ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE STANDING COMMITTEE
March 16, 2012
3:21 p.m.

MEMBERS PRESENT

Representative Kurt Olson, Chair
Representative Craig Johnson, Vice Chair
Representative Dan Saddler
Representative Steve Thompson
Representative Lindsey Holmes
Representative Bob Miller

MEMBERS ABSENT

Representative Mike Chenault

COMMITTEE CALENDAR

HOUSE BILL NO. 218
"An Act prohibiting an insurer from using a drug formulary system of specialty tiers under certain circumstances."

- HEARD & HELD

HOUSE BILL NO. 259
"An Act establishing procedures and guidelines for auditing pharmacy records; and providing for an effective date."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 218
SHORT TITLE: PRESCRIPTION DRUG SPECIALTY TIERS
SPONSOR(s): HEALTH & SOCIAL SERVICES

03/31/11	(H)	READ THE FIRST TIME - REFERRALS
03/31/11	(H)	HSS, L&C
02/28/12	(H)	HSS AT 3:00 PM CAPITOL 106
02/28/12	(H)	Heard & Held
02/28/12	(H)	MINUTE(HSS)
03/15/12	(H)	HSS RPT 2DP 4NR
03/15/12	(H)	DP: KERTTULA, MILLER
03/15/12	(H)	NR: MILLETT, SEATON, HERRON, KELLER
03/15/12	(H)	HSS AT 3:00 PM CAPITOL 106

03/15/12	(H)	Moved Out of Committee
03/15/12	(H)	MINUTE(HSS)
03/16/12	(H)	L&C AT 3:15 PM BARNES 124

BILL: HB 259
SHORT TITLE: PHARMACY AUDITS
SPONSOR(s): MUNOZ, P.WILSON

01/17/12	(H)	PREFILE RELEASED 1/13/12
01/17/12	(H)	READ THE FIRST TIME - REFERRALS
01/17/12	(H)	L&C, FIN
02/27/12	(H)	L&C AT 3:15 PM BARNES 124
02/27/12	(H)	Heard & Held
02/27/12	(H)	MINUTE(L&C)
03/16/12	(H)	L&C AT 3:15 PM BARNES 124

WITNESS REGISTER

JANET OGAN, Staff
House Health and Social Services Committee
Representative Wes Keller, Chair
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Presented HB 218 on behalf of the sponsor.

BRENDA ROBERTSON
Eagle River, Alaska
POSITION STATEMENT: Testified during the discussion of HB 218.

JIM FREEBURG, Advocacy Director
National Multiple Sclerosis Society
Greater Northwest Chapter
Seattle, Washington
POSITION STATEMENT: Testified and answered questions HB 218.

SHEELA TALLMAN, Manager, Legislative Affairs
Blue Cross Blue Shield of Alaska [Premera]
Mountlake Terrace, Washington
POSITION STATEMENT: Testified in opposition to HB 218.

REPRESENTATIVE WES KELLER
Alaska State Legislature
Juneau, Alaska
POSITION STATEMENT: Testified as the sponsor and answered questions during the discussion of HB 218.

CINDY LAUBACHER, Senior Director

State Government Affairs
Medco Health Solutions
Roseville, California
POSITION STATEMENT: Testified in opposition to HB 218.

BARBARA JONES
Anchorage, Alaska
POSITION STATEMENT: Testified during the discussion of HB 218.

BARRY CHRISTENSEN, Pharmacist
Island Pharmacy, Inc.;
Co-Chair, Legislative Committee
Alaska Pharmacists Association (AkPhA)
Ketchikan, Alaska
POSITION STATEMENT: Testified during the discussion of HB 259.

ANTONIA FIFLIS-FOWLER, ED, Director
Alaska Multiple Sclerosis Center (AlaskaMS)
Anchorage, Alaska
POSITION STATEMENT: Testified in support of HB 218.

ROSE KALAMARIDES, Administrator
Alaska Teamster Trust Funds
Anchorage, Alaska
POSITION STATEMENT: Testified in opposition to HB 259.

DIRK WHITE, Pharmacist
White's Inc.;
Member, Board of Pharmacy
Department of Commerce, Community & Economic Development
Sitka, Alaska
POSITION STATEMENT: Testified in support of HB 259.

JULIE MCDONALD, Independent Pharmacist
PHARMD;
Board Member, Alaska Pharmacists Association
Craig, Alaska
POSITION STATEMENT: Testified during the discussion of HB 259.

ACTION NARRATIVE

3:21:38 PM

CHAIR KURT OLSON called the House Labor and Commerce Standing Committee meeting to order at 3:21 p.m. Representatives Thompson, Holmes, Miller, Johnson, Saddler, and Olson were present at the call to order.

HB 218-PRESCRIPTION DRUG SPECIALTY TIERS

3:21:54 PM

CHAIR OLSON announced that the first order of business would be HOUSE BILL NO. 218, "An Act prohibiting an insurer from using a drug formulary system of specialty tiers under certain circumstances."

3:22:26 PM

JANET OGAN, Staff, House Health and Social Services Committee (HSS), Representative Wes Keller, Chair, Alaska State Legislature, on behalf of Representative Wes Keller, Chair, HSS, stated that specialty medications are used to treat complex chronic diseases continue to be the fastest growing segments of overall drug spend. While traditional drug spend slowed to an increase of only 1.5 percent in 2008 - and she believed that it is up to 16.3 percent - specially drug spend continued its steady climb increasing up to 15.4 percent. This bill would protect patients with critical illnesses from sudden changes in their drug treatment and therapy protocols which may unexpectedly deprive the patient from critical therapies due to the inability to pay for the drug or sufficient time to plan alternative financial or therapeutic strategies.

MS. OGAN continued. Currently, insurance companies can change their reimbursement policies with only a 30-day notice, often forcing the patient to absorb thousands of dollars of unexpected costs for expensive specialty drug therapy. By extending the notification period the savings for the patient will be absorbed by the rest of the policyholders on the plan. This may give the patient additional time to explore other options which may allow for a transition to a more affordable plan with similar therapeutic results.

MS. OGAN continued. Without these specialty drugs quality of life deteriorates and long-term health care cost may increase. Additionally, cost savings may be achieved by exploring options like management through specialty pharmacies that drug utilization monitoring specifically designed for hard to manage conditions.

MS. OGAN explained that this bill would extend the insurance company notification period to within 90 days to inform the insured that when these drugs go from one tier to another tier.

Specifically, insurance used to pay a flat pay for medication; however tier 4 drugs became a co-insurance drug, which means the drug recipient pays a percentage of the drug cost. If the drug costs $4,000 retail, the recipient will pay at least 30 percent or $1,200 out of pocket. She related that this bill elevates an awareness of this change to allow people with chronic illnesses to plan ahead for these changes in their therapies.

3:26:27 PM

REPRESENTATIVE JOHNSON said he reviewed letters of opposition in members' packets. He asked for driving forces for those in support of the bill and those opposing HB 218.

MS. OGAN answered that some individuals are adversely affected by the tier 4 prescription drug costs. The Multiple Sclerosis Society is assisting with the bill, since specialty drugs are typically injectable ones used by patients with chronic diseases such as multiple sclerosis (MS). The tier 4 drugs are expensive to manufacture and the costs affect many people with chronic diseases. The sponsor would like to find a balance. She recapped that the driving force behind the bill has been chronically ill patients have found themselves in an awkward position and do not have the funds or the time to find an alternative therapy. She listed some people affected by tier 4 drugs are those with chronic illnesses or diseases, including those with MS, rheumatoid arthritis, cancer, and hemophilia.

3:28:24 PM

REPRESENTATIVE HOLMES asked whether this problem is the result of a recent change.

MS. OGAN answered that tiering occurred in 2006 by Medicare and since then other insurers have reflected the Medicare changes. She pointed out that Medicare has a cap, but private insurers do not have a cap, although some patients may reach out-of-pocket deductibles ranging from $5,000 to $10,000.

3:29:11 PM

REPRESENTATIVE HOLMES related her understanding that this issue has started to emerge in Alaska.

MS. OGAN answered yes.

REPRESENTATIVE HOLMES referred to Section 3 of the bill, to the language on lines 21-22, which read,"...cost sharing, deductibles, or copayment obligations are determined by unique categories or special tiers...." She asked whether the language will be clear enough to distinguish.

MS. OGAN answered yes. In further response to Representative Holmes, Ms. Ogan agreed that specialty tiers refer to a term of art and the term is clearly understood.

3:29:51 PM

CHAIR OLSON asked whether the tier refers not just to the drug but the dollar value of the prescription.

MS. OGAN agreed it translates to the dollar value of the tier drugs.

3:30:38 PM

BRENDA ROBERTSON reported that her husband has been taking Copaxone, an injectible drug, for over 10 years to slow the progression of multiple sclerosis (MS). Last June, her medical insurer advised them their cost of the daily injection prescription drug would increase by $1,000 per month.

3:32:05 PM

The committee took a brief at ease due to teleconference reception difficulties.

MS. ROBERTSON gave a brief history. She recapped that last June the pharmacy, a specialty pharmacy, wanted to let her husband know that his copay had gone up from $30 per month to over $1,000 per month. She offered that his initial reaction was to tell her he wanted to stop taking his medication. The family had paid the insurance premiums faithfully, but now found they were facing unbelievable expenses. She described that the family has learned to live with MS, the challenges this disease brings to their lives, and their attempts to do everything possible to keep her husband healthy. Since his diagnosis, he has worked to push through the disease and be self-reliant, she stated. He still works and has never asked for special treatment, but he also did not expect to be penalized for his illness. He has no choice; however, others with the same insurance have affordable choices. He expected parity. The practice of specialty tiering discriminates among those who are

the sickest and puts their lives in danger. She asked members to imagine being diagnosed with such a debilitating disease and the ensuing suffering only to be told the one medication that could keep them functioning is financially out of reach. She said, "That is unfair and unconscionable." Raising the amount that people must pay for a lifesaving medication with no generic option or alternative by over several thousand percent with no notice is outrageous. She thinks people should be outraged to hear their story. This committee represents her husband, her family, and other thousands of Alaskans who are in danger. She predicted that insurance companies will tell the committee they need to save money. She said she is sympathetic to the drug companies, but realizing their savings on the backs of the most vulnerable Alaskans cannot be moral or ethical.

3:36:50 PM

MS. ROBERTSON stated that often these patients are the ones who push through their hardships, working, and contributing to the state's economy. Several states have banned the practice of using specialty tiers and many others are addressing this issue by placing a cap on a patient's annual expenditure. She predicted that when these Alaskans with chronic illnesses lose their jobs because they can no longer afford the tier 4 prescription drugs, the insurance companies will save money, but the state will ultimately have to pick up the costs which will increase over the long run. She and others testifying hope members will support the bill, which will require a 90-day notification period before changing someone from co-pay to specialty tier coinsurance. She further hoped this would be a first step to help the chronically ill patients manage their medical expenses. She pointed out that in 90 days there will still not be a generic drug, any alternative, or any choice; however, she also hopes her testimony will shed a light on this issue and down the road the state can do even more to help protect the chronically ill from being further victimized. She encouraged members to research what some other states are doing to protect their chronically ill citizens.

3:38:33 PM

JIM FREEBURG, Advocacy Director, National Multiple Sclerosis Society, Greater Northwest Chapter, reiterated the comments made by Ms. Robertson. He stated that this initiative is of great concern to National Multiple Sclerosis Society (NMSS). The organization has been seeing this trend become more prevalent in the nation. He encouraged the legislature to help the NMSS take

some steps to increase transparency around the use of specialty tiers and move towards the complete elimination of tier drugs in the future.

3:40:09 PM

REPRESENTATIVE HOLMES recalled Ms. Robertson mentioning trends. She explained one approach to address the problem is to require a noticing period, but some states are going to an outright ban on specialty tiers, while still others are placing a cap on out-of-pocket expenditures. She inquired as to whether he had a sense of how many states were choosing each of these remedies.

MR. FREEBURG said he did not have figures for all of states, but offered to research this. He explained that New York is the first state to adopt an outright ban and he offered his belief that Vermont has a one-year ban on specialty tiers. He related other states are still considering which approach is the best one to take. He stated that this issue may be addressed through the essential health benefits package as part of the federal PPACA. Each state may have an opportunity to address the issue through that process.

REPRESENTATIVE HOLMES related her understanding that states are still in the early stages of deciding the best approach.

MR. FREEBURG answered yes.

3:41:54 PM

CHAIR OLSON asked for clarification on actions taken in California and Washington.

MR. FREEBURG answered that a bill is before the Washington legislature that would prohibit specialty tiers, but the bill has not moved forward. He said he hoped to address this through the essential health benefits package. Montana's legislature meets biennially so this issue has not been brought forth yet, but he hopes to do so in 2013. He related the growing trend is to treat more and more illnesses and diseases with prescription drugs rather than procedures. He said insurers are somewhat slow to catch up to this and realize their coverage for medical treatments have been traditionally generous, but not for pharmacy benefits, in part, because in the last 10 to 20 years not as many treatments have been available via prescription for the chronically ill MS patients. He offered his belief that

this trend will continue as pharmaceutical companies improve drugs to treat difficult conditions such as MS.

3:43:30 PM

REPRESENTATIVE SADDLER referred to members' packets with respect to tiers 4 and 5 as specialty tiers and asked for further clarification.

MR. FREEBURG answered that tier 1 is typically a generic drug with a small $3-5 copay. Tier 2 would be a preferred brand name drug, and tier non-preferred brand name drug, which is usually the result of a negotiation between the insurer and the pharmaceutical companies. These drugs are also increasing in price; however the specialty tier 4 drugs typically have a coinsurance percentage amount. Thus tier 3 may be $30 copay but tier 4 would range from 30 to 50 percent coinsurance payments. He characterized the cost passed on to the patient as a drastic increase, which has pushed the responsibility for the drug cost to the consumer.

REPRESENTATIVE SADDLER related his understanding that the cost moves from a dollar cost to a percentage basis as the tiers progress.

MR. FREEBURG agreed. In further response to Representative Saddler, Mr. Freeburg explained that he thinks the difference between tier 4 and tier 5 drugs will result in an increasing percentage, perhaps 30 percent and 50 percent, respectively. He related his understanding it would likely be based on the cost of the drug or its relative efficacy compared to other drugs in within a similar class. He offered his belief that Medicare defines specialty drugs as those costing more than $600, but an outright ban would not fully address the problem patients are experiencing.

3:45:59 PM

REPRESENTATIVE SADDLER asked whether health care plans have backup insurance guarding against an increase in prescription drugs, similar to a rider.

MR. FREEBURG answered that he did not know. He said that frequently prescription drug costs are not capped as it typically happens with medical benefit caps.

CHAIR OLSON suggested that the high-risk insurance pool includes prescription drugs, but the pool is primarily used by patients with pre-existing conditions. He further suggested some delays are happening in anticipation of the pending U.S. Supreme Court decision in the Patient Protection and Affordable Care Act (PPACA).

MR. FREEBURG agreed. He also thought there is a limited bandwidth to tackle this complicated issue. He identified the insurers as the middleman. He has viewed increased prices by pharmaceutical companies. Additionally, some of the drugs are somewhat new so treatments and best use are still being identified. He suggested that it is also difficult for diseases such as MS since the effect varies from person to person. He was unsure about how this fits in for cancer or arthritis treatments. In New York the specialty tiers were not in place prior to the bill being passed so insurers did not have to change anything. He expressed concern that if nothing is done more and more specialty tiers will occur and at that point the cost increases will be too significant to have an impact, so if the problem can be resolved early on it will be somewhat easier to deal with.

3:48:51 PM

REPRESENTATIVE SADDLER asked whether the higher tiers of drugs are more effective or if the price is due to stratification or bracketing.

MR. FREEBURG answered that it varies from condition to condition. He stated that no other drugs are available to treat MS except specialty drugs to treat the underlying disease. He said he was unsure how that applies to cancer, rheumatoid arthritis, or hemophilia.

REPRESENTATIVE SADDLER asked whether any tier 2 or 3 drugs could address MS or if MS must be treated with tier 4 and 5 drugs.

MR. FREEBURG answered that MS drugs could be placed on tier 3, but insurers choose to place the drugs on tier 4 or 5.

REPRESENTATIVE SADDLER asked whether it is more of a price or coverage issues.

MR. FREEBURG agreed. He said the insurers may tell you they are trying to look at the efficacy for differences drugs within the same class, but that is not the case for MS.

3:50:08 PM

REPRESENTATIVE JOHNSON asked how long New York has prohibited specialty tiers.

MR. FREEBURG offered his belief the ban went into effect in 2010.

REPRESENTATIVE JOHNSON stated that if the copayment stays low the additional cost will be a shared cost. He inquired as to how much of an increase would be spread per individual in an insured group.

MR. FREEBURG answered that a California study attempted to answer this question. He referred to a summary in members' packets prepared by committee staff.

REPRESENTATIVE JOHNSON said he would like the information. He related his understanding that someone will bear the cost so he is wondering what the cost will be for the average consumer. He said it may be minimal and the size of the program would likely mitigate some of those. He thought that the smaller programs would be more affected than the larger groups.

3:51:59 PM

CHAIR OLSON characterized the pending decision in the U.S. Supreme Court case as the "900-pound gorilla" and until that case is settled and everyone knows the operating rules that it is extremely difficult to get projections from the state.

3:52:17 PM

SHEELA TALLMAN, Manager, Legislative Affairs, Blue Cross Blue Shield of Alaska [Premera], spoke in opposition to HB 218. She pointed out that she has provided the committee with a memo that outlines the concerns Blue Cross Blue Shield [Premera] as well as some conceptual amendments that might be considered as part of this discussion. She provided some background information. She stated that specialty drugs make it possible to treat diseases for which there are few available therapies. They provide new options for patient treatments. The specialty drugs are one of the fastest growing parts of the overall pharmaceutical benefits. She said less than three percent of specialty pharmaceuticals, but represents 25-30 percent of the total payor medical costs. She indicated this is a

significantly growing area impacting costs and employers have recognized this and want to offer pharmaceuticals it their employees yet want to make it more affordable. Thus the employer wants to make the overall coverage and continue to provide these benefits. The focus really should be on encouraging pharmaceutical companies to develop generic options for the specialty drugs to make it more affordable for a larger number of people. Premera offers a 3-tier or 4-tier benefit option for members. Some of the plans can offer an optional backstop such as an out of pocket maximum for prescriptions. She understood the importance of transparency and providing consumers accurate information about their benefits and out of pocket costs. The Premera currently provides detailed information about benefits upon application and renewal for individuals and employer groups.

3:55:19 PM

MS. TALLMAN explained this includes information on cost sharing, deductibles, and copayment terms applicable to pharmacies and specialty pharmacies tier. This information is provided 30 days prior to when the terms apply. The Premera provides another notice when any changes occur to the plan formularies. She provided an example, such as when a generic drug becomes available, which would shift an existing brand drug to a different tier. The Premera sends members a notice 30 days prior to the change. The Premera notifies members by mail 45 days of any changes that may impact their rate. She expressed concerns that this bill requires a 90-day notice timeframe, which would impact the application and renewal cycle since Premera would need to provide information much further in advance of the effective date. The notice requirement would be duplicative to current processes just described and the new federal health care reform requirement. This would add cost and could create confusion when members receive several notices about their benefits. She explained the requirement in the Patient Protection and Affordable Care Act (PPACA). Beginning on September 23, 2012, insurers must provide specific information to members about their coverage and benefits. This includes a very specific breakdown of the generic drug tier, the preferred brand drug tier, the non-preferred and specialty tier. Additionally, for each tier, the Premera must provide the specific cost sharing requirements. This information must be provided at initial application, renewal, and upon request by the individuals. Further, the Premera must also provide a mid-year notice triggered by any changes to the four tiers to members at least 60 days prior to the effective date of the

changes. She pointed out that this requirement will apply to all plans, including the grandfathered, the non-grandfathered plans, individual groups, and self-funded plans - including the plan.

MS. TALLMAN answered that 50 days; this will apply to all plans, grandfathered, non-grandfathered, and [Employee Retirement Income Security Act of 1974] "ERISA" plan. The Premera opposes HB 218, since it would require another notification and costs above the ones for the processes already in place and for the new requirements under the federal PPACA.

3:58:07 PM

CHAIR OLSON recalled that the problem could be partially solved by drug companies developing generic drugs for the specialty conditions. He said he thought generic drugs came about when the patents expire. Thus the generic drugs are not developed but are regular drugs after the patent life expires. He recalled specific drugs may have a molecule or two changed to make a new drug; however, he did not think specialty drugs are developed.

MS. TALLMAN said she believed he is correct. She suggested that it would be to work towards reducing the number of years a patent remains in force to encourage generic alternatives are available more quickly.

3:59:35 PM

CHAIR OLSON asked whether she has developed any models and impacts on Blue Cross.

MS. TALLMAN answered that she has not done a cost impact for the increased notification requirements from 30 days to 90 days required under HB 218.

CHAIR OLSON related his understanding the Premera does not currently know the costs.

MS. TALLMAN responded no, that it is more that multiple notices will be generated and sent out. She understood Washington and Oregon would remain at 30 days.

4:00:30 PM

CHAIR OLSON suggested the impact for Premera may be two percent or 15 percent, but Premera is unsure.

MS. TALLMAN answered yes. She said she did not currently have information. In response to Chair Olson, she offered to provide figures to the committee.

4:00:54 PM

REPRESENTATIVE THOMPSON related a scenario in which a couple has been paying insurance for 20 years, thinking it will cover medical costs. One of them gets cancer and the insurance company ends up covering hundreds of thousands of dollars for treatments and operations. He asked for the effect on insurance companies. He suggested it is not any different for prescription coverage than for medical coverage for cancer patients. He wondered if the rules could just change on copay for medical coverage. He was unsure why this is being attempted. He offered his belief it doesn't seem fair to the people who have bought insurance to have coverage and protect their savings. He pointed out that all of a sudden their deductibles are increased to $1,000 or more per month when they have been paying the insurance premiums. He expressed concern other unexpected cost increases could potentially occur besides prescription costs. He said he offers this as a statement.

4:02:20 PM

CHAIR OLSON said he has difficulty understanding the problem of changing notices from the current 45 day requirement to 90 day notice for Premera under the bill. The overall effect would be to increase the notice by 45 days. He questioned the difficulty and why this would add significant costs for Premera. He asked Ms. Tallman to provide the committee with a ball park figure for increased costs.

REPRESENTATIVE SADDLER asked for the form Premera will use to notice the increased costs. He suggested that in his experience that more companies have been moving to using Internet noticing, online accounting, or noticing by e-mail. He asked for a breakout and the nature of the costs as part of the information Ms. Tallman will provide to the committee.

MS. TALLMAN said she would try to do so. She suggested that one way is consider the patient would be paying a differences rate during the 90 day period than the 30 day period, so a

differences rate structure would occur over a longer period and would drive up the costs.

4:04:16 PM

CHAIR OLSON suggested the Division of Insurance might be able to answer that question but Linda Hall is not available today.

REPRESENTATIVE SADDLER asked for an explanation as to whether Premera bases its costs between tier 4 and tier 5 drugs and if it is based on efficacy or solely on the costs.

MS. TALLMAN responded that the tier 4 drugs are specialty drugs typically injected and used to treat complex medical conditions. These drugs usually require more specific handling and involvement with the physician so she thought the guideline was a broad guideline. She added that Premera is looking at efficacy to provide more value based and its clinical effectiveness. That would be another way to develop tiers, for example, if two drugs are in the market but one provides a better benefit such as extending their life would be placed on a lower tier versus a less effective drug which would be placed on a higher tier.

4:06:35 PM

REPRESENTATIVE SADDLER asked if a higher tier implied a more effective drug.

MS. TALLMAN answered not currently under the standard system. She pointed out that tier 4 is a way to identify those drugs that need special handling and storage and are ones used to treat more complex conditions.

4:07:01 PM

REPRESENTATIVE SADDLER related his understanding that tier implies some additional benefit that is a cumulative effect. He questioned whether the tiers should be considered as different categories of drugs.

MS. TALLMAN answered yes, that the tiers begin with generic, the non-preferred, followed by a brand drug.

REPRESENTATIVE SADDLER understood typically for tiers that each tier encompasses the previous attributes plus a little extra. He asked whether a tier 6 is forthcoming.

MS. TALLMAN answered that tier 6 might be something reviewed, but it is more about providing a value-based benefit structure for members in which the drugs fall into the various categories based on its efficacy and benefits to the member.

4:07:58 PM

REPRESENTATIVE SADDLER asked for further clarification on tiers. He related his understanding that tiers refer not just to handling but the value to the consumer.

MS. TALLMAN answered that is what Premera is currently developing. She explained it is not out in the marketplace but the Premera is focusing on trying to categorize drugs based on their quality, value, and effectiveness not necessarily the standard generic brand or preferred brand. She pointed out that one tier could encompass brand name or generic drugs but the focus is on examining the effectiveness.

4:08:48 PM

REPRESENTATIVE SADDLER understood she stated the higher tier implied not more effective, but now she is stating the higher tier would be the more effective drugs. He said he was confused.

MS. TALLMAN answered that she is talking about Premera is currently developing the value-based categories.

4:09:27 PM

REPRESENTATIVE WES KELLER, Alaska State Legislature, understood that the tier system was devised by Medicare in response to the high cost of drugs. The real problem is the high cost of health care. The tiers were developed by Medicare to manage payments for drugs and the concept has been picked up by the private sector.

4:10:33 PM

CINDY LAUBACHER, Senior Director, State Government Affairs, Medco Health Solutions, stated that Medco is the parent company to the Accredo Health Group, which is one of the largest and leading specialty pharmacies in the U.S. The Accredo Health Group's clients include state employee plans, union trust health plans, who generally manage their prescription drug costs by

maintaining a member cost share of approximately 20 to 25 percent per tier, which includes the generic tier, tier 1, tier 2 and so on. In 2013, Medco's sponsors are working on having approximately one percent of their drug spend going to specialty drugs, which will represent approximately 20 percent of their plan costs. She expressed concern about the costs of prescription drugs and in particular specialty drugs. She highlighted the development of generic drugs or bio-equivalent drugs. She reported Medco and Accredo are very active at the federal level lobbying the Congress to reduce the patent time on these very expensive high-end drugs, specifically to get generic or bio-equivalent drugs to the market to reduce costs. She highlighted that patients typically receive benefit notices prior to the start of the benefit year, and when changes occur during the benefit year. She related that Medco is very concerned about causing confusion since plans must provide 90 day, 60-day notices, and potentially another notice. She reiterated that sending numerous notices could create confusion in the marketplace and among patients. Therefore Medco and AHG are opposed to the bill. She offered to answer questions on tiers and drug costs and how to better address the issues.

4:13:51 PM

REPRESENTATIVE HOLMES said she is a little confused about multiple notifications. She referred to a letter from Premera, and acknowledged that the testifier is Medco, but the issue raised is the same. The Premera expressed concern that if federal law goes into effect insurers must notice their members at least 60 days prior to a change. She did not understand the reason the notices must be multiple notices. She asked whether the company could send on notice 90 days in advance to suffice all the noticing.

MS. LAUBACHER answered that typically Medco is drawn into helping plans manage. She pointed out the various notice include 90, 60, and 45 day notices. She offered to look at the federal law, but she thought the plans would still need to send additional notices such as the 60 day notice required under the PPACA. In response to a question on the percentage of specialty drugs, she answered that one percent of Premera' s drugs dispended under their plan - Premera is one of their clients - are specialty drugs but provides 20 percent of the prescription drug cost. She said it would be whoever is paying for plan costs.

4:17:05 PM

REPRESENTATIVE KELLER asked if some of the concern is worrying about whether the bill would create a mandate for more coverage or whether it is just the notice requirement.

MS. LAUBAHER answered that the concern is the notice since the bill would not address the issue about increased cost for Copaxone. She reiterated that HB 218 only pertains to the notice requirements and not the costs. She explained that Medco is working at the federal level to reduce patent protection to get generic drugs to the market, which should help keep costs down.

4:18:42 PM

REPRESENTATIVE KELLER has a hard time seeing that the notification is a huge deal, but has been concerned about mandates.

4:19:04 PM

CHAIR OLSON surmised that the Division of Insurance can give 90 days' notice so long as it is prior to renewal.

MS. LAUBACHER related it has been their experience that changes begin at plan year so prior to the new benefit patients are provided with information on copay. She said it is uncommon and rare for changes in copay or insurance to occur during the year. She checked with Medco and it is rare to see rate increase mid plan year for an increase from $100 to $1,000 month. She said most of their plan sponsors will cap the copay. She explained that a person may pay $10 to $20 per month for tier 1 or 2, but tier 4 drugs are usually a percentage such as 20-25 percent. Typically when someone moves from copay to coinsurance, the person would pay 20 percent with a cap of $200. She emphasized that the example made earlier really surprised her. She asked for clarification and confirmation and Medco and ACCREDO said it is extraordinarily rare for those types of large increases to happen.

4:22:18 PM

CHAIR OLSON asked if it would be safe to assume the majority of people are covered by group plans rather than individual coverage.

MS. LAUBACHER answered that Medco and Accredo are limited to group and not individual coverage. She explained that Ms. Robertson and her husband may be under an individual policy.

CHAIR OLSON related that 75 percent of the plans are renewed on January 1 or July 1.

MS. LAUBACHER answered yes. She confirmed the two dates would be the beginning of the calendar year or the fiscal year.

4:23:20 PM

REPRESENTATIVE SADDLER asked where the impetus of coinsurance comes from and if it comes from reinsurance or whether the Medco is following the Medicare's lead.

MS. LAUBACHER offered to get an answer, but generally speaking; coinsurance is a tool used as an option to clients and not all clients use coinsurance. Some choose flat co-pays. It is simply a tool available to clients to assist them in managing their prescription drug costs. She offered her belief that it typically is used for tier 4 and specialty drugs due to the high cost associated with specialty drugs.

4:25:07 PM

REPRESENTATIVE SADDLER asked whether the company offers coinsurance for cost savings or if clients demand it.

MS. LAUBACHER answered it may be both. She did not know. She said that typically the Medco responds to the market. The clients will come to them and say that their costs are skyrocketing and Medco would present coinsurance.

CHAIR OLSON offered his belief that coinsurance is used to ensure everyone has a vested interest in the cost. He said if something is free it may be over utilized, but if the client is paying for a portion of it, they have an interest in keeping the cost down.

4:26:02 PM

REPRESENTATIVE JOHNSON recalled specialty drugs represent one percent of prescription drugs filled. He asked how many people that represents.

MS. LAUBACHER said she could get answer on the number of patients served by specialty drugs. She ventured that it is typically a small market including patients with hemophilia, MS, and rheumatoid arthritis. She was uncertain a specific number is available for patients covered by specialty. She suggested that it depends on the high cost of the particular drugs. She suggested that a plan with high incidence of hemophiliacs but a low number of persons with other types of conditions so it varies by plan.

4:27:06 PM

REPRESENTATIVE JOHNSON asked how many notices would be sent out.

MS. LAUBACHER answered that the notices must be sent to everyone and not just the few patients with hemophilia, but rather the notices are sent to every plan member.

REPRESENTATIVE JOHNSON questioned whether HB 218 requires the notices must be sent to every member and not just the ones using specialty drugs.

MS. LAUBACHER agreed.

4:27:46 PM

CHAIR OLSON asked whether the term orphan drugs is what is now called specialty drugs.

MS. LAUBACHER offered her belief that is correct.

4:28:15 PM

BARBARA JONES stated that her daughter was diagnosed with juvenile rheumatoid arthritis when she was 12 years old. She was given a cocktail of drugs and needed to be hospitalized two to four times per year. She quit participating in sports and went to high school part time. About two years ago she started on a specialty drug that costs $400 per week or $1.600 month. It was a miracle for our family. She said that both she and her husband have insurance. He has been on his job for 26 years and has been contributing to health insurance long before their daughter was born. She has been at her present job for 13 years. Currently, her daughter is doing very well. She graduated from high school and is in her first year of college at the University of Alaska Anchorage. She has been accepted into the honors college. She has declared her major as

chemistry and wants to study medicine. She is on spring break and will tour a research hospital. She will receive a spirit of youth award with her work with other children with arthritis at Arthritis Foundation Camp. This bill promises 90 days' notice. She assured members she will not be confused by multiple notices. She said, "We need this bill as a start to help my daughter and all the others who need these drugs to remain productive and contributing members of our state and our community." She thanked members for their work on this bill.

4:30:42 PM

REPRESENTATIVE SADDLER asked how many notices she receives in a year for prescription medication for her daughter or health insurance notices in general.

MS. JONES answered that she did not think there would be a confusing number. She explained that she receives phone calls from our specialty pharmacy almost every week. They are not confusing. She did admit that in their family they have a division of labor and her husband maintains a log. She said she does hear the telephone messages and sees the mail. She said it is not confusing to them.

4:31:38 PM

BARRY CHRISTENSEN, Pharmacist, Island Pharmacy, Inc.; Co-Chair, Legislative Committee, Alaska Pharmacists Association (AkPhA), answered that the Alaska Pharmacists Association has not taken a position on HB 218.

CHAIR OLSON asked what impacts he sees as a pharmacist.

DR. CHRISTENSEN related the bill is a notification bill. He acknowledged that sometimes the pharmacists are caught when patient comes in and cannot afford their medications. He related that many specialty drugs are distributed through specialty pharmacies. He expressed concern for the patients but the AkPhA has not taken a stand.

4:33:16 PM

CHAIR OLSON asked for clarification on specialty pharmacies.

DR. CHRISTENSEN answered that Alaska does not have a regional specialty pharmacy but many of the drugs require refrigeration, which is somewhat problematic for some areas of Alaska. He

acknowledged that numerous specialty pharmacies exist across the U.S.

4:34:12 PM

CHAIR OLSON asked whether the pharmacies break down the drugs by condition or by drug.

DR. CHRISTENSEN answered that most specialty pharmacies handle a variety of specialty drugs and contact the manufacturer for certain drugs. He acknowledged there could be one or two pharmacies that handle one or two drugs. He related his understanding that the majority of them would handle a number of specialty drugs.

4:34:42 PM

CHAIR OLSON asked for clarification on who would regulate the specialty pharmacies.

DR. CHRISTENSEN answered that specialty pharmacies would be regulated by both state and federal regulations. He explained that the FDA primarily handles the regulation of the manufacturing of the drugs.

4:35:39 PM

ANTONIA FIFLIS-FOWLER, ED, Director, Alaska Multiple Sclerosis Center (AlaskaMS), in conjunction with the National Multiple Sclerosis Society Greater Northwest Chapter, offered her support for HB 218. This bill proposes only a simple change from 30 days to 90 days noticing, but could result in a major benefit of decreased stress. The bill would increase the time to pursue alternatives and other options for continuing therapy when patients find themselves unable to afford the increase out of pocket copay or coinsurance imposed upon them unexpectedly. Unfortunately, the stress created by unpredictable circumstances and increased financial obligation - sometimes as much as $1,000 per month - often translates into worsening conditions for people with MS, which can contribute in then not being able to continue to work. She referred to a recent survey of Alaskans with MS, which revealed that due to high cost and copays 41 percent have suffered financial strain, changed their treatment plan, skipped medication, modified their dosage or stopped treatment altogether due to their inability to pay. She emphasized that this is exactly what should be avoided. The AlaskaMS wants people to have access to these medications at a

reasonable rate. There are not any genetic alternatives and when people lose access to these life-altering drugs the U.S. will be regressing 30 years.

MS. FIFLIS-FOWLSER said when she was first diagnosed with MS drugs were not available to treat MS. Young people were told to go home and wait for the inevitable to happen. They were unable to work, were considered totally disabled, and were put on Medicare. She reiterated that people with MS were a burden to society. She acknowledged that there still is not any cure for MS, but medications developed over the past 20 years have slowed the progress of the disease. She pointed out that specialty drugs are used to treat other diseases and conditions besides MS. She said that medications slow the progress of the disease. She estimated about 1,000 Alaskans have MS. Without HB 218 and stronger legislation governing specialty tiering the most chronically ill Alaskans will continue to shoulder an inequitable burden of costs for their medication drugs than the non-preferred brand name drugs. She asked members to consider following in New York's footsteps and ban specialty tiers on the grounds that they discriminate against people with chronically ill. She urged members to vote for HB 218, which sends the message that an increase in copay or coinsurance by 25-30 percent of the cost of the drug without significant notification - which she did not find confusing - is unfair and detrimental to individuals. She concluded by stating that MS is life altering enough as are all these diseases. She asked members not to take away tools that help people with chronic illnesses to live more fully every day.

4:40:14 PM

CHAIR OLSON pointed out that the U.S. Supreme Court will make decisions on the federal PPACA and legislatures will be on hold until the new rules are adopted.

4:40:59 PM

REPRESENTATIVE KELLER thanked members. He said that pharmaceuticals are getting better and better. He said that a recent University of Alaska Anchorage, Institute of Social and Economic Research (ISER) study showed total spending for health care in Alaska is $7.5 billion. He said that equals half of the earnings of Alaskans. He predicted the rate of increase will double in nine years. He could not fathom the potential increases.

REPRESENTATIVE JOHNSON acknowledged the crisis.

[HB 218 was held over.]

4:42:37 PM

The committee took an at-ease from 4:42 p.m. to 4:45 p.m.

HB 259-PHARMACY AUDITS

4:45:00 PM

CHAIR OLSON announced that the final order of business would be HOUSE BILL NO. 259, "An Act establishing procedures and guidelines for auditing pharmacy records; and providing for an effective date."

CHAIR OLSON opened public testimony on HB 259.

4:45:09 PM

ROSE KALAMARIDES, Administrator, Alaska Teamster Trust Funds, on behalf of the Teamsters and the Teamster-Employee Trust Funds, spoke in opposition to HB 259. She said she has read through the bill and it is not well-defined and will be a confusing bill for the state, especially since the state will need to administer it.

MS. KALAMARIDES then read from a prepared memo, dated March 16, 2012, which read [original punctuation provided]:

> Plans, such as ours, hire a pharmacy benefit manager (the PBM), which provides all pharmacy services to our members and helps us control pharmacy costs. Part of the role of the pharmacy benefit manager is to audit the claims for our members.
>
> This bill clearly goes to protect the pharmacies but does little for the consumer (our member) who is the payer. This is not a revenue neutral bill. This would require state oversight which is duplicitous and unnecessary. The bill is so poorly written that it would be onerous for the state to administer.

MS. KALAMARIDES paraphrased that the contract between the PBM and the pharmacies covers much of this. When a PBM contracts with a pharmacy it covers all types of issues, including the

notice requirements contained in the first two subsections of HB 259.

MS. KALAMARIDES continued to read from a prepared memo, dated March 16, 2012, which read [original punctuation provided]:

> While we have no problem with these, they are unnecessary and an issue to the contracting parties.
>
> We take particular issue with several of the requirements:
>
> Subparagraph 3 requires the audit of a claim shall occur within two years. Medicare and Medicaid require 10 years.
>
> Subparagraph 4 is vague and not well written. In reading it, I'm not even sure what supposed problem they are attempting to address.
>
> Subparagraph 5 is vague and not well written. Who will decide the standards and parameters? What is the definition of a "similarly situated pharmacy?" The contracts between the PBM and the pharmacy already cover the auditing standards.
>
> Subparagraph 6 is the most objectionable in the proposed law. One of the major benefits of an audit is for a consumer to find fraud. For example, if a pharmacy is committing fraud by marking up prescriptions by $1, this subparagraph could hinder the auditor's authority to name it what it is—fraud.
>
> Subparagraph 7 is vague and not well defined.
>
> Subparagraph 8 is objectionable. There are several parties involved in a prescription benefit plan, including the member, the fund, the consultant, the attorney, the PBM and the pharmacy. There are already confidentiality agreements imbedded in the contracts between the PBM and the pharmacy so these reports can only be distributed to interested parties under the contract terms.

4:48:24 PM

MS. KALAMARIDES continued to read from a prepared memo, dated March 16, 2012, which read [original punctuation provided]:

> Subparagraph 9 and 10 are objectionable. Extrapolation is used in most audits. When you have volume claims, it is not possible to audit every claim, so extrapolation is a reasonable method to determine the amount the pharmacy should pay if errors are found. Extrapolation is used in all forms of audits. Besides, if the error rate is high, the auditor will continue to expand the sample until they establish a pattern. This is clearly an attempt by pharmacies to limit their financial exposure which is unfair to those who are paying these claims.
>
> Subparagraph 11 doesn't make sense. Dispensing fees are not the only revenue the pharmacy receives. They may claim this, but they make money on the drug too. There is a lot of revenue built into the dispensing fee and is paid by the plan and should be part of the overall claim.
>
> Subparagraph 12 is unnecessary. This is covered in the contracts with the pharmacy and they generally allow for 90 days.
>
> Subparagraph 13 is interesting. In the prior paragraph, the auditor must deliver the audit "within 60 days" and in this paragraph, the pharmacy has "at least 30 days to respond." Clearly this entire piece of legislation is tilted in favor of the pharmacy and away from the consumer.
>
> Subparagraph 14 is vague and could only create problems and costs for the state who will be expected to administer such a provision.
>
> Subparagraph 15 is confusing. Doesn't a final appeal come after a final audit report? 14 and 15 appear to create an unending circle. Again, this is too vague to administer.
>
> Subparagraph 16 is unnecessary. This is covered in the contract between the parties. Again, dispensing fees should not be excluded from the final analysis of an audited claim.

Subparagraph 17 is objectionable. How we pay our auditors should not be something the pharmacy dictates. The pharmacies do not pay for these audits. Plans like ours do. There are many different manners in which auditors may be paid. Restricting the consumer's freedom to contract with auditors on their own terms is objectionable.

Subparagraph 18 is objectionable. If we have overpaid a pharmacy, why should they have had the use of our revenue without refunding us, plus interest?

We have no objection with subparagraph 19.

4:51:15 PM

CHAIR OLSON asked whether the Alaska Teamster-Employer Trust Funds receive a fee or rebate from the PBM based on the audit.

MS. KALAMARIDES answered that the manufacturer, but not PBM provide the rebates.

4:51:37 PM

REPRESENTATIVE SADDLER referred to the objection in [paragraph] 11. He asked for clarification on who is paying the claim, for what, and to whom.

MS. KALAMARIDES responded that the Alaska Teamster's Plan is a self-funded plan and the plan is not insured. The money that pays for all the claims results from direct negotiations between the union and the employers who employ the members. Essentially, it is the members' money since it is part of their wage package, including their medical and pharmacy benefits. The Teamsters contract with the PBM, which is simply an agency that controls the pharmacy costs. She described the process. Members take their prescription to a pharmacy, which is also under contract with the PBM. The members bring in their prescription drug cards, which identify them as Teamster members with health and pharmacy benefits. The pharmacy runs their cards through the program, which identifies the amount the PBM will cover for the drugs and the amount the members must pay. She concluded that at the end of the day the Teamsters pays the PBM for all pharmacy transactions for all Teamster members.

4:53:44 PM

CHAIR OLSON suggested that Representative Saddler might be confusing claim and benefit. He clarified that it is a claim when the prescription is made against the plan, but the prescription is a benefit to covered employee.

MS. KALAMARIDES agreed.

4:53:56 PM

DIRK WHITE, Pharmacist, White's Inc.; Member, Board of Pharmacy, Department of Commerce, Community & Economic Development, stated that the Board of Pharmacy supports the bill. He said committee members' should have a letter of support from the Board of Pharmacy in their packets. The pharmacists do not have any issue with audits being conducted for fraud and abuse; however, when a prescription is legal, valid, and filled according to state and federal statutes and regulations it should be allowed to stand as unrecoverable. He indicated that audits can be very costly to pharmacies and if pharmacies must absorb these costs it might reduce access to the primary care community pharmacies provide when the pharmacies close. He pointed out that his pharmacy is currently undergoing several audits that total about $7,000 for two wheelchairs and he may need to close that portion of his business since his pharmacy cannot suffer that type of loss. He said the pharmacy provided the wheelchairs to the patients and the chairs worked well for the patients, but the pharmacy cannot produce a certain piece of paper for the auditors. There is no fraud or misuse, yet the auditors will likely require his pharmacy to repay the cost. He pointed out that complaints of fraud and misuse come to Board of Pharmacy and are reviewed. Thus he did not see the need for audits outside of federal regulations. He commented that he has heard previous testimony that pharmacists can negotiate their contracts, but he has never received a returned contract containing his modifications. He lines out items but the revised contract is not returned and when he calls about the contract is informed that he must accept the terms. The contracts are "take it or leave it." He also heard testimony that dispensing fees cover the costs. He recently opened a contract containing a dispensing fee of $1. The Alaska Medicaid [and Health Care Policy, Division of Health Care Services] did a cost to dispense survey three years ago and found dispensing fees should range from $11 to $27 in rural areas. He said that no insurance company or PBM is currently paying that type of dispensing fee. He urged members to please support HB 259.

4:57:04 PM

JULIE MCDONALD, Independent Pharmacist, PHARMD, Board Member, Alaska Pharmacists Association, stated that she is speaking on behalf of independent rural pharmacists. In 2008, she became a pharmacist. She initially thought the audits would be great, but she has since come to the opinion that audits are nothing more than an attempt to recruit revenue back to the insurance company. She described a scenario in which a patient named Anne obtains a prescription and the prescriber writes the name as Ann. The pharmacist fills the prescription and even though the last name, date of birth, and address make it very clear the correct patient is being served, an auditor will say the doctor did not put an "e" at the end of the name "Ann" and reach the conclusion that is the wrong patient. Next, the auditor will require repayment for the original prescription filled as well as every subsequent refill for the prescription drug. She acknowledged this scenario only represents one instance, but she has also seen independent pharmacies billed up to $12,000 on audits. Rather than highlight numerous instances of problems she has encountered, she offered to describe six trends she has observed happening in audits: First, the selection of high cost prescriptions to audit instead of an auditing prescriptions that have high error rates or those drugs which are frequently abused. Second, auditors consistently seem to arrive at the busiest time for the pharmacies, such as on a Monday or the first week of the month. Third, the audits greatly disrupt the pharmacists from providing patient care and interrupts workflow. Fourth, auditors use extrapolation to calculate overpayment, which results in grossly exaggerated figures. Fifth, auditors frequently ask for documentation that is not required by state or federal law and has not previously been requested by insurance companies. She related a scenario in which a patient needed a prescription drug filled for a vacation - a vacation supply. The pharmacist called the doctor and the insurance company before filling the prescription early. The pharmacist noted remarks on the prescription including the reason for the early filling. More than a year later the auditor wanted to know why a specific code was not written on back of the prescription. The pharmacist did not understand the need for the code and the auditor subsequently required repayment of the claim. Sixth, the most troubling of all is that pharmacies are not left any means to adequately appeal audits, which is especially true for small independent pharmacies since these mom and pop pharmacies do not have legal departments or other resources available to them. She concluded by noting that sometimes audits are conducted by insurance or PBMs owned by a large chain store. Therefore small independent pharmacies are

essentially being audited by their much larger competitors. She said she is not opposed to large chain pharmacies; however, she characterized this as similar to having Burger King inspect Bob's Hamburger Shop, which might result in a large problem for Bob. She appreciated the committee's willingness to hear HB 259.

5:01:19 PM

REPRESENTATIVE SADDLER asked for the fourth trend.

DR. MCDONALD answered that extrapolation leads to exaggeration.

[HB 259 was held over.]

5:02:18 PM

ADJOURNMENT

There being no further business before the committee, the House Labor and Commerce Standing Committee meeting was adjourned at 5:02 p.m.