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Testimony

for the

Legislative Budget Hearing
2012-2013 Executive Budget
Wednesday, February 8, 2012
Hearing Room B, LOB

Respectfully Submitted by:

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I want to thank the chairs and committee members for this opportunity to provide testimony on behalf of the Pharmacists Society of the State of New York and to also thank you for your overwhelming support of our No Mandatory Mail Order legislation you passed last session and that Governor Cuomo signed in to law.

The Pharmacists Society of the State of New York has selected several legislative priorities going forward that we feel need to be put in place this year so as to protect the integrity of the no mandatory mail order law and consumers right to choose. In addition, we have significant evidence to demonstrate that by passing our legislative initiatives, the state's taxpayers, employers, unions, school districts and municipalities will benefit financially as it relates to their prescription drug program costs.

Executive Summary

NY State's Health Insurance Exchanges and PBM Transparency:

- PBM Transparency will be required in all state health insurance exchanges as a way of 'saving the program money.' PSSNY strongly encourages the Legislature to ***require*** PBM Transparency across ***ALL*** health insurance programs in NYS.
    - Included in this testimony in the Appendix section is the "American Health Benefit Exchange Modal Act" which defines a PBM and their role in an exchange, as well as, pharmacy provisions. ***(Appendix pp. 1-15)***
    - We encourage you to take a good look at this model act and consider it in your deliberations.
    - We also encourage the Legislature to 'require' PBM Transparency across all state-issued health care policies offering a prescription drug benefit.

- ***"Pharmacy Benefit Manager (PBM) Transparency"***
    - PBM transparency legislation is critical in pulling back the veil of secrecy that is a significant part of PBM business practices.

- PBM self-dealing is rampant nationwide as they "steer" and "steal patients" from their competitors.
- PSSNY is calling for the immediate passage of legislation that would require PBMs to register with the state of New York and to provide critical information to payers that will allow them to make informed decisions.
- The business practices of PBMs are not regulated in New York State and this absence of regulation has led to hundreds of millions of dollars in ***'hidden revenues'*** for large, non-transparent PBMs at the expense of all New Yorkers who pay for prescription drug services. (see ***Appendix* pp. 16-38** on ***PBM's Tricks of the Trade***)

"Specialty Drug Designations by Pharmacy Benefit Managers"

- ***"Specialty Drugs"***
  - Specialty Drugs is a made up term by self-dealing Pharmacy Benefit Managers (PBMs) who are using this term, that has no definition in state or federal law. PBMs 'steer' or 'steal' patients, from New York community-based pharmacies to the Big Three PBM's wholly-owned out-of-state mail order pharmacy simply by calling maintenance medications "Specialty Drugs."
  - New York's community-based pharmacies have been dispensing these same maintenance medications to their patients for decades. The major PBMs are calling everyday maintenance medications 'specialty drugs' to circumvent the no mandatory provision put in the Medicaid Managed Care initiative by this Legislature and force Medicaid enrollees into mail order. (See one example of a PBM's so-called "specialty drug" list with over 200 maintenance drugs listed. (***Appendix* pp. 39 - 40**)
  - The potential for real harm to Medicaid patients is just a missed delivery away.
  - The potential loss of tax payer dollars through Medicaid managed care to out-of-state PBM wholly-owned pharmacies could be in excess of a staggering $2 billion. (Estimate based on two-thirds of Medicaid enrollees moved into managed care along with approximately $3.3 bil. drug spend ($5 bil. spend prior in FFS)

minus $528 mil. estimated spend on generics (16% of total drug spend) leaving $2.772 bil. in brand drug spend. Based on PBMs grab for any drug over $300 and calling it a 'specialty drug' leaves little for NY's community-based pharmacies).

- If allowed to continue unchecked, the Big Three PBMs will use this same 'loop-hole' to circumvent the recently passed 'No Mandatory Mail Order' law and once again deny New York consumers a choice of where to get their prescription medications filled at the same cost and the same co-pays.

"Prescription Drug/Opioid Abuse Action Items"

- To date, ***NO*** state has implemented a ***'real time' PMP program*** as the cost has been prohibitive. We must explore alternative methods for making New York's current system workable and cost effective to the state, prescribers and pharmacies.
- After lengthy review, pharmacy has concluded that ***'Opioid Abuse'*** is the ***real problem*** and everything else ***are symptoms of the problem***.
    - There are portions of the Attorney General's ***iSTOP*** program that we can support which we have laid out in detail further back in this testimony. There are others we cannot such as ***real time*** transmission of data. This is too costly and there are fears of 'hacking' into the Internet exposing patient's names, addresses, date of birth and the quantity and drugs dispensed. The current PMP system ***DOES NOT*** have to be HIPA compliant.
    - Any legislation addressing opioid abuse, diversion of controlled substances, over prescribing and pharmacy robberies needs to be addressed simultaneously. Failure to do so will substantially increase the risk of violent crimes at our pharmacies.
    - You cannot approach this problem with an enforcement attitude only. To do so would risk pushing desperate individuals to do desperate things.
    - Our ultimate goal for stopping much of the diversion of controls, doctor shopping and over prescribing is ***to mandate e-prescribing of all controls*** with few exceptions.
    - As we discovered, the use of e-prescribing for a Prescription Monitoring Programs (PMP) has a major obstacle in that the e-prescribing system uses the National Council for Prescription Drug Programs (NCPDP) D.0 HIPA compliant

software platform which is primarily used for billing and Drug Utilization Review (DUR) purposes and the PMP program uses the American Society for Automation in Pharmacy (ASAP) 4.1 version HIIPA-exempt platform and is used primarily for patient and controlled drug information being sent to PMP programs. The two systems ***DO NOT*** use the same data identifiers. We need to "bridge' the two systems.

- This would minimize serialized forms being targets for theft by organized crime or opioid addicted patients. and
- Would free up law enforcement to go after the bad players only by monitoring their prescribing and dispensing habits.
- Launch a similar campaign as Ohio called: ***"Don't Get me Started."*** Which is a public awareness of prescription drug abuse campaign that uses five videos of abusers and the impact it has had on their lives. (www.dontgetmestartedohio.org.)

"Expanding Vaccines that Pharmacists Can Provide"

- ***"Pharmacists as Immunizers Expansion"***
  - Expanding the number of immunizations that pharmacists are authorized to provide makes good public heath sense and will greatly expand access to these necessary vaccines and with that reduce vaccine preventable diseases.
  - The NYS Department of Health was due to release their report on Pharmacists as Immunizers last month. We are encouraged that it will be very favorable not only to pharmacists but to all immunizers as vaccinations were up across the board.
  - A report released last year by the CDC showed that, contrary to our critic's predictions, that immunizations by office-based physicians increased by 30% (nationally) over the past five years.
  - New York was the second to last state to authorize pharmacists as immunizers in 2008. Today, we have over 7,200 trained and NYS Board of Pharmacy registered Pharmacist Immunizers located in communities across the state. (see ***Appendix pp. 42-43)***
  - New York is well positioned in the event of any future pandemic outbreak.

Legislative Priorities:

(Background & Supporting Information)

"Specialty Drugs:"

In last year's budget, there was an MRT initiative (#11) that moved approximately 3 million Medicaid enrollees' drug benefit from Fee-for-Service to Medicaid Managed Care. In that budget language, the legislature included a no mandatory mail order provision for Medicaid Managed Care prescription drug services. The transfer from FFS to managed care occurred October 1, 2011. Just a few days after October first, Medicaid enrollees began receiving letters telling them that they must get certain drugs ***ONLY*** through the mail. The PBMs referred to these drugs as *"specialty drugs."* They describe "specialty drugs" as any medication used for a *chronic condition.* We referred to those drugs as maintenance medications and these make up between 50-65% of a community pharmacy total prescription volume.

There is ***no such definition*** of ***'specialty drugs'*** in the NYS Education Law covering the Pharmacy Practice Act. The FDA does not recognize or define any medications as *'special.'* It is a made up term by self-dealing PBMs in an effort to get around this legislature's intent of "no mandatory mail order" in the Medicaid Managed Care prescription drug program. It is a willful disregard for the law.

If left unchallenged, in excess of $2 billion in tax payer supported Medicaid dollars will be leaving this state each year to out-of-state, PBM–owned pharmacies as they self deal almost all maintenance prescription drugs to their own wholly-owned mail order pharmacies. This move by the self-dealing PBMs has caused significant disruption in the patient-pharmacist relationships, some having been in existence for decades and can lead to significant patient harm. None of the community-based pharmacies already in the health plans networks were even offered a network contract by the PBMs for these so-called 'specialty drugs.' We've had an independent specialty pharmacy caring for premature babies with underdeveloped lungs put out of business within weeks of the October 1st Medicaid FFS transition to managed care. These babies are put at risk should a single treatment be missed, late or incorrectly calculated to the babies weight during the treatment month. A number of our pharmacies both chain and independents have seen prescription volumes fall by as much as 30%. PBMs are self-dealing our pharmacy network right out of business.

The PBMs simply stole their competition's patient base by not allowing them to compete. None of these now Medicaid Managed Care enrollees were offered a 'choice' to use or not use a mail order pharmacy. In fact, they just received a letter telling them they had no choice after another 30-day supply at their local pharmacy.

Pharmacy Benefit Manager (PBM) Transparency:

Without PBM Transparency, no employer, school district, municipality or health plan will know if they are truly paying the same for a 90-day supply of medications at mail order or at a community-based retail pharmacy. PBMs claim that transparency will drive up prescription drug costs. We say PBM Transparency will drive down PBM's outrageous ***'net profits'*** and prescription drugs costs for all New Yorkers. In 2010, the Big Three PBMs 10K filings, with the Securities & Exchange Commission, boasted ***'net profits'*** exceeding **$6 billion.** (see ***Appendix* pp. 44-49**).

Many PBM's have 'gag orders' in the contracts with community-based pharmacies that prohibit a pharmacist from contacting the payer and many also a 'gag order' in the contracts of the payer prohibiting them from disclosing any information to the public. In fact, this 'payer' gag order has prevented an upstate school district from coming forward in the press to disclose how their mandatory mail order PBM overcharged them on their generic medications by hundreds of thousands of dollars each year. These plans are threatened with legal action if they do. This is no different than the bully in the school yard taking a child's lunch money everyday and the child not telling for fear of being beat up. These strong arm tactics are what keeps the public from knowing what the PBMs are really up to.

Take it, or Leave Contracts:

PBMs fax one page contracts to New York's independents and small chain pharmacies and give them five (5) business days to opt in. These contracts establish the terms of reimbursement and days supplies. Most often, the pharmacy never knows what the reimbursement is for generic drugs as the contract just refers to ESI's MAC list or Medco's MAC list. It's like asking a company to pave a road and then telling them that when they are done, come back to me and I'll tell you what I'm going to pay you for that asphalt you used in paving that road. Pharmacies and

payers are kept purposely in the dark. *The plan knows what it is paying the PBM and the PBM knows what it is paying the pharmacy but, the plan has no idea what the pharmacy is* ***'really'*** *being paid by the PBM and that's exactly how they like it.* This way, the PBM can bill the plan a ***much higher price*** and ***reimburse the pharmacy a much lower price*** and keep the difference.

At great risk of being thrown out of a major PBM's pharmacy network, one of our independent pharmacists went to his local school board and showed them 'how' they were being ripped off by mail order and the PBM that owned it. The School Board had allowed his pharmacy to participate in the last year of a four year *mandatory mail order contract* when he agreed to take the *same reimbursement and same co-pays*. Several months into the program, the pharmacist was looking through his pharmacy receipts to see if he was losing money on the plan. What he discovered was that he was getting significantly overpaid on all of the top dispensed generic drugs. He immediately went to the school board and told them that they had to change their contract and insist on *'pass-through' pricing* for all covered drugs. The PBM who had this school's mail order program *refused to participate* in the bid with the *'pass-through'* pricing requirement. A truly transparent PBM won the new contract. As one example of a generic price 'spread' used by the former PBM, they were charging the school **$333.81** and the patient paid a $16.00 co-pay for a 90-day supply of a generic for Zocor® called simvastatin. The ingredient cost of those 90 simvastatin capsules to the mail order pharmacy was **$6.90**! (See copies of receipts for several of the generics as more examples of what a 'spread' is – see ***Appendix*** **pp. 49-52**). After the school district went to their new prescription drug coverage, under the "pass-through" payment requirement, that same 90-day supply of simvastatin is now covered by the co-pay only. This holds true with many other generics, saving the school district hundreds of thousands of dollars annually.

We need to shine a light on the self-dealing of PBMs here in New York. I estimate that savings on ***eliminating*** 'generic' drug spreads alone through PBM Transparency will save New York businesses, schools, unions, municipalities and ultimately consumers in excess of **$820 million annually**. (PBM audits have found an avg. 25% spread on generic drugs for the Big Three PBMs. Generic drugs make up 16% of NYS' drug spend despite being 64% of all prescriptions dispensed. NYS's 2010 drug spend for 2010 was **$29.381 bil.** [11% of the national total of **$307**

bil. minus $39.9 bil hospital drug costs] not including hospital drug spend according to IMS Health. Generic prescriptions make up 16% of drug cost or **$4.7 bil**. Being that all health plans do not use PBMs and several PBMs are truly transparent and use pass-through pricing. I used just the BIG Three PBM's market share of 70% and a 25% avg. generic spread to get to over **$820 mil. potential savings**)

"Prescription Drug/Opioid Abuse Action Items"

To date, ***NO*** state has implemented a ***'real time' PMP program*** as the cost has been prohibitive. We must explore alternative methods for making New York's current system workable and cost effective to the state, prescribers and pharmacies such as ***"near real time"*** which could be daily or hourly uploads by pharmacies to the state database.

RECOMMENDATION: (Mandatory Prescriber Look-Up of *ALL* Controls)

- Currently, prescribers of controlled substances are ***NOT*** required to use the state's available database look-up to check patient's for potential controlled substance abuse.
- Only about 7% of prescribers use the look up tool. Prescriber's main complaint is that the states' web site ***IS NOT*** user friendly. This needs to be explored by the state with prescriber community input to modify the system to allow prescriber's and easier access.
- ***MANDATE*** that prescribers use the *'look-up' tool* until and if such time that e-prescribing systems are certified and can 'bridge" through the ASAP PMP system allowing prescribers to both prescribe a control and have it bounced off the state's PMP system and return a message to the prescriber if that patient is abusing.
- The PMP system should allow a prescriber to look back at least 60-days on each patient's controlled drug prescription history and be user friendly until such time that e-prescribing can replace the 'look-up' with a automatic Drug Regimen Review using the current BNE system modified to allow e-prescribing access to the Prescription Monitoring Program.
- Forcing pharmacies to look up every one of the 74,000 daily dispensed controls creates a bottleneck in the prescription fill process. A pharmacy has to use another system to do the lookup creating a costly new requirement. Stopping the prescription at the pharmacy counter ***creates a potential for violence*** as the addicted individual may already be in withdrawal and has expectations of getting that prescription filled. This creates a potential dangerous

confrontation at the pharmacy counter when the pharmacist has to tell the individual they cannot fill their prescription. We have to remember ***WHO*** has the pills in stock. Pharmacies do not prescribe medications nor do they receive any patient diagnosis information from the prescriber.

- Opioid abuse ***STARTS*** with the patient and accommodating prescribers. There is an inherent responsibility by the prescriber to stop opioid abuse before it gets started and to provide information for those patients who may need addiction treatment. Prescribers don't carry the controlled drugs - pharmacies do, making them targets of desperate individuals. People were not killed in prescriber's offices, they were killed in pharmacies.

RECOMMENDATION: (Using Existing System with Changes as Most Cost Effective)

Currently, the state's control substance Prescription Monitoring Program (PMP) uses the 4.1 American Society for Automated Pharmacy (ASAP) standard version for the transmission of pharmacy C-II-CV control substance dispensing information electronically sent to the state's database. The state law, using the ASAP standard, ***requires*** that the pharmacy submit the prescriber's ***DEA number, drug NDC number, drug quantity, per day use, patient's full name and full address*** and which is currently sent in batches to the state database every 30-days and no later than 45 days.

- That pharmacies be ***required*** to upload control batch data either ***daily or hourly*** to keep the state's database more current so that when prescriber's do their 'look-up' they will have the most current information on a patient who may be doctor shopping. This would include a '0 dispensed' control report for a particular timeframe.
- This will not resolve the issue of *'stolen blanks'* being used to divert controls until such time that we have either e-prescribing of controls and a way for prescribers to post the patient information and prescription serial numbers directly to the state's database.
- Additionally, pharmacies would need to get ***feedback electronically*** using the ASAP PMP program notifying the pharmacy that a serial form was reported as stolen. Again, there would need to be a 'bridge' between a pharmacy's NCPDP D.0 software and ASAP's PMP software so as not to create any copyright infringements between the two vendors.

- Currently, pharmacies can print out pages and pages listing stolen serial blank numbers. This is a cumbersome way to check for stolen numbers which requires these lists to be printed out daily or the pharmacist to go to the BNE website to do a look up.
- With a street value of between $100 and $300 per serialized stolen blank, they are usually sold, forged and potentially filled within hours well before most are even missed by the prescriber. In the case of institutions, thousands of individual serialized blanks were stolen without the knowledge of the institution. Taking a few blanks out of sequence from a case of blanks makes it almost impossible to inventory.

RECOMMENDATION: (Pharmacy Access to Control Substance Database)

Pharmacies are required by law to transmit their patient control drug prescription information to the state's Bureau of Narcotic Enforcement database at least every 45 days yet; they have ***no authority to access the data*** that they provided. PSSNY's ***strongly supports "near real-time" transmission*** of this data through the ***pharmacy's current software system and software vendors***. Again, this can be done as it is now through batch transmission only daily or hourly.

- We are recommending the Legislature pass legislation ***authorizing pharmacists and their software vendors*** (in the event that a 'bridge between a pharmacy's electronic billing transmission and the states' PMP program can be made) to access the control substances database for those situations where the pharmacist suspects abuse, tampering or forgery.
- We do not think the 'look-up' authorization needs to be mandatory for pharmacies if the changes are made to require prescribers to do a look up and require pharmacies to report control data to the state on a 'near real time' basis.
- Approximately 74,000 prescriptions for controls are presented and dispensed everyday in New York State. Mandating ***both*** prescriber and pharmacist to query the same system is not necessary. It must be stopped at the prescriber's office.

RECOMMENDATION: (Prescription Drug Rehabilitation)

The state needs to increase funding for **prescription drug addiction rehabilitation**. Without a safety net, we will be setting ourselves up for a 100 more Medford's. We can come very close to creating and air tight system but, if we push those addicted to opioids off the cliff, their survival

instinct will kick in and all our pharmacies will be placed in danger. If this happens, our pharmacies will either stop carrying opioids or hunker down like Fort Knox destroying that patient-pharmacist relationship that got them into this profession in the first place. We also don't want to see patients or their homes targeted if it is obvious that they may be taking pain medications. Health insurers should be mandated to pay for any opioid addiction treatment that may have been a result of delays in treatment for pain such as knee or hip replacements that may keep patients on pain medications much longer than necessary resulting in dependency or addiction.

RECOMMENDATION: (Prescriber Education)

- Many prescribers practicing today graduated long before many of these opioids hit the market. We are recommending that ***prescribers of controls be required to take continuing education courses*** to bring them up to speed on the ease of opioid addiction and training on ***'patient gaming'*** that is used to convince a prescriber for the need for pain medications.

RECOMMENDATION: (Pharmacist Education)

- That pharmacists who are dispensing controlled substances, as part of their Patient Safety or Law continuing education requirement every three years, take refresher courses in the controlled substance rules and regulations both state and federal and clinical training in recognizing and addressing patient dependency or abuse of prescription drugs.
- PSSNY has dedicated itself to keeping our pharmacists on top of the control drug situation at each of our conferences held twice a year and through our Affiliate continuing education programs held monthly. These programs cover pharmacists responsibilities under the law and clinically as it relates to how and when pain control medications should be used. Our pharmacists share encounters with their peers and the ***'red flags'*** that prescriptions raise at the counter. Also, pharmacists are in the best position to know who their regular patients are and their state of health.

RECOMMENDATION: (Consumer/Public Education)

- We are recommending that educational 'bag stuffers' placed in prescription bags and counter pamphlets for both pharmacies and prescribers offices, clinics, etc. be developed by the

Department of Health and patient addiction organizations to be distributed in prescriber's offices and pharmacies. These would educate the patient or their care giver on the 'signs of dependency' on opioids or other controls and about speaking to their doctor if the suspect that they may be becoming dependent and include phone numbers of addiction help lines.

- We also recommend that public awareness campaigns similar to the ***"Don't Get Me Started"*** campaign launched in the state of Ohio. This public service campaign speaks to young adults and their friends and families through five on-line videos by individuals who share their unique stories about how prescription drug addiction has impacted their lives. To view these poignant videos, you can go to: www.dontgetmestartedohio.org.

RECOMMENDATION: (Patient Care for Pain)

- The Pharmacists Society does not want to make it too difficult for patients who truly need opioids for pain relief to get their medications in a timely manner. We recommend that obvious circumstances such as end of life, cancer treatments, long term intractable pain, etc. should never have their medications delayed due to a database breakdown or other unforeseen circumstance that may substantially delay delivery of pain medications to the patient or the patient's caregiver. This is essential.

RECOMMENDATION: (Rules & Regulations – For Potential *Future Use*)

In 2010, the Legislature passed and the Governor signed into law legislation that would authorize the e-prescribing of control substances. To date, the Department of Health's Bureau of Narcotic Enforcement has yet to publish the regulations for comment despite the fact that the DEA published their final regulations in late 2010. Despite our recommendation, we are far from being able to implement this 'automated' PMP system.

- We are recommending that these regulations get published ***immediately*** and that ***all controls be subject to e-prescribing with few exceptions*** for areas of the state not yet having hi-speed Internet access so ***as to be prepared*** for the day when e-Prescribing software has been 'certified' to allow the electronic transmission of controlled substances.
- This would virtually ***eliminate stolen serialized forms*** as a vehicle for gangs to divert controlled substances.

- Today's e-prescribing systems use HIIPA compliant data points, such as using the prescriber's NPI number and not their DEA number which is used in the PMP programs. They also use a ***special patient identifier*** numbers and not their full name, address as the PMP program does.
- Those e-prescribing companies that are certified by the DEA to date, are national in scope. This would be critical in checking PMP's from adjoining states.
- Finally, there is currently no way for a prescriber to input ***'serialized form' numbers*** or receive feedback information for the prescriber as to a patient's current use of controls. All these issues would have to be resolved ***before*** e-prescribing could be made mandatory. Until then, the regulations should be published as guidance for e-prescribing software vendors. This would be the best solution as it relates to diversion and stopping a script from every leaving a prescriber's office. It could also block bad prescribers from being 'pill-mills.' Mandated e-prescribing should be explored thoroughly by all stakeholders.

New Yorkers with limited comprehension of English or with handicapping conditions such as limited vision or hearing deserve special consideration from every health care provider including pharmacists; however, the translation mandate on pharmacies included in the executive budget proposal is flawed.

- Singles out pharmacies and would subject them to a cause of action under state law (New section 3398(4) of Article 33 of Public Health Law) unique to them as compared to other health care providers.

- Gives persons who are labeled as having ***Limited English Proficiency*** extra rights of action as compared to other patients.

- Increases pharmacists' professional liability because the pharmacist is responsible for counseling the patient but has no way of verifying whether the translation provided by another person or a contracted service was accurate or appropriate.

- No government certification for pharmacy translation services. (unregulated)

- Applies to all persons with ***Limited English Proficiency*** but does not require translation into all languages. Limited to 7 primary languages.

- SED lacks resources to perform functions as required under the proposal (identify seven primary pharmacy languages and regulate pharmacy-based services for "special needs" patients broadly defined as "elderly, of limited vision or of limited English proficiency".

- Does not address persons with limited capacity of understand English when English is the primary spoken language.

- Allows the prescription form to be changed presumably so that any prescriber can indicate "LEP"; however, another section of the proposal broadens the responsibility of the pharmacist: " if the pharmacist knows or has reason to know that the patient is a limited English proficient individual". This language significantly widens the potential liability exposure for the pharmacist.

- The proposal is aimed at owners, not pharmacists, and specifically exempts independently owned pharmacies in the definition of "Covered Pharmacies", but (1) the responsibility always falls upon the Supervising Pharmacist and (2) other sections place the responsibility squarely on 'the pharmacist.'

We agree that all health care professionals including physicians, nurses, physical therapists, etc., including pharmacists, bear the responsibility to communicate meaningfully with patients. We agree that patient understanding promotes compliance that in turn improves clinical outcome. We therefore recommend as an alternative that healthcare professionals adopt the universal symbols developed by the U.S Pharmacopeial Convention as a communication aid when appropriate.

"Appendix Supporting Documentation"
Pages 1-52

Draft: 11/22/10
A new model
As adopted by the Health Insurance and Managed Care (B) Committee, Nov. 22, 2010

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Drafting Note: States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the references to "small" employers and the "small" group market.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

E. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XXVII of the Public Health Service Act, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E of this Act.

H. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection H accordingly.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

M. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in HHS Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act). States with different legal standards for counting employer size should review their definitions for consistency with federal law and substitute their existing definitions when appropriate. States should also consider the adverse selection issues that arise if different definitions of "small employer" are used within the Exchange and outside the Exchange.

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act relating to governance and operations, including sections that set out:

- The appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act;
- Authority and procedures for hiring staff and procurement resources; and
- Responsibilities of State agencies coordinating activities with the Exchange.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

Drafting Note: States should be aware that the Federal Act does not refer to "affiliate" as referenced in subsection C above. Section 1311(f)(3)(B) of the Federal Act, as related to a health insurance issuer, defines "eligible entity" as a person: 1) incorporated under, and subject to the laws of, one or more States; 2) has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and 3) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. The NAIC, through the Exchanges (B) Subgroup, intends to develop an issues paper on the topic to assist States in evaluating options in this area.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for individual coverage, but only if the Exchange has adequate resources to assist these individuals and employers. States that do so will need to reconcile the eligibility rules for participation, which are currently based on residence for individual coverage and based on employment for coverage through the SHOP Exchange.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations; and

R. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and

(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

Drafting Note: States should consider revising the language above to ensure that the commissioner, consistent with the provisions of the State insurance code and regulations, is given specific authority to investigate the affairs of the Exchange, examine the properties and records of the Exchange and require the Exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the Exchange under this Act, as may be appropriate given the structure and governance of the Exchange.

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:

(a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) The premium rates and contract language have been approved by the commissioner;

Drafting Note: States should modify the language in paragraph (2) above for consistency with their State law and regulations governing rate and form review and approval.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the

Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

Drafting Note: States whose licensing laws do not use the term "producer" should substitute the appropriate terminology.

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

Drafting Note: As states consider certification standards, they should consider factors such as consumer choice and additional costs, in light of the value to enrollees provided by the proposed standards, when evaluating whether or not to include requirements above the minimum standards under section 1311(c)(1).

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function to the commissioner pursuant to the commissioner's rate and form review responsibilities.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by

the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

Drafting Note: States that do not provide for a limited scope license should review the language above and either not include it or modify it for consistency with applicable State law and regulations.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section

1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and

(4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Section 8. Funding; Publication of Costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Drafting Note: As provided in section 1311(d)(5)(A) of the Federal Act, in establishing an Exchange under this Act, the State must ensure that the Exchange is self-sustaining by January 1, 2015.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this State. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Drafting Note: States should be aware that section 1311(d)(3)(A) of the Federal Act states that the Exchange "may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act," unless the State elects, pursuant to Section 1311(d)(3)(B) of the Federal Act, to require additional benefits and to make payments to or on behalf of enrollees to defray the cost of the additional benefits. Thus, if a State has benefit mandates that exceed the federal essential health benefit requirements, States may choose either to: 1) establish a mechanism under which qualified health plans may lawfully be offered through the Exchange without being required to provide benefits in addition to the federally designated essential benefits; or 2) establish a mechanism for evaluating and defraying the costs of the additional benefits. For States choosing to require additional benefits and defray the cost, it is recommended that the costs of the additional benefits be measured on a "net cost" basis to the extent permitted by federal law or regulations or guidance, considering both the costs of the service and any associated savings, based on an evidence-based methodology to determine the net cost, if any, of each additional benefit, and the value of the benefit to the State's residents. States also should be aware of the potential conflicts and opportunities for adverse selection created by having inconsistent benefits inside an Exchange and outside an Exchange.

Section 11. Effective Date

This Act shall be effective [insert date].

MODEL STATE EXCHANGE ACT (Pharmacy Provisions)

The National Association of Insurance Commissioners (NAIC) has drafted a model state exchange act to assist states as they move to establish and implement their state insurance exchange. The NAIC model act consists of 11 Sections that are as follows: (1) Title; (2) Purpose and Intent; (3) Definitions; (4) Establishment of Exchange; (5) General Requirements; (6) Duties of Exchange; (7) Health Benefit Plan Certification; (8) Funding; (9) Regulations; (10) Relation to Other Laws; and (11) Effective Date.

NCPA has reviewed the NAIC model act and drafted some suggested pharmacy-related additions to the model act pertaining to PBM audits, "any willing pharmacy," prohibition on mandatory mail order; and pharmacist administered MTM and preventative services. The PBM transparency provisions included in the ACA are included in proposed federal regulations but this document provides some additional PBM-related provisions that states may wish to include in the structure of their state exchange. NCPA urges you to work with your state legislature and Insurance Commissioner to implement some or all of these additions.

Insert the following pharmacy provisions into the NAIC Model Act (See previous attachment)

DUTIES OF THE EXCHANGE:

(R) Prescription Drug Benefit

(i) The Exchange shall ensure that all qualified health plans require PBMs that administer prescription drug benefits under such plans to provide to pharmacies that contract with the PBM: (1) the methodology and resources that the PBM utilizes to determine reimbursement (including to calculate the maximum allowable cost list); and (2) timely updates to pharmacy product reimbursement benchmarks used to calculate prescription reimbursement.

(ii) The Exchange shall ensure that all qualified health plans require PBMs that administer prescription drug benefits under such plans comply with the following provisions with respect to the PBM's audit of a network pharmacy:

- The PBM cannot require more stringent record keeping by a pharmacy or dispensing entity than is required by State and Federal law or regulation.

- The PBM (or entity acting on behalf of the PBM) shall not use extrapolation or other statistical expansion techniques in calculating the amount of any recoupment or penalty resulting from an audit of a pharmacy or dispensing entity.

- To the extent that an audit results in the identification of any clerical or record-keeping errors (such as typographical errors, scrivener's error or computer error) in a required document or record, the pharmacy shall not be subject to the recoupment of funds by the PBM unless the PBM can provide proof of intent to commit fraud OR such error results in actual financial harm to the PBM, an exchange health plan managed by the PBM, or a consumer.

(S) Fiduciary Responsibility of Any Entity (Including PBMs) Acting on Behalf of an Exchange

(i) Any person or entity who acts on behalf of an Exchange shall act as a fiduciary. Such person shall ensure that the Exchange is operated (i)solely in the interests of individuals participating in qualified health plans offered through the Exchange, and (ii) for the exclusive purpose of facilitating the purchase of qualified health plans

(ii) Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations or duties imposed by this section shall be liable to make good to the Exchange, the qualified health plans offered through the Exchange or participants of qualified health plans offered through the Exchange, any losses resulting from each breach and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of said fiduciary.

HEALTH BENEFIT PLAN CERTIFICATION: (The following issues—mail order and preventative services—could either be addressed in the state definition of a "benchmark health plan" or the state exchange legislation/Act as seen below)

Note: Section 1311(c)(1) of the federal Act provides that qualified health plans in an exchange must provide network adequacy, ensure a sufficient choice of providers, implement a quality improvement strategy that provides increased reimbursement or other incentives. The federal Act does not provide any detailed information on how these objectives are to be achieved, and to that end –we suggest the inclusion of the following:

The Exchange may certify a health plan as a qualified health plan if the health carrier offering the plan includes the following elements:

(a) **(Any Willing Pharmacy)**--The State must fully comply with any existing state *"any willing provider"* law or any willing pharmacy law. [If your state does not have an any willing provider/pharmacy law –consider proposing the following]:

- Permits the beneficiary, at the time of issuance, amendment or renewal, to select benefit coverage allowing the subscriber to choose a pharmacy or pharmacist for the provision of prescription drugs or pharmacy services, provided that the pharmacy or pharmacist selected by the beneficiary is licensed under state law; complies with all applicable federal and state permit requirements and has not been otherwise excluded from any federal or state program.

- No pharmacy or pharmacist shall be denied the right to participate in an exchange network provided the pharmacy or pharmacist accepts the terms and conditions applicable to all pharmacy providers in the network

- No copayment, fee or other condition shall be imposed upon a plan beneficiary for selecting a particular participating pharmacist or pharmacy that is not also equally imposed upon all plan beneficiaries selecting a participating pharmacist or pharmacy.

(b) **(No Mandatory Mail Order)** A qualified health plan may not mandate that plan beneficiaries utilize mail order pharmacy.

- No qualified health plan offered under a state Exchange that provides coverage for prescription drugs, may require any person covered under the contract to obtain prescription drugs from a mail-order pharmacy in order to obtain benefits for the drugs, or to pay an additional fee or be subjected to any other penalty for failing to utilize any mail-order pharmacy designated by the Exchange

- A qualified health plan offered under a state Exchange may not impose a differential copayment applicable to any prescription drug of the same strength, quantity and days supply, whether obtained from a mail-order pharmacy or a non mail-order pharmacy; and

- Provides the limit on days' supply is the same whether the prescription drug is obtained from a mail-order pharmacy or non mail-order pharmacy and that the limit shall not be less than 90 days

Quality and Preventative Services

Note: PPACA stipulates that "qualified health plans" in an Exchange must implement a quality improvement strategy that provides increased reimbursement or other incentives for a number of activities including: (1) improvement of health outcomes through medication and care compliance initiatives; (2) activities to prevent hospital readmissions; and (3) implementation of wellness and health promotion activities.

(c) A qualified health plan shall include as a covered service, an annual Comprehensive Medication Review administered by a pharmacist in their area. The pharmacist shall review the patient's complete medication profile to detect any potential conflicts or duplications and work with the patient's doctor(s) to optimize each patient's medication regimen. [*note; this provision is based on MTM legislation that passed in IA in 2010*]

(d) Qualified health plans operating in the Exchange shall recognize exchange network pharmacies as in-network providers for any of the preventative care services rated "A" or "B" by the United States Preventative Services Task Force that the pharmacy may offer. (Under PPACA, these services are required to be covered by all group health plans without cost sharing requirements if provided by in-network providers).

PSSNY

Pharmacists Society of the State of New York, Inc.

PBM 101 – "Tricks of the Trade"

Your Rx for Savings Success!

Pharmacy Acronyms:

- **PBM – Pharmacy Benefit Manager: A third party company who processes prescriptions for health care plan sponsors. PBMs develop national pharmacy networks and formularies, etc.**
- **AWP – Average Wholesale Price: This is the "published price" of prescription drugs and is used to determine pharmacy payment for "branded" drugs. A *discounted* AWP is typically used to reimburse a pharmacy on a "brand" drug ingredient cost. (i.e. AWP-15% + $2.00 dispensing fee.**
- **MAC List – Maximum Allowable Cost: This refers to the reimbursement that a pharmacy receives from a PBM or healthcare insurer for the ingredient cost of a "generic" drug and typically comes with a dispensing fee. (i.e. MAC + $1.00)**
- **Reimbursement Spread: - The difference between what the "plan" pays the PBM and what the PBM pays the pharmacy.**

Pharmacy Acronyms:

- **Brand Drug: This is a *single-source* innovator drug that still carries a patent and *can not* be duplicated by a generic drug.**
- **Generic Drug: This is a *"multi-source"* drug that was developed from a former innovator drug whose patent has expired.**
- **Drug Spread: The difference between what the pharmacy pays their wholesaler for a drug and the AWP published price. This is typically 20% on brand drugs if the pharmacy pays cash and every 15 days.**
- **Generics use an AWP spread system that varies widely. Pharmacies are not paid on an AWP - % basis for generics. (Reference Pricing) They are paid from a Maximum Allowable Cost (MAC) list.**

Have Pharmacy Benefit Managers

Really Managed Prescription Drug Costs?

- Prescription drug costs have gone up 16%-21% year after year. Should be flat or declining2%
- Drug ingredient costs have increased between 7%-8% annually with increased utilization of between 1%-2%
- Record number of branded drugs have lost their patents since 2003 with most Innovator drugs losing their patents by the end of 2014.

Have Pharmacy Benefit Managers

Really Managed Prescription Drug Costs?

- Case Study #1 – Large Labor union (360,000 covered lives) had a "traditional" (margin-based) PBM pricing plan.
- Had *"mandatory mail order"* only Rx plan w/ 2x co-pays for a 90-day at mail prescription.
- Fund was experiencing *15%-20% annual* prescription drug cost increases.

Have Pharmacy Benefit Managers

Really Managed Prescription Drug Costs?

- Case Study #1 – Union *'switched'* to a *fully transparent PBM* in 2006 and 'removed' mandatory mail order.
- In the First year in the *new 90-day at retail* prescription drug program, the union experienced a more than $45 million savings despite an *8% increase in drug ingredient cost* and a *2% increase in member utilization.*
- It was estimated by the fund's PBM that they would save an approximately *$210 million* over the next three years.

Have Pharmacy Benefit Managers

Really Managed Prescription Drug Costs?

- Case Study #2 – Mid-sized union (42,000 covered lives) with active & retirees had a traditional *'margined-based'* PBM prescription drug program *experiencing 19%-20% annual* increases
- Had an *incentivised mail order* plan (2 x co-pays) with 'mandatory generics'. Co-pays were 20%-30% of drug cost
- Had a *preferred drug list* for all *non-generic drugs* and members were limited to *$5,000 maximum annual coverage*

Have Pharmacy Benefit Managers

Really Managed Prescription Drug Costs?

- Case Study #2 – In 2005, the Union *'switched'* to a fully *transparent PBM* and entirely removed the mail order option in the first year. Implemented coverage of certain OTCs with no co-pays
- In first year, prescription *drug costs remained flat* despite an *8% increase* in drug ingredient cost
- Fund was able to *enrich the member benefits* with:
  - Lowered co-pays from 20% & 30% of drug cost to $10 or $20
  - Increase annual coverage from $5,000 to $7,500
  - Added a "Full Dental" benefit
  - Saved $700,000 in year one

How do PBMs make money?

Are they really looking out for you?

3 Ways the make money on *YOU*:

- ▶ Spreads on generic drugs. MAC vs. Reference Pricing vs. Pass-through Billing
- ▶ Calling Drug Manufacturer Rebates Something Else
- ▶ Varying AWPs through: payment formulas, 'repacker' NDC #s or package sizes manipulations

How do PBMs make money?

Are they really looking out for you?

Reference Pricing vs. MAC:

- ✷ Reference Pricing refers to the AWP-% that ***YOU*** pay
- ✷ Maximum Allowable Cost (MAC) is how the PBM ***PAYS*** retail pharmacies.
- ✷ The TWO are ***NOT*** the SAME
- ✷ Pass-through Pricing: ***YOUR*** Best Bet!

Price Spreads on **Generic Drugs:** Upstate NY School District – *"Reference Pricing vs. MAC Pricing"*

Mail Order *"Reference Pricing"*
(Generic for Flomax©)
Tamsulosin CAP 0.4 MG
90 Count = $283.58 pd.
Co-pay = $16.00

Retail *"Maximum Allowable Cost"*
(Generic for Flomax©)
Tamsulosin CAP 0.4 MG
90 Count = $9.02 pd.
Co-pay = $20.00

Mail Order *"Reference Pricing"*
(Generic for Zocor©)
Simvastatin TAB 20 MG
90 Count = $333.81 pd.
Co-pay = $16.00

Retail *"Maximum Allowable Cost"*
(Generic for Zocor©)
Simvastatin TAB 20 MG
90 Count = $0.00 pd.
Co-pay = $20.00

Price Spreads on **Generic Drugs:** Upstate NY School District - *"Reference Pricing vs. MAC Pricing"*

Mail Order *"Reference Pricing"*
(Generic for Paxil©)
Paroxetine TAB 30 MG
90 Count = $184.10 pd.
Co-pay = $16.00

Retail *"Maximum Allowable Cost"*
(Generic for Paxil©)
Paroxetine TAB 30 MG
90 Count = $6.95 pd.
Co-pay = $20.00

Mail Order *"Reference Pricing"*
(Generic for Norvasc©)
Amlodipine TAB 5 MG
90 Count = $106.96 pd.
Co-pay = $16.00

Retail *"Maximum Allowable Cost"*
(Generic for Norvasc©)
Amlodipine TAB 5 MG
90 Count = $0.00 pd.
Co-pay = $20.00

Price Spreads on **Generic Drugs:** Upstate NY School District - *"Reference Pricing vs. MAC Pricing"*

Mail Order *"Reference Pricing"*	Retail *"Maximum Allowable Cost"*
(Generic for Pravachol®)	(Generic for Pravachol®)
Pravastatin TAB 20 MG	*Pravastatin* TAB 20 MG
90 Count = $216.29 pd.	90 Count = $5.96 pd.
Co-pay = $16.00	Co-pay = $20.00
Mail Order *"Reference Pricing"*	Retail *"Maximum Allowable Cost"*
(Generic for Amaryl®)	(Generic for Amaryl®)
Glimepiride TAB 4 MG	*Glimepiride* TAB 4 MG
90 Count = $71.43 pd.	90 Count = $0.00 pd.
Co-pay = $16.00	Co-pay = $20.00

Price Spreads on **Generic Drugs:** Upstate Small Business - *"Reference Pricing vs. MAC Pricing"*

Mail Order *"Reference Pricing"*	Retail *"Maximum Allowable Cost"*
Omeprazole	*Omeprazole*
90 Count = $221.00 pd.	90 Count = $123.00 pd.
Mail Order *"Reference Pricing"*	Retail *"Maximum Allowable Cost"*
Simvastatin (different PBM)	*Simvastatin*
90 Count = $63.00 pd.	90 Count = $33.00 pd.

Price Spreads on **Generic Drugs:** Upstate Small Business - *"Reference Pricing vs. MAC Pricing"*

Mail Order *"Reference Pricing"*
Metoprolol Succinate
90 Count = $97.00 pd.

Retail *"Maximum Allowable Cost"*
Metoprolol Succinate
90 Count = $81.00 pd.

Mail Order *"Reference Pricing"*
Sertraline Hcl
90 Count = $87.00 pd.

Retail *"Maximum Allowable Cost"*
Sertraline Hcl
90 Count = $42.00 pd.

Price Spreads on **Generic Drugs:** *"Reference Pricing vs. MAC Pricing vs. Pass-through Pricing"*

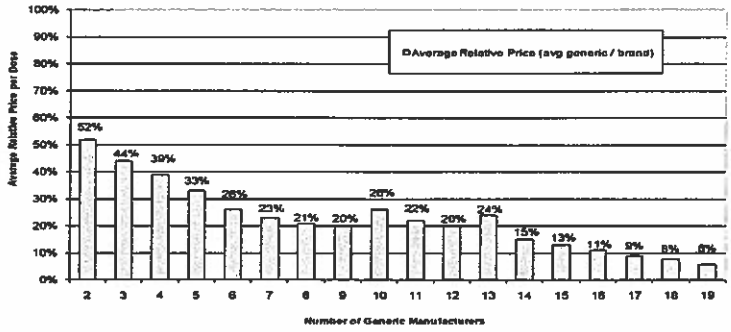
- **Pass-through Pricing:** *REQUIRES* the PBM to charge the plan sponsor only that amount they paid the retail pharmacy or the mail order pharmacy including any dispensing fees
- **Pass-through Pricing** guarantees the plan sponsor ***WILL NOT*** pay any **"Hidden Spreads"** on generics or branded drugs
- **Pass-through Pricing vs. MAC:** PBMs can *manipulate* MAC pricing and include *"spreads"* for themselves
- If you use **Pass-through Pricing**, you will have to pay either a *"per-prescription"* or *"per member, per month"* administrative fee
- **Administrative fees** are *'Transparent'* and make PBMs **compete** for your business based on **'known'** costs.

Price Spreads on **Generic Drugs:** ***"Reference Pricing vs. Pass-through Pricing" – THIS is a BIG DEAL!***

Why 'Spreads' on Generics?????

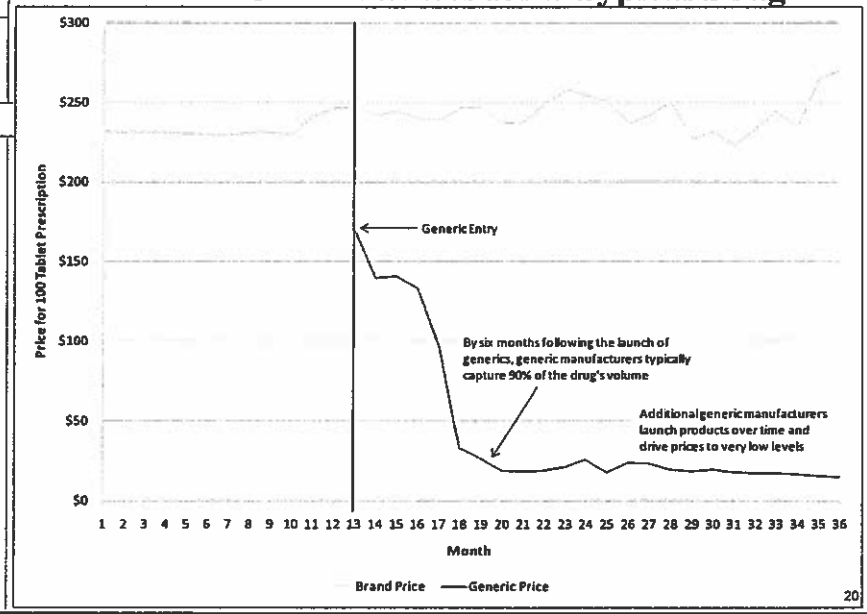
- 2003-2005 – Record number of Brands losing their patents in the history of the prescription drug industry.
- By 2016 – Remaining Innovator brands will be losing their patents.
- PBMs will be losing hundreds of millions of dollars in annually *"kept"* drug manufacturer rebates.

Generic Competition Dramatically Reduces Drug Prices



Source: FDA analysis of retail sales data from IMS Health, IMS National Sales Perspective (TM), 1999-2004, extracted February 2005

Brand & Generic Prices for a Typical Drug



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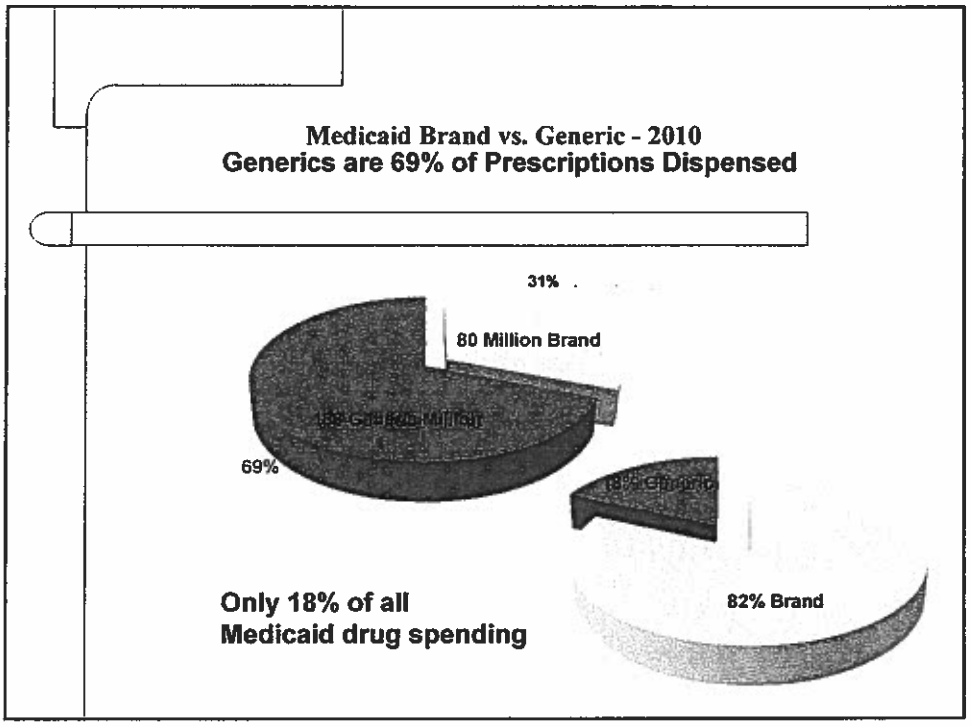
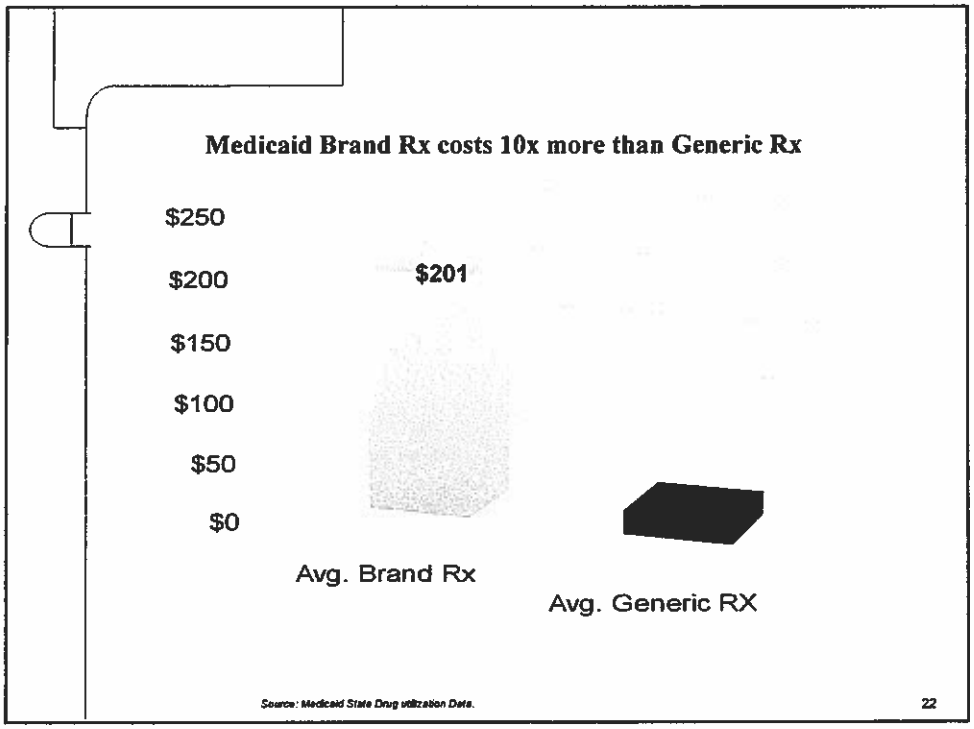

Medicaid Brand vs. Generic - 2010
Generics are 69% of Prescriptions Dispensed
31%
80 Million Brand
69%
82% Brand
Only 18% of all
Medicaid drug spending


Medicaid Brand Rx costs 10x more than Generic Rx
$250
$200
$150
$100
$50
$0
$201
Avg. Brand Rx
Avg. Generic RX
Source: Medicaid State Drug utilization Data.
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Generic Drugs: *Is there more savings there?*

- For every 1% increase in your plan's generic drug use, you *SAVE* 2.5%
- Retail pharmacies dispense generic drugs more often by *10-13% points higher* than do mail order pharmacies owned by the BIG Three PBMs
- A health plan with just *10,000 beneficiaries*, for every *1% increase in generic use*, the plan can *save* ***$180,000***
- Based on this finding, *the 10-13% higher generic utilization by retail pharmacies* can potentially save the 10,000 beneficiary plan between ***$1.8M to $2.34M annually***
- A study found that plans promoting mail order pharmacy with co-pay incentives *PAID 21.4% to 25% more for generic drugs*

Mail Order Pharmacy: *There exists a widespread perception that mail order is cheaper- Why?*

- Because PBM's control your drug costs either *directly* through terms of your contracts with them or *indirectly* through your insurer's contract.
- A surprising number of PBM contracts ***lack drug definition clarity or any definitions at all***, allowing PBMs to ***manipulate*** drug classifications.
- PBMs can *overcharge* clients on *generics* by *classifying* them as *brands* or *classify some brands as generics* to *lower rebate* expectations. **(Linda J. Cahn, J.D.; Managed Care, Nov., 2010; pp. 21-27)**
- Additionally, PBMs can bill you using *'reference pricing'* for certain high volume generics but pay pharmacies using a *MAC*.

Mail Order Pharmacy: *There exists a widespread perception that mail order is cheaper- Why?*

- PBM's may *insist* that *mail order only* contracts allow them negotiate deeper discounts from drug manufacturers based on *volume*
- Discounts are based on the *'Number of Lives Covered'* and *'Market Share Movement'* (brands-formulary) so, it doesn't matter whether you get a prescription filled at retail or mail order
- But, we saved thousands when we went to *mandatory* mail order. ***Compared to What?***
- Did you *KNOW* what retail pharmacy was paid *BEFORE* you moved to mandatory mail order? Or, just what your PBM was *BILLING* you?

Innoviant

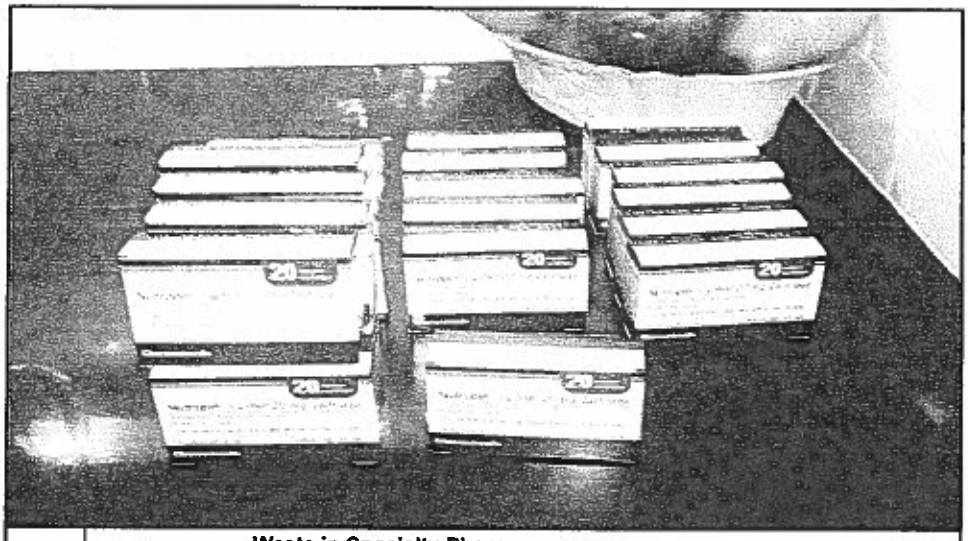
	Average Day Supply	Total Claim Volume	Total Days of Therapy	Total Claim Dollars	Cost Per Day of Therapy	Generic Utilization
Mail Order	35	540,370	46,092,530	$95,367,735.07	$1.98	46.4%
Retail 90-Day Supply	90	411,159	37,005,310	$53,654,770.07	$1.45	57.5%
Retail 30-Day Supply	24	5,419,450	130,066,800	$322,113,150.61	$2.48	59.9%

Specialty & Mail Order Drugs: *The Myth of Savings……*

- **PBM's impact on so-called *"Specialty Drugs"***
  - Buying up specialty drug pharmacies making plans think that the PBMs are the only ones that can provide these services - *Myth*
  - PBMs getting *"exclusive"* contracts with specialty drug manufacturer's which has increased prices exponentially - *Fact*
  - i.e. One PBM got the exclusive distribution contract on a children's epilepsy drug (H.P. Acthar Gel) and *increased* the price from **$1,600** *per tube* to **$23,000** *per tube* or **1400%!** (See AAI report) - *Fact*
  - NYC's PICA *(specialty drug mail order program)* costs skyrocketed in the first year. Hundreds of millions in overcharges found in audit and the program split up - *Fact*

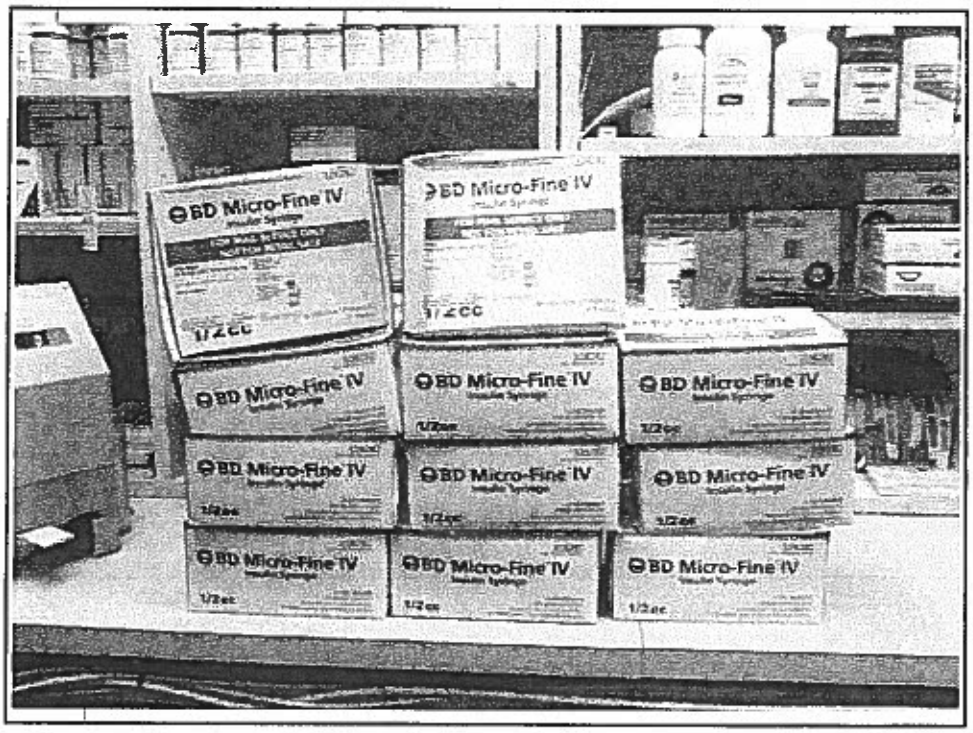
Specialty & Mail Order Drugs: *The Myth of Savings…..*

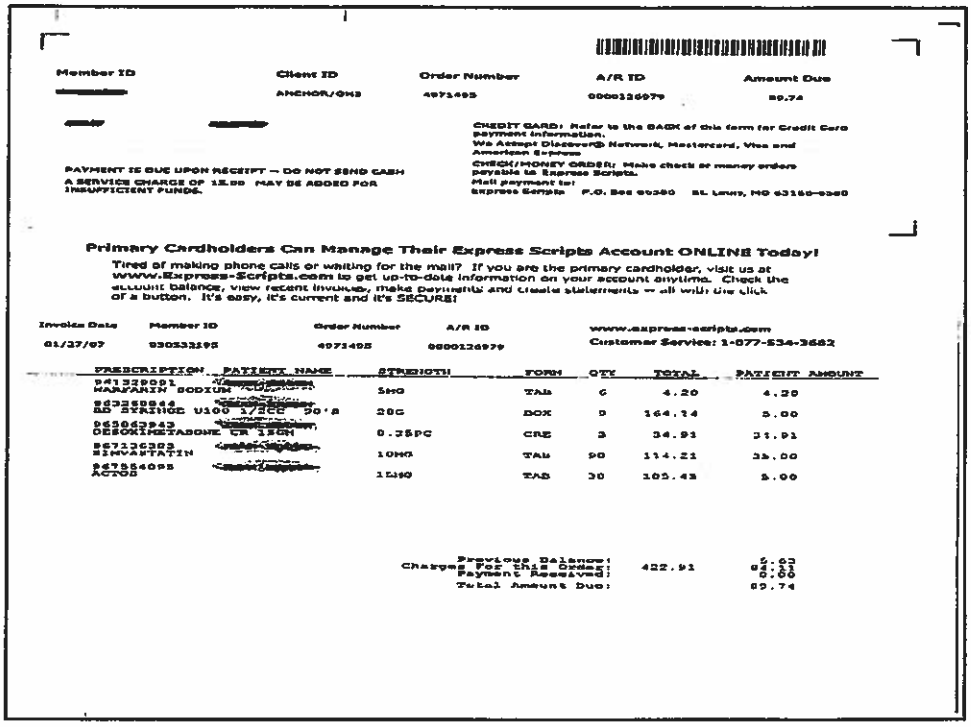
- ***Mail Order of Specialty Drugs Can Lead to Significant Cost Overcharges and Waste***
  - Very expensive specialty drug coming through mail order pharmacies have been *'over-dispensed' - Fact*
  - Mail order ***waste of 'specialty drugs'*** cost payers millions when a PBM continues to ship these medications even when notified that the individual patient was <u>deceased</u> - *Fact*
  - Wasted drugs continues to cost payers when Mail Order pharmacies ship medications *no longer used, discontinued* or *provide 90-day supplies* to now <u>former employees</u> - *Fact*



Waste in Specialty Pharmacy

This patient receives 16 months of medication therapy in 12 months. Medication cost of therapy: $3,600 per month x 4 months equals $14,400 in wasted dollars each year. Therapy will end in four years leaving 32 boxes unused or $115,200 in wasted drug cost for just ONE patient.





Member ID	Client ID	Order Number	A/R ID	Amount Due
[redacted]	ANCHOR/OH3	4971405	0000126979	89.74

[redacted]

PAYMENT IS DUE UPON RECEIPT -- DO NOT SEND CASH
A SERVICE CHARGE OF 15.00 MAY BE ADDED FOR INSUFFICIENT FUNDS.

CREDIT CARD: Refer to the BACK of this form for Credit Card payment information.
We Accept Discover® Network, Mastercard, Visa and American Express

CHECK/MONEY ORDER: Make check or money orders payable to Express Scripts.
Mail payment to:
Express Scripts P.O. Box 66380 St. Louis, MO 63166-6380

Primary Cardholders Can Manage Their Express Scripts Account ONLINE Today!

Tired of making phone calls or waiting for the mail? If you are the primary cardholder, visit us at www.Express-Scripts.com to get up-to-date information on your account anytime. Check the account balance, view recent invoices, make payments and create statements -- all with the click of a button. It's easy, it's current and it's SECURE!

Invoice Date	Member ID	Order Number	A/R ID	
01/27/07	930533195	4971405	0000126979	www.express-scripts.com Customer Service: 1-877-534-3682

PRESCRIPTION	PATIENT NAME	STRENGTH	FORM	QTY	TOTAL	PATIENT AMOUNT
841320091 WARFARIN SODIUM	[redacted]	5MG	TAB	6	4.20	4.20
863288844 BD SYRINGE U100 1/2CC 30'S	[redacted]	28G	BOX	9	164.14	5.00
863042943 DESONIDE/TAZORAC CR 15GM	[redacted]	0.25PC	CRE	3	34.91	31.91
867126303 RIVASTATIN	[redacted]	10MG	TAB	90	114.21	35.00
867854095 ACTOS	[redacted]	15MG	TAB	30	105.43	5.00

Charges	Previous Balance:		5.63
	For this Order:	422.91	89.74
	Payment Received:		0.00
	Total Amount Due:		89.74

Who Regulates PBMs?

- **In the Federal or New York State Governments?**
- **Publicly traded PBMs are regulated by the Securities and Exchange Commission.**
  - **Protects their investors not consumers or plan sponsors**
- **PBMs cannot point to a single line of NYS state code that regulates how they *conduct their business* despite the fact that PBMs:**
- **control what drugs millions consumers can and cannot have covered by their plan – called *'formulary management'***
- ***switch drugs* for corporate gain – (Nexium vs. Prilosec OTC)**
- **determine where consumers can get their prescriptions filled, and**
- **removed themselves from any *fiduciary responsibility* to their clients.**

Drug Name	Strength	Quanity	Actual Acquisition Cost per unit	Cost per Script	Average Wholesale Price per Script	Medco Charge	Gross Profit	Discount from AWP	Claims	Revenue
Furosemide	40 MG	90	$ 0.01	$ 0.90	$ 18.40	$ 5.43	$ 4.53	70%	55	$ 249.15
Simvastatin	40 MG	90	$ 0.07	$ 6.30	$ 442.60	$ 88.84	$ 82.54	80%	250	$ 20,635.00
Hydrocodone/Acetiminophe	5/500 MG	180	$ 0.03	$ 5.40	$ 82.80	$ 21.40	$ 16.00	74%	372	$ 5,952.00
Levopthyroxine Sodium	.01 MG	90	$ 0.09	$ 8.10	$ 26.10	$ 25.10	$ 17.00	4%	94	$ 1,598.00
Lisinopril	20 MG	90	$ 0.04	$ 3.60	$ 94.50	$ 23.35	$ 19.75	75%	226	$ 4,463.50
Metformin HCL	500 MG	180	$ 0.02	$ 3.60	$ 128.00	$ 39.52	$ 35.92	69%	174	$ 6,250.08
Hydochlorothiazide	50 MG	90	$ 0.02	$ 1.80	$ 19.00	$ 7.78	$ 5.98	59%	156	$ 932.88
Atenolol	50 MG	90	$ 0.02	$ 1.80	$ 76.50	$ 8.92	$ 7.12	88%	133	$ 946.96
Metopolol Tartate	50 MG	90	$ 0.02	$ 1.80	$ 48.60	$ 11.93	$ 10.13	75%	194	$ 1,965.22
Amlodipine Besylate	10 MG	90	$ 0.05	$ 4.50	$ 213.88	$ 124.10	$ 119.60	42%	132	$ 15,787.20
Lovastatin	20 MG	90	$ 0.10	$ 9.00	$ 213.30	$ 67.38	$ 58.38	68%	104	$ 6,071.52
Sertraline HCL	50 MG	90	$ 0.06	$ 5.40	$ 244.80	$ 97.70	$ 92.30	60%	132	$ 12,183.60
Alprazolam	.25 MG	90	$ 0.02	$ 1.80	$ 61.20	$ 6.46	$ 4.66	89%	194	$ 904.04
Zolpidem Tartrate	5 MG	90	$ 0.03	$ 2.70	$ 415.80	$ 153.18	$ 150.48	63%	77	$ 11,586.96
Triamterene HCTZ	37.5/25 MG	90	$ 0.03	$ 2.70	$ 34.20	$ 12.60	$ 9.90	63%	82	$ 811.80
Totals				$ 59.40	$ 2,119.68	$ 693.69	$ 634.29	67%	2,375	$ 90,337.91
Per Script				$ 3.96	$ 141.31	$ 46.25	$ 42.29			

A sample of generic drug prescriptions charged to payer by Medco Health. Note gross profit of $42.29 per prescription!

Drug Name	Strength	Quanity	Actual Acquisition Cost per unit	Cost per Script	Average Wholesale Price per Script	Charge	Gross Profit	Discount from AWP	Claims	Revenue
Furosemide	40 MG	90	$ 0.01	$ 0.90	$ 18.40	$ 3.08	$ 2.18	83%	55	$119.90
Simvastatin	40 MG	90	$ 0.07	$ 6.30	$ 442.60	$ 19.80	$ 13.50	96%	250	$3,375.00
Hydrocodone/Acetiminophen	5/500 MG	180	$ 0.03	$ 5.40	$ 82.80	$ 16.00	$ 10.60	81%	372	$3,943.20
Levopthyroxine Sodium	.01 MG	90	$ 0.09	$ 8.10	$ 26.10	$ 17.00	$ 8.90	35%	94	$836.60
Lisinopril	20 MG	90	$ 0.04	$ 3.60	$ 94.50	$ 13.50	$ 9.90	86%	226	$2,237.40
Metformin HCL	500 MG	180	$ 0.02	$ 3.60	$ 128.00	$ 10.80	$ 7.20	92%	174	$1,252.80
Hydochlorothiazide	50 MG	90	$ 0.02	$ 1.80	$ 19.00	$ 6.23	$ 4.43	67%	156	$691.08
Atenolol	50 MG	90	$ 0.02	$ 1.80	$ 76.50	$ 5.17	$ 3.37	93%	133	$448.21
Metopolol Tartate	50 MG	90	$ 0.02	$ 1.80	$ 48.60	$ 3.42	$ 1.62	93%	194	$314.28
Amlodipine Besylate	10 MG	90	$ 0.05	$ 4.50	$ 213.88	$ 8.10	$ 3.60	96%	132	$475.20
Lovastatin	20 MG	90	$ 0.10	$ 9.00	$ 213.30	$ 22.50	$ 13.50	89%	104	$1,404.00
Sertraline HCL	50 MG	90	$ 0.06	$ 5.40	$ 244.80	$ 11.70	$ 6.30	95%	132	$831.60
Alprazolam	.25 MG	90	$ 0.02	$ 1.80	$ 61.20	$ 6.46	$ 4.66	89%	194	$904.04
Zolpidem Tartrate	5 MG	90	$ 0.03	$ 2.70	$ 415.80	$ 17.01	$ 14.31	96%	77	$1,101.87
Triamterene HCTZ	37.5/25 MG	90	$ 0.03	$ 2.70	$ 34.20	$ 4.79	$ 2.09	86%	82	$171.38
Totals				$ 59.40	$ 2,119.68	$ 165.56	$ 106.16	92%	2,375	$ 18,106.56
Per Script				$ 3.96	$ 141.31	$ 11.04	$ 7.08			

The same prescriptions using a pass-through, transparent pricing model: gross profit = $7.08 per prescription.

Manufacturer's Rebates:
What's *Yours* in Mine

- Are you getting 100% of the 80% of drug manufacturer rebates your PBM promised? Or,
- Are you only getting 100% of 50% of what you were promised?
- PBMs often call rebates *something else* and keep the rest for themselves
  - Administrative fees;
  - Data collection fees;
  - Formulary Management fees;
  - Education grants
  - Research fees

Manufacturer's Rebates:
What's *Yours* in Mine

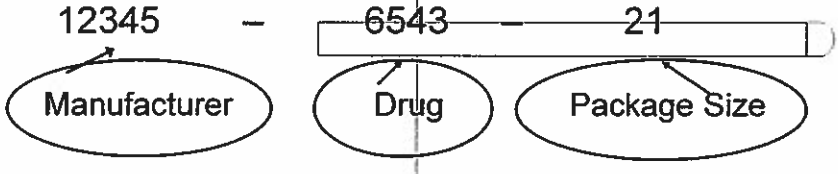
- Prescription Drug Plans should insist on **100% "Pass-through"** of *ALL* drug manufacturer's rebates
- You must *insist* on being able to *'audit'* both your *'pass-through drug pricing'* and *'rebates'*
- Your *best* friend could be your local *independent pharmacist*. They can tell you *'what'* they got paid for the drugs (top 50 most dispensed generics)
- Your contract *MUST* insist on *Transparency* for all costs including Prior Authorization's *(which should be part of the bidding process)*

Repacker Average Wholesale Prices:
A Slight of Hand Can Cost You BIG!

- ***What is A Repacker Number?***
- It's typically a branded drug (can be generics) granted a ***new NDC number*** by the FDA to reflect a ***package size*** that may be *different* than the original manufacturer's common package sizes
- Repackers *determine* what their Average Wholesale Price (AWP) *will be* on that New NDC number, *not the original manufacturer*
- What you get are AWP's that are often *higher* and even *much higher* than the *original manufacturer's published AWPs*
- *Therefore, your discount of AWP-20% may be **MUCH HIGHER** than original manufacturer's published AWP-18%*

Example:
National Drug Code (NDC) Number

- **Eleven digit number that defines manufacturer, type of drug and package size.**
- **This number may be printed on reports without hyphens.**
- **AWP (Average Wholesale Price) is specific for each NDC number.**



Repacker Examples:

Original Manufacturer's AWP (Pfizer) as listed in the 2010 Red Book

$ *Celebrex 200MG®* – NDC#00025-1525-31- 100's
- ✓**AWP - $4.43 per capsule**

Repackers AWP's as listed in the 2010 Red Book

$ *Celebrex 200MG®* – NDC#66105-0106-10- 100's
- ✓**AWP - $8.35 per capsule**

$ *Celebrex 200MG®* – NDC#68387-0552-30- 30's
- ✓**AWP - $8.60 per capsule**

$ *Celebrex 200MG®* – NDC#49999-0004-00- 100's
- ✓ **AWP = $9.31 per capsule**

Example:
Package Size Differential
Are <u>YOU</u> being Billed using only 9 NDC digits?

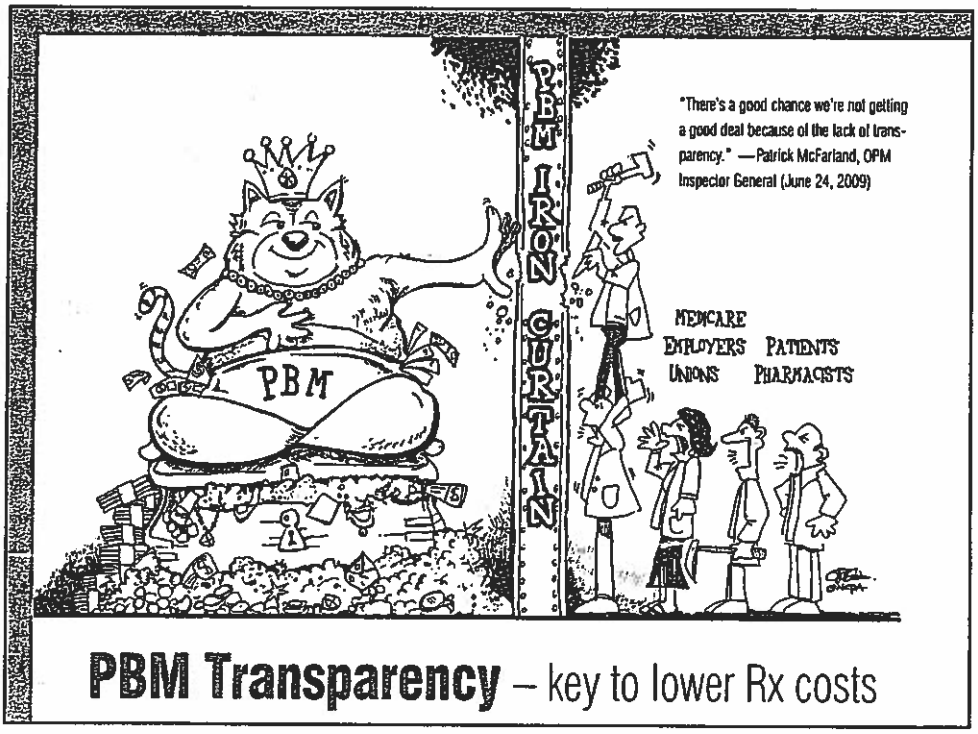
Pharmacy Paid on 1000's Size	**Client Charged on 100's Size**
AWP – 14% + $2.00 =	**AWP – 12% + $2.50 =**
AWP=$100.00 - $14.00 + $2.00 = <u>$88.00</u>	**AWP=$105.00 - $12.60 + $2.50 = <u>$94.90</u>**
	$94.90 – $88.00 =** **$ 6.90 PBM profit add-on

Protecting your bottom line requires ongoing vigilance.

Champion **Transparency!**

Transparency will:

- Keep you *aware* of the changing drug marketplace issues affecting your budgets.
- *Alert* you to what you are really paying for prescription drugs.
- *Promote* your commitment to your members or employees by keeping their out-of-pocket costs down.



PBM Transparency – key to lower Rx costs

Study References

- See ***"False Savings of Mail Order Pharmacies"*** document following these slides for all study references referred to in this presentation.

PSSNY

210 Washington Avenue Extension, Albany, NY 12203
800-632-8822 · 518-869-6595 · Fax: 518-464-0618
Web: www.pssny.org · Email: staff@pssny.org

"Specialty Drugs" List

example from Web site

January 2012

CVS CAREMARK | Specialty Pharmacy

Specialty Pharmacy Drug List

Providing one of the broadest offerings of specialty pharmaceuticals in the industry

If you are a plan member or health care provider, please contact Specialty Customer Care toll-free at 1-800-237-2767 or visit www.cvscaremarkspecialtyrx.com

With nearly 35 years of specialty pharmacy experience, CVS Caremark Specialty Pharmacy provides proactive quality care and service. We have a network of pharmacies which includes those with Joint Commission and URAC accreditation. The Joint Commission and URAC are nationally-recognized symbols of quality which reflects an organization's commitment to meet high standards of quality and safety.

ACROMEGALY
octreotide acetate (SANDOSTATIN)[1,1]
Sandostatin LAR[1]
Somatuline Depot[*,1]
Somavert[*,1]

ALCOHOL DEPENDENCY
Vivitrol[1]

ALLERGIC ASTHMA
Xolair[*,1]

ALPHA-1 ANTITRYPSIN DEFICIENCY
Aralast[2,*,1]
Glassia[*,1]

ANEMIA
Aranesp[2]
Epogen
Procrit

BOTULINUM TOXINS
Botox[1]
Dysport[1]
Myobloc[1]
Xeomin[*,1]

CONTRACEPTIVES
Implanon[*,1]
Nexplanon[*,1]
Mirena[*,1]

CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES
Arcalyst[*,1]
Ilaris[*,1]

CYSTIC FIBROSIS
Pulmozyme
TOBI

DUPUYTREN'S CONTRACTURE
Xiaflex[*,1]

GOUT
Krystexxa[*,1]

GROWTH HORMONE & RELATED DISORDERS
Growth Hormone Disorders
Genotropin[2]
Humatrope
Norditropin[2]
Nutropin[2]
Omnitrope
Saizen[2]
Serostim[*,1]
Tev-Tropin
Zorbtive
IGF-1 Deficiency
Increlex[*,1]

HEMATOPOIETICS
Mozobil[*,1]
Neumega

HEMOPHILIA, VON WILLEBRAND DISEASE & RELATED BLEEDING DISORDERS[1]
Advate
Alphanate
AlphaNine SD
Bebulin[2]
BeneFIX
Corifact[*]
Feiba VH
Feiba NF
Helixate FS
Hemofil M
Humate-P
Koate-DVI
Kogenate FS
Monarc M
Monoclate-P
Mononine
NovoSeven[2]
Profilnine SD
Proplex T
Recombinate
Refacto
RiaSTAP
Stimate
Wilate
Xyntha

HEPATITIS C
Incivek
Infergen
Pegasys[2]
PegIntron[2]
Rebetol Solution
RibaPak
Ribasphere
RibaTab
ribavirin caps (REBETOL)[1]
ribavirin tabs (COPEGUS)[1]
Victrelis

HEREDITARY ANGIOEDEMA[1]
Berinert[*]
Cinryze[*]
Firazyr[*]

HIV MEDICATIONS
Egrifta[*,1]
Fuzeon

HORMONAL THERAPIES
Eligard
Firmagon[1]
H.P. Acthar Gel[*,1]
leuprolide acetate (LUPRON)[1]
Lupron Depot[21]
Supprelin LA[*,1]
Trelstar[21]
Vantas[1]
Viadur[1]
Zoladex[1]

IMMUNE DEFICIENCIES & RELATED DISORDERS[1]
Carimune NF
Cytogam
Flebogamma[2]
GamaSTAN S/D
Gammagard[2]
Gammaked
Gammaplex[*]
Gamunex
HepaGam B
Hizentra[*]
HyperHEP B
HyperRHO S/D
MICRhoGAM[2]
Nabi-HB
Octagam
Polygam S/D
Privigen
RhoGAM[2]
Rhophylac
Vivaglobin[*]
WinRho SDF

IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA
Nplate[1]
Promacta[*,1]

INFECTIOUS DISEASE
Actimmune[*,1]

Products distributed by CVS Caremark Specialty Pharmacy, as well as products covered by a plan member's prescription benefit plan, may change from time to time. In addition, a plan member's specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance on this document at any time.

January 2012

CVS CAREMARK | Specialty Pharmacy

INFERTILITY
Bravelle
Cetrotide
chorionic gonadotropin (novarel, pregnyl)[1]
Follistim AQ
ganirelix acetate[1]
Gonal-F[2]
Luveris
Menopur
Ovidrel
Repronex

INFLAMMATORY BOWEL DISEASE
Cimzia[1]
Humira
Remicade[1]
Tysabri[*1]

IRON OVERLOAD
deferoxamine (DESFERAL)[†1]
Exjade[*1]

LYSOSOMAL STORAGE DISORDERS[1]
Aldurazyme[*]
Cerezyme[*]
Cystagon[*]
Elaprase[*]
Fabrazyme[*]
Lumizyme[*]
Myozyme[*]
Naglazyme[*]
VPRIV[*]

MACULAR DEGENERATION
Eylea[*1]
Lucentis[*1]
Macugen[*1]
Visudyne[*1]

MOVEMENT DISORDERS
Apokyn[*1]
Xenazine[*1]

MULTIPLE SCLEROSIS
Ampyra[*1]
Avonex
Betaseron
Copaxone
Extavia
Gilenya
Rebif
Tysabri[*1]

NEUTROPENIA
Leukine
Neulasta
Neupogen

ONCOLOGY – INJECTABLE[3]
Thyrogen[*1]
Xgeva[1]
Zometa[1]

ONCOLOGY – ORAL/TOPICAL
Afinitor
Gleevec
Hycamtin[*1]
Jakafi[*1]
Nexavar[*1]
Oforta[*1]
Revlimid[*1]
Sprycel
Sutent
Tarceva
Targretin[2]
Tasigna
Temodar
Thalomid
Tykerb[*1]
Votrient[*1]
Xalkori[*1]
Xeloda
Zelboraf[*1]
Zolinza
Zytiga

OSTEOARTHRITIS
Euflexxa[1]
Hyalgan[1]
Orthovisc[1]
Supartz[1]
Synvisc[1]
Synvisc One[1]

OSTEOPOROSIS
Forteo
Prolia[1]
Reclast[1]

PAROXYSMAL NOCTURNAL HEMOGLOBINURIA
Soliris[*1]

PHENYLKETONURIA
Kuvan[*1]

PRE-TERM BIRTH
Makena[*1]

PSORIASIS
Amevive[1]
Enbrel
Humira
Remicade[1]
Stelara[1]

PULMONARY ARTERIAL HYPERTENSION[1]
Adcirca
epoprostenol sodium[1*]
Letairis[*]
Remodulin[*]
Revatio
Tracleer[*]
Tyvaso[*]
Ventavis[*]

RENAL DISEASE
Sensipar

RESPIRATORY SYNCYTIAL VIRUS
Synagis[1]

RHEUMATOID ARTHRITIS
Actemra[1]
Cimzia[1]
Enbrel
Humira
Kineret[1]
Orencia[1]
Remicade[1]
Simponi

SEIZURE DISORDERS
H.P. Acthar Gel[*1]
Sabril[*1]

SYSTEMIC LUPUS ERYTHEMATOSUS
Benlysta[1]

If you are a plan member or health care provider, please contact CaremarkConnect® toll-free at 1-800-237-2767 or visit www.cvscaremarkspecialtyrx.com.

[1] Lowercase type indicates generic name and availability; lowercase type within parentheses indicates trademark generics listed only when no brand is available, products in all capital letters within parentheses indicate brand-names of generic products.
[2] Multiple dosage formulations and injectable devices are available
[3] Call CVS Caremark toll-free at 1-800-237-2767 for specific medications available through CVS Caremark Specialty Pharmacy. Listing is subject to change.
[*] Indicates Limited Distribution products distributed by CVS Caremark Specialty Pharmacy. Limited Distribution defined as less than 15 pharmacy providers
[†] Therapy class or product is part of CVS Caremark's Specialty Select offering.

Products distributed by CVS Caremark Specialty Pharmacy, as well as products covered by a plan member's prescription benefit plan, may change from time to time. In addition, a plan member's specific prescription benefit plan design may not cover certain products or categories, regardless of their appearance on this document at any time.

"Pharmacist as Immunizer"

New York Pharmacy Access Network

NEW YORK PHARMACY ACCESS NETWORK

THE NEW YORK PHARMACY ACCESS NETWORK (NYPAN) WAS CREATED TO PROMOTE CONTINUED AND EXPANDED ACCESS TO PHARMACY AND OTHER ESSENTIAL HEALTH CARE SERVICES FOR NEW YORK'S RESIDENTS. PHARMACIES PROVIDE A CONVENIENT AND TRUSTED ACCESS POINT FOR ALL NEW YORKERS, INCLUDING THE UNINSURED AND UNDERINSURED. OFTEN AVAILABLE 24 HOURS A DAY AND 7 DAYS A WEEK, PHARMACIES ARE LOCATED IN EVERY COMMUNITY PROVIDING HEALTH CARE SERVICES IN RURAL, URBAN AND UNDERSERVED AREAS.

NYPHARMACYACCESSNETWORK@GMAIL.COM

Strong Support For 2012 Legislation: S.3808-A, Fuschillo / A.6301-A, Paulin

The New York Pharmacy Access Network (NYPAN) strongly supports expansion of the law enacted in 2008 which authorizes certified pharmacists to administer influenza and pneumococcal vaccinations to individuals 18 years and older.

Specifically, the Network urges that the law be expanded to allow pharmacists to administer all vaccinations recommended for adults by the Centers for Disease Control and Prevention (CDC) and to remove the sunset which requires the existing law to expire on March 31, 2016.

Continued and expanded access to vaccinations for all patients including the elderly and those with compromised immune systems and chronic diseases is critical. Immunizations are the best defense against morbidity and mortality for diseases for which vaccines are available.

Immunizations prevent the significant health care costs that would result if patients are not vaccinated and develop illnesses that could otherwise be prevented.

It is a public health imperative that the State take all steps necessary to ensure widespread access to recommended vaccinations for all of its residents. NYPAN believes that a major step that New York must take is to expand its pharmacist immunizer law to increase vaccination rates for all New Yorkers and to address disparities that exist among those who have traditionally not been vaccinated or have very low immunization rates. ■

CDC - RECOMMENDED VACCINES

The CDC recommends ten vaccines for those over age 18, including influenza and pneumococcal. Others include Tdap which prevents Whooping cough, Zoster for shingles and Varicella for chicken pox.

These vaccines are not always available at physician offices due to cost, storage and handling requirements and other factors. In these cases, some physicians would be willing to write a patient specific order or prescription for the vaccines to be administered by certified pharmacists. By providing this additional access point, immunization rates for these vaccines will increase dramatically, particularly for hard to reach patients. ■

Assisting Hard To Reach And High Risk Patients

- According to the New York State Board of Pharmacy (the Board), there are currently 7,200 pharmacists certified to administer immunizations.
- Over 800,000 flu shots were given by pharmacists throughout 2010.
- According to state-specific immunization rates for seasonal flu issued by the CDC, New York State saw an overall increase in its adult immunization rate of 2.8% for the 2009-10 flu season.
- Studies have shown that pharmacist-provided immunizations increase overall immunization rates through increase public awareness on the need to get flu shots and other vaccines. In New York, every category of licensed health professional administered more flu shots in 2010.
- Since the law took effect, there have been no adverse events reported to the State Education Department or State Department of Health and no complaints filed by consumers or other health professionals related to pharmacist administered vaccines.
- All 50 states allow pharmacists to administer immunizations. New York has one of the most restrictive laws in the country. A number of states allow pharmacists to administer all vaccines pursuant to the CDC schedule as we are recommending. These include New Jersey, Pennsylvania, Rhode Island, Washington DC, Colorado, Arizona, & New Mexico. Also, there are a number of other states that allow pharmacists to administer all immunizations within a protocol established with a physician which usually follows the CDC guidelines.

Despite the State's strong efforts to ensure that all patients have primary care physicians and medical homes, many New Yorkers still do not have one. This is due to a number of factors including employment and insurance issues, immigration status, cultural barriers and others. Pharmacies help to bridge this gap, providing a trusted and convenient point of access for all patients available in every community, in the evening and on weekends. Also as part of the existing law, pharmacists provide patients with information on the importance of having a primary care provider.

According to the CDC, New York saw the following increases in immunization rates during the 2009-10 flu season:

- ***7.3% increase for those aged 18-49 years old at high risk (which includes individuals with asthma, other lung problems, diabetes, heart disease, kidney problems, anemia or a weakened immune system;***
- ***8% increase among African American population;***
- ***8.6% increase among Hispanic population; and***
- ***12.9% increase among Asian and other minority populations.***

In 2011, New York pharmacists provided flu shots to 18,055 Medicaid patients and pneumococcal shots to 117 Medicaid patients.

During the 2009-10 H1N1 epidemic in New York, pharmacists were essential to the State's efforts to quickly and effectively inoculate the State's most vulnerable citizens including those under age 18 pursuant to an Executive Order. Pharmacists were able to enhance the State's capacity to respond to this emergency and demonstrated their professional competence to implement public health initiatives consistent with established standards.

COST SAVINGS

Widespread immunization of all individuals, as indicated for their age and certain risk factors, results in significant health care savings by preventing the development of illnesses that lead to very high medical costs, human suffering and even death.

In 2011, the Medicaid Redesign Team (MRT) included the expansion of the pharmacist immunizer law to other vaccines recommended by the CDC in its final list of recommendations to the Governor and State Legislature. Unfortunately, the expansion was not included in the FY 2011-12 Budget.

In recommending the expansion, the MRT indicated that administration of the influenza vaccine to individuals 65 years and older creates a $182 per person savings in overall medical costs. Applying this figure to the approximately 500,000 Medicaid dual eligible patients yields a $91 million a year savings. The MRT's $182 per person annual savings figure is very conservative when considering the cost of an average hospital stay for the treatment of complications from influenza (approximately four days) which is an estimated $10,000.

Expanding the current law to provide additional points of access for patients to obtain vaccines to prevent Whooping cough, shingles, hepatitis and other serious illnesses will result in significant health care savings for the State and the health care system overall. ■

"PBM Profits"

SEC 10-K's filed in 2010

10-K 1 d10k.htm FORM 10-K

2006 – 2010

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

☒ **Annual Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the fiscal year ended December 31, 2010

OR

☐ **Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934**

For the transition period from to

Commission file number 001-01011

CVS CAREMARK CORPORATION

(Exact name of Registrant as specified in its charter)

Delaware	**050494040**
(State or other jurisdiction of incorporation or organization)	**(I.R.S. Employer Identification No.)**
One CVS Drive, Woonsocket, Rhode Island	**02895**
(Address of principal executive offices)	**(Zip Code)**

(401) 765-1500

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $0.01 per share	**New York Stock Exchange**
Title of each class	**Name of each exchange on which registered**

Securities registered pursuant to Section 12(g) of the Exchange Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, or a non-accelerated filer, or a smaller reporting company. See definition of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer ☒ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

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Item 6. Selected Financial Data

The selected consolidated financial data of CVS Caremark Corporation as of and for the periods indicated in the five-year period ended December 31, 2010 have been derived from the consolidated financial statements of CVS Caremark Corporation. The selected consolidated financial data should be read in conjunction with the consolidated financial statements and the audit reports of Ernst & Young LLP, which are incorporated elsewhere herein.

In millions, except per share amounts	2010[2]	2009[2]	2008[2]	2007[2][3]	2006[2]
Statement of operations data:					
Net revenues	$ 96,413	$ 98,729	$ 87,472	$ 76,330	$ 43,821
Gross profit	20,257	20,380	18,290	16,108	11,742
Operating expenses[4]	14,092	13,942	12,244	11,314	9,300
Operating profit[5]	6,165	6,438	6,046	4,794	2,442
Interest expense, net	536	525	509	435	216
Income tax provision[6]	2,190	2,205	2,193	1,722	857
Income from continuing operations	3,439	3,708	3,344	2,637	1,369
Loss from discontinued operations, net of income tax benefit[7]	(15)	(12)	(132)	—	—
Net income	3,424	3,696	3,212	2,637	1,369
Net loss attributable to noncontrolling interest[1]	3	—	—	—	—
Preference dividends, net of income tax benefit	—	—	(14)	(14)	(14)
Net income attributable to CVS Caremark	$ 3,427	$ 3,696	$ 3,198	$ 2,623	$ 1,355
Per common share data:					
Basic earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.52	$ 2.59	$ 2.32	$ 1.97	$ 1.65
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.51	$ 2.58	$ 2.23	$ 1.97	$ 1.65
Diluted earnings per common share:					
Income from continuing operations attributable to CVS Caremark	$ 2.50	$ 2.56	$ 2.27	$ 1.92	$ 1.60
Loss from discontinued operations attributable to CVS Caremark	(0.01)	(0.01)	(0.09)	—	—
Net income attributable to CVS Caremark	$ 2.49	$ 2.55	$ 2.18	$ 1.92	$ 1.60
Cash dividends per common share	$0.35000	$0.30500	$0.25800	$0.22875	$0.15500
Balance sheet and other data:					
Total assets	$ 62,169	$ 61,641	$ 60,960	$ 54,722	$ 20,574
Long-term debt	$ 8,652	$ 8,756	$ 8,057	$ 8,350	$ 2,870
Total shareholders' equity	$ 37,700	$ 35,768	$ 34,574	$ 31,322	$ 9,918
Number of stores (end of year)	7,226	7,074	6,981	6,301	6,205

(1) Represents the minority shareholders' portion of the net loss from our majority owned subsidiary Generation Health, Inc. acquired in the fourth quarter of 2009.

(2) On December 23, 2008, our Board of Directors approved a change in our fiscal year-end from the Saturday nearest December 31 of each year to December 31 of each year to better reflect our position in the health care, rather than the retail, industry. The fiscal year change was effective beginning with the fourth quarter of fiscal 2008. As you review our operating performance, please consider that fiscal 2010 and 2009 include 365 days, fiscal 2008 includes 368 days, and fiscal 2007 and 2006 include 364 days.

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2010,

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

FOR THE TRANSITION PERIOD FROM _____ TO _____.

Commission File Number: 0-20199

EXPRESS SCRIPTS, INC.

(Exact name of registrant as specified in its charter)

Delaware	**43-1420563**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
One Express Way, St. Louis, MO	**63121**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 996-0900

Securities registered pursuant to Section 12(b) of the Act:

Title of Class	Name of each exchange on which registered
Common Stock $0.01 par value, including related Preferred Share Purchase Rights	Nasdaq Global Select Market

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation of S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

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Item 6 — Selected Financial Data

The following selected financial data should be read in conjunction with our consolidated financial statements, including the related notes, and "Item 7 — *Management's Discussion and Analysis of Financial Condition and Results of Operations*". Results for the years ended December 31, 2009, 2008, 2007 and 2006 have been adjusted for the discontinued operations of PMG.

(in millions, except per share data)	2010	2009[1]	2008[2]	2007[3]	2006
Statement of Operations Data (for the Year Ended December 31):					
Revenues[4]	$44,973.2	$24,722.3	$21,941.2	$21,788.9	$21,532.1
Cost of revenues[4]	42,015.0	22,298.3	19,910.6	20,039.2	20,071.8
Gross profit	2,958.2	2,424.0	2,030.6	1,749.7	1,460.3
Selling, general and administrative	887.3	926.5	756.3	693.4	638.4
Operating income	2,070.9	1,497.5	1,274.3	1,056.3	821.9
Other expense, net	(162.2)	(189.1)	(66.9)	(116.1)	(83.6)
Income before income taxes	1,908.7	1,308.4	1,207.4	940.2	738.3
Provision for income taxes	704.1	481.8	431.5	342.2	265.2
Net income from continuing operations	1,204.6	826.6	775.9	598.0	473.1
Net (loss) income from discontinued operations, net of tax[5]	(23.4)	1.0	0.2	(30.2)	1.3
Net income	$ 1,181.2	$ 827.6	$ 776.1	$ 567.8	$ 474.4
Weighted average shares outstanding:[6]					
Basic:	538.5	527.0	497.8	520.8	559.2
Diluted:	544.0	532.2	503.6	528.0	568.0
Basic earnings (loss) per share:[6]					
Continuing operations	$ 2.24	$ 1.57	$ 1.56	$ 1.15	$ 0.85
Discontinued operations[5]	(0.04)	—	—	(0.06)	—
Net earnings	2.19	1.57	1.56	1.09	0.85
Diluted earnings (loss) per share:[6]					
Continuing operations	$ 2.21	$ 1.55	$ 1.54	$ 1.13	$ 0.83
Discontinued operations[5]	(0.04)	—	—	(0.06)	—
Net earnings	2.17	1.56	1.54	1.08	0.84
Balance Sheet Data (as of December 31):					
Cash and cash equivalents	$ 523.7	$ 1,070.4	$ 530.7	$ 434.7	$ 131.0
Working capital	(975.9)	(1,313.3)	(677.9)	(507.2)	(657.3)
Total assets	10,557.8	11,931.2	5,509.2	5,256.4	5,108.1
Debt:					
Short-term debt	0.1	1,340.1	420.0	260.1	180.1
Long-term debt	2,493.7	2,492.5	1,340.3	1,760.3	1,270.4
Stockholders' equity	3,606.6	3,551.8	1,078.2	696.4	1,124.9
Network pharmacy claims processed[7]	602.0	404.3	379.6	379.9	390.3
Home delivery, specialty pharmacy, and other prescriptions filled[8]	54.1	45.0	45.1	45.5	46.9
Total claims	656.1	449.3	424.7	425.4	437.2
Total adjusted claims[9]	753.9	530.6	506.3	507.0	519.6
Cash flows provided by operating activities—continuing operations	$ 2,105.1	$ 1,752.0	$ 1,091.1	$ 841.4	$ 665.7
Cash flows used in investing activities—continuing operations	(145.1)	(4,820.5)	(318.6)	(52.6)	(98.3)
Cash flows (used in) provided by financing activities—continuing operations	(2,523.0)	3,587.0	(680.4)	(469.7)	(904.7)
EBITDA from continuing operations[10]	2,315.6	1,604.2	1,368.4	1,150.5	918.5

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 25, 2010

Commission File Number: 1-31312

MEDCO HEALTH SOLUTIONS, INC.

(Exact name of Registrant as specified in its charter)

Delaware	**22-3461740**
(State or other jurisdiction of incorporation)	(I.R.S. Employer Identification No.)
100 Parsons Pond Drive, Franklin Lakes, NJ	**07417-2603**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: 201-269-3400

Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, Par Value $0.01	New York Stock Exchange
7.25% Senior Notes Due 2013	New York Stock Exchange
6.125% Senior Notes Due 2013	New York Stock Exchange
2.75% Senior Notes Due 2015	New York Stock Exchange
7.125% Senior Notes Due 2018	New York Stock Exchange
4.125% Senior Notes Due 2020	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☑

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. 48.

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The following table reconciles our reported net income to EBITDA and presents EBITDA per adjusted prescription for each of the respective periods (in millions, except for EBITDA per adjusted prescription data):

For Fiscal Years Ended	December 25, 2010[a]	December 26, 2009	December 27, 2008[b]	December 29, 2007[c]	December 30, 2006
Net income	$ 1,427.3	$ 1,280.3	$ 1,102.9	$ 912.0	$ 630.2
Add:					
Interest expense	172.5	172.5	233.7	134.2	95.8
Interest (income) and other (income) expense, net	(9.4)	(9.9)	(6.2)[d]	(34.4)	(29.9)
Provision for income taxes	906.9	823.0[e]	687.9[e]	591.3	381.6[e]
Depreciation expense	189.5	179.0	157.7	168.9	173.6
Amortization expense	287.4	305.6	285.1	228.1	218.5
EBITDA	$ 2,974.2	$ 2,750.5	$ 2,461.1	$ 2,000.1	$ 1,469.8
Adjustment for the 2006 legal settlements charge	—	—	—	—	162.6[f]
EBITDA, excluding the 2006 legal settlements charge	$ 2,974.2	$ 2,750.5	$ 2,461.1	$ 2,000.1	$ 1,632.4
Adjusted prescriptions[g]	957.0	898.8	795.9	748.3	729.9
EBITDA per adjusted prescription	$ 3.11	$ 3.06	$ 3.09	$ 2.67	$ 2.01
EBITDA per adjusted prescription, excluding the 2006 legal settlements charge	$ 3.11	$ 3.06	$ 3.09	$ 2.67	$ 2.24

[a] *Includes UBC's operating results commencing on the September 16, 2010 acquisition date.*

[b] *Includes Europa Apotheek's operating results commencing on the April 28, 2008 acquisition date, and for the subsequent periods.*

[c] *Includes PolyMedica's and Critical Care's operating results commencing on the October 31, 2007 and November 14, 2007 acquisition dates, respectively, and for the subsequent periods.*

[d] *Includes a $9.8 million charge for the ineffective portion of the forward-starting interest rate swap agreements associated with the March 2008 issuance of senior notes. See Note 8, "Debt," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.*

[e] *2009, 2008, and 2006 include tax benefits of $22 million, $28 million, and $20 million, respectively. See Note 10, "Taxes on Income," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.*

[f] *Represents a pre-tax legal settlements charge of $162.6 million recorded in the first quarter of 2006. See note [1] to Selected Financial Data above.*

[g] *Adjusted prescription volume equals substantially all mail-order prescriptions multiplied by three, plus retail prescriptions. These mail-order prescriptions are multiplied by three to adjust for the fact that they include approximately three times the amount of product days supplied compared with retail prescriptions.*

[h] *The percentage of adjusted mail-order prescriptions to total adjusted prescriptions.*

"Mandatory Mail Order Prescriptions"

False Savings and Generic Drug 'Spread Pricing'

[redacted]

01/3 RD,

AMSULOSIN CAP 0.4MG # 90 ACTAV
Generic For: FLOMAX CAP 0.4 MG
NDC#00228-2999-50 INS. PAID: $283.58 — What School Dist. paid PBM
0 REFILLS LEFT
ACCEPTED TDI
COPAY: $16.00
[redacted] DISP#:2 RBT
11031573620202

[redacted]

03/01/11 AMV E

SINOPRIL 5MG TABS # 90 MAX
C#00172-3758-80 INS. PAID: $51.02 —
REFILL(S) LEFT
CEPTED TDI
COPAY: $16.00
[redacted] DISP#:0 RBT
11060510601610

[redacted]

/01/11 AMV E

GLIMEPIRIDE 4 MG TAB # 90 TEVA
Generic For: AMARYL 4 MG TAB
IDC#00093-7256-52 INS. PAID: $71.43 —
REFILL(S) LEFT
ACCEPTED TDI
COPAY: $16.00
[redacted] DISP#:0 RBT
11032397118210

[redacted]

05/03/11 DP E

TAMSULOSIN CAP 0.4MG # 90 ACTAV
Generic For: FLOMAX CAP 0.4 MG
NDC#00228-2996-50 INS. PAID: $9.02 — What School Dist. pays now.
NO REFILLS LEFT
ACCEPTED TDI
COPAY: $20.00
[redacted] DISP#:3 RBT
11123593414594

[redacted]

LISINOPRIL 5MG TABS # 90 MAX
NDC#00172-3758-80 INS. PAID: $0.00 —
2 REFILL(S) LEFT
ACCEPTED TDI
COPAY: $20.00
[redacted] DISP#:1 RBT
11105303685204

[redacted]

05/09/11 RMF E
NY

GLIMEPIRIDE 4 MG TAB # 90 TEVA
Generic For: AMARYL 4 MG TAB
NDC#00093-7256-52 INS. PAID: $0.00 —
2 REFILL(S) LEFT
ACCEPTED TDI
COPAY: $20.00
[redacted] DISP#:1 RBT
11129460372101

2007 - 2010 - mandatory Mail Order Rx

Mail Order Pharmacy

NON-transparent PBM

This is "spread pricing" on generics!

2010 → New contract w/ mail order
- 90-day @ retail or mail
- Same co-pay
- Significant savings for School District

Transparent PBM

50.

[redacted]
02/05/11 CTH E

WARFARIN 3 MG TAB # 90 TARO
Generic For: COUMADIN 3MG TABS
NDC#51672-4030-03 INS. PAID: $28.84 — school cost
1 REFILL(S) LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $16.00
[redacted] DISP#: 1
11036730912111

[redacted]
05/07/11 JC E

WARFARIN 3 MG TAB # 90 TARO
Generic For: COUMADIN 3MG TABS
NDC#51672-4030-03 INS. PAID: $5.70 — new cost to school
1 REFILL(S) LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $20.00
[redacted] DISP#:2
11127421519905

[redacted]
02/24/11 CTH E

METOPROLOL SUCC XL 100MG(TO# 90 WATSOI
Generic For: TOPROL XL 100MG
NDC#62037-0832-01 INS. PAID: $96.59 —
REFILL(S) LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $16.00
[redacted] DISP#:1 RBT
11055475788707

[redacted]
05/22/11 AMV E

METOPROLOL SUCC XL 100MG(TO# 90 WATSOI
Generic For: TOPROL XL 100MG
NDC#62037-0832-01 INS. PAID: $75.26 —
3 REFILL(S) LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $20.00
[redacted] DISP#:2 RBT
11142378210710

[redacted]
02/05/11 CTH E

SERTRALINE 50MG TABS # 90 NORTHS
NDC#16714-0612-05 INS. PAID: $103.86 —
NO REFILLS LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $16.00
[redacted] DISP#:2 RBT
11036730811912

[redacted]
04/29/1[redacted] CTH E

SERTRALINE 50MG TABS NORTHS
NDC#16714-0612-05 INS. PAID: $0.00 —
NO REFILLS LEFT
ACCEPTED TDI
BILL CREDITCARD COPAY: $20.00
[redacted] DISP#:3 RBT
11119803527201

Mail order w/our mail ↑ Mail Order Only

w/ 90-Day choice mail Transparent PBM

BI.

[redacted]

02/23/11 JC S

AMLODIPINE 5 MG TAB # 90
Generic For: NORVASC TAB 5MG ZYDUS
NDC#68382-0122-05 INS. PAID: $108.90 — school pd
NO REFILLS LEFT
ACCEPTED TDI

COPAY: $16.00

[redacted] DISPR:0 RBT
11054313903404

02/02/11 RMF S

PRAVASTATIN 20 MG TAB # 90
Generic For: PRAVACHOL 20MG TABS TEVA
NDC#00093-7201-10 INS. PAID: $216.29 —
NO REFILLS LEFT
ACCEPTED TDI

COPAY: $16.00

[redacted] DISPR:3 RBT
11033342353110

01/31/11 JC E

SIMVASTATIN 20 MG TAB # 90
Generic For: ZOCOR 20MG NORTH
NDC#16714-0683-03 INS. PAID: $333.81 —
1 REFILL(S) LEFT
ACCEPTED TDI

COPAY: $16.00

[redacted] DISPR:2 RBT
11031573549201

03/08/11 AMV E

PAROXETINE HCL 30MG TAB # 90
Generic For: PAXIL 30MG TABS AUROBI
NDC#55802-0156-99 INS. PAID: $184.10 —
2 REFILL(S) LEFT
ACCEPTED TDI

COPAY: $16.00

[redacted] DISPR:0
11067846600507

↑ mandatory mail

mail order w/ out rec

7/11 AMV S

AMLODIPINE 5 MG TAB # 90
Generic For: NORVASC TAB 5MG ZYDUS
NDC#68382-0122-05 INS. PAID: $0.00 — school pays now!
NO REFILLS LEFT
ACCEPTED TDI

COPAY: $20.00

[redacted] DISPR:1 RBT
11158439378111

05/23/11 KLB S

PRAVASTATIN 20 MG TAB # 90
Generic For: PRAVACHOL 20MG TABS TEVA
NDC#00093-7201-10 INS. PAID: $5.95 —
3 REFILL(S) LEFT
ACCEPTED TDI

COPAY: $20.00

[redacted] DISPR:0 RBT
11143366701507

06/21/11 KLB E

SIMVASTATIN 20 MG TAB # 90
Generic For: ZOCOR 20MG NORTH
NDC#16714-0683-03 INS. PAID: $0.00 —
3 REFILL(S) LEFT
ACCEPTED TDI

COPAY: $20.00

[redacted] DISPR:0 RBT
11172401594701

06/06/11 RMF E

PAROXETINE HCL 30MG TAB # 90
Generic For: PAXIL 30MG TABS AUROBI
NDC#55802-0156-99 INS. PAID: $6.95 —
2 REFILL(S) LEFT
ACCEPTED TDI

COPAY: $20.00

[redacted] DISPR:1
11157627650507

w/ rec Retail w/ 90-day option

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