MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By **CHAIRMAN JOHN HERTEL**, on February 14, 1995, at 8:00 a.m.

ROLL CALL

Members Present:
Sen. John R. Hertel, Chairman (R)
Sen. Steve Benedict, Vice Chairman (R)
Sen. William S. Crismore (R)
Sen. C.A. Casey Emerson (R)
Sen. Ken Miller (R)
Sen. Mike Sprague (R)
Sen. Gary Forrester (D)
Sen. Terry Klampe (D)
Sen. Bill Wilson (D)

Members Excused: N/A

Members Absent: N/A

Staff Present: Bart Campbell, Legislative Council
Lynette Lavin, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 313, SB 322
Executive Action: None

HEARING ON SB 313

Opening Statement by Sponsor:

SEN. KEN MESAROS, SD 25, Cascade, distributed copies of **SB 313** explanation, **EXHIBIT #1** and proposed amendments, **EXHIBIT #2** and said **SB 313** would benefit Montana consumers who patronized home town pharmacies by ensuring equal access for purchases through drug manufacturers' discounts. He reviewed the "Statement of Intent" for **SB 313** and said it was a fairness bill based on operating equal action to those who adhered to equal criteria. He explained **SB 313** section by section and said there would be two sets of amendments, which he supported.

SEN. MESAROS said manufacturers had two classes of trade; mail order pharmacies which had about 40% of the market, and community pharmacies which had about 60% of the market. He said the dramatic price differences between the two groups, sometimes as much as 80%, was causing lawsuits across the United States. **SEN. MESAROS** stated discriminatory pricing, as identified in **SB 313**, impacted Montana because of the large number of smaller pharmacies which served the majority of Montana citizens. He said the profit margin for local pharmacies would be very slim.

Proponents' Testimony:

Jim Smith, Montana State Pharmaceutical Association, read his written testimony, **EXHIBIT #3.**

Brad Griffin, Montana Retail Association, read his written testimony, **EXHIBIT #4** and presented examples of "Shadow Pricing, **EXHIBIT #5.**

Kenneth Bergum, Member, Montana State Pharmaceutical Association, said he had been a pharmacist in Montana for 44 years, founded the Bergum Drug Stores in Helena, sold the stores to his son and hoped his son could pass the business to **Mr. Bergum's** grandson. However, this hope had been seriously challenged through a pricing system by pharmaceutical manufacturers which placed community pharmacies in the highest tier of a multi-tiered system. He said his drug stores were forced to sell the pharmaceuticals at prices which did not cover the expenses. **Mr. Bergum** said out-of-state mail order companies were being subscribed to by organizations which represented their customers (including Montana government and state institutions) who had been served by community pharmacists through the years. **Mr. Bergum** said he was worried about Montana retaining the 1,000 community pharmacists who were the vital link between the Montana public and other health care professionals. He stated he wanted these first-class citizens to stay in Montana because of their value to Montana communities, and hoped they could provide fair prices to customers through an equal access system. **Mr. Bergum** urged the committee to give approval to **SB 313.**

Linda Hapingardner, Pharmacist, said consumers were the losers in the game manufacturers were playing because they were subsidizing the artificially low prices which hospitals, HMOs and mail orders were being charged. She reported the worst part was the consumers in the third party organizations were not realizing the savings. **Ms. Hapingardner** stated senior citizens who had a fixed income and no insurance coverage were the hardest hit because they paid for their medications out of their pockets. She informed the committee sometimes these senior citizens did not follow prescription instructions in order to save money; ultimately, they probably spent much more because of potential hospital stays, more medication, etc.

Ms. Hapingardner reminded the committee if community pharmacies went out of business, many smaller chain stores would not survive, which could cause a problem because time was required for medications to be received through the mail. She said the bottom line was the installment of fair pricing which would allow purchasing at the same volume buying discounts; thereby, benefiting both consumers and providers.

Dan Severson, Pharmacy/Home Health Care Supply Store, Stevensville, said manufacturers dictated business policies by restricting customers, amount of reimbursement and access to equal prices. He stated those restrictions made it difficult to compete, and shared how his pricing book listed two prices -- one for institutional buying and one for retail buying. **Mr. Severson** said **SB 313** would help ensure small pharmacies survive in Montana.

Mary McCue, Legal Counsel and Lobbyist for Montana State Pharmaceutical Association, said she wanted to inform the committee of the lawsuits brought by community pharmacies against manufacturers of pharmaceuticals, stating they were class action suits and individual action suits. She defined class action suits as charging violations of Section 1 of the Sherman Antitrust Act (illegal price-setting schemes) and individual action suits as charges under the Sherman Act and the Robinson Patman Act, which was enacted by Congress to get discriminatory pricing. **Ms. McCue** said all lawsuits had been consolidated into a single Federal Court, under a single judge, and were scheduled to go to trial sometime next year. She declared the lawsuit consolidation and scheduling would not provide a short-term remedy for Montana pharmacies. **Ms. McCue** asked the committee to provide a legislative remedy in addition to what was sought through judicial remedy. She referred to **EXHIBIT #1**, Page 4, for further details of the lawsuits.

Robert Nickens, National Association of Chain Drug Stores, said he would not address **SB 313**; rather, he wished to inform the committee about the Class of Trade, which was not actually in the Robinson Patman Act. He stated the Robinson Patman Act said discrimination was not allowed against individuals or businesses who competed with each other. He explained years ago, retail pharmacists did not compete with institutional buyers, which was the simple, legal basis of the lawsuits. **Mr. Nickens** said the committee would hear: (1) Testimony from pharmaceutical manufacturers and those who received benefits of how **SB 313** would raise prices. He said that would mean manufacturers would make more money and he wondered why they would oppose **SB 313** so adamantly; (2) Testimony from paid lobbyists instead of the drug manufacturers themselves who did business in Montana.

Wayne Hedman, Owner, Bitterroot Drug, challenged the committee to see the harm done to Montana consumers by allowing the tiered pricing to continue. He said pharmacies watched discriminatory prices by the Federal Government and hospitals, but said nothing;

however, when HMOs and pharmacies got discriminatory prices, they were motivated to do something. **Mr. Hedman** urged the committee to consider giving independent pharmacists a level playing field to enable competition.

John "Ed" Kennedy, Montana State Pharmaceutical Association, submitted his written testimony, **EXHIBIT #6.**

Ron Kembel, Pharmacist, Cut Bank, said he needed to maintain customer base in order to stay in business in Cut Bank.

Peter Wolfgram, Pharmacy Owner, said he would like the opportunity to compete and purchase products at the same price as everyone else in similar circumstances.

Bill Stevens, Montana Food Distributors Association, said Montana grocers had begun to incorporate pharmacies; in many cases, it was the only opportunity for the customer to purchase their drugs. He expressed full support for **SB 313.**

Edmund Caplis, Executive Director, Montana Senior Citizens Association, expressed support for **SB 313** from the consumer's point of view.

Ron Bergum, Pharmacy Owner, Helena, said his stores employed six full-time pharmacists. He said he was tired of charging high prices because he felt cash-paying customers were being subsidized. **Mr. Bergum** said he would like to see pharmacy get back to being a profession dealing with health care, rather than economics.

Informational Testimony:

Annie Bartos, Chief Legal Counsel, Department of Commerce, said she was a noponent and distributed copies of amendments, **EXHIBIT #7,** explaining they would provide for direct access to district court without provisions for administrative hearing and investigative procedure under **30-14-220 - 30-14-223.**

{Tape: 1; Side: B}

Opponents' Testimony:

Steve Brown, Pharmaceutical Research and Manufacturers of America (PhRMA), said his organization was composed of approximately 80 pharmaceutical companies which researched, developed and sold most drugs used by American consumers. He agreed the concerns expressed by the pharmacists were real; however, everyone in health care was facing an uncertain future. He stated in the past few years, 40-60 thousand jobs had been lost in their industry and he stressed competition and changing demands from consumers forced everyone to deal with the question of whether

business today would be done in the same way as it was 10 years ago. **Mr. Brown** questioned whether **SB 313** offered a solution to small, independent retail Montana pharmacies, and urged the committee to vote on **SB 313** based on whether it could solve the problems presented.

Mr. Brown referred to **EXHIBIT #8a** (Number of Pharmacies) and said the decrease of community pharmacies was due to chain pharmacies. He drew the committee's attention to **EXHIBITS #8b, #8c** (ShopKo and Safeway Pharmacy coupon's) and explained nothing in **SB 313** eliminated the discounts, nor passing savings resulting giving the best, lowest price, to consumers.

Mr. Brown urged rejection of **SB 313** because it would not accomplish the main objective of the presentations, but would create price controls through establishment of government regulation of drug prices and freezing of competition and market prices, i.e. **SB 313** would hurt Montana consumers. He said legislation similar to **SB 313** had been introduced in 35 states and rejected in all but one; one of the prime reasons for rejection was the perception that competition was eliminated and consumer cost increased. He said another reason for rejecting **SB 313** was the major premise that state government, not competition, would decide who got the discounts.

Mr. Brown contended passage of **SB 313** would put pharmaceutical manufacturer indigent programs and the ability to distribute free samples at risk. He said **SB 313** was a bad business decision and referred to **EXHIBIT #8d** (letter from Bill Beck). He claimed there would be a fiscal impact which would involve the Department of Commerce as well as Medicaid.

Bob Cam, Pharmacist & Lawyer, Shawnee, Kansas, said the health care industry was moving from a fee-based system to one of managing patient care to assure better results at a lower cost. He said the fee-based system was not sensitive to price; however, in the mid-80's when cost control began to emerge, the system became price-sensitive. **Mr. Cam** said managed care systems realized the control of drug utilization by patients and change of prescribing habits by physicians could result in health care savings; therefore, they demanded price concessions from drug companies as compensation for their services. **Mr. Cam** explained the alternative for the companies was the loss of business by being eliminated from the formularies of those organizations; therefore, industry had little choice but to comply. He related formulary management (ability to control what products were prescribed, dispensed and paid for) gave the organizations the power to affect market share and demand prices which reflected savings to the manufacturer, achieved because the manufacturer no longer had to spend money for the sales reps to promote the products, increase the market share and assure utilization. **Mr. Cam** maintained the drug industry was downsizing, reorganizing, merging and restructuring in reaction to profit erosion. He also said retail pharmacy was somewhat behind the curve because it was

not equipped to control patient usage or physician prescribing; however, pharmacists were now taking a more vigorous role in managing patient outcomes.

He said the Robinson Patman Act helped promote differential pricing because the Act exempted charitable institutions; therefore, groups could demand differential prices. He said the issues were before the court and should be allowed to finish there; changes in state law would only complicate an already complex situation. **Mr. Cam** insisted differential pricing did not benefit the pharmaceutical industry, but were responses to the demands of the evolving health care system. He alleged the change of one variable in a complex equation would not meet the challenges in the evolving marketplace, which could make the solution even more difficult to achieve.

John Church, Serle and Company, said the anti-trust litigation was the fastest anti-trust litigation ever to occur in the United States; a class had been certified and every Montana retail pharmacy was a member of that class. He commented the Montana and United States pharmacies (specifically named plaintiffs) and 13 major chains representing over 10.000 pharmacies were involved in the litigation. **Mr. Church** claimed during the next few months there would be a dramatic change in the way both pharmacies and pharmaceutical companies did business; therefore, the passing of a law under those circumstances put everyone in a difficult position. He said the litigation produced the pricing documents, the policy documents and contracts from the 28 pharmaceutical defendants to the pharmacies; for the first time in history, an entire industry's pricing policies were in the hands of the pharmacies. **Mr. Church** remarked the information was being collated and made available through expert testimony which was ordered to be concluded by September, 1995. He explained in a few months, the committee could make use of an enormous analysis of pricing, pricing policies and effect of differential and unitary pricing on pharmacies and customers; it could do so with the structure in effect as of September, 1995. **Mr. Church** opined such information could be of benefit to the committee in determining whether **SB 313** would benefit those it was intended to benefit in 1995 as well as 1996 and 1997.

Mr. Church suggested by 1996, the following would be a result of the litigation: (1) Opportunity to analyze pricing policies and their effect on everyone to determine whether **SB 313** would benefit the people intended; (2) Provision of a uniform solution to pricing, which could mean third-party payers purchasing drugs outside Montana and shipping them through interstate commerce into Montana. The retail pharmacy would lose the prescription price as well as other income derived from the customer shopping while waiting for the prescription to be filled; (3) Provision of beneficial information to determine how best to proceed.

Mr. Church reminded the committee both pharmacies and pharmaceutical companies were in bad positions, because of a market structure over which they had no control.

Russ Ritter, Washington Corporation, said his corporation received $8.99 million in provider services during 1994; an estimated $1.068 million were in drug charges, $7.9 million was covered in their contract by third party administrator, but $5.48 million was actually paid out. **Mr. Ritter** said the 12% estimated cost of drugs meant the third party administrator paid out about $657,000; the difference between that figure and the $1.068 million was about $480,000+. He explained someone would pay additional costs and they did not want either employers or employees to be that someone. **Mr. Ritter** reminded the committee 34 of 35 states did not approve of legislation found in **SB 313**, and he did not think Montana should either.

Denis Yost, Montana Society of Hospital Pharmacists & Director of Pharmacy, St. Peters Hospital, Helena, said his organization opposed **SB 313** because affordable pricing came from: (1) Volume. St. Peters Hospital was one of a 1,200-member hospital group for group purchasing; (2) Single source. St. Peters agreed to keep one drug on the formulary; (3) Not for Profit. St. Peters Hospital had budgeted about $1 million in charitable health care, a major part of which would come from favorable pricing.

Mr. Yost stated pharmaceutical companies would realize the same profits, no matter what was done; in fact, previous legislation was just a shift in the charge structure of a manufacturer which gave better prices to government at the expense of the private sector. He said if **SB 313** passed, the same thing could happen again, and costs could be increased on the hospital side because the costs would be shifted to the hospital consumer.

Kay Kocew Fox, Montana Low Income Coalition, said her constituency was opposed to **SB 313** for the following reasons: (1) Impact on their Medicaid formula, which currently allowed the government to give a 15% discount, or the best price (in Montana, the best price, or 21%, was used); (2) Impact on pharmacy indigent care programs (uniform pricing could cause the indigent care program to cease); (3) Impact on doctors' free drug samples.

Ms. Kocew Fox suggested if **SB 313** passed, the effective date be delayed in order to determine what happened to Medicaid in Maine, the only state which passed this legislation, and to determine whether the current litigation would make this issue moot. She said her organization stood in opposition to **SB 313** unless it could be determined what would happen to the Medicaid benefits.

Chuck Butler, Blue Cross/Blue Shield, said their concern with **SB 313** came from the Statement of Intent, Lines 14-16. He explained the proponents said they wanted to level the playing field, but that would eliminate competition, which in turn would cause higher prices for consumers. He urged DO NOT PASS for **SB 313.**

Don Waldron, said a number of his districts belonged to the Montana Unified School Trust (MUST), and he had served on that board. He said MUST's purpose was to cut health costs, and during the time he served on the board, the emphasis was on cutting prescription costs. He said after he retired, MUST went with a cooperative company out of Salt Lake City which gave him the benefit of paying $10 for a three-months' supply of a $52/month medicine. **Mr. Waldron** emphasized both MUST and he saved money. He expressed opposition of **SB 313.**

Tom Hopgood, Health Insurance Association of America (HIAA), said when health insurance or health care costs rose, the increases were passed to the consumer. He said the effect of **SB 313** would be an increase in the cost of prescription drugs, which would increase health care, which would increase health insurance premiums. He said his organization was interested in keeping the cost of health insurance premiums down, and he asked a DO NOT PASS for **SB 313.**

Steve Turkiewicz, Montana Auto Dealers Association & MADA Insurance Trust, said his company offered its members and their employees competitive health care insurance, and in the last six years, the premiums had more than doubled. He said during that time MADA Trust struggled to work with their insurance carrier and other Montana groups to become part of a purchasing group, and had presently joined the Montana Association of Health Care Purchasers. That Association hoped to be one of Montana's first voluntary purchasing pools as soon as legislation was passed to allow its existence.

Mr. Turkiewicz said they were very concerned about the price of drugs and pharmaceuticals; drugs were one of the largest component increases in the last six years. He stated they were interested in joining other employers and employees in finding other market mechanisms to control the cost of health care, including pharmaceuticals. He urged the rejection of **SB 313.**

Questions From Committee Members and Responses:

SEN. STEVE BENEDICT asked if St. Peter's Hospital would be considered an institutional purchaser. **Denis Yost** said it was a not for profit institution.

SEN. BENEDICT referred to **EXHIBIT 5** and said institutional purchasers paid about $160-$170 for 500 400mg Tagamet, and wondered if the quoted price was accurate. **Mr. Yost** said they did not use Tagamet on their formulary; however, they would go with whomever they had a group contract, and some hospitals would not have the same prices as HMOs.

SEN. BENEDICT asked **Denis Yost** if St. Peters used Prozac, and if they would pay about $120 for 100 20mg tablets. **Mr. Yost** said they paid about $160; however, that was because it could not be

made into a single source -- if they carried only one antidepressant, the price could be negotiated.

SEN. BENEDICT asked if that was a formulary. **Denis Yost** said it was.

SEN. KEN MILLER challenged the statement there could be no competition when everybody got the same price, explaining the same price would qualify only under the same conditions, i.e. certain volume purchase, demand payment up front, etc. **Marjorie Powell, General Counsel, PhRMA,** said she had to make sure her member companies did not share confidential, company-based pricing information. She said they interpreted **SB 313** as requiring a manufacturer to provide the same price on the same terms and conditions, but not allowing a discount for a term condition which not everyone could meet, i.e. no provision for innovation which was in the market now. She said the purchaser would not be allowed to propose a risk-sharing arrangement; therefore, a uniform price with minor variations would be required. She stated Company A may not have the same price as Company B because each company made its own pricing and marketing decisions; however, both price lists would be public so each purchaser would be able to see each purchase contract.

SEN. MILLER said **SB 313** allowed different prices for different buyers. **Ms. Powell** agreed, saying they were based on the specific provisions set up in the bill.

SEN. TERRY KLAMPE asked for comment on the fact 34 of 35 states had rejected the bill. **Jim Smith** said they were encouraged by the action of the South Dakota State Senate, who recently passed the legislation.

SEN. MIKE SPRAGUE asked if St. Peters Hospital was non profit and wondered what the pharmacy gross profit margin was. **Denis Yost** said it was non profit and the pharmacy profit margin was about 12%.

SEN. SPRAGUE suggested pharmacies become non profit organizations. **Jim Smith** said it was happening; perhaps, a change of corporate status at the Secretary of State's Office could be the positive step. He said he would take the suggestion to his organization's members as a serious option, because the future for small businesses looked bleak.

SEN. WILLIAM CRISMORE asked for comment regarding the effect of **SB 313** on Medicaid, indigent program and physicians' free samples. **Jim Smith** said he thought the potential impacts of **SB 313** had been thoroughly discussed so he was surprised to hear the above three issues surface; his personal opinion was the issues were spurious.

{Tape: 2; Side: A}

SEN. BENEDICT asked what HMO would pay for Tagamet for 500 capsules of 400mg. **Chuck Butler** said he didn't have the information, but he would be happy to find out.

SEN. BENEDICT asked if it would be $160-$180. **Mr. Butler** said he did not have the information.

SEN. KLAMPE asked if the doctors were limited in choices of drugs offered their patients. **Denis Yost** said they would be, because one of the criteria for quality assurance was the purchasing group was to request information from companies receiving the contract. He said each hospital would have its own pharmacy committee look at the factors.

SEN. JOHN HERTEL asked for clarification whether competition would be limited and prices would be raised. **Brad Griffin** said prices would ultimately be lowered because of access to discounts.

SEN. MILLER asked if community pharmacies could buy from mail order. **Brad Griffin** said they could not. **SEN. MILLER** asked why they could not, and **Mr. Griffin** said it was because of the Class of Trade distinction.

SEN. MILLER asked if he understood correctly that a community pharmacist could not purchase drugs from the same mail order catalogue as HMOs or private citizens. **Mr. Griffin** affirmed his understanding, and said a prescription was required. **SEN. MILLER** commented community pharmacists were excluded from buying at their possible cheapest price, and suggested the option be considered to allow them to purchase through mail order at a fraction of their current buying price.

Closing by Sponsor:

SEN. MESAROS repeated testimony which said the threat was not manufacturers, but retail chain stores. He pointed out retail chain stores and community pharmacies stood united in support of **SB 313.** He mentioned the comment made which said the trend was HMOs and retail pharmacies were behind the curve. **SEN. MESAROS** said the majority of Montana's population get their pharmaceuticals from chain drug stores and community pharmacies. He addressed the issue of the current litigation making **SB 313** unnecessary. **SEN. MESAROS** reminded the committee **SB 313** allowed for the possibility of entities to meet the same requirements for pharmaceutical discounts and to be offered the same treatment.

SEN. MESAROS said **SB 313** deserved serious consideration based on fairness and equal access issues, i.e. prevailing of equality but not of discrimination. He asked how many Montanans had access to HMOs and mail order pharmacy, as opposed to those who used local pharmacies. He asked positive support for **SB 313.**

HEARING ON SB 322

Opening Statement by Sponsor:

SEN. JUDY JACOBSON, SD 18, Butte, said **SB 322** prohibited a waiting period for a preexisting condition if the person had previous health insurance coverage. She said portability had been addressed in small groups of 3-25; however, an individual could be at a disadvantage if he or she wished to change jobs or be covered under a new or different plan. **SEN. JACOBSON** said presently an insurance company could look back over a five-year time period to exclude the condition for a period of twelve months, even if the person had insurance covering the present condition. **SEN. JACOBSON** said **SB 322** would allow a person who had qualifying previous coverage which was current, 60 days before applying for new coverage; the waiting period could not be imposed. She clarified there was need for a waiting period if a person had not recently been insured because the waiting period served as an incentive to be insured.

SEN. JACOBSON said job lock because of fear of changing health insurance policies was a problem. She said **SB 322** went a step beyond small group reform because all consumers would have the advantage of portability.

Proponents' Testimony:

Claudia Clifford, State Auditor's Office & Commissioner of Insurance Office, said the Commissioner supported portability but saw a shortcoming in the small group reform law because only people coming into a small business had the advantage of portability. She said he encouraged the benefit to extend that benefit to the remainder of the populace of Montana. **Ms. Clifford** referred to **EXHIBIT #9** (article from the National Underwriter) and reported 87% of the American working force felt trapped by job lock and wanted to be able to carry health insurance from one job to the next, i.e. no waiting period on preexisting conditions.

Tanya Ask, Blue Cross/Blue Shield, said BC/BS supported **SB 322** and the concept of the portability of coverage. She said the bill went further than current law. She referred to and explained amendments as per **EXHIBIT #10**, saying they clarified the preexisting waiting period applied to qualifying previous coverage; and the break in coverage from 60 days to 30 days. **Ms. Ask** referred to Line 27 and said they wanted to ensure the individual had the opportunity to carry the waiting period they had already met.

Mike Craig, Health Care Authority, said his organization saw **SB 322** as a sensible bill and urged its support.

Lloyd Bender, American Association of Retired Persons (AARP) in Montana, expressed favor for the intent of **SB 322** and hoped to see it move forward.

Tom Hopgood, Health Insurance Association of America, asked the committee for favorable endorsement of **SB 322** as amended.

Opponents' Testimony: None.

Questions From Committee Members and Responses:

SEN. HERTEL asked **SEN. JACOBSON** if she had agreed with the amendments. **SEN. JACOBSON** said she did, except for changing the 60 days to 30 days. She explained that was because when people changed jobs, dealing with days was not their top priority and she hated to see the deadline inadvertently pass. **SEN. HERTEL** asked **SEN. JACOBSON** if she would prefer it be changed back to 60 and she said she would.

SEN. MILLER asked if there was a safeguard in **SB 322** to keep premiums from increasing dramatically upon job change. **SEN. JACOBSON** said there weren't.

SEN. KLAMPE said it was his experience people on Medicaid or Medicare had no qualifiers for preexisting conditions or disabilities, and he wondered it there was concern that these people would come from Medicaid onto an insurance policy. **Tanya Ask** said it was a possibility, but the desire was for more people to have access to insurance coverage. She said many people who were covered by Medicaid were not disabled, but the issue was people getting a job who had previously been on Medicaid which meant they had several months of health care coverage. A disabled person would probably remain with Medicaid; a seriously ill person could move from one employer-based insurance contract to another.

SEN. SPRAGUE wondered if reinserting "60 days" would be more beneficial during times of insurance coverage overlap. **SEN. JACOBSON** said a person or dependent with a preexisting condition would have an incentive to ensure continuum of coverage, i.e. if someone had a problem, 60 days would give them more flexibility.

SEN. SPRAGUE asked for more clarification of the rationale for "60" vs. "30". **Claudia Clifford** said the 60 days would allow for a time period where a person could go without insurance, i.e. in the event of job change, deciding what to do about insurance, etc. She said the amendments by BC/BS would allow only 30 days to decide about new coverage and to make the policy transition.

SEN. CASEY EMERSON asked if the 60 days gave someone free coverage for that time period. **Tanya Ask** said it would not; in fact, there would be no benefits for that time period. She explained **SB 322** allowed 60 days for the person to make up his or her mind before applying for coverage, which could mean an

additional 30 days before coverage would begin. **Ms. Ask** stated "30 days" was considered because it complied with other provisions in state law.

SEN. MILLER asked if there would be an objection to an amendment which would say the premium could not be higher than 150% of the average premiums of the top five insurers in Montana. **SEN. JACOBSON** said she would not object, but others may.

SEN. MILLER asked what would be acceptable to BC/BS as to premium price control. **Tanya Ask** said the objection to a cap placed on the premium was there was no cap placed on the type of coverage the individual wanted. She said individual contracts were written on an individual market basis, whereas group contracts had some savings built into them.

Closing by Sponsor:

SEN. JACOBSON said **SB 322** dealt strictly with the portability issue and she urged the committee to keep it moving so it could be integrated with other insurance bills in both the House and Senate. She said it was her wish the legislative session not end on the note of rising costs of health care.

EXECUTIVE ACTION ON SENATE BILL 239

Motion: **SEN. WILLIAM CRISMORE MOVED TO TAKE SB 239 OFF THE TABLE.**

Discussion: **SEN. CRISMORE** said he had received numerous calls saying the small operators had not been considered.

SEN. BENEDICT said **SB 239** had a good hearing and was tabled by a majority of the committee members. He opined it was best to leave it tabled.

SEN. EMERSON said he had received calls which he answered by saying he had talked with the man from the department which controlled the sale and licensing of liquor; the man said the route could be gerrymandered to get away from 75% of the calls they did not want to make in certain areas. **SEN. EMERSON** said it was his opinion there was a way around the problem without **SB 239;** however, if the committee wanted to do something, it could kill the whole law which brought the legislation about, i.e. go all the way, or not at all.

SEN. KLAMPE agreed with **SEN. CRISMORE** to bring **SB 239** up again.

SEN. BENEDICT said he interpreted **SB 239** as brought by a distributor who didn't want to play by the same rules as everyone else. He said he didn't like the idea of running government for one or two individuals.

SEN. MILLER said present law set the course for entrepreneurship at its best, i.e. a distributor was able to set up territories to distribute microbrews. He said **SB 239** had a good discussion and should remain tabled.

{Tape: 2; Side: B}

Vote: Motion **TO BRING SB 239 OFF THE TABLE PASSED** 5-4 on roll call vote **#1**.

ADJOURNMENT

Adjournment: The meeting adjourned at 11:05 a.m.

SEN. JOHN HERTEL, Chairman

LYNETTE LAVIN, Secretary

JH/ll

MONTANA SENATE
1995 LEGISLATURE
BUSINESS AND INDUSTRY COMMITTEE

ROLL CALL DATE 2-14-95

NAME	PRESENT	ABSENT	EXCUSED
STEVE BENEDICT, VICE CHAIRMAN	✓		
WILLIAM CRISMORE	✓		
CASEY EMERSON	✓		
GARY FORRESTER	✓		
TERRY KLAMPE	✓		
KEN MILLER	✓		
MIKE SPRAGUE	✓		
BILL WILSON	✓		
JOHN HERTEL, CHAIRMAN	✓		
Bart Campbell	✓		
Lynette Lamin	✓		

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MONTANA SENATE
1995 LEGISLATURE
BUSINESS AND INDUSTRY COMMITTEE
ROLL CALL VOTE

DATE 2-14-95 BILL NO. SB 239 NUMBER 1

MOTION: Renew Tabled SB 239
(to bring SB 239 back up for discussion)

NAME	AYE	NO
STEVE BENEDICT, VICE CHAIRMAN		✓
WILLIAM CRISMORE	✓	
CASEY EMERSON		✓
GARY FORRESTER	✓	
TERRY KLAMPE	✓	
KEN MILLER		✓
MIKE SPRAGUE	✓	
BILL WILSON (attached proxy)	✓	
JOHN HERTEL, CHAIRMAN		✓

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2-14-95

Sen Wilson

Votes yes to Bringing SB 339 off the table

and do pass

Bill

Senator Wilson

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 1
DATE 2/14/95
BILL NO SB 313

Senate Bill 313

by
Senator Ken Mesaros

"Equal Access to Drug Manufacturers' Discounts"

A bill prohibiting the discriminatory pricing of prescription drugs based on class of trade designations used by pharmaceutical manufacturers

Submitted by

Montana State Pharmaceutical Association
and the
Montana Retail Association

For Additional Information
Please Contact

Jim Smith @
449-3843 (W)
443-0606 (H)

or

Brad Griffin @
442-3388 (W)

Discriminatory Pricing:
Allows Drug Companies to Sell Drugs to Selected Buyers at Prices Radically Below those Available in the Retail Marketplace

"The strong movement towards managed health care we have experienced during the last few years has caused the discriminatory pricing practices engaged in by major drug manufacturers to grow from an unfair but annoying problem to one which now threatens the existence of retail community pharmacy."

James E. Krahulec, Vice President, Government and Trade Relations
Rite Aid Corporation

- Brand name pharmaceutical companies engage in discriminatory pricing by selling their drugs at artificially low prices to certain "classes of trade."

- Pharmaceutical manufacturers generally divide purchasers into two classes of trade:
    1. Mail order pharmacies, HMO, hospitals (approx. 40% of market).

    2. Community pharmacies, which includes chain drug stores and independently-owned pharmacies (approx. 60% of market).

- Discriminatory pricing means that manufacturers award very large discounts, as much as 30%, 50% or even 90%, to the favored class of trade purchasers in the first group.

"By allowing discriminatory pricing to continue, it will only lead to the majority of customers, including many of our seniors, who utilize our local pharmacies to continue to subsidize the discounted prices allowed to other preferred customers identified by the manufacturers. This bill will simply demand that equality must prevail and discrimination must not. We ask to level the playing field by offering the same criteria to all to enable equal access to the pricing of pharmaceuticals"

Senator Ken Mesaros
SD 25
February 1, 1995

EXHIBIT 1
DATE 2-14-95
SB 313

Discriminatory Pricing: Gives Mail Order Firms and Health Maintenance Organizations (HMOs) a Significant Competitive Advantage Over Community Pharmacies

- The community retail pharmacies must pay a higher wholesale price than mail order pharmacies and for profit HMOs, even when the same or greater volume is purchased by community retail pharmacies.

Examples of Discriminatory Pricing

Manufacturer	Product	Quantity	Discounted price to non-community pharmacies*	Price to Community Pharmacies	Premium Paid By Community Pharmacies(%)
Ciba-Geigy	Transderm Nitro (Cardiac)	30 Patches	$8.40	$39.89	375
Glaxo	Ventolin 4mg (Respiratory)	500 Tablets	63.84	183.71	188
Searle	Calan 40mg (Cardiac)	100 Tablets	3.90	22.91	487
Wyeth	Inderal 60mg (Cardiac)	100 Tablets	4.12	48.31	1073
SmithKline	Eskalith CR 450mg (Lithium)	100 Capsules	17.18	23.02	34
Schering-Plough	K-Dur 20mEq (Potassium)	100 Capsules	2.03	27.31	1245

Taken from manufacturers' invoices, 1992, as reported in *NARD Journal,* September 1994. The *NARD Journal,* is published by the National Association of Retail Druggists.

* including, but not limited to mail order pharmacies, HMOs, clinics, nursing homes and hospitals

"Today, drug manufacturers provide substantial discounts to selected buyers such as HMOs and mail order pharmacies. Community pharmacies, serving 130 million consumers and representing two thirds of the drug market, are denied access to these discounts even though their buying groups meet — and even exceed the terms set by manufacturers".

David Pryor, U.S. Senator (D-Ark)
Senate Special Committee on Aging
Letter to the editor, Washington Post, October 8, 1994

Discriminatory Pricing: An Anti-competitive and Monopolistic Business Practice Being Challenged in Federal Courts around the Country

- There are currently four major lawsuits (the Brand Name Prescription Drugs Antitrust Litigation) in federal district courts:
  - •The Pharmacy Defense Fund Case in San Francisco;
  - •The Pennsylvania Case in Harrisburg, PA;
  - •The Pharmacy Freedom fund Case in Chicago;
  - •The Duke-Boise Case in Chicago;

- These lawsuits charge drug companies with violations of the **Clayton** and **Robinson-Patman Acts** (for discriminatory pricing violations) and the **Sherman Antitrust Act** (for antitrust violations)

- In addition to the four major suits, 50 smaller suits, all alleging drug companies and wholesalers with Sherman Act Violations, have been consolidated into a class action case.

<u>These anti-trust lawsuits charge:</u>

1. Drug manufacturers violated the **Robinson-Patman Act** by giving substantial price breaks to mail order pharmacies and HMO's without according the same prices to retail drugstores, depriving retailers of their ability to compete and causing disadvantages to their customers.

2. Manufacturers violated section 1 of the **Sherman Antitrust Act** by entering into illegal combinations with wholesalers to sell brand name drugs to certain favored "class of trade" purchasers — including hospitals, nursing homes and HMOs — at prices as much as 50% below prices paid by community pharmacies.

3. Manufacturers entered into agreements with each other agreeing to offer certain prices and rebates only to "favored purchasers" allowing manufacturers to charge retail community pharmacies higher costs.

"These lawsuits are just one of the many avenues taken by independent pharmacists to stem the tide of discriminatory pricing. A good, balanced campaign for any cause includes initiatives in both the judiciary and legislative arenas, and currently our members judiciary efforts are in high gear."

John Rector, Vice President and General Counsel,
National Association of Retail Druggists

EXHIBIT 1
DATE 2-14-95
SB 313

Discriminatory Pricing: Increasingly Problematic as Third Party Payors Set Reimbursement Levels for Retail Pharmacies

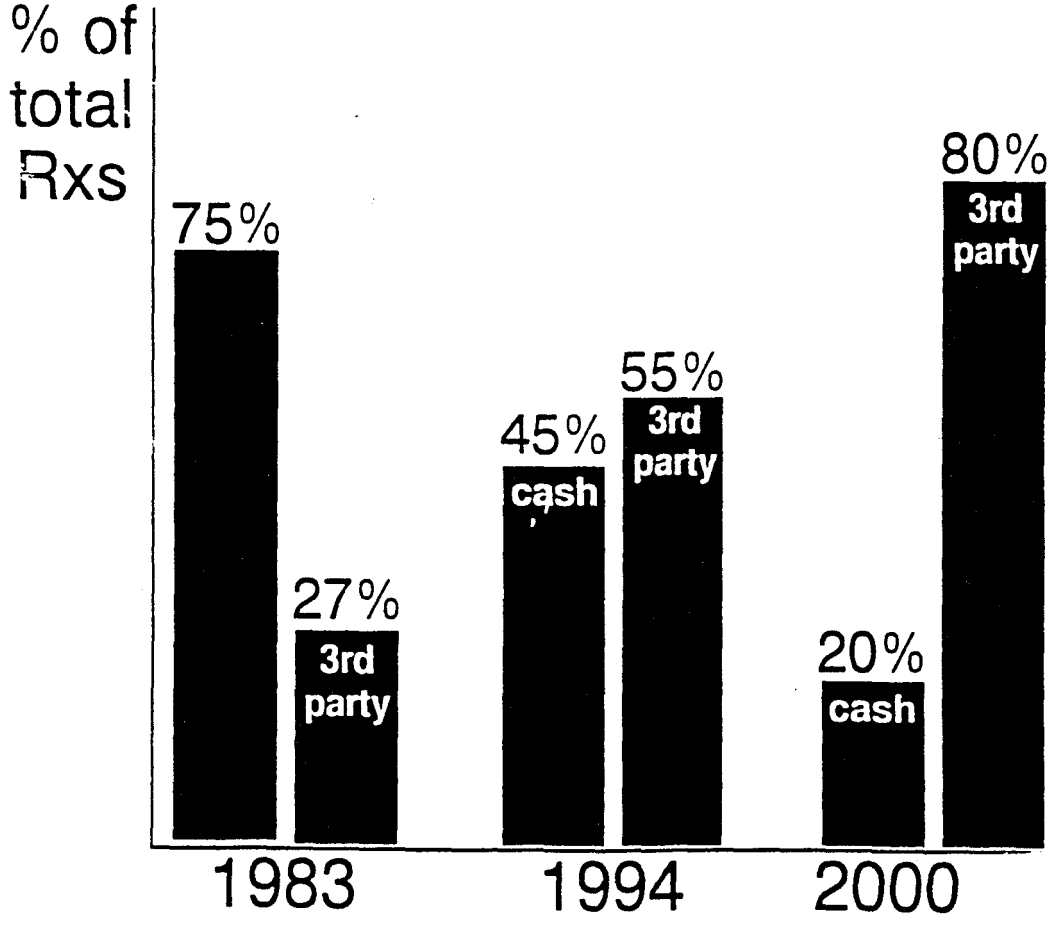
- Currently, there are two markets, two ways of paying for prescription drugs:
  — The Cash Paying market
  — The Third Party market

- In the cash market, consumers pay out-of-pocket for their prescriptions at the time of purchase.

- In the third party market, consumers pay a small portion of the prescription cost, with the pharmacy billing a "third party" for the remainder.

  — Most third-party (pharmaceutical benefit management firms or insurance companies) determine the price at which the pharmacy is reimbursed.

  — Pharmaceutical Benefit Management (PBM) firms are specialty managed care companies that contract with insurance companies and/or corporations to manage drug costs.



Discriminatory Pricing Gives Pharmaceutical Companies Monopolistic Control over Drug Distribution

- In the past two years, brand name drug companies have been spending billions of dollars to purchase third-party payers called **pharmacy benefit management companies (PBMs)**

- The three largest PBMs in the U.S. are now owned, in whole or in part, by brand name pharmaceutical companies: a case of vertical integration under scrutiny by the FTC and the US Attorney General

  — The PBM, Prescription Card Service (PCS), is owned by Eli Lilly and Company, and provides prescription coverage to 55 million patients

  — The PBM, Medco Containment Services, which pays prescription benefits for 41 million patients, is owned by Merck and Company

  — Diversified Pharmaceutical Services (DPS), a PBM, owned by SmithKline Beecham, provides prescription coverage for 14 million patients

- PBMs receive large discounts and rebates from pharmaceutical companies in exchange for putting the manufacturer's products on their formularies*

* In the past, doctors were able to prescribe whatever they wanted. Today, almost every private insurance company, corporation and government program that provides drug coverage requires that doctors prescribe from formularies, or lists of drugs approved for third party payment. If the doctor prescribes a drug not on the list, the pharmacy and/or patient does not receive full reimbursement for their prescription.
In managed care settings, the formulary is determined by discounts and rebates from manufacturers.

"Instead of competition, the pharmaceutical industry is moving toward a few mega-firms, undergoing vertical and horizontal integration, continuing to charge ever higher prices, and attempting to control the manufacture and distribution of pharmaceuticals".

Stephen W. Schondelmeyer, Pharm.D., Ph.D.
PRIME Institute, University of Minnesota College of Pharmacy
Drug Topics, August 22, 1994, p.16

an incentive on a vehicle you are shopping for, may [illegible] you should wait [illegible]th."

For savvy car buyers, that can mean big discounts. Last week, Dane Andersen, a 35-year-old foreign-currency manager at M&M Mars, paid less than $16,000 for an Infiniti G20 that lists for more than $23,000. Other auto makers are trying to lure customers with lease deals. Honda Motor Co. and Toyota Motor Corp. don't have rebates on their popular Accord and Camry models, but they are giving good lease deals. Similarly, Ford is offering generous terms on leases for its redesigned Taurus. "The more they are willing to give customers to try to get them in the door, the better," says Mark Lawrence, general manager of Lawrence Chrysler Plymouth in Richmond, Va.

Dealers, for their part, are happy to see rebates [illegible] just kept dropping," he says.

Rebates [illegible] ever, typically ranging from $500 to $1,000. But manufacturers are now offering bargains even on some popular new cars. Auto makers are using incentives to boost sales of the Dodge and Plymouth Neon, the Ford

WSJ 2/1/95

INDUSTRY FOCUS

Drug Industry Takeovers Mean More Cost-Cutting, Less Research Spending

By Elyse Tanouye
And George Anders
Staff Reporters of The Wall Street Journal

While the flurry of drug-company takeovers promises to create industry giants, *the deals—and those expected to follow—are tilting the business toward cutting costs and away from the free-spending research* and marketing of the past decade.

Far-reaching changes in the pharmaceutical marketplace are making consolidation inevitable, say Wall Street observers and drug industry executives.

"You've got a change in the balance of power," says Clinton Gartin, a managing director at Morgan Stanley & Co. who specializes in health-care acquisitions. Drug companies are losing their ability to boost prices at will and to persuade individual doctors to prescribe specific pills. Big customers are wielding more clout, as managed-care companies press for discounts and determine what pills millions of members can use.

Meanwhile, research labs have been largely frustrated in their attempts to develop a next generation of blockbuster drugs, while some bestsellers are nearing the end of their patent lives. "That's caused difficulty in raising prices and achieving growth," Mr. Gartin says. "So people need to achieve growth either through an increase in volume or a reduction in cost. Every one of the transactions we've seen is an attempt to do one of those."

In some cases, big drug makers may even use mergers to hack away at their once-cherished research and development departments, suggests Viren Mehta, a drug-industry analyst at Mehta & Isaly, New York. Mr. Mehta says these companies may eventually rely on small biotechnology companies to do most breakthrough research, and then market potential winners under licensing arrangements.

"This industry could end up being a handful of marketing and development companies, surrounded by a large number of research boutiques," he predicts.

The current takeover fervor is likely to create a leaner generation of giants. "Any time you put two organizations together, you get a chance to take costs out," says Eran Broshy, a health-care consultant at Boston Consulting Group. "And there are a lot of opportunities to trim fat in the pharmaceutical industry."

The biggest deal, **Glaxo** PLC's proposed $14.9 billion purchase of Wellcome PLC, could bring annual cost cuts of $800 million or more, analysts predict. Likely targets include eliminating duplication in corporate overhead, sales forces and manufacturing sites. Glaxo won't comment, but it has said it sees "significant opportunities to achieve operational efficiencies."

Several drug-industry takeovers completed last year have led to sizable layoffs and cost-cutting. **Roche Holding** Ltd. of Switzerland said it would cut 5,000 jobs after its $5.3 billion purchase of Syntex Corp. last October. Analysts think more belt-tightening is possible. "You could see cost savings of at least $300 million in a few years, and perhaps as much as $600 million," says Steve Buermann, an analyst at Merrill Lynch & Co.

Such takeovers also may give the combined drug company a better chance of winning business from big institutional customers, such as hospitals or managed-care organizations. "What managed care wants is one-stop shopping," says Morgan Stanley's Mr. Gartin. "They want to get as many of their products from one place as they can."

Some of the biggest customer channels, however, now are controlled by three drug companies: **Merck** & Co., **Eli Lilly** & Co. and **SmithKline Beecham** PLC. In the past 18 months, all have bought pharmacy-benefit-management companies, which run employers' prescription-coverage plans and handle drug buying on behalf of more than 100 million Americans. The acquisi-

Please Turn to Page B4, Column 3

Recent Acquisitions in the Drug Industry

DATE	ACQUIRING COMPANY	TARGET COMPANY	PRICE (billions)	WHAT THE BUYER GOT
Nov. '93	Merck & Co.	Medco Containment Services	$6.6	Distribution channel providing influence over prescriptions for 41.5 million patients
May '94	SmithKline Beecham	Diversified Pharmaceutical Services	2.3	Influence over prescriptions for 14 million patients
Aug. '94	Sandoz	Gerber Products	3.7	Consumer baby products
Oct. '94	Roche Holding	Syntex	5.3	Painkillers, anti-inflammatory drugs, research pipeline
Nov. '94	SmithKline and Bayer	Sterling Winthrop	2.9	OTC products, including Bayer aspirin in the U.S.
Nov. '94	American Home Products	American Cyanamid	9.7	Vaccines, antibiotics, generic drugs, Centrum vitamins, agricultural chemicals
Nov. '94	Eli Lilly	PCS Health Systems	4.0	Influence over prescriptions for 55 million patients
Jan. '95	Ciba-Geigy	Chiron	2.1	49.9% stake. Biotechnology products and research pipeline
Proposed	Glaxo	Wellcome	14.9	Antiviral drug Zovirax, AIDS drug AZT
In negotiations	Hoechst	Marion Merrell Dow	---	Cardizem heart drug, Seldane allergy drug, generic drugs

Source: Wall Street Journal research

WHO'S NEWS

FOOD

Pharmaceutical Industry Deals Beget Leaner Generation of Giants

Continued From Page B1

tions give the companies a big, relatively secure sales channel—and thus a potential competitive edge.

Prescription plans carry a full line of pharmaceuticals, including ones made by dozens of competing drug companies. Nonetheless, Merck says that its benefits-management unit, Medco, has been selling a greater share of Merck drugs than it did before Merck bought it in 1993.

The Merck, Lilly and SmithKline acquisitions "have put a whole lot of pressure on other pharmaceutical companies," says Mr. Broshy of Boston Consulting. That may be contributing to the current flurry of acquisitions, as rival drug makers figure that wider product lines will help maintain their presence in prescription plans.

A few drug companies are trying to diversify – one way to sidestep the tumult associated with managed care and enter a business with steady, albeit modest, profit margins and growth. **Sandoz** Ltd., for example, bought Gerber Products Co., the baby-food maker, for $3.7 billion last year. But some analysts are concerned that diversifying companies will lose focus on their core business and might lack the expertise needed to thrive in highly competitive consumer businesses.

Meanwhile, many drug makers are pursuing closer links with biotech companies – which increasingly are becoming feeder systems for drug discovery programs. Most such deals have involved small investments or licensing agreements. In an unusually big move, **Ciba-Geigy** Corp. last month agreed to buy 49.9% of **Chiron** Corp. for $2.1 billion.

Sidney Taurel, president of Lilly's pharmaceutical division, argues that big drug companies may do better if they shed some research costs and form partnerships with outsiders. Lilly has signed a series of two- to three-year agreements with biotech companies that let it explore new areas, while being free to call it quits if nothing pans out, he notes.

Analysts say size-building acquisitions may be the drug industry's best near-term hope of reviving earnings growth. But companies still must confront the underlying problem of increasing sales and profits on mature products with dwindling patent lives.

"All of a sudden, pharmaceuticals aren't a growth business," says James Giblin, a health-care portfolio manager at Putnam Investments in Boston. Drug stocks, which for many years have sold at premium price-earnings multiples, reflecting their strong growth prospects, now trade at only about 14 times projected earnings for the next 12 months, about the same as the average industrial company.

In such a climate, Mr. Giblin says, acquisitions "only make sense on a cost-cutting basis."

Wall Street analysts say more big drug combinations could lie ahead. Companies such as **Upjohn** Co. and **Warner-Lambert** Co. are periodically mentioned as targets; both companies said they don't comment on rumors. Mehta & Isaly's Mr. Mehta, in fact, jokes that the industry could become as concentrated as the car business, where many analysts follow only the Big Three domestic auto makers.

But too-rapid consolidation may not be good news for consumers, says Merrill Lynch's Mr. Buermann. "If I'm sick, I don't want just three companies looking for a cure," he says. "I want 10 or 15. I think I've got a better chance that way."

operator. He succeeds [illegible] Perkins, who resigned.

ALEXANDER & BALDWIN Inc. (Honolulu) – John Couch, president and chief executive officer of this ocean transportation, agribusiness and food-processing concern, was named to the additional post of chairman of the board, effective April 1. Mr. Couch, 55 years old, succeeds Robert J. Pfeiffer, who is retiring. Mr. Pfeiffer was named chairman emeritus.

ST. JUDE MEDICAL Inc. (St. Paul, Minn.) – Ronald A. Matricaria, president and chief executive officer, was elected to the additional post of chairman. Mr. Matricaria, 52 years old, succeeds Lawrence A. Lehmkuhl, who remains on the board of this maker of heart valves and other products. Gail R. Wilensky was elected to the board, bringing membership to 10. Mrs. Wilensky, 51, is a senior fellow at Project Hope in Washington.

CHECKERS DRIVE-IN RESTAURANTS (Clearwater, Fla.) – The company has named Keith J. Kinsey vice president-operations and Anthony L. Austin vice president-human resources. Mr. Kinsey, formerly vice president of operations with PepsiCo Inc.'s KFC division, succeeds Dale Naftzger who resigned last summer. Mr. Austin, formerly director of corporate staffing for PepsiCo's Taco Bell Division, succeeds Wayne Saunders, who resigned late last year. Checkers operates or franchises more than 490 quick-service restaurants in the U.S.

WALT DISNEY Co. (Burbank, Calif.) – John F. Cooke was named executive vice president-corporate affairs of the amusement parks, movies and television company. Mr. Cooke, 52 years old, will continue his duties as president of The Disney Channel until a successor is named, the company said. Mr. Cooke will oversee Disney's government relations world-wide and environmental issues. He also will serve on the boards of Disney's joint ventures with three regional Bell operating companies. Mr. Cooke joined Disney in 1985 as president of its subscriber-based cable entertainment channel.

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EXHIBIT 1
DATE 2-14-95
SB 313

Discriminatory Pricing: Hurts Community Pharmacies While Benefiting Big Drug Companies

Discriminatory pricing leads to slim profit margins for retail pharmacies

- Chain drug stores average profits are 2% of sales or 50 cents per prescription (Source: Value Line Investment Survey Guide, Review of the Drug Store Industry, January and November's 1993).

  — In contrast, drug manufacturers average about 17% profit on annual sales of $62 billion (Source: Value Line Investment Survey Guide, Review of the Drug Store Industry, January and November 1993 and Drug Topics, November 10, 1994).

- Discriminatory pricing makes it impossible for community pharmacies to competitively bid against out-of-state mail order firms or to make a fair return on dispensing fees.

  — More and more Montana corporations and state and county agencies are providing prescription benefits through out-of-state PBMs and mail order firms.

  —Under discriminatory pricing, these firms can purchase drugs cheaper than Montana pharmacies*, giving them an unfair competitive advantage.

* Some PBMs use their own mail order pharmacies, while others utilize networks of community pharmacies, which dispense drugs to local patients. The PBM makes money by setting a low reimbursement fee for the pharmacies, who are paying premium prices at the wholesale level. In addition, the PBM receives large rebates and discounts from the manufacturer based on the amount of drug units participating pharmacies dispense.

"...in the health care system, the drugstore business, the pharmaceutical industry, reform and change are all going to take place with or without federal law. So we have to deal with these things..."

Ronald Ziegler, President
National Association of Chain Drug Stores

Discriminatory Pricing Limits Job Opportunities for University of Montana Graduates

"Our challenge is first to better understand the competitive forces that impact our economy and then to design governmental policies and regulations, whether tax, environmental, permitting, safety, etc., that are fair to all stake holders — and supportive of the Montana business community".

Bob Gannon, president and chief operating officer of Montana Power Company, Butte, as quoted in Economic Challenge '95, Montana Business Annual, January/February 1995

- Community retail pharmacies play a vital role in the economic, social and medical well-being of every city and county in Montana.

  — The community retail pharmacy industry in Montana employs more than 1,000 pharmacists working in 200 pharmacies across the state.

  — The average annual salary of a veteran community pharmacist is $35,000 - $45,000.

- University of Montana School of Pharmacy (one of 75 pharmacy schools in the U.S.) graduates about 50 Pharmacists per year.

  — Many graduates cannot find work in Montana and are forced to seek employment in Nevada, Utah and Washington.

- Pharmacy is a dynamic, challenging health care profession.

- Detailed knowledge of pharmaceutical products, a strong commitment to their patients, and deep roots in Montana communities; these characterize Montana's pharmacies and pharmacists.

- Many Montana pharmacies are family-owned, second or third generation Small Businesses.

"The state's greatest challenge now and in the foreseeable future is the creation of good paying jobs that will attract and retain our young people in Montana".

William Brodsky, president of Montana Rail Link, Inc. , Missoula as quoted in Economic Challenge '95, Montana Business Annual, January/February 1995

EXHIBIT 1
DATE 2-14-95
SB 313

Discriminatory Pricing:
Promotes Cost Shifting to those Senior Citizens Who Pay Cash at their Community Pharmacy

"Consumer interests are compromised by permitting drug price discrimination.... because the retailers and consumers ultimately must pay higher drug prices as a form of economic subsidy to the drug supplies for the lower prices which the drug supplier charges the institutions".

US Congress. House Small Business Committee
1967 Report

- There is no outpatient prescription drug benefit under Medicare.

- More than half of elderly Americans have no outpatient prescription coverage.

- These older Americans make too much money to qualify for Medicaid, while Medicare provides no outpatient prescription benefits.

- The vast majority of the 155,000 Montanans over the age of 60 have no outpatient prescription drug coverage. Because they pay out of pocket, these elderly are hurt the most by high prices that drug manufacturers charge community drug stores.

- Others paying exorbinant prices for prescription drugs include families whose mothers and fathers work but cannot afford health insurance; or who carry policies with high deductibles and copayments; the working poor, whose incomes are too high for Medicaid eligibility.

"...The elderly patient who has no prescription drug coverage under Medicare and who probably has no insurance coverage through a retirement program ends up having to pay (the higher price) to subsidize the customer of the HMO or the mail order operation".

James E. Krahulec, Vice President, Government and Trade Relations
Rite Aid Corporation

Frequently Asked Questions about "Equal Access"

Q. What does it mean to require manufacturers to give "equal access" pricing?
A. Equal access to pharmaceutical manufacturers' discounts requires that any terms and conditions of sale, such as volume discounts, which the manufacturer chooses to make available to one purchaser or customer must be made available to all purchasers or customers.

Q. Don't all purchasers of pharmaceutical products have the ability to bargain the best possible price from the manufacturers?
A. No. Outpatient drugs are dispensed in a variety of practice settings. HMO outpatient pharmacies, mail order and long term care pharmacies increasingly compete with community retail pharmacies to dispense prescriptions to patients and customers. Manufacturers award very large discounts to some purchasers -- but not to others -- regardless of the volume purchased, promptness of payment or any other rational economic considerations.

Q. Is SB 313 unitary pricing?
A. No. Equal access to manufacturers' discount legislation (equal access) will not establish "unitary pricing". "Unitary pricing" would require manufacturers to charge the same price for their product to all buyers under all conditions. Equal Access legislation will not establish a single, 'unitary' price for prescription drugs; instead, it will give all purchasers 'equal access' to discounts established by pharmaceutical manufacturers. This legislation is intended to create an open market for ALL purchasers of prescription drugs that compete with one another in the marketplace.

Q. Will passage of SB 313 solve all the problems of price and the lack of competition in the pharmaceutical industry?
A. Probably not. Certainly not immediately. Over 40 states are introducing 'equal access' legislation this year. The major lawsuits are proceeding, with trial dates set for February, 1996. It is anticipated that the Pharmaceutical Marketplace Reform Act of 1994, by Senator David Pryor (D-AK) will be reintroduced and considered in this session of Congress. The cumulative effect of all of these efforts will, over time, force manufacturers to grant 'equal access' to all of their purchasers.

Q. Will what we do here in Montana make any difference?
A. Yes. There are only 50 States and Montana is one of them. Laws enacted in each state do matter, and will make a difference.

BILL NO.

INTRODUCED BY Senator KEN MESAROS

A BILL FOR AN ACT ENTITLED: "AN ACT ENSURING EQUAL ACCESS FOR PURCHASERS TO DRUG MANUFACTURERS' DISCOUNTS; PROVIDING EXCEPTIONS AND PENALTIES; GRANTING RULEMAKING AUTHORITY TO THE DEPARTMENT OF COMMERCE; AND PROVIDING AN APPLICABILITY DATE."

STATEMENT OF INTENT

A statement of intent is required because this bill grants rulemaking authority to the department of commerce.

The legislature intends to promote, ensure, and enforce competition among purchasers of drug products by eliminating price discounts that are based solely on "class of trade" designations used by drug manufacturers.

The legislature intends that retail pharmacies be provided equal access to the price discounts currently provided to mail order pharmacies, health maintenance organizations, and other purchasers that compete with retail pharmacies.

The legislature intends that manufacturers be encouraged to develop a variety of marketing programs. The legislature does not intend to establish a single price for prescription drugs or to eliminate existing price reduction programs that adhere to the provisions of this bill.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 7], the following definitions apply:

(1) "Charitable health care provider" means a health care provider that is exempt from federal taxation under section 501(c)(3) of the Internal Revenue Code and that provides a substantial portion of its health care services to the public free of charge or at a reduced fee based on the patient's ability to pay.

(2) "Covered transaction" means a sale of a drug to a purchaser in this state in which a manufacturer negotiates, establishes, determines, or otherwise controls the price, terms, or conditions of sale, whether by direct sale to a purchaser or through a contractual arrangement implemented by one or

more wholesalers.

(3) "Department" means the department of commerce provided for in Title 2, chapter 15, part 18.

(4) "Drug" means any substance subject to section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act.

(5) "Manufacturer" means a person other than a wholesaler who sells drugs to purchasers.

(6) "Purchaser" means a person who sells or dispenses drugs directly to consumers in this state.

(7) "Wholesaler" means a person other than a manufacturer who sells drugs to purchasers.

NEW SECTION. **Section 2. Price discrimination prohibited.** (1) In a covered transaction, a manufacturer shall sell a drug, during the same time period, to all purchasers in this state on the same terms and conditions.

(2) This section does not prohibit a manufacturer from offering a price reduction or program as long as it is made available to all purchasers on the same terms and conditions, including:

(a) a reduction justified by economies or efficiencies realized through volume purchases;

(b) a reduction available through market share movement agreements;

(c) a reduction for placing a drug on a formulary;

(d) a reduction for prompt payment;

(e) a reduction for limited site delivery; or

(f) an opportunity involving free merchandise, samples, and similar trade concessions.

(3) A manufacturer may not provide a price reduction to a purchaser based solely on the class of trade to which the purchaser belongs.

(4) This section applies to any purchase of a drug delivered to a purchaser for sale to a consumer in this state.

NEW SECTION. **Section 3. Government purchases from manufacturer engaged in discriminatory pricing prohibited.** An entity of state government or of any political subdivision of this state may not purchase a drug from a manufacturer that engages in price discrimination prohibited in [section 2].

NEW SECTION. **Section 4. Civil action for damages.** A purchaser may bring a civil action against a manufacturer for damages suffered as a result of the manufacturer's violation of [sections 1 through 7],

a rule promulgated under [sections 1 through 7], or an order or injunction to cease and desist from either type of violation. Damages awarded to the purchaser must be trebled.

NEW SECTION. **Section 5. Enforcement -- penalty.** (1) The department shall enforce the provisions of [sections 1 through 7] pursuant to the procedures established in 30-14-220 through 30-14-223.

(2) A county attorney or the attorney general may enter an action to enforce [sections 1 through 7].

(3) A person who violates [sections 1 through 7], a rule promulgated under [sections 1 through 7], or an order or injunction to cease and desist from either violation:

(a) shall pay a civil penalty of not less than $1,000 or more than $50,000 for each violation; and

(b) except in a case in which a unique and necessary drug is not available from a person other than the person who has committed the violation, may not sell drugs in this state.

NEW SECTION. **Section 6. Exceptions.** [Sections 1 through 7] do not apply to:

(1) a hospital or related facility licensed under Title 50, chapter 5;

(2) a federal, state, or local government program that purchases drugs directly;

(3) a discount required by federal law or a rebate authorized by federal law;

(4) a charitable health care provider, except a provider that issues, offers, or administers a health insurance policy or an employee benefit plan.

NEW SECTION. **Section 7. Rulemaking authority.** The department shall adopt, amend, or repeal rules necessary for the implementation, continuation, and enforcement of [sections 1 through 7] in accordance with the Montana Administrative Procedure Act.

NEW SECTION. **Section 8. Codification instruction.** [Sections 1 through 7] are intended to be codified as an integral part of Title 30, chapter 14, and the provisions of Title 30, chapter 14, apply to [sections 1 through 7].

NEW SECTION. **Section 9. Applicability.** [This act] applies to sales made or effected on or after

October 1, 1995.

-END-

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 2
DATE 2/14/95
BILL NO. SB 313

Proposed Amendments to SB 313 (Presented by Sen. Ken Mesaros)
Prepared by Mary McCue, lobbyist for MSPA

1. Page 1, lines 25 through 27.
   Strike: subsection (1) in its entirety
   Renumber: subsequent subsections

2. Page 2, lines 25 through 27.
   Strike: section 3 in its entirety
   Amend: internal references

3. Page 3, line 16.
   Following: "or"
   Strike: "related"
   Insert: "health care"
   Following: "facility"
   Strike: "licensed"
   Insert: "as defined"
   Following: "chapter 5"
   Insert: ", except for health maintenance organizations"

4. Page 3, line 18.
   Following: "authorized by federal law"
   Strike: ";"
   Insert: "."

5. Page 3, lines 19 and 20.
   Strike: subsection (4) in its entirety

nity-based nursing homes — Cen- ged, Title 53, ch. 21, part 4.

Health facility development, Title 90, ch. 7.

01. *(Temporary)* **Definitions.** As used in parts 1 through 4 of this unless the context clearly indicates otherwise, the following defini- ly:

Accreditation" means a designation of approval.

Adult day-care center" means a facility, freestanding or connected to health care facility, which provides adults, on an intermittent basis, care necessary to meet the needs of daily living.

Affected person" means an applicant for certificate of need, a member blic who will be served by the proposal, a health care facility located eographic area affected by the application, an agency which estab- ites for health care facilities, a third-party payer who reimburses are facilities in the area affected by the proposal, or an agency which assists in planning for such facilities.

Ambulatory surgical facility" means a facility, not part of a hospital, rovides surgical treatment to patients not requiring hospitalization. e of facility may include observation beds for patient recovery from or other treatment.

"Batch" means those letters of intent to seek approval for new beds or nedical equipment that are accumulated during a single batching

"Batching period" means a period, not exceeding 1 month, established artment rule during which letters of intent to seek approval for new major medical equipment are accumulated pending further processing tters of intent within the batch.

"Board" means the board of health and environmental sciences, ed for in 2-15-2104.

"Capital expenditure" means:

an expenditure made by or on behalf of a health care facility that, generally accepted accounting principles, is not properly chargeable as ense of operation and maintenance; or

a lease, donation, or comparable arrangement that would be a capital diture if money or any other property of value had changed hands.

"Certificate of need" means a written authorization by the department erson to proceed with a proposal subject to 50-5-301.

) "Challenge period" means a period, not exceeding 1 month, estab- by department rule during which any person may apply for compara- view with an applicant whose letter of intent has been received during ceding batching period.

) "Chemical dependency facility" means a facility whose function is the ent, rehabilitation, and prevention of the use of any chemical sub- , including alcohol, which creates behavioral or health problems and gers the health, interpersonal relationships, or economic function of an idual or the public health, welfare, or safety.

"Clinical laboratory" means a facility for the microbiological, serologi- [illegible] human

body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(13) "College of American pathologists" means the organization nationally recognized by that name with headquarters in Traverse City, Michigan, that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

(14) "Comparative review" means a joint review of two or more certificate of need applications which are determined by the department to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the department's review of the other applications.

(15) "Construction" means the physical erection of a health care facility and any stage thereof, including ground breaking, or remodeling, replacement, or renovation of an existing health care facility.

(16) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

(17) "Federal acts" means federal statutes for the construction of health care facilities.

(18) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

(19) "Health care facility" or "facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. **The term includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.**

(20) "Health maintenance organization" means a public or private organization which provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

(21) "Home health agency" means a public agency or private organization or subdivision thereof which is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

(22) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and the patient's family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component. The term includes:

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SB 313

MONTANA STATE PHARMACEUTICAL ASSOCIATION

PO Box 4718 • 34 West Sixth Avenue • Helena, MT 59604 • 406-449-3843 • Fax 406-443-1592

February 14, 1995

Testimony of the Montana State Pharmaceutical Association
Senate Bill 313
by Jim Smith

Mr. Chairman and Members of the Senate Business Committee: Good Morning. My name is Jim Smith. I am the Executive Director of the Montana State Pharmaceutical Association. Our Association consists of approx. 350 licensed pharmacists and 150 licensed pharmacies in the state of Montana. Most of our members come from the independent retail sector of the pharmacy community in Montana; and we join the Montana Retail Association, and its members from the chain drug stores, in strong support of SB 313.

My job this morning is to go through SB 313 with you, Section by Section, line by line, definition by definition, term by term. I will attempt to do so quickly and thoroughly. If you have questions, I'll try to answer them for you; or if I can provide you with any additional information, I'll try to get it for you.

We have, in SB 313, attempted to distill some very complex economic transactions into concepts and language suitable for inclusion in the Montana Codes Annotated. We tried to keep it simple; and to put only that statutory language that is absolutely required into SB 313. The Department of Commerce is given rulemaking authority in the bill; and administrative rules may follow, if SB 313 is enacted by this legislature.

These are all new Sections. This is new, additional language that will be added to Title 30, Chapter 14 MCA, if passed. Title 30 is the Montana Consumer Protection Act. This is the appropriate place to codify SB 313 because we believe the Montana consumer will be the ultimate beneficiary if SB 313 is passed and made into law.

I'll just begin, and try to share our thinking, our intentions and our understandings with the Committee. I'll also reference and explain the Sponsor's Amendments as we go through the bill.

The bill begins with the **Statement of Intent**. I do not think it's necessary for me to read the entire Statement; but the first paragraph sums it up very well:

> **The legislature intends to promote, ensure and enforce competition among purchasers of drug products by eliminating price discounts that are based solely on 'class of trade' designations used by drug manufacturers.'**

The rest of the bill proceeds from there and is consistent with the Statement of Intent.

Section 1. Definitions.

The first Amendment offered by Senator Mesaros strikes the definition of 'Charitable Health Care Provider' found on lines 25-27 of page 1. That definition is redundant and not necessary at this point in the bill. The term is adequately defined in Section 6, as you will see.

The other definitions, 1 through 7 represent our attempt to define, in statute, the essential interests involved in the buying, selling, purchasing and distribution of prescription drugs in the state of Montana. For the purposes of this bill, we've rendered these very complex economic transactions into a few simple definitions. The key definitions are as follows:

•Manufacturers	These are the various drug companies that produce and sell prescription drugs. Our belief is that it is the manufacturers that establish the price, terms and conditions of drug sales, in Montana and across the country.
•Wholesalers	These companies deliver drugs to purchasers at the contract price established by the manufacturer. Our belief here is that wholesalers do not establish the price, terms or conditions of the sales of drugs to purchasers.
•Purchasers	These are the entities that buy drugs from manufacturers, whether it's a retail pharmacy buying group (like Valu-Rite or United Drug Stores), a chain operation (like K-Mart, Shop-Ko or Wal-Mart); or Institutional buyers, such as Hospitals, Nursing Homes, HMOs, Mail Order Pharmacies. For the purposes of this bill, they are all purchasers of drugs.
•Covered Transaction	Our intent is a very broad application of this definition. Basically, we believe every transaction, every sale in Montana is a 'covered transaction,' and as such subject to the provisions of SB 313.

Section 2. Price Discrimination Prohibited.

This is the heart of the bill. The key language is found in:

> **(1) In a Covered transaction, a manufacturer shall sell a drug, during the same time period, to all purchasers in this state on the same terms and conditions.**

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Please note that this does not say 'for the same price.' Our intent here is exactly as Mr. Griffin explained it in his testimony: To the manufacturers we are saying, tell us what criteria must be met in order to achieve price discounts. Nothing more. Nothing less.

Section 2, (2) sets forth several rational, economic criteria that manufacturers may want to use in establishing the criteria for discounts: volume, market share movement, formulary, prompt payment, etc.

Section 2, (3) contains the prohibition against price reductions that are based solely on the 'class of trade' to which the purchaser belongs.

Section 2, (4) says that this applies to any purchase of a drug delivered for sale to a consumer in this state.

Section 2 is the key, critical section of SB 313. This is the Section that eliminates discriminatory pricing; that puts all purchasers on a level playing field; that eliminates the obsolete practice of granting discounts based upon 'class of trade' designations used by manufacturers.
While these designations may have been harmless when retail pharmacy did not compete with institutional purchasers, such as HMOs, Mail Order Pharmacies, etc.; in today's marketplace, retail is in competition with institutional purchasers; and manufacturers pricing policies should reflect that simple fact. SB 313 requires manufacturers to recognize that simple fact, and to act accordingly by renegotiating their contracts with purchasers.

Please note that Section 2 is no cure-all for retail pharmacy. The rational economic forces at work in the marketplace that are listed in (2) may still operate to the disadvantage of retail pharmacies, especially for those few that are not members of buying groups.
However, the elimination of the 'class of trade' designations is a major step in the right public policy direction, and that's what SB 313 is all about. Much will be left to the marketplace, even if SB 313 is passed and enacted.

Section 3. Government Purchases... Prohibited.
Section 3 is stricken in Senator Mesaros' Amendments. We are not aware of any entity of state or local government that is a direct purchaser of drugs.

Section 4. Civil Action for Damages.
Section 4 gives a purchaser the right to bring a civil action for damages against a manufacturer. Treble damages are required.

Section 5. Enforcement--Penalty.
Section 5 says that a county attorney, or the attorney general may enter an action to enforce the provisions of SB 313.
Reasonable Civil penalties are established in SB 313.

Section 6. Exceptions.

Our basic objective in SB 313 is to level the playing field and establish a fair competitive environment with those entities that are in competition with retail pharmacies. We recognized early on that retail is not in competition with certain segments of the market, and Section 6 sets forth exceptions to the provisions of SB 313.

The Amendments offered this morning by Senator Mesaros further clarifies our intentions with regard to these exceptions.

(1) As amended, (1) would be changed to read: "Except HMO=
'a hospital or health care facility, as defined in Title 50, chapter 5.'

We have attached a list these facilities to the Amendments offered by Senator Mesaros. It does include the various 'charitable health care providers' in Montana.

(2) This applies to the federal government. The Veterans Administration is the only direct purchaser of drugs in Montana.

(3) This applies to the State Medicaid program. The federal government was able to extract some concessions from the manufacturers several years ago, through the OBRA, 1990 (Omnibus Budget Reconciliation Act of 1990). Basically, the manufacturers agreed to give rebates to state Medicaid programs. This clause makes it clear that SB 313 is not intended to interfere, interrupt, or otherwise have any impact whatsoever on the Medicaid Program.

(4) As Amended, (4) would be stricken from the SB 313.

Section 7. Rulemaking Authority.

The Department of Commerce is given the authority to write, adopt and enforce administrative rules pertaining to this law, consistent with legislative intent.

Section 8. Codification instruction.

If enacted into law, SB 313 is to be codified as an integral part of Title 30, chapter 14, MCA, The Montana Consumer Protection Act.

This is what SB 313 is all about: How much consumers will be paying for their prescription medicines; how they will receive, or be able to receive, their prescription medicines; what kind of pharmaceutical are they are going to receive?

Section 9. Applicability Date.

This act applies to sales made after October 1, 1995.

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In conclusion, SB 313 is not a 'magic bullet' that will solve all the problems of price and the lack of competition in the pharmaceutical industry.

Nor, however, is SB 313 some kind of 'poison pill' that is going to cripple the pharmaceutical industry. Our association wants a healthy, profitable industry. We support this industry. We're the industry's first, oldest and best customers. We support Research and Development. We want a cure for MS, or MD, or AIDS found. We attempted to find some common ground, some compromise with the manufacturers before this session even began, but to no avail.

We have been very clear in our discussions and negotiations with interested parties that, if SB 313 is enacted into law; the response of the manufacturers will, in large part, determine the outcome and impact of this legislation upon consumers in Montana. The manufacturers may decide to litigate, to test this law in the courts? Some may decide to pull out of Montana, to cease selling their products in this state? Some may cancel contracts, or raise prices to their institutional purchasers as soon as possible? Or, they may decide that it makes good economic and clinical sense to keep retail community pharmacy in the business of filling prescriptions for people? That's the sort of impact we hope SB 313 will have.

SB 313 is a very small piece of a very big puzzle. For example:

- Over 40 states are introducing similar legislation this winter.
- Senator Pryor is reintroducing the Pharmaceutical Marketplace Reform Act of 1994 (S. 2239) in this session of Congress.
- Major litigation is in progress, with trial dates in some actions set for February of 1996.

Our belief is that the combination of all of these initiatives, the cumulative impact of all of these efforts, will someday bring an end to the practice of discriminatory pricing, in Montana and in the rest of the country as well.

We're asking for your help in this effort.

Last, Mr. Chairman, we understand that the entire health care system, and the pharmaceutical industry in particular, is in a period of major 'restructuring.' We understand macroeconomic trends. We understand that these companies are just following good business practices, just being good capitalists.

But, retail community pharmacy is not going to be 'restructured' out of existence due to the unfair pricing practices of major drug companies--at least not without a fight. And not as long as we believe that there are people in Montana and communities in Montana that still need, want, and rely on their neighborhood drugstore and retail pharmacies for their prescription medicines.

Thank you Mr. Chairman And Committee Members. I'll be available for any questions you may have.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 4
DATE 2/14/95
BILL NO. SB 313

Good morning Mr. Chairman, members of the committee. For the record, my name is Brad Griffin representing the Montana Retail Association. The MRA counts among it's 700 members, chain drug companies such as Wal Mart, K-Mart, Shopko and Gibsons, all of whom have a pharmacy. We also represent a number of small pharmacies across the state. Please, don't be misled, this is an issue where the independent and chain drug are united. I rise in strong support of SB 313 because this bill is about fairness in pricing practices for pharmaceutical products.

Please turn to page 2 of the handout as I give an overview of the problem. Currently drug manufacturers divide their customers into two groups or classes of trade. On one hand there is the institutional buyers like HMO's and mail order pharmacies. This group is the manufacturers preferred class of trade and as such receives discounts of up to 90% off of wholesale price. The second group, or class of trade, has 60% of the retail market and receives minimal discounts.

Your first reaction, like most peoples, is probably along the lines of "well, HMO's and mail order must sell more volume than community retail pharmacies." This is simply not true. If the discounts were awarded on volume of product sold, surely the buying clout of the independent's buying groups and the large chain drug retailers would gain them access to discounts. But even the combined buying power doesn't allow them access to manufacturers discounts. So what's happening here? In effect, what is happening is that those

of us who are not enrolled in an HMO or mail order program are subsidizing the minority of Montana's population who are.

This bill simply says to the manufacturers that they establish the criteria list for achieving the discounts. Whether it's volume, prompt payment, single point delivery or market share agreements - they, the manufacturer, set the criteria and let all retailers have access to the criteria.

Please turn to page 3. As you can see, we are not talking about small discounts. The first example is of Transderm Nitro, a patch that cardiac patients use. Mail order and HMO's pay $8.40 for 30 patches. Retailers pay $39.89 and mark it up 2-3 dollars. Mail order then can mark up their $8 product to just under the average retail price thereby making over 300% return. This practice is called shadow pricing. Again, who benefits? The HMO and mail order pharmacies bottom lines. You can see that the trend continues as you scan down the page. Please refer to the next sheet. This is an informal survey I did yesterday by calling two community pharmacists in Helena and a well known national mail order. We know what the average mail order cost is and what the cost is to retailers. You can see that that mail orderconsistently sells at or below retail. My questipon is, where is the evidence that mail order is passing their huge price discounts on to their customer?

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The point is, the manufacturers two classes of trade are obsolete and a hoax. We are talking about the outpatient prescription drug marketplace - which is one class of trade.

Montana's main street pharmacist is at a severe disadvantage because of these unfair and discriminating pricing practices. This bill will force manufacturers to deal with retail pharmacists on the same terms and conditions as HMO's and mail order pharmacies with whom they are in competition in the market place. This bill will enhance competition in the marketplace, not lessen it and it should bring prices down for the consumers.

It may seem difficult to believe that manufacturers would discriminate against a group of retailers doing 60% of their business. In fact it seems unbelievable. But the unbelievable becomes very believable when you realize that we are talking about the most profitable industry in America - one that generates a 17% net profit on sales of over $60 billion dollars.

That, Mr. Chairman and members of the committee, is why the drug manufacturers are here in force today. To protect an incredibly lucrative market. And to prevent real competition from entering an arena where they are hoding the cards. I submit that these incredible profits are being generated on the backs of Montana's senior citizens, those on fixed incomes, working families with no health insurance and Montana's citizens who are not enrolled in an HMO or mail order pharmacy.

Montana's pharmacies, the manufacturers oldest and best customers, stand before you to ask your help in rectifying these unfair pricing practices which are jeopardizing your local pharmacists very existence. We urge your support for SB 313.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 5
DATE 2/14/95
BILL NO. SB 313

Examples of "SHADOW PRICING"

We know that discriminatory pricing takes place all over the U.S.

Do HMO/Mail Order customers in Montana get the benefits of these discounts???

Apparently NOT!

For example:

DRUG	Nationally, HMOs, mail order, etc. pay about[1]	In Montana, community pharmacy pays[2]	**COMPARE RETAILS!** AARP retail price[3]	Community Pharmacy retail price[3]
Prozac 20mg/100ea	$120.28	$181.53	$190.35	$182.13
Tagamet 400mg/500ea	$166.56	$605.00	$625.75	$625.46
Calan 240mg/500ea	$123.00	$554.12	$549.75	$595.66
Slow-K 600mg/1000ea	$7.89	$143.95	$149.55	$161.72

* HMOs, Mail Order, etc., apparently fail to pass on lucrative discounts to their cash-paying customers
* HMOs, Mail Order, etc., realize a gross profit margin in the neighborhood of 75 percent on these sales
* Montana Community Pharmacy realizes a gross profit margin of less than 7 percent on these sales

1 McKesson invoice dated 9/94.

2 Actual community pharmacy cost, Helena, MT, 2/???/95

3 Quoted retail price from telephone survey, Helena, MT, 2/13/95

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 6
DATE 2/14/95
BILL NO. SB 313

MONTANA STATE PHARMACEUTICAL ASSOCIATION

PO Box 4718 • 34 West Sixth Avenue • Helena, MT 59604 • 406-449-3843 • Fax 406-443-4992

John "Ed" Kennedy, JR
5567 Highway 35
Kalispell, Montana 59901

Senate Business & Industry Committee

Re: Senate Bill 313

Senate Bill 313 is an economic retention bill: We worry continuously about economic development so here is a bill about economic retention.

If a company (manufacturer) wants to have an average retail of $6.00 on a particular bottle of medicine and he sells it to one entity for $2.00, it should be very obvious that he must sell it to another entity for $10.00 to maintain the $6.00 average.

The entity that pays the $10.00 in this case is the retail pharmacies of the State of Montana. They in turn must pass on the higher price to the customers in Lewistown, Hamilton, Libby, Bozeman, Laurel, Billings, Florence and Great Falls, your constituents. This includes senior citizens on fixed incomes that only have Social Security and Medicare (which does not cover prescriptions). As well as any other individuals that patronize your corner drug store or local pharmacy.

There are lawsuits pending claiming price-fixing violations of the Sherman Antitrust Act and discriminatory pricing violations of the Robinson-Patman Act against certain drug companies that participate in discriminatory pricing.

Montana pharmacists and pharmacies want to compete in the market place but to do so we need equal access to good prices. (The old level the playing field concept).

Senate Bill 313 could be a win, win for everyone. Drug companies could sell their product to everyone at a price that would allow adequate profit to cover their needs as well as provide money for research and development.

The retail pharmacies of Montana could buy the product for less and pass the saving on to the consumers in Lewistown, Hamilton, Libby, Bozeman, Laurel, Billings, Florence and Great Falls. Economic retention is achieved by the Montana

Pharmacies surviving, providing jobs, paying taxes and contributing to the Montana economy. While saving your constituents money.

If the drug companies are against this bill, they must not be telling us something.

Thank you for allowing me to testify before this committee.
John "Ed" Kennedy, Jr.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 7
DATE 2/14
BILL NO. SB 313

(presented by Annie Bartos

Bill Amendments to SB 313
Ensuring Equal Access for Purchasers to Drug Manufacturers' Discounts

Proposed by: **Montana Department of Commerce**
Point of Contact: **Jon Noel, Director, 444-3797**

1. Page 1, Line 6.
Strike "COMMERCE"
Insert "JUSTICE"

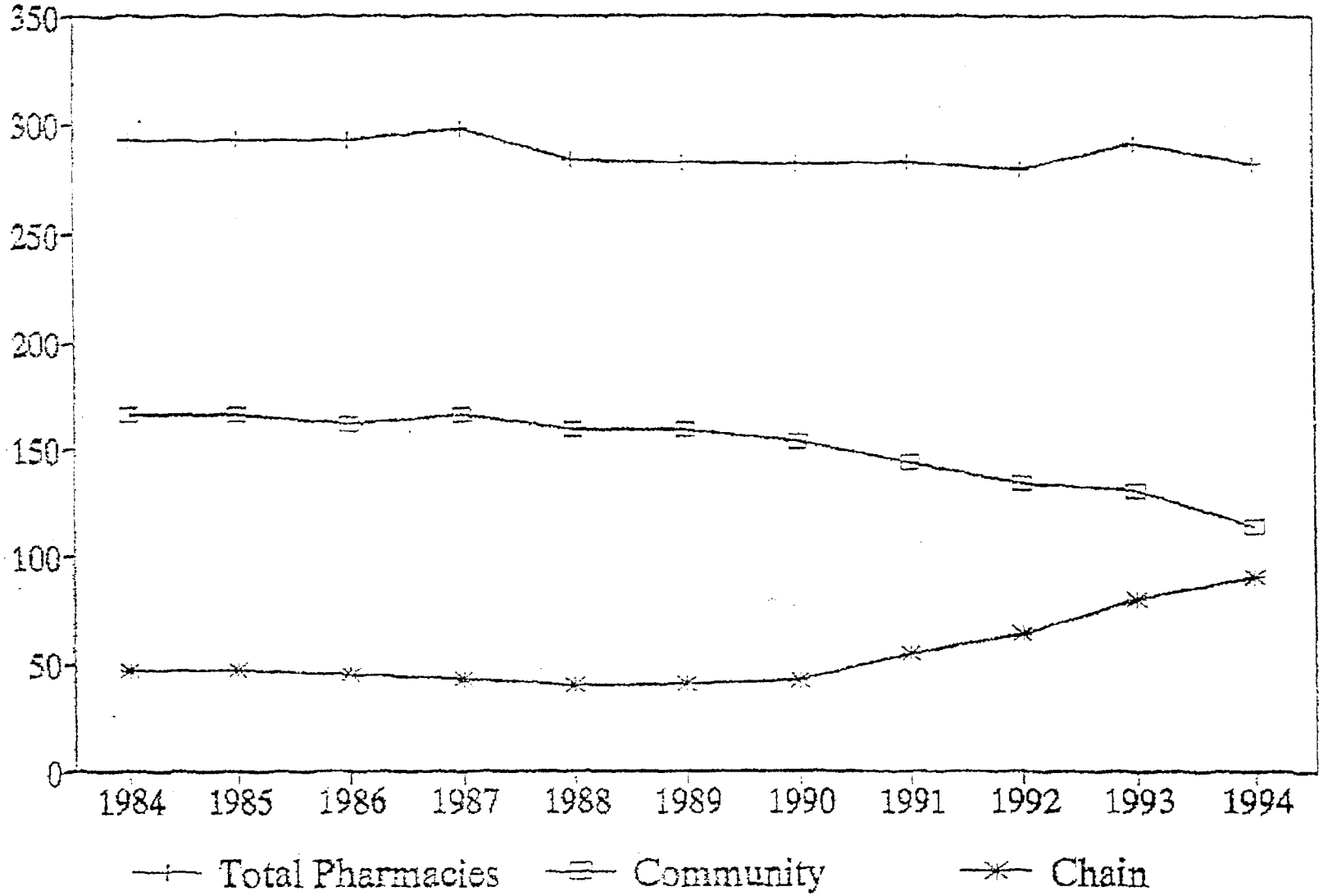
2. Page 1, Line 10.
Strike "commerce"
Insert: "justice".

3. Page 2, Line 2.
Strike: "commerce"
Insert: "justice"

4. Page 3, Line 4.
Following "penalty."
Strike "(1) The department shall enforce the provisions of [sections 1 through 7] pursuant to the procedures established in 30-14-220 through 30-14-223.

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 8
DATE 2/14/95
BILL NO. SB 313

Number of Pharmacies in Montana, 1984-1994



Source: BMI Inc., based on data from National Council for Prescription Drug Programs (NCPDP), 1994.

SENATE BUSINESS & INDUSTR
EXHIBIT NO. 8B
DATE 2/14/95
BILL NO. SB 313

R19-02-000
ALLOW

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Any new prescription or even one previously filled at another pharmacy!* Prescription under $10 is free with coupon.

Coupon good through Saturday, March 4, 1995. Limit 1 coupon per family.
Not good on prescriptions previously filled at another ShopKo Pharmacy.
Not good with any other offers. Good on new prescriptions
and ones previously filled by another pharmacy.
*Our pharmacist will contact your physician for prescription authorization.

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Address:_____
City:_____

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Coupon not valid in conjunction with any restricted insurance plans

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Guaranteed Low Prices*

on prescriptions. If you paid less elsewhere, we'll fill your prescription, match their price, plus give you $5 in cash.
*See store for details

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SENATE BUSINESS & INDUS
EXHIBIT NO. 8 D
DATE 2/14/95
BILL NO. SB 313

DATE: February 13, 1995

TO: All Great Falls Legislators

FROM: Bill Beck, Director of Pharmacy

SUBJECT: SENATE BILL NO. 313

Buttrey Food and Drug Company is a Montana-based company that currently operates in-state 20 retail pharmacies, 1 unit-dose pharmacy, and 1 mail order facility located in Great Falls.

Our in-state mail order facility has currently contracted with Montana State Employees, Montana University System and Cascade County Employees. We also are in the negotiations to contract with the members of the Montana Association of Health Care Purchasers, as is Express Scripts mail order facility located out-of-state.

Without the separate "classes of trade" offered by the pharmaceutical manufacturers, Buttrey could not competitively compete with out-of-state mail order facilities such as Express Scripts, RX America, Medco, and a host of others, for in-state Montana entities.

This would force Montana-based groups, who are desperately trying to lower their health care costs, to funnel Montana dollars out-of-state.

Most Want Specific Health Reforms Passed: Survey

By Mary Jane Fisher

WASHINGTON—Although Americans registered high levels of satisfaction with the cost, quality and choices available in their current health plan, an overwhelming 87 percent want Congress to pass specific health insurance reforms.

In the first comprehensive post-election health care survey released Dec. 14 by the Healthcare Leadership Council, the poll found Americans support targeted legislative reforms. In particular, they want to be assured they can keep the health coverage they have.

The survey by the Luntz Research Companies of Arlington, Va. found that 87 percent of 1,000 adults questioned nationwide by telephone support a plan that provides "an ability to carry your health insurance from one job to the next." They also want:

- "a guarantee of your ability to keep your health insurance if you lost your job;" and
- "a guarantee that you or a family member could not be turned down by a health insurance company because of a pre-existing condition or illness."

"The new Congress has the opportunity to enact this legislation," said Pamela G. Bailey, president of the Washington-based Healthcare Leadership Council.

"Giving Americans the assurance that they can keep their coverage is major health care reform that can and should be passed in the early days of the next session," she told reporters at a press conference to release the survey. "This is an opportunity for the President and Congress to defy expectations and hit a home run.

"Last year, the threats to common sense reforms were mandatory alliances and price controls," Ms. Bailey noted. "This coming year, the threats very well may be anti-managed care, unitary pricing or changes to ERISA that restrict the ability of employers to improve care."

The poll "helps to confirm that the system is reforming itself," she said, adding that "for six years we have been advocating insurance reform."

Republican pollster Frank Luntz, who did the polling on "Contract With America," for Speaker-to-be Newt Gingrich, said, "In all my polling, I've never seen such support as for minimum reforms. It cuts across all plans."

People want this centrist plan that "does away with all the bells and whistles," he added. The American people support universal access, not universal coverage, according to Mr. Luntz.

Noting that people "are not expecting much from Republicans" on this issue, Mr. Luntz said there is an opportunity for President Clinton and Republicans to reach a bipartisan agreement.

"If both sides can come together, it would do much to repair the damage done in the last Congress," he noted.

Survey results also demonstrated that in addition to being "far more satisfied than their fee-for-service counterparts with the cost of their plan, people in managed care are more satisfied with the quality and choice they receive as well," according to an executive summary of the report.

Advice for health care in 1995 from those surveyed include:

- categorical rejection of universal coverage; 70 percent favor universal access to services, with 30 percent favoring government guarantee of coverage to every American;
- Americans favoring a GOP-backed plan over one endorsed by the President, 44 percent to 32 percent;
- Americans calling for specific components as part of a health care improvement package, namely, portability, guaranteed renewability and Medical Savings Accounts;
- only 12 percent of those with coverage expressed dissatisfaction with their health care plan; and
- the real challenge: "Let me keep my own, and don't let anyone take it away from me."

The Healthcare Leadership Council was formed in 1988 and includes more than 50 health care industry leaders, including some insurers. ◊

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 10
DATE 2-14-95
BILL NO. SB 322

SB-322
PROPOSED AMENDMENTS OF BLUE CROSS AND BLUE SHIELD OF MONTANA

(Presented by Tanya Ask)

Line 5, following "HAD", insert, **"QUALIFYING"**
Section 1, line 16 strike lines 16 and 17 following (b)

Insert at line 16, the following: **"A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a policy or certificate of disability insurance for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services, if the qualifying previous coverage was continuous to a date not more than 30 days prior to the effective date of new coverage."**

Line 24, following "arrangement", insert: **"that provides benefits similar to or exceeding benefits provided under the policy or certificate of disability insurance issued under this section"**

Add a new section:

NEW SECTION. Section 2. Applicability. (This act) applies to a policy or certificate of disability insurance and health service membership contract entered into or renewed on or after (the effective date of this act).

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 10
DATE 2-14-95
BILL NO. SB 322

DATE Tuesday February 14, 1995

SENATE COMMITTEE ON Business and Industry

BILLS BEING HEARD TODAY: SB 313 Senator Mesaros
SB 322 Senator Jacobson

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
DAN SEVERSON	VALLEY DRUG / STEVENSVILLE FAMILY Pharm	313	X	
Tom Schneider	MPEA	313		✓
Ron Campbell	DrugMart MSPA	313	X	
Allen Buckley	Columbia Falls Chamber Co	313		✓
Steve Turkiewicz	MT. Area Health Care Providers / Mt. Auto Dealers Assn Trust	313		✓
Bill Olson	AARP			✓
John Ed Kennedy Jr	Montana Pharmacist People	313	X	
Bob Anderson	MSBA			✓
Howard Bailey	MSSF			✓
Nate Miles	Eli Lilly	313		✓
Russ Ritter	Wash Corp	313		✓
Jay Driscoll	MFSE	313		✓
Charles R Brooks	MT. Food Distr Assoc	313	✓	
Ed Caplis	MSCA	313	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE Tuesday February 14, 1995
ROOM 325
SENATE COMMITTEE ON Business and Industry

BILLS BEING HEARD TODAY: SB. 313 Senator Mesaros
SB 322 Senator Jacobson

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Jim Smith	Mt Rx Assoc	313	X	
[illegible]	GLAXO	313		✓
Bob [illegible]	PhRMA	313		✓
Brad Griffin	MT Retail Assoc	313	X	
Kenneth J. Bergum	MSPA	313	X	
Denis Yost	MSHP	313		✓
Robert Nickens	NACDS	313	X	
Mary McCue	MSPA	313	X	
Steve Brown	PhRMA			X
[illegible]	MRDI	313		
Peter Wolfgram	MSPA	313	X	
[illegible]	Pharmacy	313	X	
Wayne Hedman	Bitterroot Drug	313	X	
Ron Bergum	Bergum Drug	313	X	

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DATE Tuesday February 14, 1995

SENATE COMMITTEE ON Business and Industry

BILLS BEING HEARD TODAY: SB 313 Senator Mesaros

SB 322 Senator Jacobson

< ■ > PLEASE PRINT < ■ >

Check One

Name	Representing	Bill No.	Support	Oppose
D. B. DITZel	BRO. OF LOCOMOTIVE ENGRS	313		X
F. G. Marceau	UNITED TRANS UNION	313		X
Chuck Bona	Blue Cross Blue Shield MT	313		X
Tom Hopgood	Mth Fms. Assoc. Assoc.	313		✓
Don Waldron		313		✓
LLOYD ANDERSON		313	✓	
Claudia Clifford	State Auditor's office			
Claudia Clifford	State Auditor's office	322	✓	
L. Loyd Bucher	AART	322	✓	
Tanya PBC	Blue Cross Blue Shield	322	Statement	

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REGISTER.F10

DATE Tuesday February 14, 1995

SENATE COMMITTEE ON Business and Industry

BILLS BEING HEARD TODAY: SB 313 Senator Mesaros
SB 322 Senator Jacobson

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Shelly Griffin	self	313	X	
Pete Joseph	MFT			X
Kay Fox	Montana Law-Enforcement Coalit	313		X
Bill Stevens	MT Food Dist	313	X	
Tom Hopgood	Hlth Ins Assoc Am	322	✓	

VISITOR REGISTER

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