are sometimes charged a higher copay by their insurance at a local community pharmacy than they have to pay at a national mail-order pharmacy (which is often times owned by the PBM). Patients are sometimes restricted to a one month supply of maintenance medications at local pharmacies but allowed by their plan to receive a 3 month supply from mail-order. Often times PBMs will force individuals to receive all their regular medications from mail-order and only allow local pharmacies to fill immediate care and emergency medications. These practices serve to restrict choice for the citizens of North Dakota and also hamper the community pharmacist's ability to properly care for our patients. I personally have had a number of patients that have had no choice but to get their prescriptions from their PBMs mail-order pharmacy even though they were pleased with the care and service that they received from our pharmacy. When patients are forced to get prescriptions from more than one pharmacy it increases risks for drug interactions, allergic reactions, and poorer health outcomes. This is especially true for the medicare population who are more likely to have multiple medications, and quite possibly could have diminished ability to remember and understand all their medications. For these people, having a community pharmacist to rely upon for consultation and information is invaluable and sometimes lifesaving. This bill does affect Medicare Part D recipients because although the regulations for Part D are set forth by Medicare, a Part D PBM doing business in North Dakota must be licensed by the state insurance department and abide by the rules of the state.

It is important to remember that this bill does not mandate any sort of reimbursement, it only states that PBMs can not restrict North Dakota Pharmacies any more than they restrict any other pharmacies. Therefore any claims that forcing, or incentivizing, the use of mail order pharmacies saves money for insurance plans and consumers must be tempered by the fact that this bill is not forcing a higher payment for a prescription. It is only saying that PBMs must offer the same deal to local pharmacies. If a national PBM offers an insurance plan a price of X amount of dollars for a prescription filled at it's mail-order facility, then it must offer the same deal at local pharmacies. It is then up to the local pharmacy to decide if they accept that offer, but the offer must be made.

It is also important to note that Blue Cross of North Dakota does not force or incentivize members to use mail order. Therefore this bill would have no impact on The ND PERS plan.

Ladies and gentlemen, if you have ever had a prescription filled, or ever sought the advice of a pharmacist, you know that pharmacy services are not a commodity to be bought and sold. A patient's relationship with his or her pharmacist can be very personal and can and does lead to better health outcomes. On behalf of the North Dakota Pharmacist's association I ask you to allow North Dakota citizen's to access the pharmacy of their choice, and allow the willing pharmacies of North Dakota an equal footing with the mail-order pharmacies. I ask you to issue a DO-PASS recommendation on HB 1366.

Thank You
Dan Churchill Pharm.D. R.Ph.

#2

BOARD OF PHARMACY
State of North Dakota

John Hoeven, Governor

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Howard C. Anderson, Jr, R.Ph.
Executive Director

HOUSE BILL No. 1366 – Prohibited Practices by Pharmacy Benefits Managers
8:30 AM -Wednesday – MARCH 14th, 2007
Senate Human Services Committee – Red River Room

Chairman Lee, members of the Senate Human Services Committee, for the record I am Kyle Schwandt a Pharm D student from the NDSU College of Pharmacy. Thank you for the opportunity to speak with you today.

We all know PBMs may own and operate mail order pharmacies making them both plan administrators and providers. This is not an issue, the issue is: when PBMs allow mail order plans to offer consumers three-month supplies, while at the same time preventing community pharmacies from being able to dispense no more than a 30-day supply.

Community pharmacies are just as able as mail order to dispense 90-day supplies and would offer consumers 90-day supplies, but most contracts from PBMs prohibit retailers from filling 90-day prescriptions, and this puts retailers at a competitive disadvantage.

Thank you for the opportunity to speak with you today.

#3

March 14, 2007

TESTIMONY IN OPPOSITION TO HB 1366
IN THE SENATE HUMAN SERVICES COMMITTEE

Chairwoman Lee and Members of the Senate Human Services Committee.

My name is Pat Ward. I represent Medco Health Solutions, a pharmacy benefits manager (PBM), in opposition to HB 1366.

HB 1366 is an attempt by some on the retail side of the pharmacy distribution industry to limit the competitive flexibility of pharmacy benefit managers, also known as PBMs, in finding ways to provide PBM clients with more efficient and less costly services.

Medco and the PBM Industry

Medco Health Solutions is one of the three large pharmacy benefit managers in the United States. There are a number of other players in this highly competitive industry including smaller PBMs and regional PBMs. Some PBMs, such as Prime Therapeutics, are owned by a consortium of health insurance companies. As you know, Prime Therapeutics is owned in part by North Dakota's Blue Cross Blue Shield plan in conjunction with several other BCBS plans.

PBM Legislation

Over the last several years, numerous bills have been introduced around the country at the behest of retail pharmacy associations, Walgreens, Wal-Mart, and NCPA, in an attempt to restrict or limit the operations of pharmacy benefit managers like Medco. The vast majority of these bills have been defeated. Only

Maine, the District of Columbia, South Dakota, and North Dakota have passed any legislation restricting PBMs at all. PBM legislation was rejected in 22 states in 2006 alone.

2005 HB 1332 Interim Study

As you know, in North Dakota's 2005 session a PBM disclosure bill was passed by this legislature giving the insurance commissioner jurisdiction over health insurance plans to monitor its confidential PBM contracts. Another bill was passed requiring PBMs to register as third party administrators. An interim study of the PBM industry was also commissioned. That interim committee chose, after listening to a great deal of testimony, not to introduce any legislation this session but rather to allow the legislation adopted last session to have an opportunity to work. The Insurance Commissioner did testify on another bill this session that our statute is working.

What PBMs Do

PBMs serve an important role in keeping drug spending under control. They negotiate directly with health plans, insurers, major employers, unions, the federal government, and state and local governments in order to manage their drug benefit. They create a network of local pharmacists. They handle the accounting and paperwork, create formularies, and so forth. The PBM market place is highly competitive and has adapted to the needs of its clients. PBM clients are not here seeking legislative interference in these contractual relationships. Consumers are not here either. Only retail pharmacists are asking for this bill.

Because of the size, strength, and expertise of PBMs, they are able to go toe-to-toe with the large drug manufacturers in purchasing drugs and thereby drive down costs for prescription drugs. They also monitor the drugs being provided to the customer at the retail level (which in addition to the bookkeeping for the plan) also helps to avoid inappropriate and unsafe medicating, increase compliance and cooperation with drug regimes, and generally help overall to improve health outcomes.

Many federal government agencies have been asked by the opponents of PBMs to investigate the industry. In particular, the Federal Trade Commission, the General Accounting Office, and Price Waterhouse Coopers have undertaken investigations of this industry and each time found it to be highly competitive.

FTC Opinions

The Federal Trade Commission regulates competition in American industry as you know. The FTC is made up of five commissioners who are required to be from both parties with at least two belonging to the party not in power. Current members were appointed by Presidents Clinton and Bush. The Federal Trade Commissioners have unanimously determined that PBM legislation would lead to increased costs without any benefits to consumers.

The attached letter from the FTC was sent to Senator Richard Brown last session regarding our 2005 proposed PBM legislation, HB 1332, on March 8, 2005. The FTC expressed several specific areas of concern with North Dakota's HB 1332 including prohibiting drug substitutions, prohibiting a PBM from discriminating on the basis of co-payments or days of supply when contracting

with pharmacies, and requiring that a contract must supply the same co-insurance, co-payment, and deductible to cover drug prescriptions to all pharmacies or pharmacists in a network.

GAO Study

Also, in January 2003, the U.S. General Accounting Office (GAO) issued a report examining cost savings with mail order pharmacies under the federal employer's health plan. The finding there was that the average mail order pharmacy price for prescription drugs was 27 percent lower for brand name drugs and 53 percent lower for generic drugs than the price paid to retail pharmacies by cash paying customers.

NCOIL

The National Conference of Insurance Legislators was presented with a proposal to consider model PBM legislation. That proposal from a Virginia legislator who is a retired pharmacist was rejected by NCOIL at its recent meeting in Savannah, Georgia.

FTC Mail Order Study

HB 1366 is an attempt to bring back some of the bad parts of the 2005 HB 1332 legislation by providing that a PBM may not "impose any condition or limitation" on dispensing of a drug by a pharmacy or pharmacist licensed in this state which the PBM does not impose on any other person providing pharmacy services for the benefit of the covered individual."

This bill (may even have unintended consequences adverse to the pharmacists themselves) is apparently aimed at mail order pharmacies operated

by PBMs. This issue also has been addressed by the Federal Trade Commission. During the debate leading up to the passage of the Medicare Modernization Act of 2003, the retail pharmacy lobby sought to convince Congress that mail order pharmacies, when owned by a PBM, can result in higher costs. In response to these allegations, the FTC was charged with answering a number of very specific questions about the effect of PBM ownership of a mail service pharmacy on overall costs.

The FTC did a thorough investigation collecting financial and other data from several PBMs, insurers, and retail pharmacies. The agency also looked at the contracts between plan sponsors and the PBMs, as well as agreements between the PBMs and a group of pharmaceutical manufacturers.

The FTC's conclusions were unambiguous and are as follows:

PBM owned mail service pharmacies:

1. Offer lower prices on prescription drugs than retail pharmacies and non-PBM owned mail pharmacies;

2. Are very effective at capitalizing on opportunities to dispense generic medication; and

3. Have incentives closely aligned with their customers (the third party payers who fund prescription drug care).

The 100 page FTC report included additional findings that retail prices were higher than mail prices for a common basket of drugs. Plans that require a PBM to fill prescriptions at non-PBM owned mail pharmacies paid about three percent more than at PBM owned pharmacies. **And the most vulnerable**

customer is the cash paying customer that buys at retail. Cash paying customers pay 15 percent more for brand drugs and 50 percent more for generics at retail.

Conclusion

In conclusion, HB 1366 is an anti-competitive protectionist effort aimed at protecting some North Dakota pharmacies and pharmacists at the expense of competition. Such legislation will clearly result in higher costs to all consumers. Every comprehensive study of this industry has resulted in the same conclusion. We urge you to vote Do Not Pass on HB 1366. I will try to answer your questions.

P:\PWARD\Medco\Testimony HB 1366.doc

#4

Testimony on HB 1366
Senate Human Services Committee
March 14, 2007

Madam Chair and Committee Members, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota. We are strongly opposed to HB 1366. The wording in this bill is so ambiguous and broad that we feel it will have a significant impact upon our company.

I first want to address some factually incorrect statements made on the House floor during the debate on this bill that has confused some legislators. It was stated that BCBSND is forcing its members to purchase their drugs via mail order pharmacies. The facts are we don't even offer mail order to our fully insured plans. Only a few self-funded plans offer mail order and in most cases we still offer the local pharmacist the same ability to provide a 90-day supply. It was stated that if a member were to get a 90-day supply from their local pharmacist they would have to pay for 3 30-day supply co-pays. That is totally false. I have supplied a copy of my own recent prescription bill to prove that that statement is false. (Attachment A)

Another statement alleged something sinister about BCBSND owning its own pharmacy benefits manager (PBM). The fact is we are part owners (5.25%) with 9 other Blue plans in a PBM. This arrangement allows our company to establish a pharmacy network, process claims, and secure drug rebates far more economically than doing this work in-house or contracting with another PBM. Our members benefit from this arrangement. And to verify that our members get this benefit, all rebate information is required to be audited by the Insurance Commissioner's office. The Insurance Commissioner recently testified on another bill that all rebates are being returned to the benefit of our members, and that the 2005 PBM law is in fact working.

Initially we thought that this bill would have a minimal affect on our business. However after a more thorough review, we have determined that passage of this bill will have a negative affect on pharmacy access and/or will impact the cost of prescriptions and the health plan for our members. First you must understand that the PBM does not "impose any condition or limitation on the dispensing..." as the bill states. It is the health plan that determines their benefit plan. The PBM is contracted to enforce and carry out the provisions of the benefit plan as specified by the health insurer and approved by the Insurance Commissioner.

I would like to explain what a PBM does. Typically a PBM is hired by a health plan or a large self-funded employer group to establish a pharmacy network, by contracting with pharmacists to sign on to a network (a participating contract establishes a reimbursement schedule for prescription drugs), to process pharmacy claims based on the insurer's or self-funded entity's benefit plan, and to secure pharmacy rebates from pharmaceutical manufacturers. This is a contracted service between the insurer and the PBM.

When BCBSND established our current pharmacy network, we had difficulty getting some rural pharmacies to sign a participating agreement, because these rural pharmacists just didn't have the volume of business to make it work for them. As a result, we authorized our PBM to contract with these rural pharmacies at a higher rate. If passed, this bill would prevent us from offering different dispensing fees and ingredient reimbursements to different pharmacies. It would require a "one size fits all" approach to network contracting. Passage of this bill would require us to either pay everyone the highest rate offered in the rural areas (thus raising premium costs), or force us to pay a lower urban rate and have fewer participating pharmacists in the rural areas (reducing access).

Having participating provider agreements saves our members significant amounts of money in terms of health insurance premiums, but also reduces their cost share. If this bill passes, there would be no incentive for pharmacists to sign a participating agreement, since every pharmacy would have to have the same reimbursement amounts. Therefore, the pharmacy could establish whatever fee schedule they want for their drugs, insist on direct reimbursement from the insurer, and balance bill the customer for what the insurer does not pay in regards to their bill. I have attached an example of how it currently works between a participating provider and a non-participating provider (Attachment B). If this bill passes, our members will not only pay a higher cost share, but will also be subject to the balance billing between the allowed amount and the billed amount.

This bill also would preclude our company from establishing a preferred provider option in the pharmacy area. If we were able to establish a network of pharmacies that would provide deeper discounts than the standard network, with lower co-pay and co-insurance payments for the member, HB 1366 would specifically prohibit this arrangement.

A question was asked during a joint meeting of the Budget Committees on Human Services and Health Care on September 12 & 13, 2006 about the number of prescriptions processed by the different types of payers. Mr. Howard Anderson, Executive Director of the ND Board of Pharmacy responded with the following research:

"I did a quick survey of a few of our pharmacies and can say with reasonable accuracy that the percent of prescriptions filled by North Dakota pharmacies fall close to the following.

Cash 8%
Medicaid 6%
BCBS of ND 25%
Medicare Part D 40%
All other 3rd party 21%

There may be some variances in local areas, but this should hit pretty close to a mean."

As you can see, by passing this bill, you will be unfairly preventing a contracting option on just a minority of health plans, reducing the ability to save members' prescription drug costs.

Because this bill will only affect the fully insured plans, 50% of our business (self-funded plans) could still have all the options prohibited by this bill. In addition, this law will not affect Medicare Part D plans. In fact, the Federal government recognized mail order pharmacies by specifically providing it as an option. In addition, the Federal employee benefit plan would be exempt from this law and it currently offers mail order as one of the employee's options.

Let me make it clear on who is and isn't affected by this bill:

Type of plan	Does HB 1366 apply?
Medicare Part D plans	No
Medicaid	No
Federal employees benefit plan	No
Cash paying customers	No
Self-funded plans (50% of BCBSND)	No
Other 3rd party self-funded plans	No
3rd party fully insured plans	Yes
BCBSND fully insured plans	Yes
NDPERS	Yes

If this bill passes, it directly interferes with the right of private contracting. It will pose a dilemma for the PBM. The insurer has established the prescription benefit plan that it has contracted with the PBM to administer. If passed, the PBM will have to comply with law, but then be in breach of its contract with the insurer. A BCBSND attorney's analysis of this bill, indicates that there are several constitutional issues at play. He feels strongly that this bill could be successfully challenged in court. Among the issues that could be challenged include, federal and state anti-trust issues (restraint of trade), impairment of contracts (both state & federal constitutions), and commerce clause violations (Article 1, Section 8, clause 3, US Constitution). I have included his analysis below:

Analysis by BCBSND attorney-

Here are the potential constitutional and federal/state law issues that I believe have some merit:

Federal and state anti-trust issues (restraint of trade). Many aspects of this proposed legislation appears to create anticompetitive efforts aimed at protecting North Dakota pharmacies and pharmacists at the expense of competition, resulting in higher costs to all consumers. The bill appears designed to limit the ability of PBMs to include differentials in reimbursement for dispensing drugs between all pharmacies, thereby requiring the same treatment for all pharmacies willing to enter into agreements with them. This restricts the ability of the PBMs to create limited panel or network pharmacies, to create reimbursement differentials between pharmacies based on any factor at all, requires that PBMs offer the same terms through its contracts to all willing pharmacies, and to limit the ability of a PBM to contract with mail order pharmacies because the same contract terms with mail order will not be agreed to by the North

Dakota pharmacy community. All of these aspects serve to limit competition in securing pharmacy benefits through health benefit plans administered in North Dakota. As a result, these restrictions will lead to higher prices for prescription drugs and health insurance, which will likely increase the number of North Dakotans who either go without prescription drugs or health insurance. [Sherman Antitrust Law, Title 15; United States Code; Chapter 51-08.1, N.D.C.C.]

Impairment of contract. Both the state and federal constitutions prohibit legislation that serves to impair existing contracts. This proposed legislation will do exactly this, interfere with the agreements in place between insurers and employers sponsoring self-funded health plans, both current contracts and as these contracts are implemented moving forward. [Article 1, Sections 1 and 18, North Dakota Constitution; 14th Amendment, U.S. Constitution]

Commerce clause violations. The federal constitution prohibits states from enacting any laws that effects an unreasonable burden on the flow of interstate commerce. This proposed legalization appears to have just such an impact. [Article I, Section 8, clause 3, U.S. Constitution]

If this bill is intended to treat mail order and local pharmacies the same, it will actually hurt the local pharmacist, since the mail order pharmacy used by the self-funded plans is not reimbursed a dispensing fee. It appears HB 1366 would require that the local pharmacist also have to accept **no** dispensing fee.

This bill is so broad and ambiguous it is impossible to identify all the possible ramifications. Because of all the reasons identified, we urge you to give HB 1366 a Do Not Pass and to defeat this bill. It will only hurt our members, your constituents.

ATTACHMENT A

HAVE WE ASKED YOU ABOUT
READY REFILL? SEE YOUR
PHARMACIST FOR DETAILS!

White Drug
1100 13TH AVE EAST
WEST FARGO, ND 58078
(701)281-5695

[redacted]
ST. AUBYN, RODNEY L
[redacted]
LEVOTHYROXINE 125 MCG TABLET
[redacted] #90 EA NDC# 00527-1347-01
[redacted]
ORIG: 02/22/07 PICKUP
CURR: 02/22/07 PAY $ 17.94
Patient # [redacted]
Plan 24-296 Your insurance paid $11.76
RX DAKOTA
QOH 84

Total Allowed Charge	$29.70
Less $15.00 co-pay	$15.00
Balance	$14.70
Less 20% co-insurance $14.70 X 20%	$ 2.94
Insurance payment	$11.76

ATTACHMENT B

Example of Participating vs Non-Participating Provider

Billed Charge = $150.00
Contracted allowed amount = $100.00
Non-Par Penalty = 20%
Co-pay amount = $15.00
Coinsurance = 80/20%
Participating provider – BCBSND sends their share directly to the provider
Non-participating provider – Member pays full amount to provider and submits claim to BCBSND who then reimburses the member directly for its share.

	Participating Provider	
	Members Share	BCBSND's Share
Co-Pay	$15.00	
Coinsurance ($100-$15) X 20%	$17.00	$68.00
Non-Par Penalty	$0	
Balance bill from $150.00	$0	
Total	$32.00	$68.00

	Non-participating Provider	
	Members Share	BCBSND's Share
Co-Pay	$15.00	
Coinsurance ($100-$15) X 20%	$17.00	$68.00
Non-Par Penalty($100-15-17) X 20%	$13.60	-13.60
Balance bill from $150.00	$50.00	
Total	$95.60	$54.40

Human Services Committee
North Dakota Senate
March 13, 2007

HB 1366 (prohibiting different charges for mail order pharmacy services)

Chairwoman Lee and members of the committee, for the record I am Robert W. Harms appearing on behalf of Caremark, Rx Inc., a national pharmaceutical services company that provides PBM services nationwide, including mail order service. Caremark includes

-14,000 employees; 1,300 licenses pharmacists in 39 states.

-contracts with 60,000 pharmacies nationwide

-has 2,000 health plan sponsors

-and processes 550 million prescriptions annually; 86% of prescriptions in the US are still filled by retail pharmacists. **Madam Chair and Committee members, Caremark Opposes HB 1366.**

The Bill: HB 1366 essentially requires a uniform co-payment system for all providers (such as mail order pharmacies) regardless of their costs, efficiencies, margins of errors etc. The bill forces a "one size fits all" system in spite of overhead differences that a PBM seeks to capitalize on to reduce prescription costs to the health plan. The bill will eliminate choice among North Dakota consumers who wish to use mail order pharmacies through their health plans at substantial savings. ND consumers should be free to lower their prescription costs through the use of mail order pharmacy services.

Health plans will often choose to offer their members an option of lower co-payments on a 90 day supply of prescriptions, through mail order pharmacies. These types of practices provide substantial cost savings to the plan and ultimately to the North Dakota consumer. In 2005 the FTC determined that PBM owned mail order pharmacies offer prices lower than retail pharmacies, and effectively capitalize on opportunities to dispense generic drugs (with cost savings as a result.) Likewise, a Price Waterhouse study in 2004 found that PBM activities (such as the use of mail order services) resulted in a 25% savings in the cost of prescription drugs over retail prices. Finally, to further demonstrate cost savings, the US General Accounting Office (GAO) in 2003 found that the average price of prescription drugs through mail order pharmacies was:

27% below retail for brand name drugs and

53% below retail for generic drugs.

In short, mail order provides significant cost savings that should not be discouraged or prevented through legislation such as HB 1366.

One final point I'd like to make and that is to estimate what this bill would cost the people of North Dakota. In 2006 prescription drug spending was estimated to be $455 million. Approximately $94 million was filled through mail service pharmacies. If the growth in mail order trend continues, the cost savings to ND consumers and employers is estimated at $180 million from 2007 to 2016. If HB 1366 is passed, the estimated cost to ND consumers (in higher drug prices) for the same period is $83 million.

During the 2005 Session PBM issues had dozens of hours of hearings resulting in passage of HB 1332. During the interim, the PBM industry was studied at length, with examination of all aspects of the industry, after which the Committee took no further action. (A letter to the interim committee is attached).

The premise of HB 1366 is that by imposing a uniform system of treatment, ND pharmacies and ND consumers will benefit. The premise is false. As the Price Waterhouse study and the FTC both report, PBMs save consumers money on prescription drugs by employing a host of strategies, including the use of mail order pharmacies. (Price Waterhouse concludes that PBMs saved North Dakota consumers over $100 million in 2005). Requiring "one-size-fits" all policy will simply pay higher prices to those who provide less efficient services to the consumer. The net effect is likely to increase drug costs for North Dakota consumers.

We believe that it is clearly in the North Dakota consumer's best interest that this bill be rejected and we ask that you recommend a DO NOT PASS on HB 1366.