
Public Hearing

before

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

ASSEMBLY BILL No. 2337

(Pharmacy Benefits Management Company Act)

LOCATION: Committee Room 16
State House Annex
Trenton, New Jersey

DATE: August 8, 2002
1:00 p.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblywoman Loretta Weinberg, Chairwoman
Assemblyman Herb C. Conaway, Vice-Chairman
Assemblyman Jerry Green
Assemblywoman Linda R. Greenstein
Assemblyman Reed Gusciora
Assemblywoman Joan M. Quigley
Assemblyman Paul R. D'Amato
Assemblyman Thomas H. Kean



ALSO PRESENT:

David Price
Office of Legislative Services
Committee Aide

Wali Abdul-Salaam
Assembly Majority
Committee Aide

Tasha M. Kersey
Assembly Republican
Committee Aide

Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey

TABLE OF CONTENTS

	<u>Page</u>
LaVarne Burton President Pharmaceutical Care Management Association	6
John A. Giampolo Executive Director Independent Pharmacy Alliance of America	38
John R. Davis Director State Legislative and Regulatory Affairs National Community Pharmacists Association	41
Dick Walter Owner Walter's Pharmacy	50
Carlo Benedetti Owner The Olden Pharmacy	57
Assemblyman Joseph V. Doria Jr. District 31	66
Gerry Purcell Managing Partner Pharmacy Partners	82
Peter F. Harty Vice President Medco Health Solutions, Inc.	104
Harold Bobrow Representing Linda Witzal Quality and Service Pharmaceuticals, L.L.C.	128
Loretta Brickman Representing Quality and Service Pharmaceuticals, L.L.C.	130

TABLE OF CONTENTS (continued)

	<u>Page</u>
Laurie A. Clark Director Government Affairs New Jersey Pharmacist's Association, and Garden State Pharmacy Owners, Inc.	134
Frederick Trinkley President New Jersey Pharmacist's Association	135
Tom Viola Executive Vice President Garden State Pharmacy Owners, Inc.	142
Melanie Willoughby Executive Director New Jersey Council of Chain Drug Stores	150
Paul R. Kramer Former Assemblyman New Jersey State Legislature	156
Dudley Burdge Legislative Political Coordinator Communications Workers of America Local 1032	160
APPENDIX:	
Testimony submitted by LaVarne Burton	1x
Testimony submitted by John R. Davis	5x
Biography, testimony, and article submitted by Gerry Purcell	11x

TABLE OF CONTENTS (continued)

APPENDIX (continued)

Page

Testimony
submitted by
Peter F. Harty

35x

Statement
submitted by
Laurie A. Clark

40x

Statement
submitted by
Melanie Willoughby

41x

Testimony
submitted by
Dudley Burdge

44x

Letter
addressed to
Assemblywoman Loretta D. Weinberg
from
Paul Anzano, Esq.
Pringle Quinn Anzano, P.C.
representing
Express Scripts, Inc.

47x

Letter
addressed to
Assemblywoman Loretta D. Weinberg
from
Robert Santaloci, Esq.
Pringle Quinn Anzano, P.C.
representing
Health Insurance Association of America

51x

rs: 1-165

ASSEMBLYWOMAN LORETTA WEINBERG, (Chairwoman):

Okay. We will call to order this meeting of the Health and Human Services Committee of the New Jersey State Assembly. My apologies for the late start, but there was obviously a little public interest in why this Committee is so hardworking. (laughter) That's a new question.

But I will say that I personally appreciate the work of the members of this Committee. We have been meeting regularly, starting this past spring, in a series of hearings: three hearings, two of which have taken place, one just a couple of weeks ago, during the summer, on medical malpractice insurance; one on women and disabilities; another joint hearing with the Senate Health Committee on the nursing shortage; two planned for the month of September, one on health disparities, and another, third in our series, on medical malpractice.

So, I, for one, would like to congratulate the members of this Committee for working so hard on behalf of the residents of the State of New Jersey.

We scheduled this meeting because this is a growing issue nationally. And in case anybody would like to doubt that, I would refer you to the August issue of *U.S. News and World Report*, which recently came out, talking about the industry pharmacy benefits managers. It is a \$57 billion industry in the United States.

We invited, we advertised. Anybody who wished to come and testify was welcome to sign up in advance. And anybody from the audience is always welcome to fill out one of these white slips, and you will be called as a witness to give us testimony.

We are going to be discussing a bill which was introduced into the Assembly in the spring. I believe it came in sometime in May sponsored by Assemblyman Joe Doria, which would put the State in the business of regulating pharmacy benefit managers.

That's the purpose of this -- whether we in the State of New Jersey, in order to protect the residents of the State of New Jersey, in order to hold down pharmaceutical prices -- whether we in the State of New Jersey should be regulating that industry. And that's what I hope will come out of this hearing.

We do expect Assemblyman Doria here. He said that he did have something to do a little earlier this afternoon and would be here. And when he comes, we will certainly give him the benefit of the microphone.

In the meantime, if I may, David, would you call the role?

MR. PRICE (Committee Aide): Assemblyman Kean.

ASSEMBLYMAN KEAN: Here.

MR. PRICE: Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Here.

MR. PRICE: Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Here.

MR. PRICE: Assemblyman Green.

ASSEMBLYMAN GREEN: Here.

MR. PRICE: Assemblyman Gusciora.

ASSEMBLYMAN GUSCIORA: Here.

MR. PRICE: Assemblywoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Here.

Thank you.

And Assemblywoman Greenstein.

Yes, Assemblyman Green.

ASSEMBLYMAN GREEN: Thank you very much, Madam Chair. I'd just like to comment on the remarks you just mentioned with your opening statement. I think the timing of this particular hearing is very important.

As we all know, we had multiple hearings during the course of the budget hearings. In the 22nd district, which I represent, we have Merck, who I met with on an ongoing basis because of the fact that they were concerned about the tax increase.

But I had an opportunity, Madam Chair, to discuss this particular issue with them because of the fact that, number one, there is a gap in New Jersey that falls between the ages of 50 to 65 -- that once they lose their benefit, they don't have the opportunity to get the right type of services that they need.

So, again, I think that we need to get away from anyone, or anyone that feels this is a political issue. This is an issue that's going to be facing a lot of people here in the State of New Jersey, especially when companies now are cutting back on health care, as well as health benefits. A lot of employees in the past have had the ability to offer this when they were trying to get employers to come to their company. Now this is no longer the issue.

So it's important that we do look at this issue in terms of what's good for the people of the State of New Jersey. Again, I recommend and I suggest that we look at what's good for all of us because, again, with Merck and

some other companies in the state that I'm not able to use their names -- during the course of their budget -- they did talk about this issue. And this is an issue that all of us should be concerned about other than for political reasons.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblyman Green.

Does anybody else have a comment they'd like to make?

Assemblyman Gusciora.

ASSEMBLYMAN GUSCIORA: Yes. Thank you, Madam Chair. I actually want to commend you for holding these hearings and thank you for your invitation to take part in these.

The fact remains that Americans spend about \$122 billion each year on pharmaceutical drugs. And it's estimated about 10 percent of that is spent on the middle man or the pharmacy benefits manager. California, right now, is in a lawsuit against PBMs -- that they want to recoup \$32 million. The state of Georgia, in June, just passed an act regulating PBMs. West Virginia is moving on that. And Vermont is moving ahead on trying to get -- directly buying pharmaceutical drugs for their program.

I'm particularly interested in the testimony where it pertains to Senior Gold. As we know, in the last legislative session, we passed Senior Gold assistance, where we doubled PAAD benefits, and that there's an actual provision that would not allow PBMs to take part in Senior Gold.

So I think this is very timely. This will save many of our constituents' money in the long run. And then I think that we should remain

on the cutting edge of regulating this area. And so I think it is timely. And I welcome this Committee hearing.

ASSEMBLYWOMAN WEINBERG: Thank you, Assemblyman.

Let me just correct something I said a little earlier about it being a \$57 billion industry. The four top companies in the field make \$57 billion. The overall is \$122 billion that Assemblyman Gusciora just mentioned.

And I'd also like to just add a little footnote to that. The largest company in the field, AdvancePCS, is a subcontractor handling the State health benefits plan. And I have been told that they said they were going to submit written testimony, but now they've declined. I'm not sure if that's the absolute case. But if, in fact, it is, I'm going to ask why a company that does business with the State of New Jersey does not want to share their business practices with us.

So that's a question that remains unanswered. And if anybody from AdvancePCS is here, we encourage you, if you do not want to appear at this meeting, to at least submit written testimony to us.

Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you, Assemblywoman. I also want to commend you for holding this hearing.

Until two years ago, I had no idea what a pharmacy benefits manager was. And since I work in the health care industry, that's pretty disgraceful. But I served, at that time, on the Task Force -- the Governor's Task Force on the Affordability and Accessibility of Health Care. And it was at that time when the State was considering bringing in a PBM that I first learned what it was.

And with all deference to my friend, Assemblyman Green, it also applies heavily to people who are employed, who have benefits, who don't know that their benefits are being limited because there is a nameless, faceless entity called a PBM out there.

I learned during that meeting that the PBM is the channel between the employer and the person whose benefits are covered. And when the pharmaceuticals are going through that channel, the money sticks to the PBM like plaque sticks to arteries.

ASSEMBLYWOMAN WEINBERG: You had to remind me, right? (laughter)

ASSEMBLYWOMAN QUIGLEY: And no one knows that that's happening. So I'm glad we're doing this today, not only to regulate the industry, but just to draw attention to it so that people know that there is someone between them and their benefits.

ASSEMBLYWOMAN WEINBERG: Anybody else wish to make a-- (no response)

The first person on my list--

Well, first of all, let me-- Just a little housekeeping detail. We have three microphones there. You must speak into the microphone or you don't make it into the transcript. So when there are more than three, because we have one group that wants to come up together, you're going to have to kind of play musical chairs with the microphone.

But the first is LaVarne Burton, President of the Pharmaceutical Care Management Association.

La V A R N E B U R T O N: Good afternoon, Madam Chairwoman.

ASSEMBLYWOMAN WEINBERG: Good afternoon.

Is you're red button on there? (referring to PA microphone)

MS. BURTON: It's on now.

ASSEMBLYWOMAN WEINBERG: Okay, thank you.

MS. BURTON: Should the red be on?

ASSEMBLYWOMAN WEINBERG: Yes. It's backwards, I know.

That's a little joke among us, that only in the State of New Jersey does red mean go. (laughter)

MS. BURTON: Well, I hope you will have some sensitivity. I'm getting used to the new New Jersey rules.

ASSEMBLYWOMAN WEINBERG: Go ahead.

MS. BURTON: Thank you very much, Madam Chairwoman.

And good afternoon to the Vice Chairman and the members of the Committee.

I am LaVarne Burton. I'm President of the Pharmaceutical Care Management Association, also known as PCMA.

Thank you for the opportunity to appear before you to testify on behalf of PCMA and our membership.

PCMA represents pharmacy benefits management companies who contract with State and Federal governments, health plans, HMOs, employers, unions, Medicaid and Medicare managed care plans, and other entities to provide prescription drug benefits. PBMs deliver prescription drug benefits to approximately 200 million individuals, managing about 70 percent of the approximately 3.2 billion prescription orders dispensed each year in this country.

PCMA also represents mail-service pharmacies that dispense all of the approximately 340 million mail-order prescriptions for ambulatory care patients. Mail service is the fastest growing segment of the prescription drug delivery sector, equating to approximately 17 percent of all retail prescription drug sales last year. PCMA members employ over 15,000 pharmacists. While many of our members serve broad national populations, some also focus on specific disease needs such as HIV/AIDS patients, organ transplants patients, cancer, and diabetes patients.

Before I proceed to discuss AB-2337, I would like to define a PBM. PBMs are organizations employed by health plan sponsors to administer pharmaceutical benefits. PBMs process pharmaceutical claims, administer formularies, and manage utilization of prescription drugs at the direction of, and for the benefit of, their clients, whom we refer to as plan sponsors.

PBMs also negotiate discounts from pharmacies and manufacturers. PBMs design programs with the goal of safe and cost-effective therapies. The PBM industry has experienced considerable growth because it has furnished clients with administrative efficiencies and drug benefit programs via retail pharmacy contracts that provide substantial discounts on prescription drugs, as well as value-added therapeutic service for our patients.

The five defining functions of PBMs are: claims processing and adjudication, pharmacy network management, formulary development and management, discount and rebate negotiations with pharmaceutical manufacturers, and disease management. PBMs work very closely with health-care payers, pharmacists, and other providers.

Now, I would like to make four points that explain our opposition to AB-2337.

First, PBM activities are already appropriately and extensively regulated. The new regulatory scheme proposed in AB-2337 would duplicate and conflict with already existing State regulations. The activities in which PBMs engage in order to promote prescription drug services for employers and health plans, including the State Health Benefits Program, are already subject to regulation, including HMO regulations and the Health Care Quality Act regulations from the Departments of Banking and Insurance, and Health and Senior Services.

In particular, current State regulations already accomplish the following: They require health plans to disclose any limitations on coverage, including the use of formularies and preferred drug lists. Current regulations establish rules governing the development and use of formularies offered by health plans. Current regulations require health plans and their PBMs to follow state prompt-payment regulations. In addition, current regulations give patients an independent right of appeal for denials of covered services. Current regulations also establish guidelines for network adequacy of providers in a plan, including the network of pharmacies that must be offered under a health plan. And current regulations require PBMs, if they assume insurance risk, to become licensed by the New Jersey Department of Banking and Insurance as a risk-assuming entity. And, of course, all of our pharmacies and pharmacists are fully regulated and licensed by the State Board of Pharmacy for New Jersey.

PBMs are also subject to extensive Federal regulations. The U.S. Department of Labor regulates employer group health plan activities such as claims payment, member appeals, and coverage decisions. When PBMs engage in these activities at the direction of employer group health plans, their activities are subject to the relevant standards imposed on the health plan. The Federal Trade Commission regulates the mail-order pharmacy activities of PBMs by placing requirements on supplies, advertising, fulfillment of orders and customer refunds. And PBMs are subject to the U.S. Department of Health and Human Services's Health Insurance Portability and Accountability Act requirements for the privacy and security of individually identifiable health-care information.

Secondly, we're opposed to AB-2337 because the new regulatory scheme is unworkable. We believe it is confusing and costly, while bringing no additional benefits to health plan payers, employers, or consumers. AB-2337 would create an inappropriate and, ultimately, unworkable regulatory scheme that would subject PBM activities, related to providing the prescription drug benefit for carriers and health plans, to licensing and regulatory standards that are, number one, duplicative and potentially conflicting; developed by an agency that has no experience in regulating insurance and health benefit plans; and that are at significant variance with other State licensing and regulatory schemes for similar activities and entities.

PBM activities and the health plan prescription drug benefits would be subject to regulation by three State agencies under AB-2337: the Department of Health and Senior Services, the Department of Banking and Insurance, and the Department of Law and Public Safety. New regulation by

the Department of Law and Public Safety and the Board of Pharmacy would duplicate and conflict with existing pharmacy benefits regulations in the Departments of Health and Senior Services, and Banking and Insurance.

Moreover, provisions prohibiting PBM participation in Senior Gold and Pharmaceutical Assistance for the Aged and Disabled programs is unprecedented in the State regulatory scheme and would be costly to enrollees and New Jersey's taxpayers. Recognizing New Jersey's budgetary issues and an increasing demand for prescription drugs by seniors and people with disabilities enrolled in the PAAD and Senior Gold programs, we are concerned that New Jersey would better promote cost-saving tactics, such as those that are implemented by PBMs.

We also object to AB-2337 because the regulatory structure proposed treats PBMs differently compared to the way other industries are treated in the State. The proposed regulatory scheme is unprecedented and varies in significant ways from other licensing laws. Unlike licensure requirements for other similar entities, this bill would put in place a licensure scheme that provides no appeal mechanism or due process if a PBM's certificate of authority is denied. It sets licensure criteria on subjective standards that no regulator can measure. The regulator will, necessarily, have to make subjective decisions on who is or is not licensed based on criteria that cannot be objectively measured. And the bill narrowly defines activities that PBMs are allowed to engage in, as opposed to setting rules for how PBMs can operate.

This bill also requires the Department of Law and Public Safety to review every PBM pharmacy contract and would potentially deny contracts

based on standards developed by the State Board of Pharmacy, for reasons including reimbursement levels. This anti-competitive activity may have the result of allowing independent and community pharmacists to price fix and ban PBM activities that they feel disadvantaged by and, thereby, increase the cost of prescription drugs for employers and consumers in the State of New Jersey.

Fourth, we object to AB-2337 because the regulatory scheme would cause irreparable damage to employers, employees, and the health care delivery system. The new scheme would inappropriately regulate plans that are subject to Federal oversight already and that would pre-empt State law. This new scheme would also regulate health benefit plans not subject to State law.

New Jersey does not and cannot regulate the health benefit plans offered by self-funded employees, due to the pre-emption of State requirements in Federal ERISA law. This bill attempts to regulate the prescription drug components of health benefit plans that are not subject to State law. The proposed regulatory structure would also impose additional burden on plan sponsors, specifically employers. Consequently, the cumbersome and sometimes inconsistent Federal-State regulatory structure would increase the cost of providing health care in the State of New Jersey.

In conclusion, Madam Chairwoman and members of the Committee, according to the New Jersey Business and Industry Association's 2002 Health Benefits Survey, for a second consecutive year, half of survey participants reported double-digit increases in the cost of providing health insurance coverage to their employees. The survey also reports that the cost of health benefits rose as a percentage of employee wages paid. Due to the

rising cost of health care and increased cost-sharing for employees, the mandates and regulatory requirements in AB-2337 would only exacerbate these problems by increasing the cost of prescription drugs to employers and employees.

I would like to stress the role that PBMs have never been more needed given these cost pressures. We enhance quality, increase patient safety, provide affordable drugs, and ensure competition in the marketplace.

Again, I would also like to emphasize the four issues of concern that we have with AB-2337. We believe that PBM activities are already appropriately and extensively regulated. The proposed regulatory scheme in the new bill is unworkable, and is confusing and costly, and brings no additional benefits to employers or to consumers. The proposed regulatory structure treats PBMs differently compared to the way other industries are treated in the state. And the proposed regulatory scheme would cause irreparable damage to clients, employees, and the health care delivery system.

Madam Chairwoman, I want to make clear to the Committee that PCMA opposes this bill 2337 because PBM activities are already extensively regulated. AB-2337 would only have deleterious impact on employees, employers, and the general public and those served by the prescription drug programs.

I appreciate this opportunity to convey the views of the Association and of our member companies. And I look forward to your questions.

Thank you.

ASSEMBLYWOMAN WEINBERG: Are there any questions for Ms. Burton?

Assemblyman D'Amato.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairperson. What percentage of the prescriptions that are filled in New Jersey come through PBMs? Do you know that?

MS. BURTON: Mr. Assemblyman, the figure of approximately 70 percent of the prescriptions coming -- PBMs being involved in approximately 70 percent of the prescriptions that are filled. That is involvement either in terms of our managing them through pharmacy networks, which are retail pharmacies, or through our mail-service facilities.

ASSEMBLYMAN D'AMATO: This may seem to be an obvious question, but why does the State of New Jersey use a PBM?

MS. BURTON: I believe the State of New Jersey uses a PBM because we engage in a number of services that help to lower the cost compared to what they would otherwise would be. And they also focus quite a bit on patient safety activities such as drug utilization review, where we're able to, in the instant that a person presents a prescription, to take a look at whether the combination of drugs that a person might be taking might have some adverse effect on that person. Most of us -- and particular elderly people and disabled people -- see a number of different physicians and have prescriptions filled at a number of different pharmacies. The ability to look when a person presents a new prescription to determine whether there's likely there would be any harm to that patient is an issue of great safety concern. And that's one of the things that our companies focus on.

We also focus on issues around patient education and physician education. In this morning's *Wall Street Journal*, there is an article about diabetes disease State management programs where-- And diabetes is now the fifth leading cause of death in this country. Many of our member companies work to identify people, under the various employer health plans, who may be suffering with diabetes, through very simple actions such as sending literature, calling the patient, talking with them about the use of their drugs, about lifestyle, exercise, eating, those kinds of things, and just emphasize for them the importance of staying on a regular regimen, of paying attention to early symptoms of disease problems -- cannot only lead to positive outcomes for the patient, but, in the end, it helps to avoid some hospitalization and helps to lower the cost of the overall medical care for that patient and for the employer or insurance company that's responsible for their health care.

ASSEMBLYMAN D'AMATO: I have one final question.

You have testified that if this proposed bill were enacted into law, the PBMs would now be regulated by three State agencies or Departments. Are the present regulations that have been promulgated by the Department of Banking and Insurance exactly the same as the ones promulgated by the Health and Senior Services Department?

MS. BURTON: I think that's just the issue, sir. We know that the current regulations make us fully accountable, and the current system makes us fully accountable, both to employers and insurance companies, who may be paying the bills, as well as to the consumers in terms of our provided information on any limitations that those programs entail.

Given this new bill, it is not quite clear what additional regulatory requirements would be imposed. We believe that both because of current regulatory scheme, as well as a very competitive environment in which these companies operate, that we are sufficiently regulated and, most importantly, held accountable to taxpayers, to employers, and to consumers who pay the bills.

ASSEMBLYMAN D'AMATO: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Kean.

ASSEMBLYMAN KEAN: Thank you, Madam Chair.

Ms. Burton, thank you for being here today. I've got some -- I guess like my colleague -- some basic questions.

First, let's take a step back and talk about the pharmacy benefit managers. As an industry, the purpose is to save money for consumers. Is that accurate?

MS. BURTON: Absolutely, sir.

ASSEMBLYMAN KEAN: And for employers, as well.

Do you have any statistics to show how much pharmacy benefit managers have saved people who use these entities?

MS. BURTON: Yes, I do. In fact, the Congressional Budget Office, which is an independent arm of the Congress, has done some analysis of the impact of PBMs. The U.S. General Accounting Office has also done some analysis. And testimony before the House Ways and Means and Energy and Commerce Committee in June of 2001-- The Director of the Congressional Budget Office compared these savings that can be achieved under a PBM administered benefit, compared to cost when such an

administration is not possible, and used figures of 18 to 20 percent as possible savings under a couple of the bills that they reviewed.

ASSEMBLYMAN KEAN: Eighteen to twenty percent.

Now, when you offer -- if we can maybe talk a broader brush-- When a pharmacy benefit manager goes into a negotiation with an employer of any sort -- whether it be the State health benefits program, New Jersey Family Care -- who currently use PBM-type entities, or for private employers-- You can open a whole wide-range of options, whether they be more -- say more open -- so you can use any -- the people using these things can use any sort of pharmaceutical -- basically that they would like, or more closeness. And that's up to the entity negotiating the contract on behalf of their employees, is it not?

MS. BURTON: It is. When our companies negotiate with an employee or other plan sponsor, they tell us what their goals are. And our companies then help them to achieve those goals and evaluate the PBM on how well those goals are achieved. So it is the decision of the person who -- of our client.

ASSEMBLYMAN KEAN: And then the-- The pharmacy benefit managers don't necessarily take the place of the local pharmacists down the street. Aren't there versions wherein seniors or others can still go face-to-face with their local pharmacist, can they not -- not all mail order?

MS. BURTON: That's absolutely right.

ASSEMBLYMAN KEAN: You happen to have a mail-order component, but that's not-- If an individual was still seeking to have that individual interaction with their pharmacist, that's still possible.

MS. BURTON: That's absolutely right. Choice is a very important part of the manner in which -- of the options that our companies offer. And therefore, we offer the option of pharmacy networks where we have agreements with local pharmacies, retail pharmacies, so that one can take an insurance card and use your insurance coverage there. That retail pharmacy has the ability to quickly tap into our database to determine whether the person presenting the card is eligible for the insurance, can also track clinical issues like whether or not there's a possibility of drug adverse interaction, and then provide the prescription to that patient at that time. The individual also has mail-service options. So, it's up to the individual as to which one you want to use.

ASSEMBLYMAN KEAN: And then a final question, Madam Chair.

Pharmacy benefit managers have been the subject of increasing discussion in the Congress. In fact, as we're looking at prescription drug benefits under Medicare, the bill offered by Bob Graham, who is a Democratic Senator from Florida, as well as one of the competing versions by Senator Daschle, from South Dakota, I think it is, as well as some versions that have passed the House of Representatives -- all have a version of PBM usage within those versions, don't they?

MS. BURTON: That's absolutely right, sir. Every major bill that was considered in the House and the Senate over the last session included PBMs having a significant role in the administration of those bills. And we believe that's evidence of the importance and the contribution that our

companies have made in the private sector. And that is now being sought for the Medicare program.

ASSEMBLYMAN KEAN: Thank you, Ms. Burton.

Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Assemblyman Gusciora.

ASSEMBLYMAN GUSCIORA: Thank you, Madam Chair.

You say that it saves money. You have wholesalers and retailers. The wholesalers, I guess, are the pharmaceutical companies; the retailers are the pharmacy; and then you have the middlemen, the PBMs. It just defies logic that somehow, by adding another level, that magically saves money. It's like Goering said, "If you say it enough, people will assume it's true." How exactly does a PBM's involvement in the pharmaceutical industry save us money?

MS. BURTON: There are a number of different players, as you described, in the pharmaceutical industry with different roles.

ASSEMBLYMAN GUSCIORA: Well, you're adding another level, right? You're the middlemen.

MS. BURTON: We do add another level. What is very unique about PBMs is that our measure of success is just that. Our measure of success is how well do we help an employer or an insurance company -- an HMO -- that has to provide drugs for a covered population to provide those? How well do we do that while helping to save them money and helping to improve clinical outcomes? And we are the only sector of the pharmaceutical industry where that is our very goal. As one of our CEOs had said, "Given the issues

that this country faces today, if PBMs didn't exist, someone would have to invent them."

We use a number of different techniques. For example, we have a focus on generics first. Where there are therapeutically available generics to substitute for brands, we will-- We have specific activities in which our companies engage to encourage those. One of our companies has begun a program of detailing and providing samples to physicians as part of the physician education, and talk with them about the availability of generics.

When a person presents a prescription, part of the initial screening, after you determine that the person is eligible for the insurance, is to determine: is there an available generic that might be equally appropriate for this particular patient. If that's the case, and there's a conversation between the pharmacist and the patient or -- and with the physician to determine whether the physician agrees that that change is appropriate for that patient-- Obviously, generics, in most cases, will be a lower cost than brands. And so that's one way in which we save money.

Another way in which we save money is through the use of home delivery through mail-service pharmacy. Because of both the volume, the automation, and the refinement of responsibilities between pharmacists and nonpharmacists in a mail-service facility, that mode of delivery is, in fact, more efficient and less costly than retail. So, when a person chooses to use that, that also helps to save the consumer and the plan money, in addition to the physician and patient education activities that I described earlier.

The other point that I would make is that providing better medical care and counseling with patients and with physicians does not necessarily

always result in the use of a lower cost drug. One of the things that you might find is that for a given patient, a higher cost drug may be the most appropriate. Sometimes, the business of educating the patient results in greater compliance, which also might drive up the drug cost. But what you're doing overall is for the ultimate payer, which is the consumer, as well as the health plan, you're lowering the cost of their total medical treatment.

And those are some of the kinds of things that we do to help lower costs, help improve patient outcomes. And the cost lowering, I would emphasize, is not just on the pharmaceutical side. It's with regard to the overall medical care.

ASSEMBLYMAN GUSCIORA: As a liberal, I'm always encouraged when people in the private industry try to add up more bureaucracy as, I guess, you're describing.

Now, in this physician education, it's basically setting up a formulary where you're just going to have a registry of drugs that you're going to sell to the lower level. Is that correct?

MS. BURTON: I think that you might be combining a couple of different services that we offer.

ASSEMBLYMAN GUSCIORA: Well, why don't you elaborate on what a formulary is and how does a drug get on the formulary, and why wouldn't a drug necessarily be on the formulary?

MS. BURTON: The first step in establishing a formulary is a clinical process where the therapeutic categories of care are, first of all, laid out. And then, an independent group of pharmacists and physicians will review the clinical literature, research, and other findings with regard to those drugs.

Because the first thing you want to establish, before you begin to set the formulary, is that you want to make sure that you've got the appropriate diagnostic categories covered and that you have sufficient drugs that have been, not only, approved by the FDA, but that, in terms of the uses that are recommended for those drugs, that you sufficiently covered all those clinical categories.

Once that first step is completed, you then begin to bring into account other factors, and cost is one of those other legitimate factors to bring into account, where you want to take a look at therapeutically similar drugs. For example, you might have several drugs that in 95 percent of cases are equally appropriate for patients. What you want to do, then, is to take a look at what kinds of cost advantages can you negotiate with manufacturers on behalf of the clients that you serve, which are largely employers and insurance companies, so that you make the drugs available that people need, but that you also bring cost into that after you have determined the clinical appropriateness.

So, yes, you are able, then, to establish that list.

ASSEMBLYWOMAN WEINBERG: Assemblyman, I'm just going to interrupt to piggyback on a question you just asked.

When you're making up these formularies, do the drug companies pay you to keep a drug on the formulary in any way -- education rebates, whatever it is they call them?

MS. BURTON: The process that I was referring to, which is that after you determine -- satisfied the clinical issues of appropriateness and made sure that you've covered every category -- you then begin to compare therapeutically similar drugs. And, for example, if you have several drugs that

are therapeutically similar, there is the opportunity there to negotiate with manufacturers so that you bring into the process some competition among manufacturers. At that point, the cost is a factor. Rebates do derive out of that process.

ASSEMBLYMAN GUSCIORA: Which you benefit from. You get the benefits for putting the drugs on the formularies, which, only, the doctors can purchase a prescription or recommend a prescription if it's on the formulary.

MS. BURTON: When you say you, could you define--

ASSEMBLYMAN GUSCIORA: The PBM.

MS. BURTON: Okay. Well, no, it's not -- that's not--

ASSEMBLYMAN GUSCIORA: Who sets up the formulary?

MS. BURTON: Okay. Again, to go back to the earlier question of what's this relationship-- There's a dynamic going on between the company that employed -- the employer, the insurance company, the HMO, and the PBM. The company that employed you -- let's called it a planned sponsor -- has said, "These are my goals -- what I want you to do." And I, the PBM, am negotiating with that employer to say, "This is how I can achieve that."

Part of that negotiating is how do you deal with this rebate. And the employers will negotiate with the PBM so that the employers may get all or some portion of that rebate. They may also -- part of that negotiation may be that the PBM receives its payment for services provided as part of that rebate. So it is a negotiating process.

ASSEMBLYMAN GUSCIORA: Okay. I go to my doctor, and the diabetes that you were concerned about before-- And the doctor says, "I have

the right prescription for you but it's not on the formulary." That's when your doctors' education program kicks in, where you then tell them, "No, you have to prescribe something else." And don't you get a financial incentive if you re-educate that doctor to use a different drug, whether it be generic to save money, or maybe, perhaps, I'll have to deal with a mail order? I'm trying to find out how I, as a consumer, as a patient, can benefit from a PBM, and all I see is your bottom line. It's a very lucrative incentive for you to get a prescription on the formulary, it seems to me.

MS. BURTON: Let me emphasize again that this is a dynamic between an employer -- a person who is buying services from a PBM. Let me also emphasize the fact that a PBM is never in the position of saying no to a doctor, "You can't prescribe that drug." The doctor is the ultimate decision maker.

ASSEMBLYMAN GUSCIORA: But you'll try to re-educate them if that prescription is not on the formulary.

MS. BURTON: The PBM will provide the information to the doctor on what's available, and what the relative costs of that are to the consumer, and what the relative merits-- But the doctor makes an ultimate decision on the drug that the patient will receive.

ASSEMBLYMAN GUSCIORA: Now why-- Before, you said that it's going to be a higher cost to the Senior Gold Program. Why can't we cut out the middleman, operate our Senior Gold Program-- Well, this bill specifically says PBMs cannot get involved in the Senior Gold Program.

ASSEMBLYWOMAN WEINBERG: They're not involved.

ASSEMBLYMAN GUSCIORA: But if they get involved, as you said, you're going to have a higher-- If they don't get involved, you're going to have a higher cost. How do you get a higher cost in the Senior Gold without PBMs?

MS. BURTON: I mentioned a second ago that, according to objective independent sources, such as General Accounting Office, the U.S. Congressional Budget Office -- have indicated that PBM activities save money for drug plan sponsors to the degree that the State of New Jersey, as a sponsor of these programs, denied seniors the ability to have those activities, those actions taken on behalf of them to lower the cost -- will, in fact, increase the cost of those programs.

ASSEMBLYMAN GUSCIORA: Madam Chair, could I just request if she could supply those studies from GAO or OMB that would be great for our deliberations?

MS. BURTON: We would be happy to.

ASSEMBLYWOMAN WEINBERG: Thank you.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Quigley and then Assemblyman Green.

ASSEMBLYWOMAN QUIGLEY: Okay. Thank you.

Ms. Burton, you said that--

ASSEMBLYWOMAN WEINBERG: Microphone.

ASSEMBLYWOMAN QUIGLEY: Sorry. I forgot it myself.

You had said that the PBMs were fully accountable to employers, employees, other clients. When this dynamic occurs, of the negotiation

involving rebates and kickbacks, how do the employees know about that? How is this accountability addressed?

MS. BURTON: The employer negotiates, or an insurance company, or whoever has the responsibility for providing the health insurance coverage and the prescription drug coverage as a component of that, negotiates with the PBM.

I think one of the things that's very important to distinguish about our clients, the persons with whom we're negotiating, is that these are large companies. They don't just come to the table by themselves. They have a full array of benefits experts, from any number of companies around the country, who can advise them on the relative merits of our different companies and the relative merits of our different activities that we engage in to improve quality and to lower the costs of drugs, and can advise them on whether or not those particular activities are appropriate for them. So these people come very well-armed. We have extremely sophisticated consumers who are a part of that negotiation. And then, finally, they, of course, have the ability to review records and to do audits of the services that they're buying.

ASSEMBLYWOMAN QUIGLEY: Well, all of these sophisticated, then-- It narrows down to the employer is paying you to manage the program. The employees think they're getting something well-managed. And in between, somebody is paying you to limit their choices.

MS. BURTON: I believe that what we're doing here is working with the parties who are-- First of all, the first goal here is to provide care for patients, to provide care for consumers.

ASSEMBLYWOMAN QUIGLEY: Do people on both sides know that you're getting money from a third party or a group of third parties? How is that addressed? How is that accountability--

MS. BURTON: I go back to the conversation that I just had with the Assemblyman, that all of that is part of the discussion. That is part of the negotiation. When an employer says that, "My prescription drug cost is getting too high. What can you do to help me lower that?" the PBM will lay out some options as to how to do that. And the employer, again -- not just a single individual sitting across the table, but an individual who's armed with experts who looked at what's going on in terms of costs, what's going on in terms of new services and technologies that are available, who can advise that employer that, "I think this will work, and I think that won't. I think this company can be more effective for you than that company." And our company that's sitting there, whichever company is sitting there, is competing for that business, and wants to do the very best job that they can of explaining what they have to offer, and are providing reports to that employer on an ongoing, regular basis to prove to them that they deserve to have that continued work. And as part of that, you've got to lay on the table the total of what you're doing, all the kinds of activities that you're engaging in to lower costs, to provide a better quality benefit, and the effect that they have. And the employer is going to make an assessment of whether or not you're delivering on what you're promising or whether they should go some other place to get that service.

ASSEMBLYWOMAN QUIGLEY: Do these armies of experts have contracts in hand that specify who gets the rebates in the long run?

MS. BURTON: That is part of the agreement.

ASSEMBLYWOMAN QUIGLEY: That is part of the agreement.

MS. BURTON: That is part of the agreement.

ASSEMBLYWOMAN QUIGLEY: None of the ones I've seen have that mentioned. Never is the word *rebate* shown. So I don't know how average that is. Perhaps you could give us some samples.

MS. BURTON: Part of the agreement is what service is provided and what happens with regard to the discounts and the rebates.

ASSEMBLYWOMAN QUIGLEY: I have just one other question. You were very precise as to the amount of savings that the PBMs have. What's the ratio of savings to the employers to profits to the PBM?

MS. BURTON: I think that I'd like to provide you some more detailed information for the record. But there have been a number of financial organizations that have taken a look, recently, at PBM profit margins, and they've shown them to be actually fairly substantially low. And I would just refer you-- I would share those with you.

ASSEMBLYWOMAN QUIGLEY: I would like to see them.

MS. BURTON: Some of those documents with you that show them in the single digits in terms of profit margins--

ASSEMBLYWOMAN QUIGLEY: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Assemblyman Green.

ASSEMBLYMAN GREEN: Thank you very much, Madam Chair.

I listened very carefully to your testimony. And as you were winding it up, I was basically left to feel, what are we here today for? But, as I begin to hear the dialog back and forth, I'm beginning to wonder, where is

the check and the balance in this whole process in terms of -- seems like you're everything to everybody. At the end of the day, who really pays the bill, because if you're saying to me that you work with the manufacturer, you work with the consumer, and, I think, 80 percent of your testimony was basically explaining the side of the manufacturer rather than the consumer.

So, I would like to feel that-- Number one, I've been here 11 years. There's never been a time -- if anyone feels that if there's a law that we're trying to enact in the State of New Jersey -- that we cannot make any compromise or we cannot negotiate. So I'd like to feel that if we're doing something to protect everyone, that if there's duplications there, then we can correct those duplications.

Number two, I would like to find out, since you have dealt with this issue all over the country, what other state has checks and balances in place, or what other state has such a law that we're trying to establish today with A-2337?

So, again, I don't see where there's a check and balance in the whole process. I don't see where we cannot streamline this bill to meet the needs of everyone. Again, we're talking about an industry that basically no one controls exactly what you do.

So I would like to get from you exactly what you feel, during the course of your testimony, that would be a duplication, number one. Number two, maybe there is a check and balance in the process. I didn't hear that during the course of the whole testimony. And number three, what are the other states doing, better than what we're trying to accomplish here in the

State of New Jersey, by no more than making sure that an organization of your nature is being fair to everyone.

I've never seen an organization that can be everything to everybody and nobody is able to put in checks and balances exactly what they do, whether it's the profit, whether they're making sure that the laws are being carried out. It just seems like, at this point now, I haven't heard that. Maybe you can make me understand a little better than what I've heard so far.

MS. BURTON: Thank you, sir. I will try.

I certainly don't think that we are everything to everybody. Our goal here of our member companies is to provide a prescription drug benefit for a plan sponsor. That plan sponsor, as I said earlier, can be an insurance company. It can be an employer, an HMO, any entity that has the responsibility of providing health insurance coverage. But our responsibility is to provide a service for that plan sponsor that is at a lower cost and with a greater quality than they otherwise were receiving.

To the extent that we achieve that objective, that plan sponsor, largely the employer, will, of course, achieve savings. Those savings will be passed on to consumers. And the quality of care that's involved in that system -- because I don't want to just focus on the cost issue-- I also want to focus on the improvements in quality care, certainly in view to the consumer.

In terms of the issue of duplication, what we are saying in our industry is that we want to be subject to the same set of fair regulations and oversight as others who engage in the same activities in which we engage. Our pharmacies, our mail-service pharmacies, are fully regulated by State boards of pharmacy.

Here in the State of New Jersey, you require that we provide information both on our firms and on any limitations, for example, that we have imposed with regard to coverage. We are fully compliant with those.

In terms of our accountability, our greatest accountability is the fact that we are in, quite frankly, a very competitive business. Our clients are clients who are very--

ASSEMBLYMAN GREEN: Excuse me right there, because I don't want to get too far.

MS. BURTON: Sure.

ASSEMBLYMAN GREEN: When you say you're in a competitive market, competitive in what way -- in terms of, are there other firms out there that are doing the same service that you're doing?

MS. BURTON: Yes.

ASSEMBLYMAN GREEN: And number two, who are you paid by? Are you paid by the pharmaceutical companies or are you paid by employees? Who are you paid by? Who do you work for?

MS. BURTON: Our member companies. I'm President of PCMA, and we are a trade association representing member companies who are PBMs. Those PBMs are paid by the plan sponsors. And the plan sponsors determine how and what they are paid.

ASSEMBLYMAN GREEN: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Assemblywoman Greenstein.

ASSEMBLYWOMAN GREENSTEIN: Thank you, Madam Chairwoman.

Just a couple of questions. First of all, I understand that this is a heavily regulated industry. First of all, from your perspective, what does this new bill, which you say you object to, add to that level of regulation? How does it increase the level of regulation? How does it change things? It seems to me to have a rather minor affect on the state of regulation right now.

MS. BURTON: The new bill basically requires a certification. In providing that certification, it can basically cover any of the operations of the PBM, including things like the reimbursement level. Those measures are -- and provide that a PBM could not operate because of a reimbursement level.

The financial transaction between the plan sponsor -- the employer who's buying the service and the PBM that's providing that service, and the negotiations that go on in that relationship -- are what are to determine things like that.

ASSEMBLYWOMAN GREENSTEIN: So, right now, there's no level of regulation in that relationship, and this would add some regulation as to how much PBMs could be reimbursed.

MS. BURTON: That is an issue that is part of the competitive negotiation between the plan sponsor and the PBM. That is what is at the heart of our efforts to, basically, sell our businesses. Are we delivering something that's of value that a buyer wants, and what should they pay for that?

ASSEMBLYWOMAN GREENSTEIN: Okay. Now, the other thing-- I'm thinking back to my own career, and I'm not trying to, at all, say this is any kind of fraud here -- but my own career prosecuting Medicaid fraud. I remember there were many situations where we tried to determine, and it was

very difficult, when something was a rebate and when something was a kickback. I mean, in certain situations where doctors were getting together, other groups were getting together--

I've read a number of articles that indicate that that's one of the considerations here. Right now, of course, these companies are operating within existing law. But it's a very thin line. And the sorts of things that these companies do-- Unless there can be proof that consumers are getting some benefit from this, and you say that there are studies that can show us that consumers are directly benefiting from these moneys. Otherwise, there's kind of an aura to the whole process that somehow smacks of agreements that would not be based on benefiting consumers, shall we say. That's what it seems to me.

MS. BURTON: I would again go back to the service that we are providing and the entity to whom we're selling that service, the employer. The employers, and we're talking large companies here, who, as I say, are armed with detailed analyses, not just based upon their guess that a PBM is providing something that's of value -- that they are armed with detailed analyses of that. And the PBM is required to provide them with ongoing reports of their activities and the results of those activities, and those companies have the opportunity to audit.

I don't think that any of us would think that these companies, many of which are Fortune 500 or even Fortune 100 companies, would be paying the PBM for the PBM to have a profit and not for the company, the employer who's paying for that service, to benefit from that. It just doesn't make any sense that an employer would pay the PBM and say, "I'm going to

pay you money so that you can go out and make a profit even though I have this detailed information that shows me what you're doing, how you're doing it, and the result of that." With that kind of detailed information, the employer has to be sure that the PBM activities are benefiting the employer.

ASSEMBLYWOMAN GREENSTEIN: I can even see it maybe -- I'm guessing here -- maybe coming down to the level of the employer, but the question is, does it come down to the consumers -- the employees, I guess?

MS. BURTON: Again, there is an employer who is involved in this. The client for the PBM is-- And I say employer as an example. It can also, as I mentioned earlier, be an insurance company. It is up to, again, the employer to determine what happens in that. Does the employer, as a result of those savings, increase the benefits to the consumer? Does the employer lower copays to the consumer? The PBM is not the entity that determines that. It's the employer who determines that. The PBM is helping the employer or the insurance company or the HMO to achieve their objectives.

ASSEMBLYWOMAN GREENSTEIN: The last statement, I guess, I'd make on this is that I feel, like, if numbers can be shown that would convince me that this is benefiting consumers, then it's benefiting consumers. Intuitively, I agree with some of the statements that were made earlier that suggest that it's hard to believe that another level of bureaucracy could decrease costs. But I'm willing to look at those numbers, if they exist. So far, we have not seen those.

MS. BURTON: And again, I would point to -- not only in terms of the costs that are saved for the plan sponsors, and the plan sponsors decision on how they want to share that with consumers or with employees --

but I also point to the kinds of clinical services that are provided by PBMs to result in improved patient outcomes and improved medical care for consumers.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

Ms. Burton, I have two questions.

Do you represent just New Jersey or national PBMs?

MS. BURTON: We are a national trade association.

ASSEMBLYWOMAN WEINBERG: Okay. And you represent the national trade association.

MS. BURTON: I do.

ASSEMBLYWOMAN WEINBERG: So, if I understand what you said, when a drug company gives a rebate, an educational fee, a health management fee, whatever it is they call this, to a PBM, that information is always shared with the plan sponsor. Is that right?

MS. BURTON: That is part of the negotiation of the contract in terms of how those things are used.

ASSEMBLYWOMAN WEINBERG: So that is always in the contract. And the PBM never gets that kind of a rebate without informing the plan sponsor.

MS. BURTON: It is part of the negotiation, and the plan sponsor has the opportunity to audit the PBM records.

ASSEMBLYWOMAN WEINBERG: Well, my question is, does the PBM ever get a rebate to keep a drug on the formulary or to take a drug off without informing the plan sponsor that such a rebate is being paid? What we have been informed, and I'd like you to just give me as direct an answer as you possibly can, is that PBMs used to make their money from administrative

fees, which makes sense. If you can come in and manage a program and give it some coherence, you might be helpful to large employers. But if, in addition to your administrative fees, you are being paid by a pharmaceutical manufacturer and you have not shared that payment with the plan sponsor, or even the knowledge, then we're in a whole different area.

So, I would like a direct answer. In addition to administrative fees, when you get a rebate, an education -- whatever you call it -- I don't mean you personally, obviously, but the PBMs have various names for these, apparently. When that rebate is paid to the PBM, does the PBM always give that information to the plan sponsor?

MS. BURTON: There is some discussion between the plan sponsor and the PBM with regard to -- and negotiation with regard to how the rebates will be treated. And there is an agreement as to the level of detail upfront. I'm not sure that I fully comprehend the example that you might be pulling on or whether -- the degree of detail that might go on with regard to that discussion.

I would also add this. There is the distinction and fine line that you draw between administrative fees and rebate. The plan sponsor might decide, for example, that part of the rebate would be used in lieu of an administrative fee. So, I don't intend to-- I'm not trying to paint a simple, clear line in that way, but I am trying to make a point that the income to the PBM and the activities of the PBM are part of that negotiation. And, as you know, negotiations-- The level of details in those would vary, of course.

ASSEMBLYWOMAN WEINBERG: Yes, I know that. And you, as being President of a national trade association, are probably familiar with

the fact that the state of California is suing PBMs, based on the fact that they were not aware of these kinds of rebates that were being paid.

MS. BURTON: I've seen some articles on it, and that's the extent of my knowledge of it.

ASSEMBLYWOMAN WEINBERG: Okay. So what you're saying is that as part of the negotiation, it is in the contract -- correct me if I'm wrong -- I want to make sure I understand this -- between the PBM and the plan sponsor that if I, PBM, get a rebate, an educational fee, or whatever the variety of names are, I will give that information to you, the plan sponsor, so that you know if you are supplying-- If Zocor is on our formulary, and I was paying X for Zocor and now I'm getting a rebate in order to keep Zocor on that formulary, I will tell that to you.

MS. BURTON: I do not intend to use that on a drug-by-drug basis -- that the negotiation goes into that level of detail, but I do want to make clear that the treatment of those is part of the negotiation, part of the discussion, and it's up to those parties to decide how specific that gets.

ASSEMBLYWOMAN WEINBERG: Are there any other questions? (no response)

Ms. Burton, thank you very much for your patience and your courtesy and your willingness to answer all these questions.

MS. BURTON: Thank you, all.

ASSEMBLYWOMAN WEINBERG: Thank you.

And next we have a group. So you're going to have to share these microphones. John Davis, who is the Director of State Government Relations for the National Community Pharmacists Association; John Giampolo,

Executive Director of the Independent Pharmacy Alliance of America; Dick Walter, owner of Walter's Pharmacy, in Allentown; Carlo Benedetti, owner of the Olden Pharmacy, in Trenton; and Jim Vizzoni, owner of Vizzoni's and Segal's Pharmacies, in Trenton.

Welcome.

JOHN A. GIAMPOLO: Do we push these buttons? (referring to PA microphone)

ASSEMBLYWOMAN WEINBERG: Try to keep on one red button at a time, because that's another thing -- they don't all work when they're all on.

Please make sure, if you want to be part of the transcript, you have to talk into the microphone.

MR. GIAMPOLO: Good afternoon, Chairwoman Weinberg and members of the Committee.

My name is John Giampolo. I'm the Executive Director of the Independent Pharmacy Alliance. We represent 650 independent pharmacies in the State of New Jersey. And we fully support A-2337.

I thank you for the work, and Assemblyman Doria's work, on this issue.

ASSEMBLYWOMAN WEINBERG: I'm going to interrupt you for one minute and-- The press did ask this question of me, and I did get the information. This bill by Assemblyman Doria was put in in the 1996 session, the 1998 session, the 2000, and, of course, the 2002 session. And, since I wasn't Chairperson of the Health Committee during any of those periods, I cannot answer as to why it's never been posted.

Go ahead.

MR. GIAMPOLO: Okay.

And I would like to-- It seems as though, in the years that it was put in earlier, that it wasn't such a big issue as it is now. And as it became a bigger issue, the National Community Pharmacists Association, of which Mr. John Davis is the Director of Government Affairs-- He started working with local organizations to try to get bills sponsored. And the new awareness of the PBM problems created an issue -- an opportunity for us to get this bill changed towards a model-PBM legislation that was created by the National Community Pharmacists Association, who is sponsoring -- or is testifying around the country, at different legislatures around the country, on this issue. And so we've worked with Mr. Joe Wax and Assemblyman Doria's person -- Mr. Joe Wax -- to tailor this thing to meet the issues as they are today -- in the world today.

Some of the things you asked were very, very pertinent to the young woman that was up here testifying on behalf -- or in opposition to this bill.

I just wanted to say, just very quickly, because of antitrust implications the independent pharmacy community and their patients are at the mercy of the contract terms and formularies dictated by these unregulated PBMs. The PBM is in the middle of an insurance transaction. The insurance company, or the employer, and the licensed pharmacist, who is licensed, in many ways, by the Board of Pharmacy and by, also, his own license and his pharmacy license-- And the PBM is in the center of this transaction, hired by either the insurer or the HMO or the employer to transact an insurance

transaction. And he's not regulated by any agency, yet everybody around him, in the whole issue of insurance, is regulated. So, by that virtue, you need the regulation that this 2337 offers.

I guess the abuses, we think -- the abuses we see that belay all of the regulations that the woman before us spoke of-- All of the regulations that cover them are not stopping the abuses and the formularies and the rebates -- the patient loss of prescription that the doctor has prescribed that's being changed-- Some of the things that are going on with the PBMs, day in and day out, that are hurting the pharmacy provider and hurting the patient are just not regulated. I don't know how all of the regulations that she spoke of work together to regulate the PBM on behalf of the consumer, but it's not working.

In my office, we have a full-time person working on third-party issues, which are PBM issues, for the pharmacies that we represent. Eight hours a day, 20 or 30 problems a day, with PBMs that either underpay, reject, deny, throw the pharmacy out of the network, put the mail-order system, on behalf of that patient, into the network--

And by the way, mail order -- out-of-state mail order is not regulated in New Jersey. So all of the PBMs that use mail order do not ship to New Jersey from a New Jersey mail-order facility. They ship from out of state. They're not regulated by the Board of Pharmacy. So some of the issues that she brought to attention here were not true.

And I would just say one thing more before I let John Davis tell you more about some of the abuses. Aetna is one of the largest insurers of hospital, doctor, and prescription benefits. They do their own pharmacy benefit management within their organization. The reason they're the largest,

or one of the largest, is because they're the most competitive. Well, they've cut out the middleman. The PBM work that needs to be done is basically plan design. If you design the plan to work through the computer system to eliminate the duplicate refills, to substitute generics when necessary, therapeutic equivalent, it works automatically. And so, then, Aetna only has to have pharmacists on duty when there's an issue that a duplicate drug needs to be prescribed to that patient and the doctor needs to be -- needs to be discussed with the pharmacist. The pharmacist is educated over a seven-year period to do all the things that the PBM says that they do to save money. All you really need is a good plan design, and you don't need a PBM to design that plan.

So, with that, I think I have to turn it--

Now I'm going on a little too long, and I'd like to turn it over to Mr. John Davis, from the National Community Pharmacists Association.

JOHN R. DAVIS: Thank you, John.

I want to thank the Committee, particularly the Chairwoman, Assemblywoman Weinberg and all the members here for having a hearing on what we consider to be a very, very important issue.

My name is John Davis, and I'm the Director of State Legislative and Regulatory Affairs for the National Community Pharmacists Association.

NCPA has about 60,000 members and represents the interests of about 25,000 independent pharmacies across the country, 750 of which reside in New Jersey.

I just want to make clear that I'm here today representing Main Street, not Wall Street. I represent the small independent pharmacists, the people in your community who try and serve the patients the best they can.

I know we've already talked about what a PBM is, but let me just tell you why so many pharmacists have concerns about PBMs. I would like to, kind of, just give you a short list of the complaints.

Basically, there are a number of complaints that concern small, independent pharmacists about PBMs. Many of these claims simply state that PBMs have, in effect, sort of, crept away from their original role of a claims processor into the unauthorized practice of medicine and pharmacy.

Let me just give you a few examples of our concerns. PBMs often dictate medication formularies, in essence, overruling the doctor and the pharmacist in choosing the medications that patients receive. These formulary medications are predicated on the best rebates the PBM can pressure the manufacturer to give up, not always on what's best for the health status of the patient.

Let me give you an example. There's one PBM that is owned by a drug company, Merck-Medco. They own PAID Prescriptions. How many Merck-Medco drugs do you think are on their formularies? I would venture a wild guess they have a huge number, a disproportionate number. And, quite frankly, when we're talking about these rebates, I'm unaware of any case where any portion of these rebates have gone back to the patient or the pharmacist at all.

Another example is: PBMs dictate how much medication a patient may have and how soon the pharmacist may fill an authorized refill. PBMs

pay for a finite day's supply of medication and often allow little latitude for special circumstances. For example, a child spills their bottle of antibiotic medication. The PBM will not pay for a replacement prescription. The patient takes an extended vacation-- The PBMs are always reluctant to give an early refill. PBMs force, basically, take-it-or-leave-it prescription contracts on community pharmacists.

You will hear some representatives from the PBM community say that these contracts are negotiated. When it comes to independent pharmacies, that is completely untrue. These are take-it-or-leave-it contracts. The independent pharmacy has little option but to sign the one-sided, take-it-or-leave-it contract dictated by the PBM. Because pharmacists, by law, cannot lawfully, collectively negotiate contracts, they fall prey to the PBM's threat of limiting the patient's access to the pharmacist's business.

These contracts ratchet down the reimbursement to pharmacies, but do not seem to save any money for the health-care system. Instead, these dollars apparently go into the corporate profits and bonuses for PBM administrators.

PBMs coerce patients into using unregulated mail order. Studies have shown that the vast majority of patients preferred to pick up their drugs at a drugstore and not receive them in the mail, yet PBMs economically coerce patients into mail order, because the PBM receives rebates, pressuring the patients to use preferred medications that the PBM mandates. Rarely are these rebates passed on or even known to the payer.

There are also other concerns with mail order, such as safety. We've had a lot of hot weather lately. Could you imagine your prescription

drugs being in a mail truck for a day or two in this hot weather and being delivered to your home? Another problem with mail-order drugs is that there is thievery. Something going through the mail like that is a target for thieves. So there's a lot of problems with mail order. And, again, the vast majority of people preferred not to have mail-order drugs, but to pick their drugs up at a pharmacy.

Despite PBM claims of saving money, the cost of medications have actually increased. I don't think that's a big surprise to anybody. Now, if the PBMs were saving all this money, and there are more and more PBMs taking over -- getting larger market shares -- the cost of prescription drugs would be going down, but, of course, they're going up.

Last year, according the GAO study, prescription drugs went up 17 percent. This came after an increase the year before that of 19 percent. Despite the fictitious cost-savings claims made by PBMs, they -- we think they actually increase the cost of medication. The average cost of brand medication prescription drugs approaches \$70, while the average price of a generic prescription is about \$19.20. PBMs' generic substitution rate is about half that of a community pharmacy. Independent community pharmacies have a generic--

ASSEMBLYWOMAN WEINBERG: I'm sorry. Would you just repeat that last statistic you just said?

MR. DAVIS: Sure. The independent community pharmacists have a generic rate substitution of approximately 50 percent. The average brand--

You want the cost on the drugs.

ASSEMBLYWOMAN WEINBERG: Yes, and then the--

MR. DAVIS: The average cost of a brand medication prescription approaches, in the neighborhood of, \$70, while the average price of a generic prescription is \$19.20. Community pharmacists have a generic substitution rate over 50 percent. And the data we have on PBMs is their substitution rate is generally about 25 percent.

One reason for the underperformance of PBMs may be that they receive significant rebates for not substituting equivalent cost-saving generic drugs for higher priced brand name drugs.

When the speaker from PCMA was talking about all the savings, and the GAL study, I believe she used the term or phrase, there could be savings of 18 percent. As far as we're concerned, we have seen no savings. So, when it comes to the question of PBMs and savings, it reminds me of that old Wendy's commercial, "Where's the beef?" We haven't seen any savings, whatsoever, from PBMs. They have not lived up to their promises of saving money for the consumer, the employer, or for the pharmacists.

Another big problem for independent pharmacists is the unscrupulous audits over charging pharmacies. Although PBMs have little or no regulatory oversight, they check the prescription claims by pharmacies, often using extrapolation methods not recognized as good accounting procedures. The audits tend to be one-sided. And since the PBMs' reimbursement -- the pharmacy for products the pharmacy has purchased, the pharmacy is extorted into paying exorbitant and unwarranted audit penalties.

Ironically, because of the lack of regulatory oversight, there are no checks and balances in this system to help the independent pharmacists with the audits from PBMs.

Basically, we think PBMs are creating chaos in the community pharmacy community. PBMs are not allowing the pharmacists to perform their function by forcing pharmacists to act as the plan intermediaries. The pharmacist is usually a person who, without payment, has to inform the patient of plan changes, including changes in medication coverage and increased copays.

Now, I have an example with me from one of our members from New Jersey. They sent in a letter they got from a PBM. And the letter says to the patient, "We've overcharged you for your prescription drugs." Did they put a check in the mail with the letter? No. They said, "Go to your pharmacist and try and figure out how much you should get back." So they put all the burden of the administrative processing on the backs of the independent pharmacists.

Pharmacists must contend with a variety of inconsistently formatted prescription cards generated by PBMs. The lack of continuity between prescription cards causes logistical nightmares for many pharmacists.

I just want to say, too, that NCPA strongly supports this type of legislation. This legislation, basically, unlike most states, separates out the regulatory function of regulating PBMs, because they are PBMs. In most states, they simply regulate third-party-- They regulate, basically, PBMs by function. And this statute, or this proposed law, regulates PBMs simply on the fact that they are PBMs. And in these other states, where we regulate PBMs

by function, basically what happens is the PBM says, “That’s not what we’re about.” Under a third-party administrator statute in some states, we have found, although the State insurance department thinks the PBMs are regulated, the PBMs don’t think they’re a third-party administrator, and they’re not complying with the statute.

So we think it’s a very effective tool to have a statute that regulates PBMs in and of themselves. In fact, we think that’s such a great idea that we created our own model bill that’s very similar to this one that’s been introduced in a number of states. We put the bill out late in 2001, and this-- By late, I mean September of that year. Three states tried to amend it onto current legislation. Those states are Michigan, New York, and Wisconsin. This year, a number of states have introduced the bill. If I could give you that list-- It’s Alabama, Illinois, Iowa, Maryland, and New York.

In addition, very early in 2001, before we put out our model bill, the state of Georgia passed -- introduced legislation, and eventually got it passed, that regulates PBMs. So this is sort of a first this year.

I just want to tell you that it’s not just NCPA and independent pharmacists that are concerned about the lack of regulation of PBMs. State boards of pharmacy, the National Association of Boards of Pharmacy, the National Association of Insurance Commissioners, consumers, and other practitioners have had a growing concern about the lack of oversight of PBMs.

Despite the huge number of people that these PBMs serve, for the most part they are really unregulated, despite what the lady from PCMA says. In fact, let me quote to you a study done by the National Association of Board

of Pharmacy. They created a task force on PBM regulation. I just want to tell you a little bit about what they said, since these are regulators.

Basically, they said that they recently examined the various roles and activities of PBMs and, in doing so, noted the complexities of these entities and the difficulty in trying to categorize their different operations. They recognized that the role of these entities has basically evolved from, very simply, administering prescription drug plans for plan sponsors to helping them contain their overall prescription costs, often through activities that can be categorized as the practice of pharmacy.

The task force members were emphatic in their position that if these entities were engaged in the practice of pharmacy, they should be regulated.

Let me just finish by saying, too, the last conclusion of the report was that the task force reviewed the current regulation, and they indicated that, even when state regulation was present and there was oversight by a state agency, it does not -- most of those regulations do not specifically address the practice of pharmacy issues or provide uniform oversight on behalf of the patient.

So we think the current regulatory scheme throughout the states definitely needs to be looked at. And NCPA is not alone in that concern.

Again, we think this is a great bill. We would propose a few different changes to it or additions. One of the things that we think it needed is that the PBM should be identified as the agent of a health plan with fiduciary responsibilities when they pick up the prescription costs of prescription plans for a payor.

We also think-- The lady also mentioned that this could be a very expensive regulatory process to be involved with. That's true. We think the PBMs should be assessed for the cost of that regulation, as many industries are done.

We think the PBMs should be required to provide a contract to a pharmacist that is written in plain and understandable language. We think each contract should have the same coinsurance or copayment and deductible to cover the cost of the prescription drugs, even if it's mail-order drugs.

We think no pharmacy benefit manager plan should mandate any pharmacist to change an enrollee's maintenance drugs unless the presiding physician and the enrollee agree to such a plan.

Basically, too, we have seen, recently, a number of lawsuits that have begun to be developed regarding the conduct of PBMs. We think consumers and employers have filed lawsuits against several PBMs, claiming that they inflate the cost of drugs for customers and violate their duty to act in the best interest of the customers.

Some say the drug plan managers actually contribute to the rising cost of medicine, because they strike deals that then lead them to induce patients to use more expensive medications. For example, after Merck-Medco care was sued by several employers and consumers who said the company was not serving the customer interest, lawyers and consultants for the company said, in court documents and in interviews last year, that Merck-Medco and other pharmacy benefit managers sometimes ended up promoting the most expensive drug in a class because Merck and other drug makers paid them the most to do that.

I just want to say, in closing, that NCPA welcomes the work of this Committee, and we stand ready to help in any way that we can.

Thank you.

ASSEMBLYWOMAN WEINBERG: I have a quick question. Can a PBM change a prescription without your checking with the doctor?

DICK WALTER: The usual thing is we'll receive a postcard in the mail, or the consumer will receive a postcard in the mail, that they have contacted the physician -- this is after the fact -- that the physician has agreed to the change. Please check with the physician to make the change on the next refill. When it's done the first time around, they'll just say, "The drug is not covered by this plan. Please contact the physician." In most cases, no, they don't force the change without consultation with the doctor. But it's--

ASSEMBLYWOMAN WEINBERG: So, if you didn't get an okay from the physician, you would not change the prescription.

MR. WALTER: That's part of the problem. We're faced with the situation of receiving that message on our screen, and, for a smashing fee of \$1 or \$2 per prescription, we now have to spend 15 or 20 minutes trying to find the doctor. The patient is waiting out front. They're on their way home from the hospital in pain with a Percocet prescription, but they can't have Percocet. They've got to have something else. So we have to chase it down, make the calls, and everything else -- resubmit the claim, and get charged again for using their 800 number, and then fill the prescription. The consumer is hardly benefiting from this kind of treatment. It's pretty one-sided. There's other horror stories I will go into in a minute.

ASSEMBLYWOMAN WEINBERG: I'm sorry. Next on your list.

MR. DAVIS: That's it.

ASSEMBLYWOMAN WEINBERG: Next speaker.

MR. WALTER: I'm Dick Walter.

ASSEMBLYWOMAN WEINBERG: Oh, I'm sorry. You all have questions? Okay.

Assemblywoman Quigley, then Assemblyman Green.

ASSEMBLYWOMAN QUIGLEY: I wanted to ask you a question about something that you said earlier. If, for instance-- I want to make sure I formulate the question properly. When you're talking about a brand name drug and a generic drug, and you're pointing out the differences between the patterns of what the pharmacists do and what the PBMs do-- Now, if, for instance, the cost of the generic drug is, say, \$50 and the cost of the brand name drug is \$100-- If the-- Is the employer paying that \$50 or that \$100?

MR. DAVIS: Yes, that's correct. And, as I said, our data shows that community pharmacists are more than twice as likely to switch to the generic brand. And there's huge-- I'm not sure if all of you are aware of it, but there are huge savings -- it's a tremendous savings when we switch from brand name to generic. And it's a result of the whole process of how our drugs are developed with the patents and whatnot. But there are huge savings. And many times, really, the PBM has, in many ways, almost a disincentive to switch to generic.

ASSEMBLYWOMAN QUIGLEY: So what would happen then is the employer is either paying \$50, or 10 percent off, a \$100 drug. That's the savings?

MR. DAVIS: Yes, whatever the difference is between the generic drug and the brand name. Yes.

ASSEMBLYWOMAN QUIGLEY: All right. So it's a discount off a higher priced product in many cases.

MR. GIAMPOLO: And the rebate still goes to the--

ASSEMBLYWOMAN QUIGLEY: Plus the rebate. And we're not talking the difference between Coke and Pepsi here, are we?

MR. DAVIS: That's what I was trying to point out. It is a huge-- We're talking the difference between a Porsche and a Toyota or a Hugo. (laughter)

ASSEMBLYWOMAN WEINBERG: Be careful.

ASSEMBLYWOMAN QUIGLEY: And we're also talking life-saving drugs. I mean, it's not a brand preference. It's what works and what doesn't.

MR. DAVIS: And they're exactly the same. I mean, they're, absolutely, exactly the same. The reason why we allow the brand name drug to be so expensive is because, the theory being that, the drug manufacturers did all this research to create the drug. And then they get the opportunity to-- You can have a patent to -- and exclusive right to market the drug. So the drug is an expensive proposition. But then, once it's allowed to go for others to manufacture, the generic price is always a very, very substantial drop.

ASSEMBLYWOMAN QUIGLEY: Well, I've been in a situation where the pharmacist has said to me, "The computer says you can't have this. You can only have that." Now, I don't know whether they've gone back to the doctor to get that approval or not, but the basic-- The bottom line is, if you

want the drug you prefer, pay for it. So, it's not that the doctor has the ultimate decision. Yes, the doctor says, "I'm willing to allow you to switch." But if the consumer wants the drug that he or she thinks works, reach into the pocket. And we're talking hundreds and hundreds of dollars.

MR. DAVIS: Exactly. You're talking a substantial expense. That's really-- Usually, the expense is prohibitive.

ASSEMBLYWOMAN QUIGLEY: Thank you. I was hoping you'd say something else, but it's as bad as I thought.

ASSEMBLYWOMAN WEINBERG: Assemblyman Green.

ASSEMBLYMAN GREEN: Yes. Listening to the other speaker and listening to your Association, it's like we're going in two different directions. It just seems like-- I'm going to be real quick, and maybe I can get some direct answers.

I'm pretty sure-- You listed some of the questions I was asking. I'm a bottom-line individual in terms of who really regulates the PBM. Who's in control? Who do they answer to? Who can--

MR. DAVIS: It depends who you talk to, quite frankly. But I will tell you this. If you look in a statute books in some of these states, there are, what they call, third-party administrator statutes, and drug utilization (indiscernible) statutes, and some other kinds of statutes that technically are supposed to cover PBMs. However, it's been my experience, going around this country, that in some states where we've had these kinds of statutes, the PBMs, when we've tried to introduce this bill, or a bill similar to this, have said, "We're already covered under the third-party administrator statute," or whatever the statute might be.

The fact of the matter is, though, in a number of these states, the regulators have come forward and said, "They've never come forward to tell us they've been regulated. They haven't licensed with us. They haven't filed with us." So there is definitely a real -- not huge -- number of loopholes and gaps in our regulatory scheme out there in the states.

ASSEMBLYMAN GREEN: If we move ahead with this particular bill, would this cause the chaos that was basically said earlier, in terms of creating problems or red tape, the whole nine yards, or would this, basically, streamline, putting everybody in the position where there's a check and balance in the system now? It's obvious, listening to what you're saying, it is not a check and balance. Everybody is not being treated equally. Everybody is not being looked out for equally.

MR. DAVIS: I'm here representing independent pharmacies. I think I made it clear. And we're dealing--

ASSEMBLYMAN GREEN: Have you benefited from this authorization -- being part of the process?

MR. DAVIS: I beg your pardon?

ASSEMBLYMAN GREEN: Have you benefited -- has your Association benefited from a PBM?

MR. DAVIS: No, not at all. Clearly, when you're talking about an independent pharmacist-- Some of our members own one store, and they're dealing with a PBM that's billions of dollars of assets -- huge corporation. It's a very difficult process for them to negotiate with them. Clearly, the negotiating power is all on one side, and that's on the side of the PBM.

ASSEMBLYMAN GREEN: My last question-- If we were successful in trying to bring everyone together, do you feel what we're trying to accomplish today would be a benefit to the average consumer, in terms of this wouldn't be another level of government that's being portrayed -- more paperwork, confusion. And, anytime you have that, you're talking about somewhere along the line, someone's going to pass the expense onto someone else; or do you feel, if we had an industry of this nature -- regulated -- that if everyone was on the same page, in fact, people would probably get better service and, also, it wouldn't cost the taxpayers any more money? Would you feel that's the -- essentially where I'm headed?

MR. DAVIS: That's definitely-- We strongly believe that there's a role for PBMs to play. We do think they do need to be regulated. We regulate the insurance industry, and we also, to some extent, regulate the pharmacy.

The problem with PBMs is that they, in effect, have almost fallen through the cracks. We've had situations where, in other states, where pharmacists have gone to their associations and said, "We have to complain about something." So they say, "Okay. Let's go to the insurance director and tell them, "The PBM is doing this -- this kind of market conduct is unfair." And they've had situations where the insurance director will tell them, "That's not under my jurisdiction. That's under the jurisdiction of the board of pharmacy -- the Board of Pharmacy in our state." Then they, of course, go to the Board of Pharmacy, and the Board of Pharmacy says, "No, this is an insurance problem."

So there seems to be a lot of confusion out there with regulators as to, really, what kind of entity we're dealing with, not just with members of this Committee, but with a lot of regulators. PBMs are something of an enigma. Nobody quite knows what they are or what category they fall into, even the PBMs themselves.

And so we think we need to clarify that. And the best way to do that is the way this legislation is set up -- having a separate statute that deals with the regulation of PBMs.

ASSEMBLYMAN GREEN: Thank you.

Thank you, Madam.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Greenstein.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

I just had a couple of questions. The lady who testified earlier, I believe Ms. Burton, I think, was the name, said very clearly, several times, that when there is a disagreement as to the drug-- I remember her saying, "Doctors make the ultimate decisions." But what I'm hearing here, and my impression has been that, ultimately, the doctors have to fall into line and the pharmacists have to fall into line. Which is true?

MR. WALTER: There's enough pressure put on, yes.

ASSEMBLYWOMAN GREENSTEIN: If a doctor was very sure that he wanted a certain drug that was not on a PBM formulary, would he be able to make that happen?

MR. WALTER: In some cases. In most cases, they belong to a-- They practice through a particular group. It may be Horizon Blue Cross and so on. They want to stay in that group. They get a call from the third-party

benefit management company saying the company wants it switched from brand A to brand B. They're reticent to say, "No, I'd rather not do that." So the switch goes through. It's arm-twisting pressure, financial.

ASSEMBLYWOMAN GREENSTEIN: The other thing-- I know that when I'm prescribed something, my doctor will usually check something on a prescription as to whether I can have a generic or not. I guess it isn't just a cost issue. Sometimes there's some reason, on a certain medication-- That's what I've read. I don't know how true that is. There are reasons, other than cost, why you should have a name brand instead of a generic. I don't know if that's true. Or is it always an economic issue?

C A R L O B E N E D E T T I: There are issues that come up sometimes between brands and generics. People, sometimes, cannot tolerate a generic, for example. The physician -- if the physician prefers to use brand-name medication from his familiarity with what he has--

Let's put it this way, there's very unique -- everybody's an unique individual, and there's really no umbrella to put everybody under that covers everybody so finely that there's no issue. Every issue can be a little bit different.

ASSEMBLYWOMAN GREENSTEIN: I guess, really, what my question is on this, in a sense, is, if my physician is designating whether I can have generic or not, and my pharmacist can talk to me about that, I don't understand the role of the PBM in that at all. That was one of the things that the lady said, that the PBM gets into this whole negotiation on generics or not. But my doctor has already stated it. If the doctor feels a generic is safe for me, medically, and I certainly would want to save money, I would probably go for

the generic. I might choose to go for the more expensive one. But I don't understand what role-- In a way, I'm asking-- I should have asked the last person. But I don't really understand the role of the PBM in that process.

MR. BENEDETTI: Quite honestly, it's a role of the pharmacist, being a pharmacist myself, an owner of a business, and doing this on a daily basis many times a day. One of my jobs is to discuss with you, as the patient, do you want the brand or generic. The physician makes a suggestion, and if he does put that he requires the brand, then we follow the guideline. If he puts he requires the generic or writes generic substitution is allowed, you still have the right, as the consumer, to make a choice. You also have the right to make a choice if he writes the brand name, and you have a cost concern-- We then get on the phone ourselves with the physician, maybe discuss with them that, "This patient has an issue of, instead of paying \$100, they'd rather pay \$5. Can you possibly reconsider?"

It's a give and take that has to occur. And it's the pharmacist in the community pharmacy that, on a daily basis, hundreds and hundreds of times a day, does this. This is what we do, not the PBM.

ASSEMBLYWOMAN GREENSTEIN: But just to-- In a PBM system, as we have now, if my doctor checks off that I can get a generic, you have the generic, the PBM can force the name brand?

MR. BENEDETTI: To be truthful, there are so many varied circumstances that can come up on a daily basis with each prescription. There is a possibility. There was a good example. There was a prescription medication for blood pressure years ago that one PBM insisted that we do not use a generic. They forced the brand name irregardless of circumstance.

When you billed the claim through the computer, as we do with the insurance claim, they rejected the claim, indicating that we must give the patient the brand-name medication. I'll leave the names out for the moment, because it's irrelevant at this point.

The issue was, of course, at the time, the drug cost approximately \$125 a month versus \$5 or \$10. Why, in God's name, would a PBM, in their right mind, want to make the consumer spend that much more money on an individual prescription every time they come, no matter what the circumstance was?

It was quite interesting, because one of the examples where this happened in the past -- I'm sure it's happened again. So, that's just-- There is an outside chance it can happen, sure.

ASSEMBLYWOMAN GREENSTEIN: My last question would be on mail orders. I think it's possible you misspoke before, I'm not sure, because you said that the PBMs can use economic reasons to force a patient to do mail orders. Maybe that is what you meant to say.

MR. DAVIS: That's what I meant.

ASSEMBLYWOMAN GREENSTEIN: You did. Okay. So, indeed, they make the mail order less expensive.

MR. BENEDETTI: The economic pressure -- simply -- that if given the choice of a community pharmacy, mail-order pharmacy, we've come to the conclusion that most people, unless they cannot get out of their homes and there's no delivery service in their immediate area, which can happen, prefer the community pharmacy. It's apparent to us, over the years, the only way to get the consumer into a mail-order program is to make the price point

less. If I, as a community pharmacy, have to charge you \$10 for a 30-day supply that you can obtain a 90-day supply for \$1 from a mail service, in essence -- making me charge you \$30 over 90 days versus, let's say \$1 or \$5, it becomes a cost issue.

And yes, there are consumers that will forsake the community pharmacy for a mail-order pharmacy, only for cost, which is a very unfortunate circumstance. It should not be that way.

ASSEMBLYWOMAN GREENSTEIN: To play the devil's advocate on that one, is that necessarily a bad thing? My husband, for example, cares about the cost, and he'll be that way.

MR. WALTER: Can I answer that?

ASSEMBLYWOMAN WEINBERG: I would like to keep it on the subject of PBMs and their role in this. I sat through several months of hearings on generics versus brand names. I don't want to--

ASSEMBLYWOMAN GREENSTEIN: No, no. I'm not talking about generics. I'm talking about mail order.

ASSEMBLYWOMAN WEINBERG: --start that over again.

ASSEMBLYWOMAN GREENSTEIN: Just mail order, the idea of--

MR. WALTER: Can I just comment on the mail order for one quick second? I'll keep it brief.

ASSEMBLYWOMAN WEINBERG: Sure, and then I have more questions here.

MR. WALTER: Based on that first person's testimony, she said mail order saves based on scale, that they fill so many prescriptions, and with

all this automation, they can save money. We distribute a drug from the manufacturer to the wholesaler to us to the customer. It takes maybe five minutes for us to do it. How do you save \$20 and \$30? You don't. Mail order is granted special prices because they deal with different people than the ones we do.

The Robinson-Patman Act in this country says same price to everybody based on size of purchase. I belong to a buying cooperative over 3000. We buy just as well, or we should buy just as well, as Merck-Medco, Baxter Healthcare, and anybody else. The volume is there. We can't get the prices. Who owns Merck-Medco? Merck. Baxter Healthcare -- drug companies and third-party benefit management companies own it and they're skimming the profits out. And it's not helping the consumer. The consumer's the one that's paying the extra bill for all this.

I didn't mean to drag on that. There's other issues in here with this that are more important.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Kean.

ASSEMBLYMAN KEAN: Thank you, Madam Chair.

Thank you for coming here today, on probably one of the better days that we've had over the last couple weeks. Thank you for spending time here.

This legislation is different than your model legislation. Briefly, can you describe how it's different?

MR. DAVIS: Well, we're sort of in the process of having two model bills right now. We have, sort of, a basic one that we created and

released in 2001, September. Since then, we've made a number of revisions. And I don't know if we're ready to release that or not, quite frankly.

But this bill, the bill that's before us here, is very similar to the original model bill we have now, I guess, currently. There are some differences. We provide for an assessment. Our bill, in and of itself, too, deals with who shall regulate the PBMs. We have part of it being done by the Board of Pharmacy and part of it being done by the Insurance Department.

Now, we've talked about this -- NCPA has, internally. We are not, in any way, hung up on who regulates PBMs. We'd just like them to be-- We think they need to be regulated. So, if one state wants to have the department of consumer affairs do it, that's fine. I mean, we're going to leave that up to the pleasure of the Legislature to determine that.

ASSEMBLYMAN KEAN: And so far, you say there's legislation that's been introduced in, let's see, six states -- has been introduced legislation -- your model legislation has been introduced in six states.

MR. DAVIS: Yes, it's been introduced this year.

ASSEMBLYMAN KEAN: This year.

MR. DAVIS: It was introduced in Alabama, Illinois, Iowa, Maryland, Missouri, and New York. And the year before that -- and again we did it very late, but there's a number of states that have full-time Legislatures, Michigan, New York, and Wisconsin. They toyed around with -- I believe, sort of had it in amendment form.

ASSEMBLYMAN KEAN: What is the status in those states?

MR. DAVIS: In all those states, they got it in committee and it stopped there. I also want to add though, in Georgia, there was legislation that was put out that regulates PBMs, and that has been enacted into law.

ASSEMBLYMAN KEAN: What about in Illinois and Maryland?

MR. DAVIS: All those states have got it into committee and stayed there. And that, to me, quite frankly, is not surprising. I mean, it is a new concept. We wanted to get it out there. We were not going to the mat, as to say that -- to push the bill. But we wanted people to get it out. We really wanted it to be used as a starting point for negotiations, talk about the whole concept of regulating PBMs. And we think that's an important concept to be discussed.

ASSEMBLYMAN KEAN: And if we are in a situation whereby, as you know, all the versions, at the Federal level, have some sort of PBM component in them: New Jersey Family Care, the New Jersey State Health Benefits Program -- all have PBM components with them. Can you add -- tell me, specifically, why -- maybe, I guess, with the sponsor here, it may be better to ask him when he comes before the Committee as to why, specifically, were Senior Gold and that PAAD excluded?

Is that question better asked of the sponsor?

MR. DAVIS: Yes.

ASSEMBLYMAN KEAN: Okay. Then I will--

Thank you, Madam Chair.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato, do you have questions?

ASSEMBLYMAN D'AMATO: Yes. Thank you very much.

You are familiar with the regulatory process, I assume, in the other 49 states.

Mr. Davis, I'm sorry--

MR. DAVIS: I'm sorry. What?

ASSEMBLYMAN D'AMATO: I assume you are familiar with the regulatory process in the other 49 states.

MR. DAVIS: I try to be.

ASSEMBLYMAN D'AMATO: Okay. My only concern about this bill, and this is something I like to discuss with Assemblyman Doria, is that this bill calls for the Division of Consumer Affairs and the Department of Law and Public Safety to be involved. We already have the Department of Banking and Insurance, we already have Health and Senior Services. In the other jurisdictions, do they have the regulatory control of these PBMs in one department or one agency?

MR. DAVIS: They're really pretty much all over the board. I'd say, if there was any trend, it would probably be the insurance department that has some authority over them. And, as I said, I think there's clearly a need for a new regulatory scheme toward PBMs, just by the simple fact that, look who is looking, creating legislation or proposing legislation -- the national associations or boards of pharmacy. They think they need to be regulated.

The National Association of Insurance Commissioners are making a model bill. I mean, if they felt the insurance departments in their states were doing an adequate job, they wouldn't be making a model bill right now. So they're in the process of also making a model bill. And I think that clearly

speaks to the fact that they understand that the current regulatory scheme is just woefully inadequate.

ASSEMBLYMAN D'AMATO: Thank you.

ASSEMBLYWOMAN WEINBERG: Unless either of the two additional speakers have something new to add, I would like to call on the sponsor of the bill, who has arrived.

MR. WALTER: Just one more point.

ASSEMBLYWOMAN WEINBERG: Yes.

MR. WALTER: That was overall cost savings pointed out by the first witness. Yes, savings probably went down initially. In other words, the way prices were 20 or 30 years ago, there were some immediate savings. But, when you initiate programs with a benefit management company like they're running it today, requiring rebates to have a drug on the formulary, it doesn't take a mental giant to suddenly realize that, if you're a manufacturer of pharmaceuticals, and you know, up front, that a third-party benefit management company is going to want \$50 back on a hundred dollar bottle, you're not going to keep the price of a hundred dollar bottle at a hundred dollars. You're going to make it \$150. And that's what we've seen.

I heard the price increases quote by a friend on the left over here of 17 and 19 percent. Well, naturally, it's way ahead of inflation. And why? The answer is obvious. It's right here in front of our noses, that these manufacturers are not sitting by and saying, "Okay, we'll reduce prices. It will only go up cost of living." We've got to give a "kickback -- rebate," call it whatever you want. Somebody breached on the medical ethics of it before.

It's right there. We've got to pay it. We've got to pay the bribe to get our product being used. If we're going to do it, let's raise the price.

So now the consumer who doesn't have a third-party card and doesn't have insurance walks into the pharmacy, and what do they pay? They may now pay the rebate the manufacturer would have given back to the manufacturer. And they're paying it all.

So, what I'm trying to say is, somebody better grab a hold of this thing like your looking at and regulate these guys, because if you don't, there's going to be major problems out there. It's that simple.

ASSEMBLYWOMAN WEINBERG: Thank you very much. Thank you, gentlemen.

And while Assemblyman Joe Doria is coming up, obviously a man of great foresight because he had this bill in, in three prior sessions-- So he certainly knew that this was a growing problem. And now that it seems to have reached maturity, in terms of its problem, we're finally hearing the bill.

I am going to ask our staff, by the way, to find out from our PBM manager, that is the group that handles the State health benefits, if, in fact, we know and are a party to whatever rebates, educational fees, whatever they call them, if that information has been shared with the State of New Jersey.

Assemblyman Doria, thank you for appearing and for speaking about this bill.

ASSEMBLYMAN JOSEPH V. DORIA JR.: Thank you very much, Madam Chairperson.

I just want to begin by saying I'm very happy that, for the first time since this bill is introduced since 1996, it's being heard and that today

we're going to have a hearing on this issue, because I think it's an extremely important issue.

I just want to point out, as you've, so well, already stated, this bill has been introduced. And it was introduced on a bipartisan basis. Assemblyman Jack Kelly, who's no longer with us, who was the Republican Assemblyman--

ASSEMBLYWOMAN WEINBERG: He is with us, but not in this Legislature. (laughter)

ASSEMBLYMAN DORIA: Well, he's no longer in this House. He's alive and kicking, thank God. We miss him in this House, let me just say, even though he was a member of the Republican party, we all miss him. He's a good friend, and he was the co-prime sponsor of this legislation in the '96-'97 session, the '98-'99, the 2000-2001. And I introduced it by myself. I didn't have time to get any other co-prime sponsors or co-sponsors. But I want to begin by saying, obviously, anyone who wants to join on, including yourself, Madam Chairperson, Assemblywoman Quigley, the Vice-Chair, or anyone else, that this is a bill that I consider to be extremely important. Why is that?

Let me begin by saying, even though there would be those who say that PBMs are presently regulated sufficiently, I would argue they are not, because they fall through the cracks. And why is that?

When you talk about regulation by the Insurance Department, they are not really regulated unless they're part of an HMO or are an HMO. Then they would fall within the jurisdiction of the Insurance Department. But if they are not an HMO, then the PBM is not regulated by the Insurance Department. So that's very important to understand that first, so that when

you start saying that the Insurance Department regulates them, that's not true in every instance, depending if they're an HMO or they're not an HMO.

When you say the Department of Health regulates them, again, it depends upon who they're providing the service to. If they're providing services through programs such as Senior Gold or through the PAAD program, then there would be some regulation. Otherwise, there would be no regulation.

So, what we have is, if you would want a third-party administrator. And that's what they are. If you would want, they're a middleman. And in my opinion, the middleman results in higher costs to the consumer, because you have now someone in between who's creating formularies. And formularies are lists of drugs to be used and which are used for specific purposes -- that it creates specific formularies -- many instances dependent upon the rebates. I know Assemblywoman Quigley used the word kickback earlier. We won't use that word because it's a political term that's always dangerous.

ASSEMBLYWOMAN QUIGLEY: How about bribe? (laughter)

ASSEMBLYMAN DORIA: It is incentive. Incentive is the word. It would be an incentive. It would be an incentive to allow for the use of a specific drug. As you know-- And I know doctors -- number of you-- We have a doctor sitting on this panel. But he can tell you of the fact that drug companies spend a lot of money. And there's been a lot of TV coverage of drug companies spending a lot of money giving doctor's trips, encouraging them to use--

ASSEMBLYMAN CONAWAY: I don't know anything about that.
(laughter)

ASSEMBLYMAN DORIA: Going to Broadway shows--

ASSEMBLYMAN CONAWAY: I'm putting that on the record.

ASSEMBLYMAN DORIA: --to create incentives for the doctors to use specific drugs. And we've seen, for the first time in recent years, the use of advertising to the general public for prescription drugs. Now, that never occurred until recently. So, we've seen now, the advertising of prescription drugs, Celebrex, let's say, or any prescription drug, to the general public -- or the new Nexium -- so that they're all advertising. The purpose is to build a greater--

ASSEMBLYWOMAN QUIGLEY: Viagra.

ASSEMBLYMAN DORIA: Viagra, right, for those who need it?
(laughter)

ASSEMBLYWOMAN WEINBERG: Those are my favorite ads, actually.

ASSEMBLYMAN DORIA: Bob Dole. It was a way for him to continue his presence in the public. (laughter) That was proof positive that he couldn't get embarrassed by anything.

ASSEMBLYWOMAN WEINBERG: I didn't mean to throw you off. I'm sorry.

ASSEMBLYMAN DORIA: You threw me off. You threw me off. I'm sorry, I didn't mean to get partisan here. (laughter)

But, what we have here is, that's the incentive towards the doctors. The same thing exists with the PBMs. They receive incentives. In many instances, it's a cost savings. And the last speaker, I think, pointed out very effectively the impact. If the companies know that they're going to have to provide some type of incentives, the cost of the prescription drug goes up.

Obviously, there's a legitimate cost of research and development, which we all understand. But the advertising isn't, obviously. That doesn't relate to this bill. But, obviously, the incentives are costs that have to be included in the total price of the prescription drug.

So the end result is the total cost of prescription drugs goes up for the consumer. And the PBMs are the major beneficiary of the increased benefit. They do provide a service. They do help to push generic drugs, which we know are cheaper. But they're making money, in many instances, as they're pushing the generic drugs. The PBMs also have a great deal of influence on doctors. And it's not unusual, and they can argue this, but I've been told and have various reports that they, many times, call a doctor. And when a specific drug is being prescribed -- and try to convince that doctor to use Vioxx instead of Celebrex, let us say, for arthritis, because they got a better deal on the Vioxx than the Celebrex, and they're getting a better rebate on that product.

Now, you can argue which one is better, and I'm not an expert on that. But, what I'm saying is, what we have here is the PBMs are a new form of enterprise. And, again, in our free enterprise system there's nothing wrong with that. They're a new form of free enterprise, which, in the end, should result in cost savings, but in many instances result in increased cost, to the consumer. And, given the fact that the Congress has seen fit in their wisdom not to pass a prescription drug benefit for our senior citizens, we have a situation where those on Medicare will not have that benefit -- and we know so many seniors are dependent upon their drugs. In many instances, it's a

choice between being able to feed themselves and taking their medicine or cutting back on their medicine. We know that impact.

My concern here is that the PBMs serve a useful purpose to a degree. But we should make sure that, as with all free enterprise -- and we've seen a lot of that recently, unfortunately -- the Tycos of the world, and the WorldComs and the abuses that exist within the business community -- we don't allow that to occur in New Jersey and that we set up a system of certification through the Division of Consumer Affairs, which is an appropriate place to do that, to make sure that the contracts that are signed and that the programs that are run through the PBMs are legitimate, that they truly are providing a savings to the citizens of the state, that they truly are providing a service, and that it's not just another way for a group of individuals, who run these PBMs, to make more money for themselves.

I'm not saying that that's true, but, again, I don't think there's any reason why they should not want to be able to prove that they're doing a service rather than making a killing. And this bill is not an onerous type of situation, where they're going to be asked to do too much. Rather, it allows for the certification process to take place on a three-year basis through the Division of Consumer Affairs, which is not the most strenuous of certifications. If we had done it through one of the other departments, we might be much more demanding than the Division of Consumer Affairs.

Myself and Assemblyman Kelly felt very strongly about this. Now, why do we include Senior Gold and PAAD, and why do we say they shouldn't be able to use a PBM? For one reason. Why should the intermediary be able to make the money? Why shouldn't the state, through the use of its own

formularies, be able to get the rebates directly and save the money to the taxpayers of the state so we can provide a better benefit? We can do it ourselves. We don't need a PBM. We should be able to use all the same mechanisms. And we have already started to do that through the PAAD program. And that is, to work our rebates with the company, since they've already had that built into their cost of doing business and it's already into their profit margin -- so that the State of New Jersey gets the total direct benefit of the rebate rather than sharing that rebate with an independent PBM. That's the reason why we included that prohibition within the legislation -- so that the State gets the basic benefit, which is much greater than if they were through an independent PBM.

I'd be happy to answer any questions.

ASSEMBLYWOMAN WEINBERG: Assemblyman Kean.

ASSEMBLYMAN KEAN: Thank you, Madam Chairwoman.

If we're focusing on, I guess, excluding Senior Gold and PAAD from the purview of the pharmacy benefit managers, why not go -- why not include Family Care and the State Health Benefits Program, as well? What is the difference between all those programs? And also, the philosophy that the State can do it better for cheaper, overall -- is the philosophy. And we had the discussion on the side about the investment philosophy of the State. We want to keep it in-house -- don't pay outside sources.

ASSEMBLYMAN DORIA: Again, the reason is because those programs are not basically a drug provision program, thus it would be more complicated and they would have to spend more time in those programs to deal with the issue. Now, if the State just--

And I'd be willing to include that. But what would have to happen then, in my opinion, and I'm not an expert in this area, Assemblyman, but I would think then the State would have to set up its own formulary for all of them and run it as a totality. Family Care, for example, is basically a health care program that provides some drugs, not a lot. Okay? Medicaid is another one that provides some drugs. It's part of a total program of health care that -- but that's not the primary focus in the provision of the drugs -- prescription drugs. So, you would then need more time spent in those programs.

But if the State were to set up a program -- total program dealing with prescription drugs, and they were to participate, then I would think, yes, they should be included. But that would go a little further than my bill intended. But I think there's a logic to what you're saying.

ASSEMBLYMAN KEAN: Thank you.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairperson.

Assemblyman Doria, you touched on this, but I need clarification.

Is it conceivable that the PBMs could be regulated just by one agency as opposed to, if you're bill's enacted into law, we're going to have three?

ASSEMBLYMAN DORIA: Well, they're not-- As I said, some of them may be regulated under the Insurance Department -- Banking and Insurance Department if they are an HMO, but most of them are not because they're not HMOs, so they would only be regulated by one. And under this bill-- In the end, they'd only be regulated by one except if they're an HMO, because there would be no need for the Health Department to deal with them, because this bill -- there would be no PAAD and Senior Gold, which the Health

Department is responsible for. So, the Health Department would be taken out of it.

The only ones that would be regulated by the Insurance would be those that are HMOs. So then every other PBM would be regulated by Consumer Affairs. I mean, I have no problem in saying that all of them should be regulated by Insurance or by Consumer Affairs. But, right now, only that very specific group, the smallest group, the ones that are HMOs, are regulated by Insurance. So there's a potentiality, but there's not an actual regulation.

ASSEMBLYMAN D'AMATO: The only reason I suggested that is that, if the regulatory process is within one agency, that means there will be one Senate committee, one Assembly committee that will be hearing the various issues, and there will be consistency. That's my only comment.

ASSEMBLYMAN DORIA: I don't disagree. I was not sure. What I didn't want to do, by this piece of legislation, is take the HMO PBMs out from under the control of Insurance and Banking. I mean, am I open to that as a possibility, in putting it all under Insurance and Banking? I have no problem putting it under Insurance and Banking rather than Consumer Affairs. It's a little bit more of an onerous type of regulation. I put it in the Division of Consumer Affairs because it's a less onerous type of regulation to have to go through and a much less complicated system. But I'd be open to a discussion of making them all either go through Insurance and Banking or Consumer Affairs.

ASSEMBLYMAN D'AMATO: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway, for the first time this afternoon.

ASSEMBLYWOMAN QUIGLEY: And we're timing you.
(laughter)

ASSEMBLYMAN CONAWAY: Do you feel the breeze coming through?

ASSEMBLYMAN DORIA: We know Assemblyman Conaway never goes on any of those trips. (laughter)

ASSEMBLYMAN CONAWAY: Well, I can't help but mention, when you talked about incentives -- for the record -- at least for this position-- And I don't know of a single physician that, for these trinkets -- I guess they're more than trinkets taken by some folks-- No one, though, would just change someone's medication based on those incentives, because it's not good for patient care.

We in this game -- all the people in this game-- We're health care providers that have to have the patient's concern first. And switching drugs around very often, in my opinion, inures against the provision of quality care. And one of the comments that was raised is the confusion and the expense of these intrusions by these third parties into the doctor-patient relationship.

Every time you change somebody's medication, that person is less likely to change their medication -- or to take their medication the way it was instructed. It generates additional doctor visits in order to make sure that this new medication, beyond (indiscernible) they now go to new medication. You'd have to increase monitoring.

So there are costs associated with this interference in the system causing people to have to switch their medications -- often driven by financial concerns.

My question is on the bill, if you don't mind. And that is, do you contemplate, given what the independent pharmacists said during their testimony-- Do you contemplate that the regulators of the PBMs would be involved in looking at the contracts that these PBMs set up between these pharmacists? Their contention is that the financial incentives for rebates and other things actually raise cost. Do you contemplate that the regulators will be looking to dig out the presence of those cost-drivers and to do something about regulating? Do you contemplate the regulators setting the kind of return that these PBMs can get so the consumers do, indeed, get all the savings they're supposed to get from the intrusion, the involvement, of PBMs in health care delivery?

ASSEMBLYMAN DORIA: Let me say that when this bill was written, it was not intended to establish any type of profit margin. This bill does not do that. It does not contemplate that. I think since this bill was initially written and amended -- that given some of what we're seeing happening out in the business environment, it might not be a bad idea. This bill does not contemplate that. It does not require that.

It would require that, as part of the certification process, the contracts be made available. They would not be-- They would not have the authority -- the Department of Community Affairs would not have the authority to say this rebate is not legitimate. They would have the authority, if the contract was questionable as to legal questions rather than the profit or the size of the rebate, would have the authority to deal with those issues. But they would not be involved in establishing profit margin as of this bill now.

This bill could be changed. And some of what you said-- Obviously, some of what's going on might make me say maybe it should be a little bit more stringent. But it was not contemplated to be that stringent. It was more contemplated to establish a system of registration to have a better knowledge of what was going on and actually what the PBMs were doing and actually what they were making -- not stopping them from making it, but, rather, making that public record to know what they were making and why they were, because, I agree with you -- that the third party here increases cost. And let me just say, I never intended to imply that doctors would change medication as a result of incentives.

ASSEMBLYMAN CONAWAY: It doesn't happen.

ASSEMBLYMAN DORIA: Unfortunately, just as we're in the political business, the perception is created that is a negative perception, and we deal with that often. And, unfortunately, that's true of all professions.

But, no, this does not contemplate establishing a cap on profits.

ASSEMBLYMAN CONAWAY: Do you anticipate that the Department will be involved in looking at the various procedures and saying that this procedure is something that's (indiscernible). Let me give you an example. I take over. I come in and take over the pharmacy benefits management for some company. I've got a patient-- This happened to me just the other day -- been stable on a medicine for a number of years. All of a sudden that medicine doesn't show up on her formulary. She either decides to pay more money to stay on the medication that she's been on, stable for years, or she's got to pay -- and pay more, or she's got to switch. And, of

course, there are intended costs that are associated with that to her and to her health.

Do you think that that kind of-- Do you contemplate, under regulations, that that kind of intrusion would be something that the Department might say you can't do, or you can't send, blasto, these faxes of mail into my office asking me to change medication all the time, which irritates the living daylight out of me? Some of those intrusions--

I think that the PBMs do-- If they are-- If there are certain threshold questions -- a patient's on 10 different medications and they want to review that to see that there's no conflicts, I think that's a good thing to do because that's good for patients -- or to look for other kinds of conflicts, even with people who don't have multiple medications--

Once they get down to the nitty-gritty of looking at each individual medication -- perhaps somebody's on one medication or two medications, and they're sending letters and sending mail and, of course, causing these people to switch medications, that's bad quality care, bad for patients, and costly in my view.

So, do you think that the Department's going to get into those kinds of practices as they regulate?

ASSEMBLYMAN DORIA: I mean, part of this would be what the regulations are once this legislation-- As you know, regulations sometimes go beyond the intent of the legislation. I don't perceive this as being onerous to the PBMs. I think, rather, it's meant to protect the citizens who may be the resulting beneficiaries of PBMs. So some of what you say may occur. I think that if there's onerous interference, I think that that, obviously, would be

something that the certification process would look at. I think the purpose here is to make sure that the public is not, in any way, being detrimentally affected and that the companies are running a legitimate operation that, in the end, benefits the public, as well as benefits the health care system in the State. That's the purpose. It's not meant to be onerous, but it is meant to require disclosure.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Quigley.

ASSEMBLYWOMAN QUIGLEY: Thank you.

That was the perfect segue, because disclosure was what I wanted to talk about, because I think it's a great bill. But, based on what we've been reading recently, and some of the things we heard today, I would like to make sure that, somehow, the PBMs are required to disclose to their clients, the employers, and to the enrollees in the plan, what the interrelationships are -- what with mergers and takeovers and ownerships and other kinds of relationships by drug companies -- so that people clearly understand who's paying for what.

Now, I was marveling at Ms. Burton when she spoke to us, because the way she answered questions was the way I wish I could answer questions when the press asks me the tough ones. She never quite said yes, and she never quite said no, because we asked her repeatedly, in many ways, do the clients and the enrollees know where rebates are being paid and who's paying them.

ASSEMBLYWOMAN WEINBERG: And the answer was, not on a drug-by-drug basis.

ASSEMBLYWOMAN QUIGLEY: Yes. The answer also was, “Well, they have armies of experts and layers of expertise. And it’s all part of the negotiation,” which lead me to believe, if you ask, maybe we’ll tell you. But if you don’t ask directly, you ain’t never going to find out.

So, is there some way we can write this into the bill so that it is open?

ASSEMBLYMAN DORIA: This bill, I think-- No, that could be-- That’s not what’s here right now. I think it would be a good addition to the bill, and that’s why hearings like this are helpful. I think it would be a good addition to the bill.

I think that when we did the HMO reform legislation-- A lot of what we’re talking about here, as it relates to PBMs, is what we did with the HMOs, if you remember. And disclosure was an important part of the process. And whether it be our State legislation, which was a model, or whether it be what happened at the Federal level I think the question of disclosure is extremely important. One of the problems is, if you ask, they’ll tell you. But, when companies or individuals negotiate with PBMs, they don’t know what questions to ask.

The problem is, you don’t know what the questions that should be asked are. So you don’t ask them, but you don’t get the answer. Whereas, if there’s a requirement of total disclosure-- And see, that’s what the review of the contracts by the Department of Consumer Affairs would do. Unfortunately, that part doesn’t then get translated into disclosure to the individuals who use it, the employers, the groups that use it. So, that addition

to this legislation, I think, would be a benefit, but it's not specifically in the legislation right now.

ASSEMBLYWOMAN WEINBERG: I'm going to ask David Price if he would come up with some wording over the next several weeks, perhaps work that out with you, which would include the disclosure issue.

ASSEMBLYMAN DORIA: Sure. I'd be happy to do that.

ASSEMBLYWOMAN WEINBERG: And when we consider this bill for release in September, we will be able to, hopefully, include wording like that in it.

ASSEMBLYWOMAN WEINBERG: Assemblywoman Greenstein.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

I know you said, Assemblyman Doria, that right now, in the bill, it's simply a disclosure bill but doesn't talk about the results of that disclosure, as Assemblyman Conaway was mentioning. Do you anticipate later legislation that would deal with that, because what if there are all sorts of things revealed as a result of the disclosure that would show problems for consumers?

ASSEMBLYMAN DORIA: Obviously, once we set up the system-- And we don't know what it will show. We don't know what the certification process will result in. Once that happens, then if there were problems, sure, we-- I mean, that's the purpose of why we're here, so that if the problems did result, if they couldn't be handled through regulation, then, obviously, they should be handled through legislation. And that would take place once we went through the entire registration process.

ASSEMBLYWOMAN GREENSTEIN: So, this is sort of step one in a process.

ASSEMBLYMAN DORIA: This would be step one. We're not-- At this point, we have, really, except for those that are HMOs, no direct involvement with PBMs. They, basically, are out there acting independently.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Doria, if you can stay, we'd appreciate it.

ASSEMBLYMAN DORIA: I'm going to have to run because things just-- I apologize for being late. I had a press conference about a golf course that's being built in Bayonne. That's why I'm-- As you know, I don't play golf, but I have a golf tie on. (laughter) I'll stay for a little while, but I, unfortunately, have to run back to another meeting.

Thank you all very much. And I want to thank the Committee and the Chairperson for having this public hearing, because I think it's very important. This is an important issue. Unfortunately, it's gone for a long time without being dealt with. As I say, Assemblyman Kelly and I both thought it was important enough that we introduced legislation over the last -- for three terms, now in the fourth term.

ASSEMBLYWOMAN WEINBERG: Well, if you haven't gotten it, I suggest that you get the August 5, 6 issue of *U.S. News and World Report*, which has finally caught up with your legislation and is titled, "When is a Rebate a Kickback?" And it is all about the PBM business.

ASSEMBLYMAN DORIA: I actually have seen that.

Well, it's good to see where every once in a while, we're ahead of ourselves. (laughter)

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Gerry Purcell, Managing Partner, Pharmacy Partners.

The next is a group. Well, we have two groups coming up after Mr. Purcell.

GERRY PURCELL: Madam Chairwoman, I have some materials. If I could approach--

ASSEMBLYWOMAN WEINBERG: Sure.

MR. PURCELL: Madam Chairwoman and honorable members of the Assembly Health and Human Services Committee, I've prepared a brief statement I wish to present and enter into the record. Attached to the statement is my bio, which outlines my experience as a former insider in the PBM industry and my current experience helping plans negotiate with their PBMs.

In the interest of time, I will try to move as quickly as I can, even given my southern dialect, which tends to come out later in the day. So, I'll try to do the best I can.

From my extensive travels--

First of all, let me thank you for conducting these hearings and the privilege you've granted me to offer testimony before you today. It is, indeed, an honor to be here. New Jersey is, indeed, one of the first states to conduct this type of hearing on the practices of pharmacy benefit managers. From my extensive travels and contacts around the country, I know that many states are watching closely and will, indeed, follow your lead in the coming months.

Your decision to hold hearings on this matter is very timely, as there has been a flurry of unfavorable PBM coverage in major news

publications such as the *Wall Street Journal* and, as has been already mentioned, the *U.S. News and World Report*. Interestingly, I think it is important to note that the negative coverage on PBMs has come in publications that are generally considered to be business-leaning and pro-business.

I believe that your efforts today to more closely examine PBMs serves the best interests of consumers, but it also serves the best interest of businesses across New Jersey. Further, I believe that your efforts today will be a starting point towards helping the leaders across New Jersey and its citizens develop a better understanding of a very complex segment of the health care industry, perhaps the most complex.

Ironically, while PBMs manage the prescription dispensing of some 200 million Americans, few knew what a PBM was several years ago, much less the intricate and complex practices PBMs use to create profits.

A reporter from *Business Week* recently asked me if I believed that, in this era of information and exponential technological advancement, prescription programs are more complex or less complex than several years ago. Just ask a senior citizen that question, a senior who may routinely be forced to decide between food and medicine, or ask a private business owner who can no longer offer health coverage because he or she cannot afford the rate increases, due in large part to increasing drug increases. My answer, just like theirs, is: certainly more complex.

While many Americans, particularly those who carry a prescription drug card, now know what a PBM is, few understand the complexity of how they operate. I suggest to you today that the complexity is not accidental, but is calculated and by design.

PBMs have created a complex and elaborate scheme. In almost every area where there is an opportunity to create a rebate or kickback, a spread, a subsidy, an administrative fee, a marketing fee, an interest float on claims and rebate payments, a data sales fee, a telecommunications fee, a grant, and numerous other clever names, or to book member copays and claims costs as revenue, even though they are not at risk for those dollars -- I would suggest that the PBMs have taken that opportunity, while claiming, at the same time, to represent the best interest of taxpayers and self-funded plans. As many of these practices are hidden, the average taxpayer or self-funded private plan has no idea the reach and extent of this multi-faceted scheme.

One must ask what affect this increasing complex scheme has on drug costs? And we've had some discussion of that today. Drug costs are clearly the only segment of medical care that have sustained 15 to 20 percent annual cost increases for the last 15 years. While many areas of medical costs in the '90s stabilized -- in some areas the cost increases were negligible or even negative -- drug costs have consistently been 15 to 20 percent annually. Unfortunately, almost every expert predicts continued 15 to 20 percent annual increases.

Much of the blame for cost increases has been laid at the feet of drug manufacturers. They have become an easy scapegoat. A lot of the criticism is deserved, to be sure, but to single out the drug manufacturing industry misses the mark and does not fully offer a solution.

With all of the criticism of drug manufacturers in recent years, cost increases have remained in double digits. Let's be fair by appropriately

fixing responsibility and accountability. The drug manufacturers have never claimed to be cost-containment managers.

The group that does claim to be “managers”, as in pharmacy benefit managers, managing 200 million Americans’ prescriptions, have managed us right into 15 years of double digit increases, while simultaneously telling us that they control and contain costs.

Seriously, how can the managers, again, who manage the purchasing power of 200 million Americans, claim to cut costs when we know costs are out of control, at least how can they make that claim with a straight face? Perhaps, if the PBM industry would be more transparent about having failed to control costs, and as the managers take responsibility to fix it, maybe the mounting scrutiny would be less severe.

Indeed, I believe the problem is much bigger than drug manufacturers. I believe the power equation is now shifting to the PBMs. The reason is simple: PBMs manage the dispensing of 70 percent of prescriptions in America and, as already stated, the purchasing power of 200 million Americans.

In many respects, in order to maintain market share, drug manufacturers are now at the mercy of these giant managers known as PBMs. For the drug manufacturer, it really comes down to a very simple economic proposition. In order to avoid a situation where millions of Americans, members of PBMs, are denied access to their products, to keep their products on the almighty formulary and be competitive, they must pay the piper. And the piper is the PBM.

At the very minimum, the relationship between PBMs and drug manufacturers is now a full-blown, co-dependent relationship. Managing 200 million Americans, the PBM industry has become the chief enabler of out-of-control drug costs.

Until very recently, PBMs have escaped scrutiny. While managing the drug benefit for 200 million Americans, as stated, PBMs are, indeed, the least regulated component of the health care industry, contrary to their claims.

You see, it is difficult to get a straight answer from the PBMs about who does regulate them. Let me share an example. It is my understanding that in Federal legal findings, PBMs have claimed plaintiffs lack jurisdiction because they are not fiduciaries and therefore fall outside of ERISA governance.

Conversely, in State legal findings, PBMs have claimed plaintiffs lack jurisdiction because they are managing a self-funded plan and are, therefore, pre-empted from State regulations. So, if they are, indeed, heavily regulated, as it has been stated, there seems to be a huge gap of understanding, at least from their perspective, in this particular area. If they are not subject to Federal jurisdiction and also fall outside State jurisdiction, in their mind, who exactly does regulate them?

Fortunately, this circular, nonsensical defense is soon coming to an end, as litigation against PBMs is catching steam around the country. These issues will ultimately be decided by the courts. The fact is, many public sector and private plans and individuals have had enough.

In my home state of Georgia, third-party administrators are required to be licensed by the state insurance department. A recent check with the department, however--

ASSEMBLYWOMAN WEINBERG: Mr. Purcell, I'm going to interrupt you because this written statement is pretty lengthy. You don't have to read it all. We have your written word.

MR. PURCELL: Sure.

ASSEMBLYWOMAN WEINBERG: If you could just summarize the rest of it, I'd appreciate it.

MR. PURCELL: If I could move on, Madam Chairwoman, to the discussion on PBM practices specifically-- I have provided a checklist for you, which outlines a number of practices. I would like to discuss, very briefly, the practice of rebates and financial incentives, because it has been brought up on a number of occasions here this afternoon. And it's also the area of interest that Jim Sheehan, the Deputy U.S. Attorney, is looking at.

We have heard today that PBMs fully disclose and allow the clients to audit the rebate contracts. I want to suggest to you that that is not true, that it is also very misleading. And I think it may even be misleading by design. You see, what happens in the rebate negotiations with the manufacturers, the PBMs sign an agreement with a plan sponsor, a taxpayer plan, while they've already negotiated a contract with a manufacturer. And while they say that they have disclosed or they offer to the client the rebate, the problem is that they will not release the contracts so that the plan can audit to ensure that, indeed, they are maximizing the rebates.

Even more concerning is that now that many of the plan sponsors in the United States, particularly since the late '90s, have become more savvy and sophisticated to these rebates, the PBMs have simply changed the name. They've changed the nomenclature of these payments. So you have payments, as I've previously mentioned, that are defined as -- and has been stated -- health management fees, data sales fees, subsidies, administrative fees -- I mean, all types of nomenclature. And the big problem is that the PBMs are the ones that have discretion over what the labeling is. So the PBM is the one who decides whether this is going to be a health management fee or this particular payment is going to fall into the rebate bucket. And so they have the discretion over those decisions.

When a plan asks to audit those records, some PBMs will, indeed-- The range of response ranges from outright denial to putting up obstacles, which include determining or vetoing who the particular auditors can be. It also-- If they do, indeed, share rebate contracts, they do it on a limited basis, and they share rebate contracts that are heavily redacted, in a lot of cases, so they don't give the entire picture.

So, when-- As Ms. Burton has stated -- in deference to her, she stated that PBMs do disclose these rebates. Well, they may, indeed, disclose a portion of the rebates, but they rarely disclose all of these other financial incentives that go along with those payments.

And I would suggest to you today that the amount of those payments, in some cases, is 60 percent of the total incentive dollars coming back, both rebates and financial incentives combined, coming back to the PBM -- as much as 60 percent. Now, the PBMs will vigorously deny that, but they

will not share the contracts that regard those other types of financial arrangements. And I think that's a problem, creating other types of--

The taxpayers and self-funded plans -- even though they have become more sophisticated, they're, often, totally unaware of the existence, and certainly the extent, of these financial incentives. And, again, the discretion lies with the PBM, not the plan.

In some contracts, the PBMs have become very clever, and they have said in the contract that, "Yes, indeed, we do receive other payments," without disclosing how much those payments are, "but we are not going to disclose those payments to you." So the clever language that they use is that they are disclosing that they are not disclosing. That happens quite frequently, particular with the larger PBMs. And I don't believe, personally, that that type of clever language is going to relieve the PBM of the obligation to disclose those assets.

The difference here, too-- A lot of people ask me, what is the difference? Why should a PBM not be able to do this? If you go down and buy an automobile, there's all kinds of margin built in. And the consumer is certainly not entitled to know what those areas of margin are. We are not talking about manufacturing widgets here. We are talking about a situation where a PBM has been hired as an administrator, as a manager, and they are paid an administration fee to manage the assets of that plan.

And one of the biggest distinguishing aspects is, it's not their money. They are not at risk through the use of their clever contracts with both the pharmacists and with manufacturers. They have insulated themselves from the risk of those dollars. So, clearly, those dollars are plan assets. And it--

ASSEMBLYWOMAN WEINBERG: And if I'm covered by a plan under a given PBM, I can't go comparison pricing like I can for my automobile.

MR. PURCELL: That's correct, you can't, because you will never-- It's designed, Madam Chairwoman, in such a way that you would never get to all of the information that you need to make a great decision. And even, as Ms. Burton pointed out, these PBMs come in -- I stand corrected -- these plan sponsors come in with all types of consultants and high dollar folks that are supposedly experts in this area. But, even if they ask all of the right questions, the PBM will never disclose 100 percent of rebates and financial -- all total financial arrangements to the plan.

ASSEMBLYWOMAN WEINBERG: Well, among the materials you gave us is an article from the *Wall Street Journal* dated August 1, a few days ago, in which it says, "The Assistant U.S. Attorney, James Sheehan, wants to know what deals AdvancePCS," who apparently manages our prescription plan, ladies and gentlemen, "is making -- what deals AdvancePCS is making with big pharmaceutical companies in return for steering millions of Americans to certain prescription drugs and not others. Wall Street analysts know, generally, that Mr. Sheehan has been investigating pharmacy benefit managers for four years, but to Wall Street, the probe is just background noise," etc., etc. So, if the U.S. Attorney's Office can't find this information, I doubt an educated consumer can.

But I certainly feel that the State Health Benefits Plan should certainly inform the pension, the Health Benefits Commission, exactly what this deal is in that contract. And I would hope that sometime over the next 30

days this Committee's going to be able to get that answer from AdvancePCS, which might give us a little window into looking into the business practices of this industry.

MR. PURCELL: That's correct. Absolutely. I believe the net effect of all of these practices is that it does, indeed, drive up cost. As the *U.S. News* article pointed out, I think, correctly, it listed three examples of three drug agents where, when a similarly efficacious generic drug came on the market, the brand drug -- the price of the brand drug actually went up, which is, as one professor in Minnesota pointed out, perverse economics. It's one of the few, if maybe the only, industry where, when a competing similar product comes out, the price actually goes up. And it wasn't just a small, incremental increase. In some cases, these increases were 15 to 20 percent increases. And that money was used, I would submit to you, to prop up or to pay additional incentives in order to incentivize the PBM to continue to push those drugs into their marketplace, even though there was a similarly situated generic drug at a much lower cost. So I think the net effect is that they do, indeed, drive up costs.

Now, I want to suggest to you today that I do think PBMs -- and sort of in closing here -- I do think PBMs provide value in terms of claims processing, their original charter of setting up networks, providing drug utilization review, therapeutic programs, disease -- State management-type programs. I think all of those things are excellent.

The problem is, they've gotten away from their original charter, and they've placed themselves squarely in the middle of the distribution of

drug products, profiting on both ends of the equation while representing themselves to work in the best interest of the client.

I mean, they -- truly, when you sit down in a marketing presentation, what they tell you, as a client, is that, "We are here to represent you. We are here to contain your cost and control your cost." And it simply is not true, because they have competing loyalties and divided loyalties, because they are getting paid on both ends of the spectrum.

I would also suggest, just again in closing, that I am totally in support of what New Jersey -- of what you're trying to do -- the Committee's trying to do with AB-2337. I would strongly suggest, as was pointed out earlier, that you look at the disclosure language. I do not believe that we are going to fix the problem in America, and certainly not in New Jersey, if we cannot require, particularly in taxpayer plans, where there are taxpayer dollars at stake -- if we cannot require PBMs to disclose 100 percent of the money that they receive from both the drug manufacturers and any margins that they try to drive off of the pharmacist. I don't think that we're going to fix it until we can get to that.

That concludes my remarks. You have my prepared statement. I'm certainly happy to answer any questions that you might have.

ASSEMBLYWOMAN WEINBERG: Assemblyman D'Amato and then Assemblyman Conaway.

ASSEMBLYMAN D'AMATO: Thank you.

Did I understand you to say that a PBM initially goes to a drug manufacturer and tries to work out a contract and then goes to, say, the State of New Jersey? Why do they do it that way?

MR. PURCELL: Well, the contracts are already in place, and you could -- they could probably argue that that's by design -- that they have to have formularies set up in order to anticipate growth with new clients. But what they tell you, and I think we heard it even today, is that the client has a say in that formulary design. And I want to submit to you that that may be the line, but in reality, that is not the way it works. If you are not a large client with 200,000 or more lives, you're going to have very little latitude in customizing a formulary.

Now, here's, again, the fine tuning of the language that they use. They tell you that you can decide, as the plan, what drugs you cover. But what they don't tell you is that if you eliminate-- You can eliminate a therapeutic class of drugs, but you cannot modify drugs within a therapeutic class. You cannot say, "I'm going to-- I want to take this one rather than this one," in the same therapeutic class, because what happens, then, is it messes up the financial algorithm that they've established with the drug manufacturers. And it completely skews the business model that they have for their payback, for their kickback from the manufacturer. So, even though they say they give you latitude, the latitude, in effect, in reality, is very little latitude.

ASSEMBLYMAN D'AMATO: A follow-up question.

Do you know of any state that, in your mind, has promulgated the most effective set of of regulations that, perhaps, this Committee should look at?

MR. PURCELL: No, sir, I am not aware of that. I would suggest if you, as has been discussed-- If the State of New Jersey does include the disclosure language that we have addressed here today, I think that New Jersey

will lead the nation in terms of-- And I believe that there are a lot of states that will follow.

ASSEMBLYMAN D'AMATO: Final question.

Do you know of any committee of the United States Congress that's studying this issue?

MR. PURCELL: In terms of the prescription drug bill, there are a number of senators who are looking at -- and in some bills, indeed, there has been disclosure or there has been inclusion of language that, on the rebate side and the financial incentives side -- that when we flip the switch on an additional 15 to 20 million Americans going into a senior program, that all rebates and financial incentives have to be returned back either to the government or to the consumer.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chair.

MR. PURCELL: Yes, sir. Thank you.

ASSEMBLYWOMAN WEINBERG: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Thanks for your presentation. I have a couple questions, if I may.

You mentioned -- and I gather you were on the inside. You were involved with the PBM at one point. Is that right?

MR. PURCELL: Yes, sir. That's correct, Assemblyman.

ASSEMBLYMAN CONAWAY: And I guess, in your management role, that you're in a position to, sort of, cost out the various services that were being provided.

One thing I have wondered-- We're told about all these wonderful services we're going to get. HMOs tell us that all the time. They're forever

inventing some plan, that I assume costs some money, to help me do my job better. And I wonder, if people knew they were paying for this in their health care costs, whether or not they would agree to have these other people, sort of, do my job for me.

But these services that are cost out, for instance, the medical management or disease management services-- Isn't that an expensive thing for someone to do, disease? I thought I was a disease manager. But isn't that an expensive thing for somebody, to do disease management that, I guess, people are paying for -- employers are paying for? What's the-- Is that a large cost? Should consumers be paying for that?

MR. PURCELL: It can be a substantial cost. In addition, with the hidden agreements aside, the fees that some PBMs charge for disease management programs could range anywhere from \$10 to \$100 or even more per occurrence. So, in other words, if they make a switch to Zocor, let's say -- if they make a switch, then they charge -- it's interesting -- they may charge for the disease management involvement or intervention, while at the same time, there's another financial incentive, over here, to make the switch.

ASSEMBLYMAN CONAWAY: They're making the switch, and they're getting money back on that.

Now, have any of them in the industry ever brought forward evidence that these interventions, interferences, however you want to characterize them, actually produce good outcomes?

MR. PURCELL: Everybody talks about outcomes, Assemblyman. I have seen very little conclusive information on outcomes from PBMs.

ASSEMBLYMAN CONAWAY: Now, getting to other kinds of evidence, because it's been mentioned here by the independent pharmacy folks that there are differences-- And independent pharmacists-- I've got 3000 people buying. And, of course, these PBMs are buying. They say that they are actually paying different costs for these things, and it puts them in a financial disincentive.

Are you aware of that? Do you agree with that assertion? Is anybody in the government looking at this? I mean, it seems to me that we ought to know or be able to find out exactly what's going on so that we can determine whether or not these PBMs are helpful or hurtful or what have you. Is somebody studying it? Is a university looking at it? Is somebody able to collect this data? It sounds like it's tough to get data. What's the evidence about this differential treatment of these various entities? Please.

MR. PURCELL: There's a body of evidence around the general industry services, around pricing, around what the PBMs do. HICVA has produced studies -- a number of studies. A number of nonprofit organizations have produced studies. The problem, as you correctly mentioned, is getting the data, so you can never really complete the puzzle. You can never complete the loop. I would say that in the last HICVA study that I did, which was produced -- or I reviewed, which was produced by Pricewaterhouse in Atlanta, a very sophisticated consulting firm -- did not mention the extent of these financial arrangements. In the HICVA study that was commissioned, they did not mention data sales fees, health management fees. They did not mention that this sometimes comprises 60 percent of the total incentive coming back to the PBM. I think that's a relevant, important piece of data.

ASSEMBLYMAN CONAWAY: I wonder who audits the PBM? We've had some interesting issues with auditors and their relationship with their client.

To play devil's advocate -- and I think this is my last question -- and that is, I'm a business person. I'm coming to offer a service, and I've got a contractual relationship with my client. And what right do I, as the buyer of this service -- what right do I have to know about all of the business arrangements and details of the person who's providing this service? I don't-- Should I know how -- all of the intimate details of how they run their business, and is there a parallel in other industries that I, as the consumer of the product, know everything about the business arrangements of someone who's offering this service to me? Is it fair that we ask PBMs to come forward with this information about their rebates and things like that? What makes them unique that we want to require them to give us this information?

MR. PURCELL: Perhaps it is not as important if we, as the payer, relinquish our risk on the health care spending.

ASSEMBLYMAN CONAWAY: We as the employer paying for the -- relinquish our risk. Okay.

MR. PURCELL: The problem is that the employer maintains the risk. The PBM has insulated itself from the payment to pharmacies if the client-- If the employer goes belly up, the PBM is not liable. If moneys are not paid from the manufacturer for rebates, as they're supposed to be paid in the contract, the PBM insulates itself from that risk, as well. So the PBM is this huge entity in the middle that is making all of these discretionary decisions,

without the knowledge of the client, while they have no risk. The client is at risk.

There is, interestingly, in the ERISA environment, in the self-funded environment, there is a requirement, if you are a trustee of the plan, if you manage those plan assets, that you do everything possible to manage those assets in the best interest of the plan. But because you, as a trustee, cannot get to the data, you cannot fulfill your fiduciary obligation in the fashion that I think you should be able to, because they're withholding that information from you.

ASSEMBLYMAN CONAWAY: I'm sorry. You say you should be able to. And that's my question. Should you be able to get at this information? I'm trying to think if I'm a -- the information about a car was (indiscernible) and I'm going to buy a car, and I've got several options, I guess, to buy a car-- Should I know about how Ford buys its engines and what they pay in Mexico for putting these things together? I mean, is it my right to know that, or should I confine myself to the scope of the contract and what I'm paying for these services, and hopefully have different competitors with which to choose from in order to decide who's going to provide the service that I need? I mean, should I know about that stuff? I mean, should I be allowed to get at that information?

ASSEMBLYWOMAN WEINBERG: Well, who is I in this case?

ASSEMBLYMAN CONAWAY: As the person (indiscernible). I'm the employer.

ASSEMBLYWOMAN WEINBERG: As the person who's negotiating the plan.

ASSEMBLYMAN CONAWAY: Yes, for -- negotiating with the PBM to provide services -- HMO -- I'm providing -- they're doing -- they're--

ASSEMBLYWOMAN WEINBERG: Okay. I just want to make sure the question is clear.

MR. PURCELL: I think you could make a judgement call on it, personally, as to how you felt about that. But in the wisdom of ERISA, ERISA is pretty clear that it's a plan asset -- that that asset still belongs to you, the purchaser. So, if they are leveraging your asset and they're using your asset to go negotiate a side deal and not telling you about it, they are self-dealing. So they no longer deal on your behalf. They have competing interest, and they then begin to deal on their own best interest.

But that's contrary to the representations that they make, which is another issue as to why I think they should reveal this information -- is because they represent to you that they are here to manage the benefit, to be an administrator. Essentially, they are a third party administrator, just like a medical TPA. And a medical TPA is governed by these regulations. So a PBM TPA should be governed, as well, that they cannot self-deal and they have to disclose when they're being paid.

ASSEMBLYMAN CONAWAY: So, if I understand it, because ERISA law states that even as they pay out for services to manage the health care of their beneficiaries, that asset belongs to them. And so, because it belongs to them, that -- you ride out on that -- really the ERISA law to allow you to get to this information, which I'm-- I guess one of my other corollary questions was, ordinarily, people wouldn't have a right to know? Is that right?

MR. PURCELL: Yes, sir.

ASSEMBLYMAN CONAWAY: This is my last question.

I'm sorry, Madam Chairwoman. Thank you for your indulgence.

Can you explain to me about this concept of kickback in business and business relations? Now, I understand that if I go down -- if I've got some company and I go down to some other country or any place, I can't pay something -- I'm not supposed to pay something in order to get the business outside of-- That's illegal and against Federal law or something. You talk about the concept of kickback and these payments and, sort of, why they're illegal and why its important that we not allow them.

MR. PURCELL: I guess, again, in that scenario, I would go back to, the kickback puts them in a position of self-dealing, of dealing on their own interests, when they're obligated to deal in the interest, as an administrator, on behalf of the client.

ASSEMBLYMAN CONAWAY: Thank you.

MR. PURCELL: Yes, sir. Thank you.

ASSEMBLYWOMAN WEINBERG: Any other questions?

Assemblywoman.

ASSEMBLYWOMAN GREENSTEIN: Just a quick--

Can you just briefly talk about-- You said that you thought there were some good uses for PBMs, and you feel that how they're being used now is not a good one. Can you talk briefly about that?

MR. PURCELL: The good uses-- I would say that, just, most importantly, the ability to process thousands of claims electronically and to capture that data and to prepare reporting around that data, so that a plan should be able to use that reporting to manage their benefit appropriately--

DUR checks, refill too soon at the point of service, or drugs that have interactions and the ability to capture that immediately at the point of service-- I think that's a valuable process that they provide. The ability to have a single administrator to administer thousands of pharmacy contracts under one single administrator-- Instead of cutting checks to 50,000 pharmacies every couple of weeks, you only cut one check to the PBM. So, those are-- From an efficiency standpoint, I think it's a brilliant concept. PBMs are a brilliant concept.

ASSEMBLYWOMAN GREENSTEIN: Isn't it really a management concept for, perhaps, smaller plans that can't do this on their own?

MR. PURCELL: That's correct.

ASSEMBLYWOMAN GREENSTEIN: For example, the State of New Jersey, if I understood, does not use a PBM. And that would be because it's so large, it can do many of these computer-type services, I guess, on its own.

MR. PURCELL: Assemblywoman, I think that from my own experience, that somewhere around the 100,000 life mark, that a group that has at least 100,000 participants can begin to look at doing some of these functions on their own and save substantial dollars. So, instead of-- Let's say you're getting a rebate that may be \$1.50, maybe you get a rebate that's closer to \$3 to \$7 back. So you doubled the money that's available to you from the manufacturers, which you can then use to reduce the cost of the plan.

ASSEMBLYWOMAN GREENSTEIN: And my last question-- Based on your standard of a good PBM, are there some around the country?

MR. PURCELL: I believe there are. I believe there-- Unfortunately, I think they are the exception rather than the rule. This has become such a lucrative business. And I think Ms. Burton proudly pointed out the growth of PBMs. Well, I'm not so sure that it's such a badge of honor, knowing how they have derived that type of growth. And it's been on the backs of businesses and people and citizens across America, with these hidden margins.

ASSEMBLYWOMAN GREENSTEIN: Thank you.

ASSEMBLYMAN CONAWAY: Please, I have to ask this question. I won't be able to sleep unless I ask this--

ASSEMBLYWOMAN WEINBERG: I'm definitely going to have to get you a bag of M&Ms. (laughter)

ASSEMBLYMAN CONAWAY: I'm on a diet. I can't eat the darn things. It's killing me.

You raised -- mentioned this 100,000 lives. And the cost issue might inure to the benefit of someone who can get 100,000 lives. And I'm wondering maybe that's-- Maybe we ought to be creating a competitive environment for these PBMs, so that we can allow the aggregation of folks so they can capture 100,000 lives or more. And then maybe they won't -- behave like the PBM -- maybe they can offer savings to folks. And we can do it by competition. Is that something that-- Is any state doing that? Do you see ways that we, as a state, can help people get this aggregation and get their arms around people that make these -- to make these -- to bring these services in-house, as it were?

MR. PURCELL: I think that's a timely question, because, in my own personal business, I have had a number of clients approach me about joining together in a coalition-type arrangement, where they can create economies of skill and they can do these negotiations and cut the PBM out of the loop, particularly on the negotiations with manufacturers.

Vermont-- I think one of the state senators from Vermont very strongly quotes in the *U.S. News* article that the days of PBMs telling us that they're saving money, and lining their own pockets, is over. We're taking this back. We're taking this function back. It's not rocket science, processing a claim. It's a commodity business. When they tell you that they're producing all these savings -- I can negotiate with my friends in the independent community pharmacists group, and I can, just as a business person, group together with several other business people. I can get comparable rates now. Having a minus 13, 14, even minus 15 percent rate off of average wholesale price is not a huge, stellar thing anymore. That's a commodity business now. So, it is possible do to that. And I think a lot of organizations are looking in that direction. If we can't fix the disclosure issues, I think you're going to see a lot of groups move in that direction.

ASSEMBLYWOMAN WEINBERG: Before he thinks of something else, thank you very much. (laughter)

Thank you very much. We appreciate your coming up here to speak to us and providing to us some of the background material that is very helpful.

MR. PURCELL: Thank you. It's a privilege to be here.

ASSEMBLYWOMAN WEINBERG: We have, on the printed list, those people who signed up to testify early when the notices went out.

Is Peter Harty, who is Vice President of Policy and Government Affairs for Medco Health, here? (affirmative response)

I think your company's name has been mentioned a few times this afternoon. (laughter)

ASSEMBLYWOMAN QUIGLEY: It is familiar.

ASSEMBLYWOMAN WEINBERG: And then, following that, I'm going to ask the group of Linda Witzal, Harold Bobrow, and Loretta Brickman to speak next.

Thank you, Mr. Harty.

PETER F. HARTY: Thank you, Madam Chair.

I'd like to start by saying, in response to Mr. Purcell, I hope that he perceives us as being one of the good guys in this debate.

As you know, my name is Peter Harty. I'm the Vice President, at what's now known as, Medco Health Solutions.

ASSEMBLYWOMAN QUIGLEY: Is your red light on? (referring to PA microphone)

MR. HARTY: I'm sorry?

ASSEMBLYWOMAN QUIGLEY: Is your red light--

MR. HARTY: Yes, the red light is on.

ASSEMBLYWOMAN QUIGLEY: Okay.

MR. HARTY: Would you like me to move closer to the--

ASSEMBLYWOMAN QUIGLEY: My ears are fading. (laughter)

MR. HARTY: Medco Health Solutions, which is the new name for the company that was formerly known as Merck-Medco--

I've submitted a prepared statement. It runs to about four pages or so, which I will not read.

ASSEMBLYWOMAN WEINBERG: Thank you.

MR. HARTY: I assume that you will all read that for yourselves.

ASSEMBLYWOMAN QUIGLEY: We like you better already.

MR. HARTY: Thank you.

What I would like to do, though, is just reinforce -- touch on some of the basic points that I would have made, had I read that statement. Then I'd also like to address some of the discussion that has taken place earlier today, if I may, just to touch on some of those things with my response to it.

I'd like to begin by just mentioning that Merck-Medco -- I'm sorry, Medco Health Solutions is headquartered here in New Jersey at Franklin Lakes. We have upwards of 5000 employees in the State of New Jersey at our headquarters in Franklin Lakes, plus we have some facilities -- an automated mail-service pharmacy in Willingboro, another mail-service pharmacy in Parsippany, a call center in Parsippany. And we also have PAID prescriptions, which you've heard referred to, as operations here in New Jersey, as well. So, we are a very large employer in the State of New Jersey and have been here for the last 15 or 20 years or so.

I would like to reiterate what Ms. Burton said earlier. I want to make sure that the members of the Committee understand the relationship between us and the plans. And I want to use two specific examples to demonstrate this and the regulatory relationship between us and the plans.

If you think about, in the State of New Jersey, Aetna, which was mentioned earlier as being an entity -- an insurance entity -- an HMO that does not use a PBM to administer the prescription drug benefit for its member- - The fact that it does not carve that benefit out and have another entity administer that benefit for them does not mean that Aetna, an entity in its own right, does not perform those same functions in-house that we do on a carved-out basis for a variety of other managed care organizations, employers, and insurance entities. It's the exact same functions that we do on a carved-out basis that they do on a carved-in basis.

This bill, I noticed, in Section 4, would exempt from regulation the Aetnas of this state, because it says any entity that has a portion of the business that performs these same functions is not subject to this bill, because it's already subject to regulation by the Department of Health and Human Services. Aetna is excluded from this for that reason.

Think about Oxford for a moment. Oxford is also subject to regulation by the Department of Health and Human Services. But, instead of performing those functions in-house, it carves that function out and contracts with, in this case, Medco Health Solutions to provide that benefit.

The same regulatory structure that applies to Aetna, in its administration of the benefit that it offers to its members, applies to Oxford in the administration of benefits that it offers to its members, as well. Just by carving the benefit out, Oxford does not escape its regulatory obligations from the Department of Health and Human Services.

And I can tell you, from personal experience, that the plans that we contract with work with us on a regular basis to see to it that we help them

meet their regulatory obligations. So those who think that, as we administer the benefit, we're completely without regulation in that regard don't understand that sort of relationship. The same regulatory scheme that applies to the plans themselves also applies when they subcontract with us to provide that benefit.

As far as direct regulation of PBMs themselves, I would like to address some of that. Yes, indeed, we have subsidiaries that are mail-service pharmacies. We have a number of them around the country. Each one of those pharmacies is licensed by the home state board of pharmacy. So, for instance, our facility in Nevada is licensed by the board of pharmacy in the state of Nevada. Our two facilities here in the State of New Jersey are licensed by the New Jersey Board of Pharmacy. Forty-three states around the country have nonresident licensure requirements or registration requirements for mail-service pharmacies. If you want to send drugs from Nevada into Florida, you have to get a license from the state of Florida to be able to do that. New Jersey does not have one. I'll be willing to admit that. But the fact of the matter is, there is currently a bill pending in the Assembly. I think it's Assembly Bill 570, which we're working on with some folks to try to pass it and create that scheme here for the State of New Jersey.

So, the practice of pharmacy is fully regulated in that regard. Anything that is the practice of pharmacy is conducted in a licensed pharmacy, as far as that goes.

There's been a lot of discussion about TPA licensure, third-party administrator licensure, previously. I can tell you that we hold about 13 different TPA licenses around the country. Where we're required to get a

license, we get a license. In New Jersey, last year, you passed a TPA bill here that specifically excluded PBMs, because of the fact that PBM activities did not fit within the definition of third-party administrator activities. That was a conscious decision on the part of this Legislature.

ASSEMBLYWOMAN WEINBERG: So, are you saying there are 13 states that regulate you as a third-party benefit administrator?

MR. HARTY: That's correct. We have licenses in those states -- in 13 states.

ASSEMBLYWOMAN WEINBERG: That don't carve out PBMs.

MR. HARTY: That don't carve out PBMs.

So, depending on the specific definitions, where a third-party administrator is in those given states, the regulatory authorities there, usually the department of insurance, will decide whether or not our activities fit within the scope of that definition or not. If we have to get a license, we get a license.

So those who would suggest that, really-- And then, on the other side, there have been some mentions about ERISA. And to the extent that we operate on behalf of self-insured employers, obviously, the ERISA regulatory scope applies to their plans. When we administer that plan on their behalf, we have to comply with those regulations for them, as well.

So those who would suggest that we're unregulated, we're largely unregulated, and that we're operating without any sort of oversight or governance by any sort of governing government authority, I think, really don't understand what really happens in the marketplace with this, because we really are regulated, directly and indirectly, through the plans that we administer.

I will be-- If you'll excuse me, I do want to touch on some of the other things. I'm going to skip over some of the other points that I thought that, perhaps, I would want to make.

ASSEMBLYWOMAN WEINBERG: Can you, as you're reviewing this, talk to us a little bit about-- Your parent company is a drug manufacturer, correct?

MR. HARTY: That's correct.

ASSEMBLYWOMAN WEINBERG: So -- how you, as a pharmacy benefits administrator, interact with the pharmaceutical manufacturer, and how you decide how your formulary is going to be done.

MR. HARTY: Okay. If I can, sort of, in a hypothetical, at the moment-- I mean, had the stock market not taken a nose dive over the course of the last couple of months, at this stage in the game we would be an independently publicly traded company. We were supposed to have an initial public offering of 20 percent of our stock just about a month ago, but the stock market problems prevented that from happening. But Merck remains committed to a complete spinoff of our business unit into a publicly traded company sometime within the next 12 months.

So, while I'll answer your question, I just want to put it in the context of: it's largely a historical question, as opposed to one that will continue going forward.

But, in terms of the current relationship, the two companies are independently operated and managed. Shortly after the merger of the two companies back in 1993, we created a firewall, if you will, between the two companies with the exception of certain senior management and corporate

functions, such as legal and finance, which had responsibility for the company as a whole, as opposed to the two different portions of the company.

And that-- Under that firewall agreement, there's no opportunity -- and again, I've been involved in some of these discussions, personally, within the company for the parent, Merck, to influence the clinical or the financial decisions that the subsidiary, Merck-Medco, is making, and vice versa. There's no opportunity for the subsidiary, Merck-Medco, to influence the clinical or the financial decisions of the parent.

And, frankly, that is not just the company policy, but it's also imbedded in a consent decree with the Federal Trade Commission, which has jurisdiction over-- If ever they found that there was a problem with that, they would have the ability to come and enforce that. That consent decree was entered into, probably, eight or nine years ago, and there's never been a problem with it. So, from that point of view, the two companies are completely separate.

In terms of development of the formulary, if that was part of your question, Madam Chair-- The formulary, in our case, is specifically the first component of that, as Ms. Burton referred to previously -- is a clinical decision in terms of what drugs should be on the formulary to begin with, from a clinical point of view. And that determination is made not by Merck-Medco, not by Merck, but is made by an independent panel of, I believe, nine pharmacists and physicians on that panel, none of whom are employees of our companies, who make the first determination in terms of what would be in a clinically appropriate formulary for these populations. We have three basic formularies that we've put together, with varying degrees of restrictions

associated with them. And they make that first determination in terms of what drugs clinically should be on that formulary. And they're not influenced by Merck, and they're not influenced by Medco. But they make those decisions in their own--

Does that answer that question?

ASSEMBLYWOMAN WEINBERG: Now you have your formulary. Do you negotiate whatever you call them: discounts, education fees, so on, with other drug manufacturers?

MR. HARTY: Yes, we do.

ASSEMBLYWOMAN WEINBERG: And do you tell whoever is the plan sponsor what those are?

MR. HARTY: What the precise rebates from each manufacturer are? (affirmative response) I honestly don't know the answer to that question. I know that you posed that question earlier, and I did make a note that that is something that, with your permission, I'd like to go back and talk to some of the folks who are involved in the contracting of the plans and find out exactly what that disclosure is. And I would like to get back to you with that specific information.

ASSEMBLYWOMAN WEINBERG: Any other questions?

ASSEMBLYMAN CONAWAY: Just going down some of the things that you mentioned, without being accusatory because I'm not. I'm not. But you mentioned that the legal and finance departments arms of your operations are integrated. And it seems to me, unless I've misunderstood the testimony, that one of the concerns are precisely these financial arrangements

between the entity PBM, in your case, I guess, Medco Health Solutions, and the pharmaceutical manufacturers.

You're not concerned that the fact that there is this integration or cost fertilization or whatever, however you want to put it, between your financial legal department's involvement with the drug company, the manufacturer, and the PBM -- that that integration-- Isn't that sort of the point that people have been making about the kinds of financial arrangements that exist between the PBM and the pharmaceutical companies and others?

MR. HARTY: I don't know that that's the point that people have been making, because, really, what I'm saying there is that, as a matter of management of the corporation, the company as a whole, there are certain functions within the organization that have to be responsible for that corporation as a whole, as opposed to discrete units that are associated with them.

Our corporate policy and the FTC consent decree, that I talked about before, prohibits Medco from disclosing to Merck any confidential financial information, which is anything that is a discussion about what rebates Merck is able -- or Medco is able to generate from other manufacturers, or discounts that they're able to generate. And it also prohibits Merck, on the other hand, from disclosing to Medco any pricing concessions, whether it's rebates or discounts or anything, that it gives to any of Medco's competitors. So Medco operates in that arena completely independent from the parent company in terms of it's operations. I hope that answers the question.

ASSEMBLYMAN CONAWAY: Well, I guess my -- the one question I do have, however, is because -- and I presume that's part of the

reason why you are trying to separate yourselves -- is that there must -- there's a concern between the manufacturing arm of this unified company and the PBM arm of this unified company. I mean, you may not be disclosing information across different competitors, but what about between the two of you involved in the same company? I mean, what happens there?

MR. HARTY: I'm sorry, but I'm not sure that I understand your question.

ASSEMBLYMAN CONAWAY: I mean, since there's a relationship under one entity-- I mean, you're owned by one entity, right?

MR. HARTY: Correct.

ASSEMBLYMAN CONAWAY: And you make drugs, and you manage a pharmacy benefit.

MR. HARTY: Correct.

ASSEMBLYMAN CONAWAY: Now, you're not allowed to share information-- The PBM can't talk about its relationship with other manufacturers, and Merck-Medco can't talk about its price concession, vis-à-vis Medco. But what about their direct relationship between Merck and Medco itself? I mean, did I ask that question the wrong way? (laughter)

MR. HARTY: I think you asked the question, but--

ASSEMBLYWOMAN QUIGLEY: Are you asking what happens at the water cooler?

ASSEMBLYMAN CONAWAY: Well, yes, I guess.

Thank you, Joan.

MR. HARTY: We're in completely separate -- we have separate water coolers.

Yes, Merck reported, for instance -- and if I'm misunderstanding your question, for instance-- But Merck has reported, for many years, consolidated fund financial statements that take into account Medco's results, as well as Merck's results. And that's-- For those purposes, presumably, there are people in our financial department who have access to that information. They roll it up into one report, and off you go.

But you're correct. See, you started that last question by saying perhaps this is one of the reasons why the spinoff is happening. Certainly, there are a lot of reasons why the spinoff is happening, but the spinoff will happen sometime in the next 12 months and will not be an issue any more, from that point of view.

ASSEMBLYMAN CONAWAY: Now, you mentioned that a panel decides what the formulary is and that the, I guess, PBM itself -- in this case, Medco Health Solutions -- doesn't really determine that. But, I mean, if I understood the point that people were making -- that the -- that even if you -- that once you have your formulary, even if you're not going to go to a question of things that you might want to add to the formulary -- that there are issues with the ability of the PBM to get concessions from the manufacturers of things that are on the formulary, regardless of how it got there. Isn't that the point of the-- I mean, how does telling us about the fact that there is a panel making the formulary insulate Merck-Medco from the problems, the concerns, that people have about the way Merck-Medco and others act in the marketplace, vis-à-vis the manufactures that are producing the drug?

MR. HARTY: Again, I'm not sure that I understand the question completely.

ASSEMBLYMAN CONAWAY: Am I inarticulate today?

MR. HARTY: I want to make sure that I answer your question, because the first thing is-- The point is that, the first determination as to what drugs are going to be included on the formulary is made from a clinical point of view.

ASSEMBLYMAN CONAWAY: Fine.

MR. HARTY: It's just doctors and pharmacists deciding these are the drugs that are really necessary in this therapeutic chapter. People are specialists in these areas who are deciding, of all the choices we have across the board, we're going to include -- in a narrower formulary, we may include just three or four drugs. In a broader one, we might include five or six. In a completely open one, we might include everything that's out there in the marketplace to treat that type of condition. That's the first decision that's made.

ASSEMBLYMAN CONAWAY: I'd like to see the true open formulary. But go ahead.

MR. HARTY: I'm sorry.

ASSEMBLYMAN CONAWAY: I'm not sure a true open formulary exists. But go ahead.

MR. HARTY: Okay.

ASSEMBLYMAN CONAWAY: It doesn't.

MR. HARTY: So, that's the first decision that is made. It is from that clinical point of view.

The second decision that will be made--

And by the way, let me just interject with this for a second. I described the three basic formularies that we have. We also administer more than 100 formularies that are created by our clients, directly. They have their own PNT committees. If they're not happy with what some of the programs are that we've put together, they have the ability to customize their own formularies, to work a little bit differently around some of the ones that we do. So, if people are concerned about what's on the drug list, they have the ability to change that if they want. I just wanted to make that point clear at first.

So, the first thing that happens is, let's assume that there are five drugs in a given category. There are five drugs that are available. The PNT committee has decided, after looking at it, that there are really two out of those five that offer significant clinical advantages over the other three in the program -- the other three in that category. There are two from a safety or an efficacy point of view, or what we would call a must-have drug on the formulary. The other three might be characterized as something that you'd call-- And if I'm going into too much detail--

ASSEMBLYMAN CONAWAY: Well, actually, I am going to stop you because -- and I bet there wouldn't be -- I will take the prerogative of the Chair now.

ASSEMBLYWOMAN QUIGLEY: It's me at the moment.

ASSEMBLYMAN CONAWAY: Oh, you're the Chair.

ASSEMBLYWOMAN QUIGLEY: I'm the Chair.

ASSEMBLYMAN CONAWAY: Okay. I'm sort of responding as the -- to your-- I mean, I presume you're telling us about these drug panels to allay our concerns about the use of the formulary as a weapon against the

manufacturers to drive rebates and other things that inure to the benefit of the PBM. That's not why you mentioned that.

MR. HARTY: That's not why I mentioned it. In fact, the formulary is one of the great tools that actually creates price competition among manufacturers. It is one of the great tools that we use in order to force that sort of price competition.

ASSEMBLYMAN CONAWAY: Price competition. Well, we'll just get beyond that then. And I misunderstood, then, why you raised the question of the panel, because I guess I was waiting, in your comments, to directly answer those questions -- those charges that are being made about the rebates -- some people want to call them kickbacks or the other financial incentives -- for you to talk about whether or not to use them, how they're employed, and, I guess -- obviously feel that they are appropriate -- and perhaps some of the financial issues concerned with that. You can answer that if you'd like. And I'm going to give you two questions -- I'm going to give you -- and then I'll stop.

My second question was, you mentioned that there's a lot of regulation that currently impacts your ability to do business here in this state and in other states. And I guess what I wanted to know was, what's the State of New Jersey doing -- I mean, if this legislation arise -- is arised now, because there are some perceived needs, there's a question of cost and whether its consumers are getting what they ought to be getting, taxpayers in particular, since we have these benefit programs.

Tell me about the regulatory burden imposed upon your operation by, I guess, the Department of Health and Human Services. What do they do?

What do they make you do? How do they-- Do they look at these rebates now, currently? Do they look at these incentives? Do they-- I guess they have some view -- look at what formularies you're doing? But how much do they look at your business practice, vis-à-vis suppliers as an example, and your interaction with physicians as another?

MR. HARTY: Okay. To just go back to what I said-- I mean, what-- The entity that is regulated by the Department of Health and Human Services is the HMO or the other managed care organization for which we're managing the benefit. They're the entities with the regulatory responsibilities. The direct interaction would be between that regulated entity and the regulator themselves. And then if, for instance, if they needed information to help them respond to questions or anything from the regulators, they would come to us and get that. If our clients have, for instance, appeals requirements under the patient's bill of rights, they will require us to provide that appeals process to their members just as though -- just the same as if they were to operate it internally themselves. If there are certain formulary requirements, in terms of what had to be on the formulary, if there's a mandate that a particular drug or a particular category of drugs be included on the formulary, we would have to include that drug on the formulary for that particular client. It's that sort of derivative regulatory association, as opposed to a direct line between us and the Department of Health and Human Services.

ASSEMBLYMAN CONAWAY: So, I take it from your answer, if it was a complete one, that -- and I presume that's what you intended it to be -- that no one in the Department of Health and Human Services now is delving into this question that is, I felt, the point of this hearing. And that is,

what are the relationships between PBMs, in your case, Medco Health Solutions, and your suppliers? How do the rebates or other incentives work? How do you use them? Does the Department now do that? I mean, I thought you raised it because you may have just been talking about general regulatory burden. The bill on the-- The point of the legislation, however, I think, is to get at these relationships and the fact that those relationships might be interfering with the deal that consumers and beneficiaries are getting under their health plans, particularly as it regards to their pharmacy benefit.

So, my question is, what does the Department do now with regard to what, I think, has been the gravamen of this hearing? And that is, what is the financial relationship-- What do you have to explain to the Department regarding--

ASSEMBLYWOMAN WEINBERG: Nothing is the answer. The answer is nothing.

ASSEMBLYMAN CONAWAY: Nothing? Okay.

MR. HARTY: No, I think the answer is, I don't know the answer to that question.

ASSEMBLYWOMAN WEINBERG: I think the answer is nothing.

MR. HARTY: It is another one that I can find out. But, frankly, I don't see that this bill deals with that issue at all.

ASSEMBLYWOMAN WEINBERG: Well, we talked about adding the idea of disclosure. And I think that's what's important -- that the plan sponsor know what it is that is going on between his or her pharmacy

benefit manager and, in fact, the pharmaceutical manufacturer, if that's where it's taking place. So disclosure would answer a lot of those questions.

But I believe that the answer to your question, Assemblyman, is that there is no regulatory oversight. And that's what's wrong here. This seems to be some -- my words -- secret, for want of a better term, business relationship that is not necessarily divulged to either the plan sponsor who initiated the contract, and certainly not to the consumers, and that somehow, this middle person adds to the cost of pharmaceuticals. And the only person who's making that money is the PBM, not the consumer, and not the plan sponsor who would like to save money -- that there is a built-in fee in there, however it's derived at.

And that's one of the -- that's probably the major thing that we are trying to get at, along with who makes the decision about who prescribes the drug and what's best for the patient.

MR. HARTY: Madam Chair, can I address the question of the rebates specifically, separate and apart from the question of who comes in and takes a look at that from a governmental point of view?

The reality is, speaking for our company specifically -- and I know in speaking to some of the other companies -- that the bulk -- the majority of the rebates that PBMs receive from manufacturers are passed back to the plan sponsors in one form or another.

Let me just give you, sort of, the proof in that. We've heard lots of numbers in terms of how much money PBMs make and so on and so forth. The reality of it is, our net profit margin for Medco Health Solutions ranges from anywhere from about 2 percent to about 4 percent. That's our net profit

margin. If anybody thinks that that's making a real killing and that that's lucrative amounts of money--

ASSEMBLYWOMAN WEINBERG: Well, a percentage depends upon what it's 4 percent of, whether you're making a real killing or not.

MR. HARTY: Okay. But the reality of it is, just going back to-- And Medco is in somewhat of an unique position by virtue of the fact that, through this whole spinoff process, we've had to file certain documents with the Federal Securities and Exchange Commission, etc., etc. You can look at not only our financial statements, but the other PBMs' financial statements. They're publicly traded. You can see how much money they make.

If we make billions and billions and billions of dollars in rebates, still, the fact of the matter is, the net profits that we make at the end of it range in the hundreds of millions of dollars, which will demonstrate that the reality is, the bulk of that money that we get from the manufacturer goes back to the plan sponsors for whom we're administering the plans.

And it goes back in a couple of different forms. To some extent, it goes back directly through a pass through the rebates. And it's based upon whatever contracts you have with that plan sponsor. The plan sponsor will negotiate for a certain amount of rebates. Some of them ask for more than others do. Some plan sponsors actually prefer to receive none of that rebate dollars. They don't want any of that. What they want is the certainty of reduced pricing in terms of other functions that we perform for them. So, what they want is, they want to lower costs for the drugs that are dispensed through the retail pharmacy, a lower cost for the drugs that are dispensed through mail-service pharmacy, and they would prefer that we use the rebates

in order to lower those costs so they know, on a regular basis, what it's going to be as opposed to having to get a return of the rebates at some point further on down the process. So, the bulk goes back to the plan sponsor. We do not keep most of that money.

ASSEMBLYMAN D'AMATO: Madam Chair.

ASSEMBLYWOMAN WEINBERG: Yes, Assemblyman.

ASSEMBLYMAN D'AMATO: Thank you.

Sir, presently, Medco Health Solutions, Inc. is a subsidiary of what corporation?

MR. HARTY: Merck and Co., Inc.

ASSEMBLYMAN D'AMATO: I'm sorry, what?

MR. HARTY: Merck and Co., Inc.

ASSEMBLYMAN D'AMATO: Is Merck -- is that corporation a subsidiary of any other corporation?

MR. HARTY: Merck is the mother -- is the parent corporation.
(laughter)

ASSEMBLYWOMAN WEINBERG: We'll score one for your side.

ASSEMBLYMAN D'AMATO: What other subsidiaries are there of Merck?

MR. HARTY: Merck is a global manufacturing company, and it has subsidiaries in, I forget how many, countries around the world. But it has subsidiaries in many different places -- separate corporations.

ASSEMBLYMAN D'AMATO: But it's strictly related to the manufacturing and distribution of drugs, correct?

MR. HARTY: That is certainly it's primary business. Yes, sir.

ASSEMBLYMAN D'AMATO: What percentage of the drugs sold, prescription drugs sold, in the United States would you say Merck has? What percentage of the market--

MR. HARTY: Merck's market share -- and I don't profess to be an expert on this -- but until just recently, the market share of no manufacturer in the United States was more than 10 percent. All manufacturers had something in the single digits. I believe, and if there's anybody in the audience who has other data on this-- But I think, with the most recent merger -- discussions between Pfizer and Pharmacia-- That's the first time you're going to have any drug manufacturer in the United States that actually exceeds single digits in terms of total market share. And that's only going to be something on the order of 10 or 12 percent.

ASSEMBLYMAN D'AMATO: What percentage of the prescription drugs that are used for your PBMs -- that is Medco Health Solutions PBM -- are drugs that are, in fact, manufactured and distributed by Merck? What percentage?

MR. HARTY: Percentage of--

ASSEMBLYMAN D'AMATO: The drugs manufactured--

MR. HARTY: --actual drugs?

ASSEMBLYMAN D'AMATO: Yes.

MR. HARTY: I would venture a guess. I don't know the precise answer. But I would venture to guess that virtually all Merck drugs are -- maybe not all-- And I don't honestly know the answer to this. But it's somewhat supposition, but certainly most of them, because going back to the question of how is the formulary determined, it's determined by the clinical

group of doctors and pharmacists who determine whether these drugs should be on the formulary or not.

ASSEMBLYMAN D'AMATO: So then if all of the prescription drugs utilized by Medco Health Solutions are, in fact, manufactured by Merck, why would there be a rebate from Merck to Medco?

MR. HARTY: Not all of our drugs are just Merck drugs. I mean, we have drugs from virtually every manufacturer in the country, including generics manufacturers as well.

ASSEMBLYMAN D'AMATO: What percentage? That was my question before. What percentage of the drugs-- And I thought you said virtually all.

MR. HARTY: Perhaps I misunderstood your question, but I thought your question was how many of the Merck drugs are on our formulary, to which I responded I think virtually all are.

ASSEMBLYMAN D'AMATO: Okay. Let me rephrase it. You go up to a plan sponsor. You offer a program. You say, "Here's what we're going to do for you." What I want to know is, once that contract is signed, what percentage of the drugs that the employees, let's say, of the State of New Jersey, are going to be using are drugs that are manufactured by your company?

MR. HARTY: I honestly don't know the answer to that question. Rather than speculate, what I'd prefer to do, Madam Chair, if that's okay with you-- I'd prefer to get an answer to that and respond factually.

ASSEMBLYMAN D'AMATO: The only reason I brought this up, Madam Chairperson is that if it's-- Let's say it's 98 percent. Well then, we're

not going to feel too sorry for you that you only have a 1 or 2 percent profit, because what you're doing is, you're, in fact, using all of your drugs that are manufactured by Merck, the parent company, who's making all the money. Is that an oversimplification?

MR. HARTY: If I could just, sort of, respond to that by talking about the marketplace-- Virtually no client-- Think about what we've talked about before in terms of this competitive process by which plan sponsors decide which PBM is going to provide the benefit, or is going to manage the benefit, for their members. Virtually no plan sponsor would ever accept us in a formulary that was overweighted with Merck drugs if they thought what we were doing was really working to Merck's benefit.

What they're looking for is the clinical program and other things that will actually provide the most cost-effective, highest quality benefit to their members. And in that marketplace, you can't come up with a program that's virtually all Merck drugs, because no client would allow that just in terms of the competition that would take place there.

I'm not sure-- Does that respond to your--

ASSEMBLYMAN D'AMATO: No, but that's okay. I think I made my point.

MR. HARTY: I would like to get the facts specifically, and we'll respond to that.

ASSEMBLYMAN D'AMATO: Thank you.

ASSEMBLYWOMAN QUIGLEY: May I just follow up?

ASSEMBLYWOMAN WEINBERG: You almost sounded like a Democrat there. (laughter)

ASSEMBLYMAN D'AMATO: And the good doctor sounded like a Republican when he asked the questions about whether we're entitled to know what they're doing.

ASSEMBLYMAN CONAWAY: I'm suspect everywhere I go.
(laughter)

ASSEMBLYWOMAN WEINBERG: I'm sorry. Joan.

ASSEMBLYWOMAN QUIGLEY: One quick question, just following up on Assemblyman D'Amato's question.

What's Merck's cholesterol drug, for instance?

MR. HARTY: Merck has a couple different cholesterol drugs. There's Mevacor, which was one of the original statins, and then there's Zocor, which is one of the secondary ones.

ASSEMBLYWOMAN QUIGLEY: Let's assume, just assume-- I'm not going to ask you if they're in the Medco formulary. But let's just assume they are. What would another manufacture, ABC company, have to do, when they get approval for a new drug and doctors want to begin prescribing it, to get into your formulary? What would be the process?

MR. HARTY: The first step in the process would be the clinical review we talked about before and a determination from the PNT committee that that drug should be on the formulary. If that new drug offers significant clinical advantages over the existing therapies there, either from a safety or from an efficacy point of view, it will be added as a must-add to the formulary, and we would have to include it.

If, however, it was relatively comparable to some of the other drugs that are already available in that therapy -- then the clinical decision having

been made that is roughly equivalent -- then Medco, not the PNT committee -- they've made the clinical judgement-- Then Medco would work on negotiating with the manufacturer to see what sort of pricing concessions they were willing to give in order to get that drug on our formulary.

ASSEMBLYWOMAN QUIGLEY: All right. That negotiating then -- that's the bidding war of rebates?

MR. HARTY: That's correct.

ASSEMBLYWOMAN QUIGLEY: Okay. That's all I needed to know. Thank you.

ASSEMBLYWOMAN WEINBERG: Mr. Harty, thank you very much. I appreciate your candor and willingness to come forth.

MR. HARTY: By the way, if I might just add -- I don't think I said this, but we do oppose this bill. (laughter) I just want to make one thing perfectly clear while we're here.

ASSEMBLYWOMAN WEINBERG: We were going to put you down as undecided.

MR. HARTY: And by the way, if I may, just one more thing. I would like to extend an invitation to virtually anybody who would like to, to actually come and visit some of our facilities here in the State of New Jersey so that we can take some of the mystery out of it for you. If you want to visit our mail-service dispensing pharmacy down in Willingboro, if you want to visit our other facilities-- We can talk to you in the context that you can see for yourselves exactly what it is that we do. And I really would sincerely like to extend that invitation. I hope that you would take us up on it.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

All right. Two groups. The first is Linda Witzal, Harold Bobrow, and Loretta Brickman. And then it's going to be followed by Lori Clark and the group that you have. And perhaps Melanie Willoughby will join your group.

H A R O L D B O B R O W: I'll be testifying in favor of the bill.

Madam Chairwoman and members of the Committee, my name is Harold Bobrow. I'm a--

ASSEMBLYWOMAN WEINBERG: Could we kind of keep it down back there, please?

MR. BOBROW: I'm a pharmacist speaking on behalf of Linda Witzal, who, unfortunately, is not able to be here today. Linda Witzal is a pharmacist and a principal owner of Quality and Service Pharmaceuticals, an alternate health care pharmacy provider located in Fairfield, New Jersey.

What's in a name? The PBM, a pharmacy benefits manager, is defined in the bill as a corporation that administers a plan which provides high quality pharmaceutical care at the lowest possible cost.

Due to the unique population that our industry serves, and the lack of understanding by the PBM for this population, we feel that an ongoing liaison committee, comprised of representatives from the PBMs and alternate health-care pharmacy providers, meets on a quarterly basis to develop a process to deliver optimum pharmaceutical care to our unique population.

Healthcare, as you all will agree, has changed drastically over the last five years. The population that is the most vulnerable and requires the most number of clinical interventions are in nursing homes and alternate care

settings. The average age for patients entering a long-term care facility is 86-plus years. These patients average 12 to 22 medications with three to six active disease states.

It is our responsibility to act as a gatekeeper, guardian, for the health-care needs of our patients. Numerous health-care issues, such as shortages of pharmacists, nurses, and medically trained personnel, must be addressed to manage these patients. We would like to work collectively to tap into the expertise of all clinicians and you, the pharmacy benefit manager.

It is not about the unit of cost of medication. We need to think out of the box. The end result is the patient. If we work together, we can decrease hospitalizations, increase quality of life, and decrease cost to the taxpayer and the corporations.

We at QSP, realizing that a need exists to disseminate vital information such as found in this bill, have created departments of patient advocacy and legislative liaison. We feel the more knowledge that the patients and their caregivers have, the better result the entire process will have. We at QSP look forward to working with the liaison committee in the very near future.

Madam Chairwoman, I wish to thank you and the Committee, on behalf of our patients, for giving me the opportunity to speak here today. If you have any questions, we will be happy to address them. That's after Loretta has her say, here.

LORETTA BRICKMAN: Madam Chairwoman and members of the Committee, my name is Loretta Brickman. I am a pharmacist with Quality and Service Pharmaceuticals in Fairfield, New Jersey.

I would like to thank you for giving me this opportunity to speak to you this afternoon in favor of bill A-2337 with suggested amendments. QSP's primary commitment is to the health and welfare of our patients. It is for this reason that we are here today.

As stated within the bill, the purpose of this bill is to promote, preserve, and protect the health, safety, and welfare of the public. In order to accomplish these objectives, many issues need to be addressed. The issues that arise in alternate health care settings such as nursing homes, assisted living facilities, comprehensive personal care facilities, and residential sites such as group homes, are unique and essential in being able to provide appropriate healthcare for our patients.

Possibly due to the lack of knowledge concerning this unique population, PBMs do not speak to the needs of these patients. Unfortunately, PBMs insist on treating such patients the same as the general public. In order for the PBMs to provide high-quality pharmaceutical care in a cost-effective manner, which ensures adequate availability and accessibility of pharmaceutical services, the use of the mail-order component should not be included when a patient is in one of the alternate health-care settings.

In order to explain our position, I will illustrate an actual situation that arose in one of the nursing homes we service. The nursing home admitted a resident after giving approval to utilize her pharmaceutical mail-order plan. The administration did not realize, at the time, the numerous issues that would arise. Due to the risks that the patient and nursing home were subjected to, the admission packets for all new patients now state that these patients may not use the mail-order component for their prescription coverage.

The patient and her spouse were located at two different nursing homes. Unbeknownst to the patient, her family, and the nursing home, the mail-order provider would only mail medications to one location. The medications for both persons were mailed to the spouse's address. Due to lack of communication between the two nursing homes, this patient did not receive her medications. After explaining the situation to the mail-order provider, a second request for medications was made. The mail-order provider agreed to send the medications to this nursing home. Again, medications were sent to the other nursing home. The patient ran out of her medications. The nursing home requested that we send those medications. We did so without hesitation.

The patient's daughter refused to pay the mail-order provider because her mother never received those medications. The mail-order provider refused to send anymore medications due to lack of payment. The daughter has refused to pay us because the mother should be covered by her prescription plan. We continue to supply the necessary medications. We practice continuum of care protocol.

Many other issues arose, as well. The mail-order provider would not accept physician order forms, which, in a nursing home setting, are acceptable medication orders known as prescriptions. Originally, the mail-order provider said they would accept them. They also only wanted prescriptions for a 90-day supply with three refills. That's not appropriate in a nursing home setting.

This patient was on Warfarin, a blood thinner. The dosage of this medication changes frequently based on specific blood tests. The physician would have had to write for every available strength in order to guarantee

availability of administering the correct dosage. That's highly unacceptable. Not only is it not cost-effective, it presents a very strong possibility for medical error and inappropriate medical practice.

The director of nursing and the nursing staff usually clarify medication orders when needed. The company would only accept clarification from the nurse in the physician's office. That nurse knew nothing about the patient. The company would call the physician's office once for clarification and leave a message. If they did not get a response to their message, they just held the medication.

Nurses were spending 15 to 20 minutes on hold with the company every time they called. That takes away valuable time from necessary patient care. Multiply that by the number of patients in a unit. This becomes an untenable situation.

This nursing home receives their medications in the unit dose dispensing system. The mail-order company would only dispense medications in conventional vials, which creates difficulty in accountability and administration.

This is only one scenario. There are many. I could go on for hours, but I know we don't have the luxury of time. (laughter) If the PBMs want to ensure high-quality pharmaceutical care to all, they must exempt nursing home patients from their mail-order component.

While we may address the health-care needs of patients differently than the PBMs, we do agree that our ultimate goal of providing better pharmaceutical care in a cost-effective manner is the same. Therefore, we request that you place in this bill the necessity to create an ongoing liaison

committee of PBM representatives and alternate health care pharmacy providers to meet on a quarterly basis to develop appropriate coverage for this unique population. It is imperative to look at the broad scope of health-care costs. We believe that by doing this, we will effectively save valuable health-care dollars with respect to optimum pharmaceutical care.

Madam Chairwoman, I wish to thank you and the Committee, again, for giving me the opportunity to speak here today. If you have any questions, we will be happy to address them.

ASSEMBLYWOMAN WEINBERG: I am going to send these remarks to the sponsor of the legislation, Assemblyman Doria, to see how he would feel about incorporating this -- any of these ideas into his bill.

I think the problems that you spoke about, with nursing homes having to deal with mail-order, are well-spoken. And I think it's a new issue that, at least, I had never thought of. So I'm glad you brought it to our attention.

MS. BRICKMAN: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Any questions? (no response)

Thank you. Thank you very much.

MS. BRICKMAN: Thank you.

ASSEMBLYWOMAN WEINBERG: Next group.

L A U R I E A. C L A R K: Thank you very much, Madam Chair.

I'm Laurie Clark, Director of Government Affairs for the New Jersey Pharmacist's Association and Garden State Pharmacy Owners. And I'm very, very pleased to be here. And I would like to commend the Committee

members for their diligence in listening. The hour is very late, and I want to commend you all, because you have shown an outstanding proficiency in this very difficult topic right off the-- And I didn't really expect any less from what is a very fabulous Committee to work with.

I have with me today our President of NJPhA, Fred Trinkley. He is a registered pharmacist and owner, diabetes educator, a very, very accomplished pharmacist. And I have GSPO Executive Vice President, Tom Viola. Tom is also a registered pharmacist. And he is an expert in the area of PBM practices.

Fred would like to share an-- And I wanted to-- I'm sorry. We're very honored to have our colleague, Melanie Willoughby, who is the President of the New Jersey Council of Chain Drug Stores, with us. So, we can really say that we represent the profession and community pharmacy all at this one table.

As I was beginning to say, and I'll move to the side, our President, Fred Trinkley, would like to share with you some of his personal patient experiences with PBMs. And then Tom Viola will give you some PBM practices right from his own experience.

Thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you, Laurie.

FREDERICK TRINKLEY: Thank you. It's a pleasure to be here.

I really don't want to get into specifics on this. What I want to do is deal in generalities. First of all, I've heard all the speakers before us, especially those from the PBMs, and I would love to live in the world that they profess happens. Unfortunately, it doesn't. The patient is the ultimate, end result of what happens, and they're not too happy.

Let me tell you that there's a rumbling in the jungle. And we need to get-- This is a good start. I don't think it takes care of it, but if you listen to the patients--

PBMs are separated. They have a firewall. They don't have to listen to the patient, I do. And three out of four people that come to my counter that I have to counsel are not very happy.

The problem is with the PBM, although it is a good idea. I've been in the practice of pharmacy ever since the inception of PBMs. I've been practicing for 35 years -- early '70s. Our own Blue Cross and Blue Shield started the prescription program process. It was an in-house type of situation. They have since given it up. And that's when most of the rise in the PBMs took place. And also, because a lot of small businesses couldn't afford to get prescription coverage, they had to go to a PBM. And this is why they were mandated by the public.

And, consequently, it worked beautifully. It was a God-save for pharmacies. We didn't have to do all the paperwork for processing and everything else. But now they've gotten too big, as far as I'm concerned, for their britches. They don't have any respect for what's going on. All they want to do is do what they want to do without any repercussions from the people that are in the trenches in the end result, which is the patient who gets the benefit.

And consequently, this is where-- If you're going to regulate them, this is what you have to do. Make them accountable for what they want to do. If they want to set up a formulary, fine. I have no problem with it. But please make sure that everybody knows. You've got people who work for businesses

who are telling them what kind of formulary they want. I don't have any idea what their formularies are.

I just ran into a case yesterday where the patient has been on a drug, had been doing very well. They changed PBMs. The drug is different now with what's on the formulary. They won't pay for it. She has to now switch back to one or pay for it out of her own pocket. This is not fair to the patient.

Unfortunately, in this country, we do not look at healthcare in the whole picture. PBMs are not controlling costs, because I think they're the biggest problem for rising costs because ever since the beginning-- Before they came into being, actually, prescription costs were dropping, because there was a lot of competition.

They talk about the competition, but that's among themselves. There is no competition on the drug manufacturer's side. There is no competition on the delivery system. It's all the same. You've got to take it or leave it. That's what you get. You don't get anything else. So there is no competition. This is like socialized medicine to me, because big brother is telling me how to run my business.

Consequently, what's going to happen? You look at any other -- socialized countries, service goes down, costs go way up. And that's exactly what's happening. But what I said-- We need to look at healthcare's total picture, not just PBMs, not just patient care in general. We need to look at it from the top to the bottom, hospital care physicians all the way down to the patient, so that they can get the proper care. And we will be, probably, back

to number one in the world. Right now, we're at the bottom of the list, as far as our healthcare goes.

So, this is a step in the right direction. And the New Jersey Pharmacist's Association wholeheartedly supports this as a beginning.

I thank you very much for your time.

ASSEMBLYWOMAN WEINBERG: Thank you.

MS. CLARK: Fred, one thing. Are you able to, without going into any specifics on the PBM, talk about an example of a medication that a patient was denied in a particular setting?

MR. TRINKLEY: Well, I just had one two weeks ago. I mean, I can give you a million of them.

MS. CLARK: The Committee would be interested to hear the one that you had told me about the--

MR. TRINKLEY: A woman who had a mastectomy -- women in the audience may understand this. A drug called Tamoxifen is usually given to control the reproduction of the cells. There are incidents of a resistance that occurs after a while, and the cancer cells can start growing again, especially if they can't get all the cancer cells. They try to get the majority of them.

When this resistance happens, the Tamoxifen is no longer of benefit. There are several drugs out there. They cost a heck of a lot more money. They're injectables; Faslodex being one of them. The patient was denied the Faslodex. They told her to go back to taking Tamoxifen. That's all they would pay for, and I got the denial.

One other thing that I wanted to tell you is, as far as the way they deal with denials -- is completely unacceptable to the public, which is part of

the reason why they're getting so uptight about this. They don't have a system of communication in place. It's either the patient has to call the doctor, or, in most cases, I do, because the patient has no idea what the problem is. And then the doctor has to call the PBM or the insurance company, which then calls the PBM, which doesn't tell anybody that it's been approved. It could sit there without an approval.

What I suggest they need to do is, they need to be regulated, that they have to make a decision within 72 hours. They have to notify not only the physician -- the pharmacist who originally did it, and the patient, that that prescription is available; because, without that, they have no clue. That's how they save their money.

The other thing is, we have in place, in our great state, with our Medicaid and PAAD program, a system, First Health, who is like a PBM for us, which, if you're talking about doing the State workers, you could probably use them as your modified PBA and still save a--

ASSEMBLYWOMAN WEINBERG: What was the name again?

MR. TRINKLEY: First Health. It does oversee-- And they do have somewhat of a formulary. They have formulary restrictions. You have to get prior authorization. It takes me a two-minute call to them to get a drug approved. There are no problems. They then get in touch with the physician. If he doesn't respond, then the patient won't get it. But at least they're not denied the medication in the beginning.

And, I think, if you want to create a formulary, and you're going to tell these people they can't have it and you're going to deny treatment, then

pay for at least a short period of time without any hassles, and then let the PBM go after the doctor and find out why he needs to do it.

The doctor doesn't have time. I have to prod doctors three and four times -- they're busy -- so am I -- to get them to call. I've got some physicians who refuse to call. That's still denying the patient. He says, "I can't be on the phone for a half hour. I don't have the time." And this is true. A PBM can call a doctor when they're free to talk to them and not have them on hold. They don't have phone systems in place to take care of things immediately. That patient is standing at the counter, is sick and does not want to be standing there -- would have to come back. That's why they're getting mad.

ASSEMBLYWOMAN WEINBERG: Mr. Viola.

Oh, I'm sorry, Assemblywoman.

ASSEMBLYWOMAN QUIGLEY: I spent some time yesterday talking with a hospital pharmacist who used to moonlight on the weekends in a family drugstore, and who told me stories like yours. She said, "I can't do this anymore. I am so tired of--"

MR. TRINKLEY: That's why there's a pharmacy shortage.

ASSEMBLYWOMAN QUIGLEY: "--yelling at me, crying on me, and walking away without medication." I thought, you take one anecdote, you don't build a premise on it-- But hearing what you're saying, I believe even more the kinds of things you said.

MR. TRINKLEY: Well, a lot of pharmacists have given up the practice of pharmacy, and it's one of the reasons why we have a shortage today. It's because they don't want to get into the business or the profession because

of the hassels that you have to put up with. Thirty-five years later, I still cannot practice the way I was trained to practice, and it's a shame. People out there--

I mean, I see diabetics who are supposedly under PBMs who are not well-controlled. They're supposedly doing all this stuff. I see them under the Medicare program that are not being well-controlled either. I see asthmatics -- the same thing. I saved one patient -- an insurance company -- over \$50,000 with one, one-minute session, with a patient who has asthma. He was averaging at least four visits to the hospital a year. He has not been to the hospital in three years since I had that one-minute session with him. Did I get paid for that? Did I get paid for saving that insurance company all that money?

See, we look at each individual--

ASSEMBLYWOMAN QUIGLEY: Did you get a rebate?

MR. TRINKLEY: No. (laughter) The thing is, if I went and tried to get money back from the insurance company, they wouldn't even want to talk to me. But it's not that.

It has been proven time and time again. There have been studies in various states where they have had pharmacists doing more, as far as collaborative practice with physicians and everything else. And it does show that the drug costs go up, but the overall health-care costs go down.

So, we can't look at cost the way we've been doing it all the time. There are some give and takes that have to be done. And I'm not entirely against PBMs, but I think they need to be regulated and be made more

atonable for their actions and not just say, "Okay, fine, I want this," and sit back and watch the show. And that's basically what happens.

Thank you.

ASSEMBLYWOMAN WEINBERG: Mr. Viola.

T O M V I O L A: Madam Chairperson and members of the Committee, thank you for your patience.

ASSEMBLYWOMAN WEINBERG: Is your microphone on?

MR. VIOLA: I think I'm on now.

Thanks for your patience. It's been a long session. I must admit to -- just up front -- and I'll make my comments brief -- that I'm impressed with your grasp of the issues and what's going on.

I represent GSPO, Garden State Pharmacy Owners. We are the organization of independent pharmacy owners of the State of New Jersey. I consider myself well-learned in the benefits -- in the business of benefits management. I will tell you that my wife said it best, and I'll say it now, keep it simple, stupid.

Let me take my pharmacist hat off and talk about things from the patient perspective, so that we can finally address that issue. And we've heard from a lot of segments today, but we really haven't heard things -- although Fred has eluded to it -- from the patient's perspective.

I'm going to gauge my comments based on the glaze factor, which is -- after speaking with my wife last night -- how quickly her eyes glazed over at the jargon. So, if it's got a high glaze factor, I'll skip it.

In essence, recently, a PBM principal was asked about this issue. And his comments were in regards to escalating drug costs: PBMs are not part of the problem, they're part of the solution.

I will say, to keep it simple, let's look at it this way: By adding a level of administration to the entire process -- and through deceptive practices, which I'll qualify later, which ensure profitability is prioritized over patient care -- PBMs drive up costs, which in turn justify their very existence. So PBMs make a name for themselves by saying, "We keep costs down." But they're very existence, and in the practices that they perform, they drive costs up, and so it's self-fulfilling.

There are three streams of revenue for a PBM. But really, what does a PBM do? What would I like a PBM to do? I would like a PBM to do two things: allow my patients access to their benefits and provide reporting on the back end. Allowing access means putting together a network, get contracts in place, issue ID cards, and let pharmacies transmit claims. I don't see any use for a PBM beyond those functions, because everything that PBMs tell that they do -- patient education, counseling-- Those are things that pharmacists do already in their community, patient to patient, face to face. We don't need those services.

As the first person who spoke today said, "We don't want to be in the business of duplicating services." That's exactly what PBMs are doing. They're duplicating the very services that community pharmacies and our partners at the chain pharmacies provide.

But to get back to my point. What are the three streams of revenue for a PBM? Administrative services: they perform a function. They

manage a benefit. Capitalist society -- I'm sorry. They should be able to charge a fee and collect it. And so they do.

What are the other two streams? Those are a little more troublesome. The first one has to do with formulary management, as we've heard ad nauseam today. Quite frankly, though, from the patient's perspective, it goes like this: My doctor prescribes Claritan for my allergy symptoms. I go the pharmacy, and the pharmacist says, "I'm sorry, your plan doesn't pay for Claritan. It pays for Zyrtec." "Well, wait a minute, my doctor prescribed Claritan. Why can't I have that?" Well, the pharmacist is put in the unenviable position of having to defend the PBM, the very organization that's cutting his reimbursement.

The pharmacist says, "Well, you can call your benefits administrator." Well, the benefits administrator may not understand all of the intricacies of formulary. But the bottom line is this, if I'm Joe Public and I want to be good and save my employer or save my public municipality some money, I might take one for the team and say, "Okay, I'll take the Zyrtec." My problem as a pharmacist is, I know that, in many cases, the preferred drug is not less expensive than the drug prescribed.

How could that be, you might ask? I thought PBMs were in the business of saving money. Wouldn't they want to prefer the less expensive drug? Quite frankly, the drug that's on the formulary is -- and I think Fred can attest -- is usually the drug that gives them the most rebate dollars.

ASSEMBLYWOMAN WEINBERG: So, do you know how often this happens in your particular pharmacy? Can you quantify it, in any way,

that the drug that's on the formulary might be more expensive than what was prescribed? You have to figure out why.

MR. VIOLA: It would vary, based on the formulary, because as the person from Medco said, there may be hundreds of formularies, some that prefer certain drugs and some that don't.

ASSEMBLYWOMAN WEINBERG: But it does happen often -- that it comes across.

MR. VIOLA: Yes, it does.

MR. TRINKLEY: I can give you an example in mine, and I would say, probably, about 25 percent of the time.

ASSEMBLYWOMAN WEINBERG: About 25 percent.

MR. TRINKLEY: I do, roughly, about 200 prescriptions, and my tally log says it's usually about 50 times during the day that I have to either call a doctor and get them to change to another one, or we get a slip from the PBM telling us we have to change it.

ASSEMBLYWOMAN WEINBERG: But, I mean, how often do you find out that it's a more expensive drug that you're being forced to use?

MR. TRINKLEY: Most of the time, it is. We normally wouldn't switch for a more expensive one. We're not allowed to, by law. And, consequently, we are told, at the time of transmission, that it's going to be rejected, and the choices that you have. Not all of them give you choices. Some of them just say it's a nonformulary drug, and you have to go find out what is.

But some of them are a little more sophisticated. And we'll give you examples. I just had one on Verapamil and Calan. They'd only pay for

Calan. They will not pay for the generic. Now, I'm supposed to, by law -- if the doctor says substitution's okay and the patient says substitution's okay -- is give the generic, but the plan will not pay for the generic. They will only pay for the brand.

MR. VIOLA: And it's hard to tell because of the different formularies that exist. But let's get down to the bottom, or the base, which is, if the PBM is preferring a drug that's more expensive, because they're going to get more rebates for that drug being preferred, then I would hope -- and you might imagine -- that they would shift the extra rebate dollars they collected back to the client to offset the cost for preferring a more expensive drug. And I can tell you that's not the case. So, those extra rebate dollars don't necessarily get back into the clients hands.

We talked about allergy symptoms. Let's talk about something a little more complicated. We'll talk about blood pressure or diabetes, where tight control can make the difference between whether or not I live and how long I live. Maybe I don't want to take one for the team at that point. Maybe I'm a little concerned that, because my PBM is telling me to take a different drug, my life is going to be affected. Well, in that case, then, I'm not so willing to take the drug that's preferred.

What are my choices? My choice is this: if you want the drug that's not preferred, you pay the difference. So now I'm further, as the patient, subsidizing the process. Again, PBMs adding a level on increased costs to justify their own existence.

The last point, or step three in the revenue stream, is a little-known process called retail spread. And that is because we have two separate

contracts in place. We have a contract between the PBM and the client, and we have a contract between the pharmacy and the client -- and the PBM. So, the PBM and client, PBM and pharmacy--

Real quick scenario-- A drug costs, after all of the contracted rates are established, \$100 to the client. The client only sees their end of the contract. There's a blank wall there. I know, as the client, I'm going to pay \$100. The pharmacy, on their side, not seeing the contract the client has, is told, "We're going to reimburse you \$98." Who keeps the \$2 spread? That's an issue, and that has yet to be addressed. I haven't heard it mentioned today, and it is an accepted practice.

ASSEMBLYWOMAN WEINBERG: So, if I understand you correctly, besides the administrative fee, and besides the -- whatever rebates they're getting, they're also getting a rebate from you.

MR. VIOLA: There's a retail spread -- a price spread that they keep a small percentage of the cost of the claims. They are making money on the claims.

ASSEMBLYWOMAN WEINBERG: On your--

MR. VIOLA: Yes. Correct.

ASSEMBLYWOMAN WEINBERG: Yes, Assemblyman Kean.

ASSEMBLYMAN KEAN: Thank you, Madam Chair.

Thank you for staying here all day and testifying.

The question that I have is, what percentage of your clients, the people who come and fill the prescriptions, utilize PBMs? What percentage of your client base--

MR. VIOLA: Well, if you were to extract the State programs, which are technically not run by PBMs -- and I just asked Fred this question before -- we agree it's probably around 80 percent. So, 80 percent of the prescriptions filled today are administered by PBMs, not counting the State programs.

ASSEMBLYMAN KEAN: And that's--

MR. TRINKLEY: I told him that. And 10 to 15 percent is usually PAAD or Medicaid. I have about a 5 percent -- and I usually follow the national average quite close--

MR. VIOLA: Now, you may say some of these allegations are outrageous. I implore you, I ask you, go back to your constituents and ask them to produce these contracts. There are many contracts signed between PBMs with public entities, municipalities and boards of education. It's public record.

ASSEMBLYWOMAN WEINBERG: We can ask them to produce the contract they have with the State Health Benefits Plan.

MR. VIOLA: I would challenge you to find language in those contracts that details the whole rebate structure and who's getting what. I've looked at them. I've gone down to town halls and pulled them. And I can't find any language that says, "You're going to get this percentage of rebate dollars. We're going to guarantee you this." That whole thing, before, about: we negotiate rebate dollars with the clients-- If that happens, it happens verbally and not in writing, because it's not anywhere that I can see.

And to reiterate the point from before, pharmacists don't negotiate at all. It's take it or leave it. And pharmacists sure as heck don't get any of those rebate dollars.

The last point I want to make today, and I realize it's getting late, is that accounting practices need to be brought up, as well. The gentleman from Medco said before, quite frankly, that he was not aware or wasn't sure if there is a fiduciary or financial arrangement between Medco and Merck in regards to using Merck products.

Well, I'm not a very well-read guy. I'm too busy filling prescriptions, but I do read the *Wall Street Journal*. And in the *Wall Street Journal* a couple of weeks ago, it said, very clearly, that in Merck's stock -- their -- I'm sorry -- their financial statement-- It said, very clearly, in that statement, which was published and proclaimed, that Medco, once spun off, would be required to maintain a certain market share of Merck products in their book of business. And if Medco could not maintain that market share percentage, that Medco would be required to pay Merck cash for the difference.

Now, I find it hard to believe that, if that arrangement doesn't exist now, they would enforce that relationship later on, considering it's not a true IPO. Only 20 percent of the stock is being disseminated. I have problems with that.

The other problem I have is, Merck, not to single them out, and their Medco unit claims copays as revenue. Copays are the things you pay when you pick up your prescription as a consumer. So, if I go to the pharmacy and pay \$5 for my prescription, Merck is counting that \$5 as revenue for their Medco unit.

Let me give you an analogy. If you get into a car accident on the way over here, God forbid, and you have to pay a \$1500 deductible for that claim, is that \$1500 revenue for your insurance agent? It's the same analogy.

I find that hard to believe, in any era of questionable accounting practices. I think that needs to be addressed. Again, *Wall Street Journal* -- recent article.

The last thing I want to mention, folks, a principal in a PBM was recently quoted, when pharmacists would not support his political campaign -- what he thought about that. And he said, "They're jealous." He's right. I am jealous. I'm jealous of every one of those \$15 million that went into funding a political campaign that should have gone into funding better patient care for my patients and reducing tax burden to my friends and family as taxpayers of New Jersey.

Mom said, "Never criticize anybody until you've walked a mile in their shoes." Well, maybe my shoes that are donated by the PBM will be made out of gold. They're not going to protect me from the quicksand around the bend.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Mr. Viola.

Melanie Willoughby.

MELANIE WILLOUGHBY: Thank you, Madam Chair and members of the Committee.

I represent the New Jersey Council of Chain Drug Stores. It appears I'm, seemingly, close to last. And you certainly have heard quite a

number of people testify today, but I'd like to try to address a number of issues that I thought might be helpful.

First of all, we absolutely support Assembly Bill 2337, because we believe that pharmacy benefit managers should not be practicing pharmacy, or medicine, or acting as insurers unless they are appropriately regulated. And this bill, we believe, would be a step in that direction.

We do want to let you know that prescription administration, presently, is concentrated, really, in three PBMs -- a little fact. In January of 2000 -- so this report is two years old -- but the Kaiser Family Foundation reported that 20 PBMs manage an estimated 71 percent of the volume of the prescription drugs dispensed to retail pharmacies. So, two years ago, it was 71 percent.

According to the Kaiser report, the PBM industry is concentrated in the top three PBMs. They are Merck-Medco, PCS Health Systems, and Express Scripts, who together manage approximately 45 percent of all third-party prescriptions. The reason that I raise this for the Committee today is that, where an industry is controlled by so few players, consumers and providers doing business with that industry are really at an extreme disadvantage in negotiating fair prices and terms and conditions of service. So I wanted to bring that, first, to the Committee's attention as to why we feel it's important to be regulating PBMs.

Number two is that, really, I think one of the reasons that the bill is up today, and the reason it's so much on everyone's mind, is because of how PBMs have changed over the years and the fact that when Assemblyman Doria had put the bill in, and he was so farsighted to do this -- but, really, back when

he put it in, it really wasn't an issue, because PBMs were really only a claims administrator. And, really, the first PBM was actually created in 1969. I mean, that's how long they've been around as claims administrators.

But, really, it was in the late 1980s that PBMs started to get involved in the practice of pharmacy. They started utilization review, formulary development, the conduct of disease management programs, and a number of other practices that, really, you could perceive as practicing medicine, practicing pharmacy, or engaging in the business of insurance. And I think that's, really, one of the reasons that we're, really, here today -- is to, really, try to address all of the ways that they are now involved in many of these practices without being properly regulated, as those who do engage in those practices, like our pharmacists, who are regulated.

And I wanted to raise a point as to how they've changed from claims administration to the practice of pharmacy and, really, also how they've been compensated, which my colleague Tom Viola had touched on and which you had asked a question about. And in an investor conference call on November 6 of the year 2001, AdvancePCS's CEO said, "The way we're compensated has been changing significantly over the past three years. In 1995, when you look at our share of rebate, we had zero percent of our gross profit coming from manufacturers, because we were a claims administrator. It all came from the payers. Today, over 50 percent of our gross profit comes from the manufacturers."

ASSEMBLYWOMAN WEINBERG: What are you reading from, Melanie?

MS. WILLOUGHBY: I'm reading from the investor conference call of a company called AdvancePCS, which was done on November 6 of the year 2001. And I'd be more than happy to share that with you.

ASSEMBLYWOMAN WEINBERG: Please.

MS. WILLOUGHBY: So that gives you an idea of how their revenue stream has changed, in terms of their priorities, and where their dollars come from.

And so, as a result of this change, PBMs' way of dealing with their client base, with the employers who have utilized them, and of the way they deal with pharmacies, obviously, has changed. And so, they now have gotten into the business of really restricting access to drugs and needed therapy by the patients that the pharmacist has to deal with.

And just to, sort of, give you just a really quick rundown -- it's in my testimony. But, essentially, our belief is that they design formularies based on manufacturer rebates, not clinical effectiveness. They restrict access to pharmacies. They impose unaffordable copayments without regard to population economics. They steer to the use of mail-order services, which is less expensive. They impose discriminatory and wasteful dispensing rules on quantities. They squeeze the reimbursement out of retail pharmacies. And they omit important medication therapy management. That's the way we feel, in a nutshell.

ASSEMBLYWOMAN QUIGLEY: And you don't like the bill.

ASSEMBLYWOMAN WEINBERG: Other than that--

MS. WILLOUGHBY: But they have a useful purpose as a claims administrator.

And so, in summing up, we very much are supportive of this legislation, and I was very pleased to hear Assemblywoman Quigley had mentioned the issue of -- would like -- liking to -- liking to, listen to me -- it's late in the day -- of desiring an amendment to the legislation that would require additional disclosures.

We, through the National Association of Chain Drug Stores, together with the New Jersey Council of Chain Drug Stores, would like to offer language, which we have offered to the sponsor and would like to offer to the Committee -- language that we have drafted dealing specifically with disclosure specificity as it relates to rebates, discounts, market share incentives. And so--

ASSEMBLYWOMAN WEINBERG: Will you please share that with David Price?

MS. WILLOUGHBY: I have it here, and I'd be more than happy to share it. And I really thank the Committee for having the hearing today, because I think it's so very important to bring so many of these issues to the forefront.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you.

Any questions?

Assemblyman.

ASSEMBLYMAN D'AMATO: Thank you, Madam Chairperson. Mr. Viola, I want to go back to something you said about contracts.

MR. VIOLA: Yes.

ASSEMBLYMAN D'AMATO: We heard about contracts that the PBMs have with the plan sponsor. Tell me about the contracts that you have. Are you saying that you have to have a contract with every PBM that your patients or clients have?

MR. VIOLA: Pharmacies have contracts with every PBM. So, in order for us to participate in a particular benefit management plan, we have to have a contract with that benefit manager, the PBM. That contract, while it is with -- between the PBM and the pharmacy is private, because it's not subject to public disclosure -- and such, it is invisible to the client, who has a separate contract with the PBM. And that is it's municipality's -- part of public record.

ASSEMBLYMAN D'AMATO: So, what will happen is, if you do not have a contract with a certain PBM, an individual cannot get his or her prescription filled at your place.

MR. VIOLA: Yes, that is correct. That is a source of major dismay to pharmacies, because their very livelihood depends on people walking into their store. And if they don't accept this take-this-or-leave-it contract, they're faced with: "Okay. I don't take it, so I don't make any money because people don't walk in my store, or I take it, and I don't make money because my reimbursement is too low, but the people are walking in my store."

MR. TRINKLEY: There have been several states that have had problems with reimbursements that have actually -- the whole state has refused -- and I don't mean the whole state as a whole, individual chains have refused to fill prescriptions for certain PBMs because the reimbursement level is way too low. And I, for the first time this year, had to refuse two.

MR. VIOLA: Let me give you some scope. Most pharmacies purchase drugs at an average wholesale price minus about 17 percent. Most reimbursement contracts with pharmacies are at an average wholesale price of minus 15 percent. At that point, your overhead is completely eating up that profit.

Okay, well there's a dispensing fee. Every time a pharmacist fills a prescription, there's a fee paid. One of the latest contracts from AdvancePCS -- \$1. Go home tonight, look around your neighborhood, and see how many retail pharmacies, that were there, aren't there anymore.

ASSEMBLYMAN D'AMATO: Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you very much. I appreciate your patience in spite of the fact that you were among the earlier callers to get on the agenda. So, my apologies for keeping you so long. But there are actually about three more speakers after you. And we appreciate it.

Perhaps they're not all here.

MR. VIOLA: Thank you.

ASSEMBLYWOMAN WEINBERG: Greg D'Orazio. Is he here?

(no response)

We outlasted him. That's good.

Then the last two are folks who signed up late.

Paul Kramer -- former Assemblyman Paul Kramer, who says he's representing himself, and he has no position on the bill. (laughter)

ASSEMBLYMAN PAUL R. KRAMER: Come up?

ASSEMBLYWOMAN WEINBERG: Please do.

ASSEMBLYMAN KRAMER: What, am I supposed to have the red button on? (referring to PA microphone) See how soon I forgot.

Thanks very much, Madam Chairwoman. I appreciate you hearing me today. I know how late it is. I've been through this myself many times.

First, I will tell you that I'm a registered legislative lobbyist. However, I'm not here in that role.

You're going to hear a little different story from me. And what prompted me to come here today was articles recently about Hamilton Township, where I was the finance director for 24 years and then, somehow or other, the PBM that I worked with ripped off the people of Hamilton Township.

Thirteen years ago, we had a prescription program with a carrier, directly with Blue Cross and Blue Shield to be honest with you. And a PBM came to me and said, "We think we can save you some money." And we went into that contract with them. They did a utilization review. They showed me some of the areas where money was being overspent, etc., etc. I want to try to make this very quick. So I went into a contract with them. That contract did not include rebates, by the way. It was just a deeper discount on the drugs that were prescribed by physicians at the time.

However, subsequent to that, maybe three years later, which is the legal requirement for rebidding any business you do with this kind of entity, I did have someone come to me and say, "Look, I don't have to have any administrative fee. I'll do this for you for nothing." I said, "Wait a minute. You can't be doing this for nothing. What are you going to do?" He said,

“Well, we have this program--” and at that time, I don’t remember if it was called formulary or not -- “We have specific drugs. And if we point people in the direction of those drugs, we get a rebate.” And I said, “You get a rebate? If you get a rebate, then I get a rebate.” They said, “Yes, we can work out that, too.” I heard today from several people that that wasn’t available to a client when, in fact, if you’re an administrator, as I was, and you’re negotiating a contract, everything is available to you if you negotiate it properly.

However, in discussions with my PBM at the time, I saw the downside of the formulary system because, again, customers would be forced to go to a certain pharmacy, be forced to use a certain prescription drug. I didn’t think there was any sense to that.

What’s interesting is that for 13 years, we had this PBM relationship. And during those 13 years, not only was I an administrator, I was an elected official, both in the county and then in the Legislature. And on numerous occasions, I met with the Medical Society. I met with the pharmacists in Mercer County, in my district. I never had a complaint. We had 750 people in Hamilton Township. I wasn’t in a position to negotiate a deep discount, but the PBM was in that position. We saved money. I never heard a complaint.

All of a sudden, today -- and you, as legislators-- The New Jersey State Health Benefits Prescription Plan is administered by a PBM. Have you ever had anybody complain to you that, somehow, there’s something going wrong that isn’t right?

ASSEMBLYWOMAN QUIGLEY: But recently. It’s all happened recently.

ASSEMBLYMAN KRAMER: All happened recently. I guess there's been some exposure in the newspaper that there might be things going on that aren't necessarily going on.

ASSEMBLYWOMAN WEINBERG: Well, that's how it begins, as you know, Mr. Kramer.

ASSEMBLYMAN KRAMER: I know, and I agree. I think you need to have the--

ASSEMBLYWOMAN WEINBERG: And not just in the newspapers-- We're talking about *U.S. News and World Report*; we're talking about the *Wall Street Journal*. They're both rather conservative publications.

ASSEMBLYMAN KRAMER: Let me make reference to that. There's an article-- There's an individual who said PBMs are driving up health care costs. He said that he looked at the contract in Hamilton Township. And that's what really brought me here, because I'm tired of this kind of criticism when, in fact, this guy is supposed to be an expert, Mr. Purcell--

What that means is that the PBM is keeping all of the rebates it receives and does not tell its clients that it receives it. Well, he read a contract where there is no rebates, and he assumed that somebody's getting ripped off, particularly the people of Hamilton Township.

I know I'm probably--

ASSEMBLYWOMAN WEINBERG: Yes, Mr. Kramer -- Paul.

ASSEMBLYMAN KRAMER: You can call me Paul, Loretta.

ASSEMBLYWOMAN WEINBERG: Yes, we know one another well enough for that.

We have not said anything about Hamilton Township.

ASSEMBLYMAN KRAMER: I know you haven't.

ASSEMBLYWOMAN WEINBERG: We haven't said anything about the PBM you have there.

ASSEMBLYMAN KRAMER: I'm just explaining to you why I'm here -- as a reaction to my experience-- Everybody else has anecdotal stories about bad experiences. My experience with PBMs has been good.

ASSEMBLYWOMAN WEINBERG: Good.

ASSEMBLYMAN KRAMER: Okay? And I wanted you to know that. And I appreciate your time. And if I'm the last patient, have a good evening.

ASSEMBLYWOMAN WEINBERG: No, we have one other after you.

ASSEMBLYMAN KRAMER: Do you need to follow me anywhere so you can find your way? (laughter) That's an inside joke.

ASSEMBLYWOMAN QUIGLEY: I miss you.

ASSEMBLYMAN KRAMER: Thank you very much.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

The last person who signed up is Dudley Birdeye, (phonetic spelling) who represents the--

D U D L E Y B U R D G E: Burdge. (indicating pronunciation)

ASSEMBLYWOMAN WEINBERG: Oh, I'm sorry. You've got bad handwriting. You must have gone to medical school. (laughter)

MR. BURDGE: Well, I haven't.

ASSEMBLYWOMAN WEINBERG: You're representing the Communications Workers.

MR. BURDGE: Thank you.

I will try to be brief, because, obviously, a lot of the issues I was going to raise have been either covered by people testifying or a number of you have raised the question.

The Communications Workers, as you well know, represents some 30,000-plus State employees with the State of New Jersey, also quite a few people who work for the State and local government and, also, particularly in the telecommunications sector.

We, in general, support the concept of A-2337. I'm not saying that every piece of it is perfect, but we're generally in support. We've been looking at this issue of the rebates and that type of thing for a while now, for two reasons. One, in terms of-- We see that the State Health Benefits Plan is spending 15 to 20 percent more a year on prescription drugs. We know that, at some point in time, this is going to come back, and somebody's going to come up with some strategy to cut those costs. And, too often, in the past, that has been primarily for the employees.

We, for instance, have been asking the State Health Benefits Plan for information on the amount of rebates they got at least since the beginning of this year. I have to tell you, up to now, we have gotten no substantial information whatsoever.

We do get-- I've talked to their people, and they've given me quite a few details on how much they've essentially ratcheted down the payments to the pharmacists. But when you get into the question of what kind of rebates are they able to get from the State, it's not there.

We have a lot of questions about, particularly, the State Health Benefits Plan -- how the State really could be on top of it the way it's administered now. The State does not contract with the PBM, which they just switched, as you know, July 1, to AdvancePCS. But rather, it's Horizon Blue Cross that contracts with AdvancePCS.

And, in just looking at it, to us, that's two other pockets that money can flow into. We suspect that no one's looking too closely at this rebate question. As Mr. Purcell made clear, it's not an easy thing to look at.

I did want to also-- I mean, the other concern is, obviously, in terms of the budget situation in the State. And, along with everyone else, if there's a way to save money, we'd like to do it. We estimate that the State, in total, probably pays around a billion dollars a year for prescription drugs in the various programs: State Health Benefits, PAAD, Senior Gold, Medicaid. And you also have institutional purchases for institutions and things of that type. And, in many cases, we think this is done with the services of PBMs.

I did want to mention-- I believe there was a question asked at one point about what some other states are doing. There is an initiative that actually, interestingly, West Virginia started. And it's an initiative that a number of southern and western states have joined. They have-- West Virginia put out, as the lead state, a request for proposal for a PBM. Now, I'm not a legal expert. I don't have the background -- Mr. Purcell was here-- I know that they did put language in that request for proposal that whoever got the contract would be required to share all the financial information with them. And they put in some, what are seemingly some, fairly significant penalties --

financial penalties if the PBM doesn't comply. That might also be a direction you might look at.

We think that this Committee, the Legislature, and the administration need to carefully audit and review the use of PBMs that this State uses or goes through other contractors to use. If evidence develops that indicates that rebates are not being passed on by PBMs, then the Attorney General should bring legal action.

Finally, I wanted to draw attention to this question of whether PBMs are a solution to escalating prescription drug prices. We think they may well not be. I'm not saying that they don't provide some important services in terms of processing and, perhaps, disease management, although, I think there's a question of who should appropriately be doing that kind of educational work and whether they're the appropriate people or not.

Our research indicates that the Federal government has something that's called -- it's Federal supply service. And they pay approximately 50 percent of the retail price for drugs. Now, the retail price, as I understand it, for drugs -- they call the average wholesale price. But that actually is the retail price. In some cases, the Federal government even pays less.

This is something that you don't hear in the media. I've seen lots of reports in the media about seniors and others taking bus trips to Canada to buy the drugs at Canadian prices. Well, it appears that our own Federal government purchases these same drugs for close to the same price for their internal use in veterans administration and other types of places.

The PBMs do not come close to matching these prices that the Federal government gives, even though a PBM like AdvancePCS -- I believe

they claim to have 70 million lives that they represent. They make use of formularies, which they say give them bargaining clout. I think that theory of how those formularies could give them bargaining clout makes sense. But, yet, they don't match the price that the Federal government gets on behalf of a few million people.

I'm not enough expert to know, but to me, that raises a lot of questions about how much -- you know, the nature of the negotiations between the drug manufacturers and the PBMs.

We have three quick suggestions. One is the comprehensive review of the PBMs that the State uses now, particularly focusing on the type of rebates they get.

As some of you have mentioned, you should look at this question -- to what degree should the State be using PBMs? Should the State, perhaps, be using them for some services and not for others -- that type of thing.

Finally, it's clear that the State must find a way to get the information on rebates, discounts, and all the other types of fees that the PBMs negotiate with the drug manufactures.

ASSEMBLYWOMAN WEINBERG: Thank you, Mr. Burdge.

Does anybody have any questions? (no response)

Thank you very much. You know, if you listened this afternoon, we're certainly going to look into the arrangement that our PBM has with the State of New Jersey.

Just for the record, we did get written testimony from Express Scripts through their representative.

And, just before we adjourn, I would like to, again, thank David Price -- we've really given you overtime work over the last number of months on these hearings-- And the OLS staff; and Tasha Kersey and Wali Abdul-Salaam from the partisan staffs, who sit here very patiently and are not allowed to talk, which is probably the most frustrating of all. So we appreciate all the help that you have given to us throughout this. And we still have more to go.

ASSEMBLYMAN D'AMATO: She talks a lot. She tells us what questions to ask. (laughter)

ASSEMBLYWOMAN WEINBERG: I know. But I know how much they really like to talk out loud, having been in that kind of position myself.

And thank you to the public for your patience. This has gone on for about four-and-a-half hours, I guess.

Thank you for my Committee members who stuck with us. And I hope that you'll all agree that we learned a lot this afternoon.

Thank you.

(HEARING CONCLUDED)