

Senators & Representatives,

I am a community pharmacy owner. My store is in Bristol, and it has been in business for 36 years, I have owned it for the past 26 years. I employ 6 full time staff, 14 part time staff, and pay annual wages in excess of \$800,000 dollars. All of my employees live within 10 miles of my store, pay taxes in Bristol and surrounding communities, own homes in Bristol and surrounding communities and support Ct and it's economy. I will not be able to attend the public hearing on HB 6322, but feel the need to present written testimony. If I were to attend I would ask the following questions and make the following comments regarding each question. I appreciate your taking the time to read my testimony, and have provided my contact information if you have any questions for me.

Sincerely

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If I were there,

**I would ask if HB6322 will increase the present per prescription co-pay, or maximum co-pay per month paid by entitlement recipients.**

Prescription co-pays were instituted during a previous budget crunch. As a front line provider, I was amazed that the sickest people are asked to pay the most in co-pay. Patients who don't use the prescription benefit continue to enjoy a level monthly stipend, while prescription recipients are being asked to pay up to \$15 per month toward their prescription expense. I would think the State should have figured out that by reducing everyone's monthly stipend by a small amount, the savings of the prescription co-pay program would have been borne by all eligible recipients. To consider a further increase in co-pay per prescription or maximum monthly co-pay would be a disservice to the sickest of the eligible clients.

**I would ask if there will be any changes to the list of covered medications.**

In my experience, the discontinuing of coverage of many older, less expensive prescription products and of most OTC products has failed in reducing costs. At the retail level, I see patients that are prescribed inexpensive OTC's, being prescribed covered RX only items which are much more expensive.

**I would ask if there will be any incentives for clients to patronize one particular pharmacy in favor of another pharmacy, or to obtain their maintenance medication from mail-order sources.**

These programs are presently being used by all PBMs which own pharmacies to remove prescriptions from the local retail economy and move them to out of state mail order prescription fulfillment centers. Reading the professional literature, there are as many studies which favor local prescription processing as there are favoring large mail order fulfillment centers. It seems apparent that business removed from the local economy can't be good for the local economy. The State is spending millions of dollars to keep jobs in Connecticut. Why would the State be considering a conversion to a PBM, if there is a

strong likelihood that it will reduce CT jobs and further reduce the number of small businesses in the State.

**I would ask what will happen to the employees who currently provide the administrative functions related to the prescription drug program. How many jobs will be lost in Ct that will transfer to the claims processing center of CVS/Caremark, which is located outside of CT.**

1st & foremost, 2011 appears to be about retaining jobs, retaining needed services, and reducing the cost to provide those services. HB6322 appears to be concerned only with reducing the cost. It throws out an attractive number (\$66 Million), and proposes the way to obtain some of the cost reduction is to pay an out of state company, with out of state employees, which pays out of state taxes, to administer the current program. The program is presently being administered in-state in an efficient manner. Replacing the current system of claims processing will be expensive, confusing for clients, and could cost the State more than it's current administrative system.

**I would ask precisely how will the \$66 Million dollars be saved? I would ask that the proposed savings be broken down into specific categories, with the specific mechanisms that will be used to achieve the proposed savings. I would also ask if audits of the PBM, by the State, will be allowed to be performed to assure compliance with any agreement between the State and the PBM. What will be the frequency of those audits and the consequences of not meeting expected goals?**

The idea that HB6322 will give the administrative function for the State program to any other entity, without going through a competitive bidding process, seems to me to be fraught with potential problems. It is a well known fact that for profit administrative expenses in the health care arena far outpace administrative expenses in a government run health program. It would be poor fiscal management to just assume that the current CVS/Caremark model is the most cost effective for the State. It may propose to save the State money, but how it is done should be spelled out precisely, so all parties understand the proposed mechanisms. Other entities should be allowed to enter discussions with the State to provide administrative services, or the current State Employees program should be brought into the same system as the State entitlement system, thereby shifting the duplicate expense of program administration to the less expensive government run option.

**I would ask, what guarantees will exist to assure that CVS/Caremark PBM will not supply CVS/Caremark retail, mail order, or specialty pharmacy with prescription information obtained by processing claims from it's competitors' pharmacies. An additional question is, Will CVS/Caremark retail, mail service and specialty pharmacy be given unlimited access to the full listing of all eligible recipients, similar to what was provided at the time of the transition of the State Employees program?**

The choice of a Pharmacy owned PBM is of concern. The current contract between CVS/Caremark and the State created much confusion between the recipients of service and where they had to go to receive their services. Just the fact that the PBM is named CVS/Caremark continues to cause confusion and is designed to make clients think that they have to go to CVS retail stores. CVS/Caremark PBM information, prominently listed all the major chain pharmacies in their brochures, but omitted many Independently owned stores. CVS also always listed their store in the first position on any listing that was produced. CVS retail stores were mentioned first by the Pharmicare customer service representative. These issues were later resolved, but not until the confusion had occurred and not until after a legal proceeding had been begun and was settled. CVS/Caremark PBM has access to my customer lists and my retail pricing. Based on the fact that our industry has never been given a

copy of the current contract between the State and CVS/Caremark, how can I be assured that CVS is not using my information to undermine my business. CVS/Caremark is presently involved in a number of legal challenges alleging unfair business practices, etc. Until proven otherwise, I do not trust it's assertion that there is a solid firewall between it's PBM division and it's Retail and Specialty Pharmacy divisions.

**I would ask if any actively practicing retail, long-term care, or institutional pharmacists participated in developing this proposal.**

HB6322 seems to be another quick fix proposal to solve a longstanding problem, the ever escalating cost of providing necessary and cost effective prescription drug medications. Unfortunately, some of the root causes of the issue are still not being addressed, and I don't see this proposal as anything but another reduction in provider reimbursements. \$66 million is a lot of money to come out of the approximately 700 licensed pharmacies in Connecticut. The bill does not address the largest portion of the current expense, which is utilization of brand name medications when therapeutically similar generic medications are available at a fraction of the cost. I have ideas, and data to back them up, which I know would save the State many prescription procurement dollars. Necessary care will not be compromised, nor will the livelihood of thousands of Connecticut workers, employed at Retail, Long Term Care, or Institutional pharmacies throughout the State, be threatened.

**I would be asking how many prescriptions are paid for each year in the affected programs, what the average price per prescription was, and how much money will have to be saved on each prescription in order to realize the \$66 million savings.**

**I would ask what the current rebate program brings in and if the current program is going to be scrapped. I would ask if the new program will assure a cost of goods that makes the State whole, including the additional \$66 million, without affecting the Pharmacy current reimbursement according to the present State AWP minus formula (brand name medications) and the current State maintained MAC formula (generic medications).**

After receiving the numbers, I would then decide if the number seems realistic or just wishful thinking. Of the average prescription cost, pharmacy is reimbursed \$2.90/prescription, the rest is the cost of the product. I don't understand how this bill would improve the cost of product beyond it's current cost structure. My understanding is that the State already receives rebate dollars from any manufacturer that wishes it's product to be covered by the current State entitlement programs. Apparently this money goes into the general fund and is not used to determine a net cost of the prescription program. How will any new purchasing arrangement be better at reducing the current cost of goods enough to generate an additional \$66 million in savings, without affecting provider reimbursements.

If you would like to talk, I can be reached at 860-584-0587 (home) or 860-583-1006 (work).

Thanks for your time and attention to my concerns.

Sincerely  
Bob Wollenberg