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# ***Committee Meeting***

of

## ASSEMBLY FEDERAL RELATIONS COMMITTEE

*“Testimony concerning the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the impact the Medicare drug program will have on the State’s Pharmaceutical Assistance to the Aged and Disabled and Senior Gold Programs”*

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**LOCATION:** Committee Room 9  
State House Annex  
Trenton, New Jersey

**DATE:** February 26, 2004  
10:00 a.m.

**MEMBERS OF COMMITTEE PRESENT:**

Assemblyman Reed Gusciora, Chair  
Assemblywoman Linda R. Greenstein, Vice-Chair  
Assemblyman William D. Payne  
Assemblywoman Mary T. Previte  
Assemblyman John S. Wisniewski  
Assemblyman Guy R. Gregg  
Assemblyman Joseph Pennacchio



**ALSO PRESENT:**

Catherine Z. Brennan  
Linda Earley Chastang  
*Office of Legislative Services  
Committee Aides*

Beth Schroeder  
*Assembly Majority  
Committee Aide*

Mark Duffy  
*Assembly Republican  
Committee Aide*

***Meeting Recorded and Transcribed by  
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## TABLE OF CONTENTS

	<u>Page</u>
William Vaughan Director Government Relations Families USA Washington, D.C.	2
Kathleen Mason Assistant Commissioner Division of Senior Benefits and Utilization Management Office of the Public Guardian for the Elderly New Jersey Department of Health and Senior Services	5
Sy Larson Representing AARP, New Jersey	35
Assemblyman Samuel D. Thompson District 13	35
Doug Johnston Governmental Affairs Officer AARP, New Jersey	41
Laurie A. Clark Representing New Jersey Pharmacists Association, and Garden State Pharmacy Owners, Inc.	50
Beverly Roberts Director Mainstreaming Medical Care Program The ARC of New Jersey	53
Colleen O'Dell-Multer Disability Advocate/Coordinator Ocean County Monday Morning Project	57

## TABLE OF CONTENTS (continued)

	<b><u>Page</u></b>
Edward Goldman Private Citizen	64
Patrick Morrisey, Esq. Deputy Staff Director House Energy and Commerce Committee Washington, D.C.	67
<b>APPENDIX:</b>	
Statement plus attachments submitted by William Vaughan	1x
Testimony submitted by Kathleen Mason	23x
Testimony plus newspaper articles submitted by Doug Johnston	26x
Testimony plus statement from Darlene LaRue submitted by Beverly Roberts	32x
Testimony submitted by Colleen O'Dell-Multer	36x
Statement submitted by Patrick Morrisey, Esq.	39x
lmb: 1-98	

**ASSEMBLYMAN REED GUSCIORA (Chair):** Welcome everybody to the Federal Relations Committee, and is there a role call?

MS. BRENNAN (Committee Aide): Chairman Gusciora.

ASSEMBLYMAN GUSCIORA: Present.

MS. BRENNAN: Assemblywoman Greenstein. (no response)

Assemblyman Payne. (no response)

Assemblywoman Previte.

ASSEMBLYWOMAN PREVITE: Here.

MS. BRENNAN: Assemblyman Wisniewski.

ASSEMBLYMAN WISNIEWSKI: Here.

MS. BRENNAN: Assemblyman Gregg.

ASSEMBLYMAN GREGG: Here.

MS. BRENNAN: Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Here.

ASSEMBLYMAN GUSCIORA: We have a quorum.

I wanted to welcome all our guests here today. I think it's very important that we've had new Medicare law enacted into Washington, and I think it's important to see how that fits in with our own Pharmaceutical Assistance Program for the Aged and the Disabled, as well as Senior Gold. We want to make sure that we have a smooth transition and that, hopefully, the two programs will be compatible. So we are here to explore that and to see what we can do on this end to shore up these benefits and ensure that our seniors are taken of.

With that, would our ranking Minority member have a statement, or if anyone has a statement, or just go right into the testimony?

ASSEMBLYMAN GREGG: Okay. Just go into the testimony, Mr. Chairman.

I just want to thank you for having these hearings. I think this is an issue that affects an awful lot of New Jerseyans at this point. There's a lot of confusion, I think, out there and, perhaps, some misrepresentations about whether this will be better or not for New Jersey. So I'm looking forward to the testimony today, and I thank you for having the hearings.

ASSEMBLYMAN GUSCIORA: Thank you.

ASSEMBLYMAN GREGG: Did you fix my mike here (laughter)?

ASSEMBLYMAN GUSCIORA: I can just turn you off (referring to PA microphone). They have a switch-off-Gregg button.

ASSEMBLYMAN GREGG: You been trying to do that all our careers together (laughter).

ASSEMBLYMAN GUSCIORA: I could never do that, not to you.

I'd like to welcome Bill Vaughan, the Director of Government Affairs (*sic*) at Families USA, and Kathleen Mason, our own Assistant Commissioner for PAAD, New Jersey Department of Health and Senior Services, to give us an overview and where we're going. I understand Kathy did the yeomans work of coming up on a train, and she's going to go right back to make sure that there is a smooth transition.

So, Bill, if you'd like to lead off, and then Kathy second.

**WILLIAM VAUGHAN:** Thank you very much for having us up to testify. Families USA is a small, private foundation that works for health consumers, better Medicare, Medicaid, to try to reduce the number of uninsured.

And congratulations to you all in New Jersey for having done so much for so many years to help your lower-income seniors, up to 300 percent of poverty, or disabled, with the drug benefit. I think you're a model of what the rest of the nation should have been. And it's very, very sad to us, as a consumer group, that the new Federal law has so many gaps and is likely to be somewhat disruptive to your folks under 300 percent.

This is a complex and difficult law. It costs about half a trillion in the next decade, and probably a couple trillion in the decade after that, unless we get a handle on prescription drug inflation. And New Jersey taxpayers, a lot of them, are going to have to help pay for this. And I'm not sure that many of your folks get much. They don't get much in addition, because your PAAD and your Senior Gold Program have been so very good. I'd like to say, well, it would be neat if Washington could change this, that your program could continue, and Medicare would pay you guys, and nobody would be disrupted, but I don't think that's likely to happen in the near future.

Folks want to let this law move forward for a little bit. I think there's some fear of opening it up, because there's criticisms in a number of areas. I think this is what you got for a while. And so, how do you live with it? And to get any savings as a State, as taxpayers, it seems to me you're probably going to have to let Medicare be primary and kind of wrap around and fill in the gaps, which is going to be a hassle for a lot of your people.

This new program -- you basically get the drug benefit through Medicare HMO -- it's been out there for a while -- or for some brand new, stand-alone, drug-only insurance companies, which are new. Basically, they're kind of mini-HMOs in a sense. They will make their money by managing and

controlling drug usage, which can be good. God knows, overusage and all is bad, but there will be a hassle factor there that probably most of your people have not seen before. It's something that is likely to leave to some grumpy constituents. We hope that you all take a deep breath and continue your program and continue supporting extra benefits for the lower-income, middle-income people, because the new Medicare law is pretty weak on the benefits.

We did some written testimony, which I'm not particular following, that's available on all your desks, and there's a few extra copies back over there (indicating). In the attachments, the most interesting -- I hope all of them might be of interest to you -- but the most interesting would be Attachment No. 3, where, basically, describe the benefit. But then you talk about how with inflation the benefit package changes. It's the one called Your Medicare Drug Bill: What it Looks Like in the Future. You can see this doughnut. You've heard this term that came up out of Washington. There's a place between \$2,250 and \$5,100 in the Medicare bill called the doughnut. Hole -- meaning there's nothing there. There's just a big, empty hole, and you pay all that money in the middle, unless you have a state Pharmacy Assistance Program, like New Jersey's.

Well, that grows. Look how it grows to \$5,066 -- a doughnut hole. That's more than a doughnut hole, that's a -- I don't know -- pizza pie or something. But it gets huge and is going to be very, very tough on a lot of people unless your State programs continue to help fill in.

And even more interesting, I refer you to the back of that table where we have the average drug use by a senior in 2006 -- is 3,167, and it grows

to 5,400. But then you look at how median income grows. And because drug inflation will be so much more than people's Social Security COLAs and so forth, seniors disabled are falling behind. Over this period, they will still be paying more out of pocket for prescription drugs. So they're going to need PAAD. They're going to need Senior Gold, still, to help fill in this.

And the best part of the new Medicare law, unquestionably, is its help for the low income. It does a lot of good stuff, except you guys are already doing it. In the rest of the nation, it's wonderful in the low-income area. But even there, there are gaps in the new law, in the sense that there's an asset test that disqualifies about 1.8 million lower-income seniors nationwide. And then, as I understand it, New Jersey today has zero co-pay for the dual eligibles, those who are Medicare, Medicaid.

**ASST. COMMISSIONER KATHLEEN MASON:** Right.

MR. VAUGHAN: Zero. 2006, those people be asked, under Medicare, taking this over to pay \$1 for generics, \$3 for sole-source brand kind of drugs and say, "Well, big deal." Well, when you're living on Medicaid qualification, in most of the nation is \$18.40 a day, you're living on that for everything. And somebody says, "Three bucks and you got five, 10, 15 prescriptions a month, "Ouch." So, again, I hope that the New Jersey program can continue to try to fill in some of those gaps.

In our testimony, we try to walk through the impact of this bill on your State's budget, fiscal relief. There's pros and there's cons. A con would be like the clawback. There's a woodwork effect where more people may sign up for things like the Medicare Savings Program, QuiMBy, SLiMBy, that kind of stuff. But folks -- gentlemen, ladies -- nobody knows. The really good analysts



at the Congressional Budget Office, on December 8, were saying this was a \$400 billion bill in 10 years. Sixty days later, the really good analyst, actuaries said Medicare, were saying, "Sorry, we think it's 534 billion." One hundred and thirty-four billion dollar change in cost estimate by two really good groups of professionals in 60 days. So for me to come up here and say, oh, this will mean X for the State of New Jersey's budget is way beyond my IQ or chutzpah level.

Also attached, we've done something that might be helpful to your budget work this year, which is an analysis of the President's Fiscal '05 health requests. And as you'll see, once again, the administration is pushing for some cuts in Medicaid. I think your Medicaid administrators might say that things have gotten tough administratively. There are a lot of new hassles. There's a death by a thousand bites of bureaucratic hassles and questions that is discouraging Medicaid. And then there are these legislative proposals. So that you're going to face some budget pressures there.

Again, we hope you'll hold the course and continue to support Medicaid. We oppose block granting, which would be a long-term disaster for your lower-income people. I'd like to make one sales pitch, lobby you all. I would hope you could urge your congressional delegation on a bipartisan basis to support an effort to continue last year's temporary increase in the Federal Medical Assistance percentage. That was a \$10-billion thing last year, where they increased, just a few points, the percentage of help to the states. That expires June 30. And most of the states -- I don't know about you all -- are still in deep trouble, and there's likely to be some serious cuts July 1. This is a long shot. This is a long shot. It probably won't happen, but it's one of our best

shots. And the advocacy community in Washington is working to get an extension, and we would love to have your congressional delegation support.

Let me stop there. And if there are questions later.

ASSEMBLYMAN GUSCIORA: Bill, can you walk us through just the mechanics of the Medicare beneficiary. Obviously, we have to pay a premium. How much is that premium?

MR. VAUGHAN: The first year -- and again, things will inflate fairly rapidly. Because, in fact, they'll inflate at about 8.6 percent a year on average, according to the Congressional Budget Office. But starting in 2006, forget this little drug discount card, which has an important \$600 thing that New Jersey should get, darn it, and ought to get. But that starts June 8 and ends December 31, '05. So that's just a little bridge, and that's the first thing up. So there's a lot of attention to it. But the big game, the long-term game, is what starts January 1, '06, and you'd pay roughly-- You're going to do this through private plans, whether it's an existing Medicare HMO or these new things that are going to offer just a drug benefit only. And they're going to be for-profit, at-risk, small drug-only insurance companies. And they'll have a formulary, and it may be rather restrictive compared to, for example, PAAD and Senior Gold. And you'll pay roughly \$35 a month premium. Then you'll have a deductible of 250. Between 250 and 2,250, it's pretty good. Medicare will pay three-fourths, you'll pay a fourth, \$500. So we're up to 750 by the time you get to 2,250.

Then you're on your own. Then you're on your own. Your family can help you. But if you have a company coverage or Medigap, you got to get rid of, basically, your Medigap that covers drugs. The only kind of exception

is your State Pharmacy Assistance Program, State-only money, not Medicaid, but State-only money can help fill that gap. But there's this doughnut gap that runs for \$2,850. Add 2,250, 2,850, you get to 5,100 before you get really pretty good catastrophic coverage. Above 5,100, you'll pay 5 percent of your drug costs. I keep using that as shorthand. Actually, the law says, the greater of 5 percent or \$2 for generic multi-source or \$5 for sole-source special kind of pill. And then the sky's the limit. You can go out 10,000, 20,000, and you're getting help at the 95 percent level. But it's getting through that doughnut that is causing-- If there's a pill for heartburn, sales will go up, as seniors figure this one out.

ASSEMBLYMAN GUSCIORA: But if you have a private plan or a Medigap plan, you would not be able to utilize the benefits?

MR. VAUGHAN: Correct, to fill the doughnut. Correct. Yes.

ASSEMBLYMAN GUSCIORA: Is there a reason for that?

MR. VAUGHAN: You have one of the nation's real experts here today, Pat Morrissey. He's going to be a witness, and he's one of the councils who helped draft it. But, in general, one, Congress had 400 billion to do this. And by not particularly getting better control on drug inflation, 400 billion spent on seniors who are going to use 1.83 trillion -- 1,830 billion in drugs over that same decade, gives you a benefit. If you do the math, if you did it equally, every pill would get 22 percent coverage. Well, Congress, I think, did the right thing and said, "The low income can't handle that. We'll push a bunch of money into low income. And the very, very sick can't handle it, so we'll do well by the catastrophic." So it sucked that money out of the middle. And so, in the doughnut area, in the middle -- the moderate to heavy use of pharmaceuticals --

there's no money left. I think Pat would agree with that. And that's the main reason.

But there's also a philosophical one that, "We got to have a deductible." You can't help fill in and stuff, because people are overutilizing pills. People are taking too many of them, and we got to make people have some money in the pot and be more careful. Okay, that kind of works for middle class and rich folks. Again, when you're living on under 10,000 a year, the literature is very clear that co-pays mean people quit taking their medicines. They cut the pills in half. They go without, and they get sicker. So there is some philosophical reason for it, but I think mostly budget driven.

ASSEMBLYMAN GUSCIORA: Is there an estimate of the average senior -- what their drug costs are per year?

MR. VAUGHAN: Yes. The chart that shows in the year 2006, the estimate will be that the average will be using 3,167. But it's all over the lot. Ten percent of seniors use zero, and 1 percent this year used more than 20,000 -- sick, sick people.

ASSEMBLYWOMAN PREVITE: Oh, my sakes.

ASSEMBLYMAN GUSCIORA: Now, would the State have an ability to negotiate with drug companies to purchase bulk drugs to benefit the recipients?

MR. VAUGHAN: Well, that's one of the costs of this bill to you all, in that-- Because Medicare takes over that function, and to the extent you guys have said, "Hey, we've got a Medicaid budget, and it's half a billion dollars for drugs." The drug companies say, "They're big buyers. I'll give them a discount." Well, now, most of your customers go away. They become

Medicare beneficiaries, and you're really only buying pills now for your 30-year-old mother and her kid and maybe your prison population, or something, but your buying clout has diminished enormously. I think you're going to have a tougher time getting a good deal from the companies, maybe.

ASSEMBLYMAN GUSCIORA: Do any members have any questions?

ASSEMBLYMAN PENNACCHIO: I have a question.

ASSEMBLYMAN GUSCIORA: Mr. Pennacchio.

ASSEMBLYMAN PENNACCHIO: Yes. You had mentioned that the bill went from 400 billion to 534 billion. Do you know how much New Jersey is due to get out of that \$534 billion?

MR. VAUGHAN: No, sir, I don't, Doctor. And I don't even know which side is right. I think I'd split it. It's probably about a \$480 billion bill. And if you take Medicare's primary, and your program now wraps around and your people join Medicare first, which they won't want to do particularly. And this is the problem you all face with angry constituents. If I was in PAAD, I wouldn't join Medicare. I'd say, "Whoa, this is better for me. I'm going to stay with this." So you're going to have to-- To get savings, to get that tax money, you're going to have to push your constituents. And that's--

ASSEMBLYMAN PENNACCHIO: Well, I guess we didn't get a number then, Bill, did we? Do you think that the law, as written, gives the State -- all State legislators enough discretion to fine tune and to wrap around the existing program, such as New Jersey has -- PAAD and Senior Gold?

MR. VAUGHAN: Again, congratulations to your State. Yes, with state-only money, you can do it. Most states -- you're so far ahead of most

states. Most states would say, "State-only money? We don't have it. We need the Medicaid wrap, but we need the Medicaid match," which then can't be used, basically. You all are unique, and you have shown flexibility and courage, and I hope you continue to.

ASSEMBLYMAN PENNACCHIO: Thank you.

I apologize that I haven't done this through the Chair, Assemblyman -- Chair.

ASSEMBLYMAN GUSCIORA: Go right ahead.

ASSEMBLYMAN PENNACCHIO: And thank you for -- to include us from New Jersey State. So a lot of the arguments that we hear when we listen to TV and the talking heads about this program, some of the criticism may not apply to New Jersey, because we are ahead of the curve and we can fine tune whatever the Federal Government is going to give us.

MR. VAUGHAN: I think that's very fair, yes.

ASSEMBLYMAN PENNACCHIO: Okay. And just -- you had spoken about the hassle factor. Not to be critical, but I assume the hassle factor, you mean that people now actually have to do something in order to get this benefit, something new that they hadn't to do before?

MR. VAUGHAN: When they join the benefit, which is going to be easy. People are going to be knocking on the door and selling these things right and left. These companies will make their money by a restrictive formulary. And if you need a pill off of it, you got to appeal and fight for it. This is going to be like the Medicare HMO fight in the mid-'90s, when people got real grumpy about HMOs. And then there were some court cases came along and kind of made the HMOs be more responsive to patients. We're going to be

back, I think -- Pat may disagree -- but we're going to be back to the days where there's going to be -- you can make money in these companies by hassling folks. And that's where your constituents may get grumpy. The act of signing up is going to be easy.

ASSEMBLYMAN PENNACCHIO: But again, what I asked you before, through the Chair, that may not necessarily be true in New Jersey. The Legislature can come and address that through the existing PAAD and Senior Gold Program. If nothing else, could we not even expand those programs?

MR. VAUGHAN: There is a provision where the states shall not interfere in the ability of these companies to manage and control costs and care. So the fact that they may be tough on your constituents, I think, there's a real limit.

ASSEMBLYMAN PENNACCHIO: I think you misunderstood, through the Chair.

MR. VAUGHAN: I'm sorry.

ASSEMBLYMAN PENNACCHIO: If we chose to do so, using these Federal dollars that are coming in, and my estimates have been 4 billion over 10 years -- \$20 million a year -- which, coincidentally, is about the cost, I think, of what we paid for PAAD -- could we not, as a Legislature, then expand the existing PAAD and senior programs?

MR. VAUGHAN: Absolutely.

ASSEMBLYMAN PENNACCHIO: Make it a little less hassle free, maybe instead of having the current means test, maybe increase the eligibilities and increase the scope in the sense, even decrease the deductibles that the

Federal Government uses as a guideline versus what we could do, because we're already there.

MR. VAUGHAN: Yes, sir.

ASSEMBLYMAN PENNACCHIO: Okay. I appreciate that. Just finally, again, not to be critical, but it sounded like you were being critical that we were spending from 400 million to 534 million, yet we had some complaints there about maybe finding additional moneys for that \$1 co-payment and the 500 -- and yet, this money has got to come someplace. So, if nothing else, the scope of this Federal bill, in my view, is probably going to get larger, not smaller, in order to satisfy some of those things that you have concerns with?

MR. VAUGHAN: Yes and no. I don't mean to be--

ASSEMBLYMAN PENNACCHIO: Okay. The yes part I understand. Tell me the no part (laughter).

MR. VAUGHAN: The no part might be at this rate of inflation, I don't think the nation can sustain this program. We're going to have to get a handle on prescription drug costs and some of the overpayments to the HMOs, because the baby-boomer retirement is coming, and it's just -- we can't afford it.

ASSEMBLYMAN PENNACCHIO: Thank you.

MR. VAUGHAN: But that's a long run.

ASSEMBLYMAN PENNACCHIO: Okay. Thank you.

Thank you, Mr. Chair.

ASSEMBLYMAN GUSCIORA: Assemblyman Wisniewski.

ASSEMBLYMAN WISNIEWSKI: Thank you, Mr. Chairman.



Mr. Vaughan, just so that I can understand, is there a way that the new Federal law can be worked so that it's a supplement on top of PAAD, or does it operate at a separate program?

MR. VAUGHAN: Not for you to get the money. In other words, Medicare is going to have to be primary on this, and you wrap around.

ASSEMBLYMAN WISNIEWSKI: So, in order--

MR. VAUGHAN: I mean, we can try to change the law in Washington. I just don't see that happening in the near future, sir.

ASSEMBLYMAN WISNIEWSKI: So, in order for New Jersey to respond to this, we would have to rework our PAAD Program?

MR. VAUGHAN: I want to defer to your next witness, but I believe so.

ASSEMBLYMAN WISNIEWSKI: And do you have any information about what -- knowing what New Jersey spends on PAAD, do you have any information about what that would cost us to rework New Jersey's PAAD Program to make the Federal program provide better coverage than our citizens have already?

MR. VAUGHAN: Oh, I think you can do that. The Medicare Program--

ASSEMBLYMAN WISNIEWSKI: I'm sure we can do it -- just what is it going to cost?

MR. VAUGHAN: Less than you're spending now in a sense. In that, if Medicare will come in and do the basic core work, but it will have these big gaps, like that doughnut, and it will have the co-pays for the Medicaid people.

ASSEMBLYMAN WISNIEWSKI: And those gaps continue getting bigger--

MR. VAUGHAN: And they keep inflating, right.

ASSEMBLYMAN WISNIEWSKI: --over time.

MR. VAUGHAN: But the money you save by Medicare covering the core will probably be a hunk, as the gentleman said -- was going to be a lot of money. So that your potential to wrap around and improve your current service to seniors is enormous without going further into your budget spending. I mean, your net spending doesn't have to go up for New Jersey to continue to have one of the greatest programs in the nation.

ASSEMBLYMAN WISNIEWSKI: Is there any way to have New Jersey's Program be primary and have the Federal program fill in the gaps?

MR. VAUGHAN: I wish -- that would be our devout wish. But, politically in Washington, no, sir. Not for the next few years.

ASSEMBLYMAN WISNIEWSKI: Why do you say not for the next few years? I mean, is it going to change in the next few years after that?

MR. VAUGHAN: We think that as folks understand this law and as it works its way through, there will be some major changes in three or four years. But right now, everybody is real proud of what they've passed, with some justification, and don't want to open it up, other than side issues like Canadian reimportation, which is, kind of, a side issue, frankly. These big structural things, we're not going to get to for a few more years.

ASSEMBLYMAN WISNIEWSKI: Isn't it true that in a couple of years when it gets reopened up, there's an equal likelihood that someone may

look at it and say, “Well, the cost is way too much. We’ve got to scale it back?”

MR. VAUGHAN: Scaling back of major benefits -- pretty rare. Medicare Catastrophic passed in '88 and was repealed before it started. I was one of the staffers working on it. I always thought, if the benefit had started, if people had gotten a taste of that good benefit, they would have accepted the tax. And instead, we started the tax before we started the benefit, which was kind of dumb back in '88.

ASSEMBLYMAN WISNIEWSKI: Thank you.

ASSEMBLYMAN GUSCIORA: Assemblyman Payne.

ASSEMBLYMAN PAYNE: Thank you and good morning.

You said when people get to understand this more that they’re going to be looking at it again and maybe reopen it. It is extremely complex now, and the fact that no one really knows what the costs are. The fact that at one point we’ve talked about a \$400 billion and then just shortly thereafter, we come up with another 135 billion. I mean, it’s obvious that no one really knows what the cost of this is going to be. I mean, two bodies, well-respected and competent bodies come up with two different figures. It’s absolutely a nightmare, really.

Just some comments. I don’t know you-- You said a side issue would be the Canadian purchase -- that’s a side issue. Would not that have some kind of a-- Isn’t it more than just a side issue, though? Could it not impact significantly on this program if, in fact, we were able to enjoy those benefits?

MR. VAUGHAN: Yes, sir. Opening Canada -- and that tends to be to individual buyers -- can certainly help individual constituents. Getting the savings into the Medicare Program is tougher. If these new, free-standing drug-only companies that are going to deliver the benefit, if they can contract with Canada and get a really good price, the bigger issue is-- And actually, Canadian prices aren't that particularly good. Because what Canada does is looks at us, plus about six European nations, and averages that price together. If they left us out, they would get the basic European price of the French and the Germans and the Brits and the Italians. If we had importation that's broader and what we'd really be importing is a kind of reference price or parallel price system that would make a tremendous difference in the long run on U.S. prices. But we bought every pill in Canada -- it's a country smaller than California. It won't make that much difference. But if we made the precedent, if we started the idea that other nations do have good ways to buy prescription drugs, yes, sir, that could make a huge difference in the long run.

ASSEMBLYMAN PAYNE: You suggested that we encourage our Congress members to extend beyond June -- it's due to expire in June. But if we have that kind of influence with our members of Congress, why then can't we influence them to also do exactly what you just stated, relative to the purchase of drugs? For instance, if down the line we're going to come to this, if we can use our influence with our congressional people to extend the deadline, then it seems to me that we might be able to influence them so that the individual users, that pharmaceutical companies, or whatever, can buy these wholesale and thereby impact on the end price. I think that's the way we should go. We don't want to open this up. It's a very difficult political issue we don't want to open

up again now, etc., etc., etc. But in the end, the people that suffer are the end users.

We say that philosophically one of the reasons why we -- this doughnut exists is so that we can discourage people from overusing of drugs, etc., etc. I mean, that's a secondary reason for this, I think you said. It is secondary, really not that important. I'm not sure that there is such that percentage of folks that just use drugs excessively and therefore be influenced by the fact that they may have to pay for themselves. I don't know whether that's the correct way of getting at that problem.

MR. VAUGHAN: We agree.

ASSEMBLYMAN PAYNE: And so we have to look at ways to make this better. I mean, it's difficult, but the fact that it was presented to us now tells us that nobody can tell us what the cost of this really is going to be, when we have all the greatest experts in the world coming up with \$135 billion difference in the cost of this. It's really extremely perplexing to me, and I just don't know what the answer is. But there must be some other ways of handling this situation. These are just some statements and just shows you my frustration with this entire thing.

Mr. Chairman, thank you.

ASSEMBLYWOMAN PREVITE: I want to express my concern. I am a member of AARP, and I am a senior citizen. I'm looking at this doughnut that you're talking about. Do I hear you correctly by saying that at some point I can't afford to take the medication any more? And there's a gap of how many thousand dollars that I just don't have that in my pocket, so I

stop taking my medication. And then when I get really maximum sick, then you'll pay for it?

MR. VAUGHAN: You could spin down, qualify for Medicaid in some states, that sort of thing, yes. I mean, it could be a real problem.

ASSEMBLYWOMAN PREVITE: Well, what kind of an outrageous plan is that? I mean, you didn't make it, I know. You didn't vote for it, but still. I mean, that is an absolute outrage that forces people to skimp, get very, very sick, and then we say, "Oh, you're very, very sick. Now, dearie, we'll pay for it."

MR. VAUGHAN: In a hospital situation, if you're bronchitis turns to pneumonia, yes, that's the danger -- is people don't take the pill, they get sicker. What is not well-known or shocks a lot of seniors is this cycle repeats every year. I mean, the deductible, the doughnut. You go through it each year. This isn't a one-time doughnut. This is a yearly thing, and folks are surprised at that.

ASSEMBLYWOMAN PREVITE: Well, this will be a very big hassle. A hassle with all capital H-A-S-S-L-E -- all of those capital letters when it hits.

ASSEMBLYMAN PAYNE: Excuse me?

ASSEMBLYMAN GUSCIORA: Yes, Assemblyman Payne.

ASSEMBLYMAN PAYNE: You're telling me that we have to repeat this threshold. Once you reach it, you don't stay there? I mean, do you have to go--

MR. VAUGHAN: No, sir. This is a yearly cycle. You pay your premiums all the time, but your deductible each year -- you get help in the next

two thou and then you're in that doughnut each year. Yes, this is not a one time-- No, sir.

ASSEMBLYMAN PAYNE: Till you die, I guess.

ASSEMBLYMAN GUSCIORA: Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Yes. Bill, excuse me for calling you Bill, I forgot your last name.

MR. VAUGHAN: Doctor, please.

ASSEMBLYMAN PENNACCHIO: There some concern for the doughnut, because we don't want to see anybody not having any pharmacy care, especially when pharmacy care is needed. Right now, there is no doughnut.

MR. VAUGHAN: Not in New Jersey.

ASSEMBLYMAN PENNACCHIO: Without this law, there's no doughnut?

MR. VAUGHAN: Well, below 300 percent in New Jersey, correct. No doughnut.

ASSEMBLYMAN PENNACCHIO: There's no doughnut. So this is a law that we're spending almost \$500 billion, okay?

MR. VAUGHAN: Uh-huh.

ASSEMBLYMAN PENNACCHIO: There's a question about a doughnut. But right now, don't you think it's maybe a little bit more outrageous that there was nothing done at all before? And now that this law addresses at least part of the concerns that our citizens have? Or is it better to be outraged that there's a law that we can always address as a state and make better, or in your view, is it more outrageous if there is no law at all?

MR. VAUGHAN: Oh, no. This is a law that's a good beginning and needs some big fixes, but we're sure glad it's something to build on.

ASSEMBLYMAN PENNACCHIO: Just a final -- if you could wave a magic wand -- and excuse me for being hypothetical here -- and make this law go away and be the same as we were a year ago, in just discussing the law, would you make this law go away?

MR. VAUGHAN: Absolutely not.

ASSEMBLYMAN PENNACCHIO: Thank you.

ASSEMBLYMAN GUSCIORA: Assemblyman Wisniewski.

ASSEMBLYMAN WISNIEWSKI: Thank you, Chairman.

Mr. Vaughan, referring to the financial model as being a doughnut, maybe it should have been a corn muffin -- I don't know (laughter). If somebody looked at this and said, "Well, this makes sense." Can you educate us as to what the rationale may have been as to why it was desired to create this doughnut that would create this hardship?

MR. VAUGHAN: Totally, 95 percent, I think, driven by budget. This law was signed December 8. This law was set in wet cement in April, when the Budget Committee said, "You got 400 billion." When seniors were going to spend-- The Congressional Budget Office said, "1.83 trillion." So that gap gives you a lousy insurance product. And back to, if you put a lot of money into low income, money into catastrophic, you got nothing in the middle. Now, where groups like Families have a big fight is, who said it has to be 1.83 trillion in spending? Why didn't we do more to control that fight? There's an ex-governor in Oregon, a Dr. Kitzhaber, who said, "The whole Medicare



prescription drug debate was silly. The debate ought to be, why pills cost so much, then how you could develop pills and still encourage research.”

Congress, by not addressing that and having said, “We can only do 400 billion. We’ve got Iraq. We’ve got the tax cuts. We can only do 400 billion.” That’s what you get.

ASSEMBLYMAN WISNIEWSKI: Thank you.

ASSEMBLYMAN GUSCIORA: Bill, I just have two more real quick questions, and then for purposes of time, why don’t we move on and jump Kathy in real quick.

The persons that are already enrolled in PAAD, will they be automatically enrolled in Medicare or do they have to apply to Medicare?

MR. VAUGHAN: Oh, the benefit is voluntary under Medicare. And so, they will have to apply.

ASSEMBLYMAN GUSCIORA: Have to apply. Okay.

MR. VAUGHAN: But, sir, if they -- I’m sorry -- if they’re eligible and don’t have something as good as this Medicare package, actuarially, and they wait, they’ve got a 1 percent -- at least 1 percent a month enrollment penalty. So you waited three years, you’d be paying 36 percent more, at least, than all your neighbors. So it’s voluntary, but with a bite.

ASSEMBLYMAN GUSCIORA: Okay, great. So there will be a penalty if they don’t enroll in Medicare.

I’d like to welcome our own Kathy Mason. And before she gets train lag, if she’d like to give testimony.

ASSISTANT COMMISSIONER MASON: Yes, thank you.

Mr. Chairman, members of the Committee, my name is Kathleen Mason. I'm the Assistant Commissioner for the Division of Senior Benefits and Utilization Management in the Department of Health and Senior Services. I've worked for the Pharmaceutical Assistance for the Aged and Disabled Program for the last 24 years. Thank you for the opportunity to speak to the Committee about the new Medicare drug program, and its relation to the PAAD Program.

Yesterday, I attended a conference in Washington on the new drug program. I returned to Trenton, today, just to attend this hearing, and I'll be returning on the train again this afternoon to continue the conference.

The Interim Medicare Discount Card Program is a short-term program for 18 months to provide immediate relief to certain beneficiaries without other coverage or with low income, until more comprehensive Medicare drug benefit is put in place in 2006. Enrollment in the Interim Medicare Discount Card and Transitional Assistance Program for low-income beneficiaries will begin in May of 2004, and the discounts will be available this June of 2004. Therefore, we're focusing our efforts, now, on the discount card program for our immediate action.

The PAAD Program will send a letter to every PAAD beneficiary telling them to wait for further direction from PAAD before they enroll in any Medicare discount card program. They'll be many different Medicare discount cards offered in New Jersey to seniors for them to choose from. Each will offer different discounts on different drugs and may have different networks or pharmacies that participate. We want to reduce the anxiety for PAAD beneficiaries by advising them the best way to proceed.

The Interim Medicare Discount Program has two parts. First, the Medicare-approved discount cards will offer eligible seniors and disabled individuals who apply and pay an enrollment fee an estimated 10 percent to 25 percent off retail prices for drugs covered by that selected card at specific pharmacies that participate in the selected cards network.

Discount card enrollees who have income below \$12,123, if single, or \$16,362, if married, which is 135 percent of the Federal poverty limit, are also eligible for what's called transitional assistance. It's a \$600 credit per year in 2004 and again in 2005 on the discount card they selected. It works like a debit card. Transitional assistance beneficiaries also have to pay a 5 to 10 percent co-payment on each drug purchased. Discount card program sponsors may charge up to a \$30 enrollment fee, but the Federal Government will pay the enrollment fee for low-income beneficiaries who are eligible for that transitional assistance, those below 135 percent of poverty.

There are approximately 190,000 Medicare beneficiaries enrolled in the PAAD Program. Of these, approximately 81,000 beneficiaries have income below 135 percent of poverty, and they'll qualify for that transitional assistance. If those 81,000 PAAD beneficiaries use the \$600 in transitional assistance available in June 2004, with an additional \$600 in benefits applied to their debit card in January 2005 before they were to use their PAAD benefits, the State could avoid approximately \$90 million in these costs.

PAAD beneficiaries that apply for transitional assistance will not incur any additional costs. The enrollment fee will be paid by the Federal Government and the PAAD Program will pay the difference between the 5 or 10

percent co-insurance on each claim and the \$5 co-payment. So we will wrap around the benefit provided for the discount card.

Now there are approximately 109,000 PAAD beneficiaries who do not qualify for the transitional assistance, because their income is over the 135 percent of the Federal poverty level. For these PAAD beneficiaries, the 10 to 25 percent savings off the retail price provided through the Medicare discount card will not be as generous as the PAAD benefits. These beneficiaries would also need to pay a \$30 application fee. Therefore, the State is not recommending that these beneficiaries enroll in a discount card program and that they just continue to use their PAAD benefits.

Senior Gold beneficiaries should also continue to use their Senior Gold Card, as the Medicare discount card will not offer a lower price than they currently receive through the Senior Gold Program.

The PAAD Program will evaluate the discount cards available in New Jersey and the CMS regulations allow us to identify one PAAD preferred discount card for transitional assistance. So we'll be looking at which card covers the same drugs in the same pharmacies as the current PAAD Program.

PAAD has income information for our beneficiaries on our files, so we basically know which beneficiaries will qualify for the transitional assistance. And after the State selects a PAAD preferred discount card for our PAAD beneficiaries applying for transitional assistance, the program will send them a preprinted enrollment form for the PAAD preferred discount card to those 81,000 people who were eligible for the transitional assistance, those who can get that \$600 credit. They will just sign the application form and return it.

Now, I do have to say that we know that all 81,000 people will not return an application form that we've sent to them. There's no incentive for a beneficiary to enroll, since the PAAD plan is more generous than the Medicare benefit. We've been working with other states, including New York and Pennsylvania, that have large state-funded programs like PAAD. We have asked the Center for Medicare and Medicaid Services, CMS, to allow us to automatically enroll all the beneficiaries eligible for transitional assistance into the preferred discount card program. AARP and PhRMA representatives in New Jersey have agreed that this is the best way to ensure the savings with the least disruption to our beneficiaries. AARP and PhRMA have agreed to work with us in lobbying CMS for automatic enrollment.

To date, however, CMS has insisted that although states may designate a preferred discount card provider, all Medicare beneficiaries must have the option to pick another discount card program, if they choose. Now, this is problematic, since the Medicare law does not require any discount card sponsor to coordinate benefits with a State-funded program like PAAD. With the short time frame to implement this program by this spring, we do not expect that all the different discount card programs in New Jersey will be ready to coordinate benefits so that PAAD can wrap around Medicare benefits. In fact, we requested a list of potential discount card vendors in the state from CMS and have not even been able to get the contact names from CMS to begin this process of working with those discount card programs on coordinating benefits. As the Governor said in his budget address, "We won't stand idly by and insist on replacing New Jersey's program with Washington's."

We would appreciate any assistance this Committee can provide in lobbying CMS to allow PAAD to automatically enroll our beneficiaries in a discount card program that is prepared to coordinate benefits between Medicare and PAAD. We know some are prepared to do that. It seems unnecessary to require our beneficiaries to complete another application for the discount card program when PAAD already has all the necessary information to enroll our beneficiaries in transitional assistance. We have their names, their Social Security numbers, their income, everything that the transitional assistance application asks for. PAAD is one of the most generous prescription programs for low-income seniors in the country. New Jersey seniors and disabled residents should be able to utilize the Federal benefits for which they are entitled without an reduction in the comprehensive benefits they now enjoy through PAAD and Senior Gold.

I would be happy to answer any questions this Committee have regarding this issue.

ASSEMBLYMAN GUSCIORA: Thank you, Kathy.

It sounds like we certainly have a challenge. How much is New Jersey expected to lose that we ordinarily-- If we had a crappy program, obviously, everyone would take advantage of the Federal Government. But since we have a better program than the Feds, how much is it estimated that we'll lose in Federal aid?

ASSISTANT COMMISSIONER MASON: I think the issue is, is getting our beneficiaries to enroll in the Medicare Program. Certainly, there are significant savings to our program and the PAAD benefits if we can get our beneficiaries to enroll. The thing is, they have no incentive to do so. If we

could even, in the next Fiscal Year, '05, if we could get all the people eligible for that transitional assistance to enroll and use that debit card before they use their PAAD Program, we could potentially save \$91 million. The problem is, how many people will actually fill out that form? Even -- we've gotten CMS as far as allowing us to preprint the form, send it to the people saying, "Sign, this, and send it back, but that will, in itself, create anxiety for some of our beneficiaries because they'll know something is changing. We could probably do this much, or seamlessly, if we could just automatically enroll them in one of the discount card programs that is prepared to set up the coordination of benefits. Even with the transitional assistance, a person has to pay a co-payment of 5 to 10 percent of the drug cost. So we would want the PAAD Program to pick up that co-payment for our beneficiaries. So they just keep paying the same \$5 and we would enjoy the savings from the transitional assistance.

ASSEMBLYMAN GUSCIORA: Is there any mechanism in the Medicare bill that would just give the states a block grant and say, "New Jersey, you have a program. We don't want to mess around with it. Here's a chunk of money to help you administer your program?"

ASSISTANT COMMISSIONER MASON: Senator Corzine had proposed an amendment that would provide a subsidy. So, basically, PAAD would keep on running, and the Federal Government would pay us. So what would be considered the actuarial equivalent of what a Medicare prescription drug plan, a PDP would pay. We had worked with Senator Corzine's office on drafting that language. It was proposed, but unfortunately, the final version of the bill did not include that amendment. That would have been ideal.

Unfortunately, it didn't make it all the way through the Federal legislative process.

ASSEMBLYMAN GUSCIORA: And my final question. To get the drug discount card, would a person have to be paying the Medicare premiums for the drug program?

ASSISTANT COMMISSIONER MASON: No. We're talking about just enrolling the low-income people who don't have the \$30 enrollment fee. The higher income people over 135 percent of poverty would have to pay a \$30 application fee. And since the benefit to the program might not be worthwhile, we're concentrating our efforts on the population that receives the enrollment -- is paid for by the Federal Government so there would be no cost to the State to getting the people to enroll. That's why we're focusing our efforts now on that 81,000 people who have low income and who are eligible for the program without a cost.

ASSEMBLYMAN GUSCIORA: Thank you.

Any questions from any of the members?

Mr. Payne, you're next.

ASSEMBLYMAN PAYNE: Yes, Mr. Chairman.

You mentioned that -- I think you said the amount of money that we could potentially save was about \$91 million?

ASSISTANT COMMISSIONER MASON: That's in Fiscal Year '05. The benefits, of course, change in January 2006. The estimate of \$90 million would be if everyone who is eligible for transitional assistance on PAAD enrolled in the discount card program, the interim plan that begins this spring.



So that's an optimistic number, the best case scenario, if we got everyone to enroll. Under automatic enrollment, that would be much more feasible.

ASSEMBLYMAN PAYNE: But we don't have automatic enrollment.

ASSISTANT COMMISSIONER MASON: Right.

ASSEMBLYMAN PAYNE: Therefore, the question I have is what are we doing to try to encourage those folks to enroll? We have other programs, Family Care, etc., etc., that for years we had a problem getting people to enroll. And we had to develop various kinds of proactive initiatives, and it's beginning to improve the enrollment in those programs. What are we doing here, if there's a potential of saving \$50 to \$90 million? What are we doing and what can we do to encourage that to happen?

ASSISTANT COMMISSIONER MASON: Assemblyman, through the Chair, what we would -- our first step is to identify the preferred discount card vendor in the State. The hitch to that is so far CMS hasn't even given us the names of potential discount card programs so that we could contact those people. What we're trying to do is identify a discount card program that will agree to offer basically the same coverage and the same pharmacy network as we already have in the PAAD Program. What we want to be able to tell our beneficiaries is, if you just sign this form that we've preprinted for you, you will not have any change in your benefits and you will be able to use this discount card at the pharmacy you're already using.

We already have had some potential discount card vendors come to us and say that they would be willing to set up a system like that for us. We believe that we'd probably would need to do an RFP to pick which one would

be the preferred discount card, and I need the contact names in order to release an RFP. So we're ready. We have an RFP drafted. We're ready to go out and pick one that would work the best with us. We just don't have the names so that we can release the RFP. Once we get a preferred discount card vendor, though, we'd be able to guarantee our beneficiaries that if you just sign this form, and send it back, we're going to handle the rest for you. Because we're going to handle the coordination between PAAD and the discount card program through the pharmacy point-of-sale system.

ASSEMBLYMAN PAYNE: Thank you.

ASSEMBLYMAN GUSCIORA: Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Thank you, Mr. Chairman, and good morning, Kathleen.

ASSISTANT COMMISSIONER MASON: Thank you.

ASSEMBLYMAN PENNACCHIO: Just a little confused, because I had thought that it was confirmed by Mr. Vaughan that there's enough discretion in the Federal bill that we can improve and expand the scope of existing PAAD and Senior Gold Programs. You're making it seem like we can't. The obstacles are so great. Can we improve of Senior Gold and PAAD using the influx of moneys from the Federal bill?

ASSISTANT COMMISSIONER MASON: Assemblyman, if I understand your question correctly, you're asking if we could use the savings that we would receive from the Medicare discount program to expand the existing program?

ASSEMBLYMAN PENNACCHIO: Yes.

ASSISTANT COMMISSIONER MASON: Of course, that would require State legislation.

ASSEMBLYMAN PENNACCHIO: Yes.

ASSISTANT COMMISSIONER MASON: But if the State passed a law to expand the income limits -- the concern I have is that we don't want to spend money we don't have yet. We first need--

ASSEMBLYMAN PENNACCHIO: I just sat through a budget address, and you said you don't want to spend money that you don't have yet? (laughter) Sorry, I just--

ASSISTANT COMMISSIONER MASON: We first have to make sure that we can work out the system to automatically enroll our beneficiaries. As I said, if we don't get all 81,000 people to fill that form out and send it back in, we won't receive the full \$90 million savings. So I just want to make sure people understand that \$90 million is best case scenario.

ASSEMBLYMAN PENNACCHIO: Okay. But assuming we can, through the Chair, that \$91 million, or whatever the number is -- if it's 50 million, 60 million, what's the difference. It's only a couple million dollars. We can address the doughnut. We can expand the scope of PAAD and Senior Gold and raise the eligibility income level. We can do a whole -- sorts of things. Even maybe discount some of the more expensive drugs. So we can actually make the current system of PAAD and Senior Gold even a better system.

ASSISTANT COMMISSIONER MASON: Right.

ASSEMBLYMAN PENNACCHIO: Okay.

ASSISTANT COMMISSIONER MASON: The doughnut hole and the benefit that you're talking about begins in January 2006. What I was mostly focusing on, at this point, is the interim transitional assistance program.

ASSEMBLYMAN PAYNE: That's an 18-month period?

ASSISTANT COMMISSIONER MASON: Yes. Yes.

ASSEMBLYMAN GUSCIORA: Kathy, how much does a PAAD Program cost the State?

ASSISTANT COMMISSIONER MASON: About \$500 million.

ASSEMBLYMAN GUSCIORA: So 90 million would be a 20 percent increase, right?

ASSEMBLYMAN GREGG: Give or take.

ASSEMBLYMAN PENNACCHIO: Of what, 500 million?

ASSEMBLYMAN GREGG: About 20, about 18 percent.

ASSEMBLYMAN GUSCIORA: Yes, 18 percent. But that's-- And the best scenario, under Medicare that would supplement the PAAD Program, it would be a \$90 million benefit to the State?

ASSISTANT COMMISSIONER MASON: Right.

ASSEMBLYMAN GUSCIORA: In your estimation?

ASSISTANT COMMISSIONER MASON: That's next year. The savings would likely be more in 2006 when the benefits expand to the full-blown Medicare Part D Program.

ASSEMBLYMAN GUSCIORA: Great.

ASSEMBLYMAN PENNACCHIO: If I could just finish. With that, I'm confused. Because that's not the only savings we're going to get. The estimates I got are 4 billion over 10 years.

ASSISTANT COMMISSIONER MASON: Right.

ASSEMBLYMAN PENNACCHIO: So if it's 90 million a year, let's assume -- where's the other 110 million a year for the next 10 years. Or, no, not even, 310.

ASSISTANT COMMISSIONER MASON: Right. The 90 million savings was on the interim plan -- 2006 for benefits.

ASSEMBLYMAN PENNACCHIO: Oh. Then that pot of money grows exponentially and then some of these things that we talked about -- expanding the program, making a better program, including maybe a reduction in some of those costly meds -- that all can be included because of this bill.

ASSISTANT COMMISSIONER MASON: Right. Again, with the provision that we'd need to get our beneficiaries to enroll in order to receive savings. We can only save money if people enroll in a Medicare plan and use the Medicare Program first with PAAD providing wrap around. If they don't enroll in Medicare, which they don't have incentive to do, we'd lose the savings.

ASSEMBLYMAN GUSCIORA: Great.

MR. VAUGHAN: One second. Just a consumer issue: There's a scam starting out there where people are going door to door, particularly in the inner cities, saying, "\$30. Give me \$30, and I'll give you this approved card." Tell your constituents it hasn't started. Don't give anybody any money. It's outrageous, but it's started, and it's sad.

ASSEMBLYMAN GUSCIORA: But we'll look out for that.

Okay. Thank you very much, and get us some more money in Washington.

ASSISTANT COMMISSIONER MASON: Thank you. I'll try.  
Thanks.

ASSEMBLYMAN GUSCIORA: We have our very own Dr. Sam Thompson, that we always like to interrupt our long line of testimony, but-- But we also want to bring up Sy Larson and Doug Johnston, if we can. And Sy is -- you're representing Doug?

**S Y L A R S O N:** I'm representing AARP.

ASSEMBLYMAN GUSCIORA: Oh, okay.

MR. LARSON: Do you want us now or after?

ASSEMBLYMAN GUSCIORA: I like panels, so if we can-- It moves it along a little bit faster. And then you can keep Dr. Thompson honest.

**A S S E M B L Y M A N S A M U E L D. T H O M P S O N:** Good morning, Mr. Chairman. Thank you.

I did leave the Health Committee to come down here, and we're having a hearing up there I have to go back to.

Of course, as it has been indicated, the Medicare Reform Act, an act passed last fall -- the primary purpose of it was to provide prescription coverage for seniors. While New Jersey, at the present time, has, perhaps, one of the best and certainly one of the most generous programs in the nation with PAAD and Senior Gold, I believe, again, there is room to-- There are many seniors still hurting out there. We need to be able to do more for them.

As was mentioned in some earlier testimony there, not only are you talking 90 million in the next year, but there are projections, depending on who you believe -- Senator Corzine or Congressman Ferguson -- the State will achieve between \$2.6 and \$4 billion in moneys from this program over the next 10

years. Obviously, it's not going to be even, because it starts out at 90 million-- But at a minimum, you're certainly going to get an additional \$260 million a year. I believe this money should be utilized to improve, expand the existing PAAD and Senior Gold Programs. This is, of course, a priority of the AARP to expand the programs.

I am concerned that unless appropriate action is taken that as this money comes in the administration, and I'm not speaking just to this administration, because during 10 years, there'll be several administrations there, that these administrations will take this money and rate it and God knows what they will spend it for, rather than the federally intended purpose of providing prescription care for seniors. Consequently, I have submitted ACR-122, which currently has 31 additional cosponsors, which would require that the savings, the moneys that we receive from this Medicare Reform Act, be constitutionally dedicated to expanding PAAD and Senior Gold. And I believe that is the only way that we can assure that this money will go for those purposes, as opposed to selected tobacco settlement money. It's gone. It's not there. We enact this. We're not spending money we don't have. We're just saying, "When the money comes, this is what it will be used for." So I would hope that you would agree with me and support this effort to have this money dedicated for these purposes.

ASSEMBLYMAN GUSCIORA: Thank you.

Does anyone have questions?

Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Good morning, Assemblyman.

Does that have to be constitutionally dedicated?

ASSEMBLYMAN THOMPSON: If you do not constitutionally dedicate it, if you simply pass a statute, then in next year's budget, you can change it. We've seen that happen very frequently that we'll pass legislation saying that from now on they'll be this money for this program, but due to budget considerations next year, they change the law. It's not there.

ASSEMBLYMAN PENNACCHIO: Does your bill address that? Is it a constitutional amendment or is it just a statute?

ASSEMBLYMAN THOMPSON: I'm sorry.

ASSEMBLYMAN PENNACCHIO: Does your bill address that as a constitutional amendment or a statute?

ASSEMBLYMAN THOMPSON: My bill is a proposed constitutional amendment.

ASSEMBLYMAN PENNACCHIO: Okay. Thank you.

ASSEMBLYMAN GUSCIORA: You guys can get together afterwards and sign on. (laughter)

ASSEMBLYMAN THOMPSON: Oh, he's already signed on. As is Assemblyman Gregg.

ASSEMBLYMAN GREGG: We were hoping you guys would sign on.

ASSEMBLYMAN GUSCIORA: I'll look at it. After I look I finish looking at your bills.

ASSEMBLYMAN THOMPSON: And I would invite you to also come on.

ASSEMBLYMAN GUSCIORA: Thank you very much, Assemblyman.



And welcome Sy Larson and Doug Johnson from AARP.

MR. LARSON: Thank you.

I feel that Assemblyman Thompson could have taken my seat here. I mean, he said everything that we want to say. We do agree with many of the speakers that the bill is complex and there will be a hassle factor. We do support some of the State efforts.

For example, the question of automatic enrollment, which the CMS, so far, I think, has turned down. But if you have automatic enrollment, then you can guarantee that the 81,000 people will be able to come into the program. If there is not automatic enrollment, then we will do our best to work with the State to see that people are enrolled.

The hassle factor comes from the fact that even when you talk about PAAD today, there's not a meeting that I don't go to where I don't pick up somebody who is eligible for PAAD, doesn't know about PAAD, and you have to sign them on. So I really kind of wonder what's going to happen when you try to sign up 81,000 people to join into this new program. And certainly, we will help to do it.

I'd like to divide the bill into two parts. The first part is when you sign up this prescription drug discount card. You sign up in May. It takes effect in June, and it ends in January of 2006. In January of 2006, well, then the other program begins. So I'd like to take each part of the program to discuss it.

Also, following what Assemblyman Thompson said, we think that the money that will accrue from the savings on the transitional discount card should be utilized. Number one, there'll be many people who will not sign up for the card who may have mental problems, who may have physical

disabilities, and we don't think that they should be penalized. We think that the money should be utilized for these people. Also, you're going to have a factor when you sign up for these new transitional cards, they'll all have formularies. And since they're going to have formularies, people have to go through an appeals process. You and I know if we were ever acquainted with the appeals process, we may be able to successfully monitor the way through it. Many people can't. So many people may be denied the drugs which they must have. And therefore, we think that out of that 90 million, that some of it should be utilized to help people who simply will not be able to get the kinds of medicines they want if they go into these private insurance programs through their formularies.

Under Part D, you have, of course, the dual eligibles. Well, under the present arrangement in New Jersey, a dual eligible doesn't have to pay anything for their prescription drugs. But when they go into these private insurance plans, which will be set up in 2006, they'll have -- if they're 100 percent below the Federal poverty level, they'll have to pay \$1 and they have to pay \$3. We think that the money that is saved by the State from these programs should be utilized to help some of these people pay. It may not seem to us like much between \$1 and \$3, but it's an awful lot for people who just simply live on 100 percent below Federal poverty level, which runs about \$8,900 for a single. I think it's 11-something for a person, that's a couple.

Not only that, based on the way the law says that these amounts will begin to accrue based on, I think, its drug inflation. So you can see the amount is going to go up year after year after year. We think that the State ought to help to pay for that.

We also believe that PAAD, after 2006, PAAD should be retained. It should be retained to fill in the various gaps that are going to come from these private insurance plans. So we don't think there's any need to eliminate PAAD. We should maintain PAAD, utilize whatever moneys we can be saved to help people who somehow fall through the cracks of these different plans.

Of course, we're all talking about the doughnut. And I think the doughnut was aptly described here. The middle class will suffer a great deal from this plan. For example, from 2,250 to 50,100, there is absolutely no coverage. And 50,100, the catastrophic coverage kicks in and catastrophic coverage is very beneficial, since you only have to pay approximately 5 percent. But what happens to people in the middle in the doughnut? And what we may consider, I think -- what was brought up by the gentleman here and by Assemblyman Thompson -- is that some of the money can be utilized to fill in for that doughnut to help people in some way who simply find it extremely difficult to pay for their drugs.

It's not only doing something to help these people, but it also helps the State in terms of saving money. Because what happens to these people? Look, I came across an individual one day who has glaucoma. Well, glaucoma is a very easily treatable disease, provided you take three drops a day of your medication. Well, this individual couldn't afford it. He couldn't afford it, so what was he taking? He was taking one drop a day sometimes, two drops a day. The result is that over the years he was gradually losing his sight. He was losing his sight more slowly. What happens when he loses he sight, he becomes, more or less, a ward of the State, and it costs extra money to take of him.

So we think that these kinds of measures would be helpful, not only for the State, but also be helpful for the individual. I don't think I have any more to say, unless there are any questions from the--

**D O U G J O H N S T O N:** My name is Doug Johnston, Governmental Affairs Officer. I just want to mention one quick thing. The third way in which the State -- and actually this is the only way in which the State will get direct moneys from the Federal Government, is through a \$62.5 million grant that goes to states, and that's a direct cash grant to states that already have prescription drug benefit assistance programs. It's been estimated that New Jersey will get about \$17 million, which I know is not going to fill any doughnut holes, but that \$17 million is designed for the transition period. So you've got \$17 million to spend on making sure that you get those 81,000 people signed up for that \$600 and then another \$600 for the next year. So, if you use that 17 million wisely, you should save that 90 million that's estimated in the budget the first year and then, presumably, another 90, or so, million the second year.

In our testimony, we provided copies of a news article, which is attached to our testimony, from-- It was right before the vote. And Senator Corzine is quoted in there addressing -- "Senator Corzine did yeoman's work on this, fighting to protect PAAD and Senior Gold in the Federal legislation." And while he did vote against the final legislation for a wide variety of reasons, it was due to his good work that the State of New Jersey is in pretty good shape, as pretty much everyone has testified to.

So I just wanted to say, also, that AARP has a lot of resources, a lot of materials that we are providing to our members. And I want to offer to make those available to you. They are materials designed to explain the benefit and

how it's going to work. And then last, but not least, I want to give you our public commitment, which we've already communicated to the Governor, that we will work with you hand in hand, day after day, to make sure that any transition is as smooth as possible and there is no disruption in service for beneficiaries of PAAD and Senior Gold.

Thank you.

ASSEMBLYMAN GUSCIORA: Just actually a comment. I think it's a shame that we have to spend that \$17 million when the Federal Government could have simply granted automatic enrollment status. Washington claims they had to do so many incentives, it's actually a disincentive for our seniors to take advantage of the Medicare Program.

The other real problem that I have is with the dual beneficiaries with the Medicaid that enjoy Medicaid status and enjoy their premiums paid, now will have to have a tax on themselves. And I think it's a shame that now they have to bear some of the burden when we had taken care of them before. And now, they're going to have to pay more. So I think that's a pitfall -- a very big pitfall.

MR. JOHNSTON: Absolutely. And we freely admit that there are a lot of things in the Medicare Prescription Drug Benefit Program that we believe need to be fixed and changed. As a matter of fact, I attended the Families USA Conference a couple of weeks ago in Washington, and heard Senator Edward Kennedy and a whole host of speakers address the program listing the various concerns and things they wanted to fix. And AARP is in 99 percent agreement with most of those items.

And I will say that none of those speakers from Senator Kennedy on down was talking about repeal. They were talking about fixing it and making it better. And that's our message, absolutely.

ASSEMBLYMAN GUSCIORA: Assemblyman Payne.

ASSEMBLYMAN PAYNE: Yes. Just along the lines of dual eligibles. The fact is either there is a disproportionate number of the folks in that category are African-American and Hispanics, and it hits them pretty hard. The reason, since there's a disproportionate number of African-Americans and other minorities in the low-income bracket, etc., etc., they fall into this category, and therefore, this may be more expensive for them than it would be otherwise, because of the fees that are charged -- the \$3 per month for brand name and etc. What's your reaction to that or what's been the comment in Washington?

MR. LARSON: Well, you're absolutely right. It does fall very heavily on these people. But the State is going to save an awful lot of money. There's no reason why the State cannot pay that \$1 and that \$3 for the money it's going to save -- from not only, one, the transition card, but also in 2006, the State will begin to save money. It's hard to put a figure on it at this time. But it will save a lot of money, and there is no reason why the State could not pay that \$1 and \$3 for these people who are dual eligibles.

ASSEMBLYMAN GUSCIORA: We hope so.

MR. LARSON: Well--

ASSEMBLYMAN GUSCIORA: After we spend the 17 million to get them enrolled.

MR. LARSON: The money is there. That's up to you, gentlemen.

ASSEMBLYMAN GUSCIORA: Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Good morning, Doug. How are you?

Listening to TV, we heard pros and cons, even amongst AARP. But again, you have to flavor this that we live in New Jersey and that I represent the people within New Jersey. This Federal bill, in your view, do the good points outweigh whatever criticism there was towards this bill? Is this a good bill for New Jersey?

MR. JOHNSTON: Well, it's a good bill, but it may be a bitter pill for some people, quite honestly. Just this week when you all were--

ASSEMBLYMAN PAYNE: Just the poor people. What the hell. Who cares about them--

MR. JOHNSTON: Well, actually, this is going to help approximately 4.2 million poor people in this country who don't have prescription drug coverage right now. We have to remember there are 40 million Americans in the United States who don't have any health insurance. This bill is a step in the right direction, but it's a bill with holes and gaps that we believe you can do part to fill and that we will fight to continue to work with the Congress to fill. But it's definitely going to help a lot of people.

ASSEMBLYMAN PENNACCHIO: Does it help New Jersey or is it good for New Jersey or not good for New Jersey on the whole?

MR. JOHNSTON: Well, certainly it is--

ASSEMBLYMAN PENNACCHIO: It is.

MR. JOHNSTON: --because you're going to save a lot of money, and those dollars that you save, if you do the right thing -- and we believe you will -- if you use those dollars you save, you can fill in those gaps. So, yes, in

the long run, it's definitely going to help. But the transition is the hard part. We can't under estimate that. It's going to be complicated.

As a matter of fact, we spoke to 430 seniors just this Tuesday in Wildwood. We spoke to 50 seniors who were all low income. We asked them to -- how many of you are on PAAD? And 90 percent of the audience raised their hand. And this was just earlier this week. And they are confused and some of them are scared, and so that's why we're working very closely with the administration every day to make sure we get the information to them. And we really do think that the administration is working in the right direction -- is going to protect those folks, both from the confusion that's going on, but also so that they don't see any disruptions in service. But it's complicated, but it's doable.

MR. LARSON: It's not an optimum bill.

MR. JOHNSTON: Yes.

MR. LARSON: Really, if you want to pass it-- It's really a political problem. If you want to pass a bill which would not only save the State and save the country money, you have to control in some way the price of prescription drugs. It is controlled in every other single industrialized country in the world. But it is not controlled in the United States. And unless you put some kind of controls on the price of prescription drugs, than you're going to have a problem. That problem is going to escalate year after year after year. And sooner or later, in my opinion, it's going to implode.

ASSEMBLYMAN PENNACCHIO: As a dentist, as a doctor, I prescribe those drugs. And not to get into a philosophical argument here, but it's a very expensive proposition, drugs, until somebody you love or yourself



needs it. Then we don't care about whatever the cost is, we just want to make sure that we get that proper medication for that patient, to help that patient along.

Having said that, I agree with you. You had alluded to it, and I think you were echoing what I had to say that all of these questions that we have to make it a better bill, we had within our power in this Legislature to take that extra moneys that we're going to be getting -- \$4 billion up to estimates -- and provide for those people that are disproportionately affected as was mentioned before and to expand the scope and to increase the benefits maybe for all of New Jerseyans. Do you agree, gentlemen, or disagree?

MR. LARSON: No, I agree, Doctor.

The one addition I would make is, we're all interested in research. We're all interested in a blockbuster drug. But the question is, is there a direct correlation between the prices that the drug industry charges and the invention or development of these new blockbuster drugs. We made a study on it, and it isn't. You'll find that most of this research money in the United States doesn't come out of the pharmaceutical industry. Most of it comes from the NIH, and it comes from other institutes, and it comes from universities. That's where the majority of the money comes from

What the industry spends-- They consider it proprietary information. They will not make it known as to exactly what amount of money they spend on research. But from what we can gather is, they spend much more on marketing than they spend, for example, on research. The Food and Drug Administration only tests for two criteria. That criteria is safety and effectiveness. So that if you develop a drug which is a little better than an

aspirin, the FDA will pass it. What happens if the pharmaceutical industry takes it, advertise, and it becomes a major drug, becomes a blockbuster drug with a \$2 pill.

The best example is the research done on blood pressure, when you have diuretics, when you have beta blockers, and calcium blockers. Well, all the research shows that the diuretics, the water pills, are just as effective as -- and they're all generics -- are just as effective as these highly advertised drugs. But there is no, what we call, evidence-based preferred drug list. No comparative drug effectiveness in this country. It's not legal. In this new bill, \$50 million was dedicated to comparative research. What happened? When it went before the Congress, they took the \$50 million out. So it's in the bill, but there's no money for it. You know where that's going to go.

ASSEMBLYMAN PENNACCHIO: I think, just in closing, the answer lies somewhere between what you just said and what the pharmaceutical companies are saying, because there's always a third side to that story. Maybe one day we can work together and we can find out what that third side is.

Thank you.

MR. LARSON: Well, I once debated the pharmaceutical industry. I didn't see the third side, frankly. (laughter) I only saw my side. Maybe I'm biased.

ASSEMBLYMAN PENNACCHIO: You're a senior citizen. I understand. (laughter)

MR. LARSON: Okay.

ASSEMBLYMAN GUSCIORA: Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Mr. Chairman.

Let me thank you. You have great patience. The latitude you have given on this bill for this issue today is quite large. The issue really today that we're talking about and learning about, and I appreciate the learning curve, is about the Federal Program and how it relates to New Jersey, which is about access and who gets it, how they get it, as opposed as to what it costs. That's going to be a debate we do another day. It's certainly part of the formula, but today it's about access.

I just want to be clear with you gentlemen. I know we're waiting for the person who virtually wrote this bill to testify, and we're looking forward to that part of the education -- as Paul Harvey would say, "The rest of the story." But I do wish to read from your testimony. It says, "In conclusion, it is clear that if the State makes the right choices, that if PAAD and Senior Gold beneficiaries will be protected, then the State will reap substantial savings. Such savings should be fully utilized to preserve and improve these programs." That's your concluding comment in your testimony. I think it's a good concluding comment. You didn't say it, so I'll say it for you.

MR. LARSON: Thank you.

ASSEMBLYMAN GREGG: And I think it's a very good statement, no matter what happens today and throughout this testimony that we're going to have interaction between the Federal and State laws. The good thing is New Jersey is way ahead of the curve. The country's a little behind us. How we put them all together is going to be the end all. But we're going to end up ahead, because it appears that we've got \$500 million we've been putting in every year into this program, or more. And it appears we could be getting 400 million

more a year. So I can only see a positive end to the story, but I am looking for the details, which is usually where the devil is.

So I thank you for your testimony and thank you for that last comment, and we certainly concur with that.

ASSEMBLYMAN GUSCIORA: One last question here. I'm reading my packet here and under the bill payments to oncologists have been cut, and it's particularly a concern because New Jersey has so many patients with cancer. Do you know anything about that?

MR. JOHNSTON: I know there's been a lot of e-mail traffic about that, and I can't give you an answer at the moment, because I have to confess I haven't read them. But I will get the Committee an answer, if you'd like, and provide it to your office, if you'd like, because I know that is an issue.

ASSEMBLYMAN GUSCIORA: Okay.

Thank you very much.

MR. LARSON: Thank you.

MR. JOHNSTON: Thank you, Mr. Chair.

ASSEMBLYMAN GUSCIORA: Okay.

I'd like to call up Laurie Clark from the New Jersey Pharmacists Association and Beverly Roberts, from ARC New Jersey.

**L A U R I E A. C L A R K:** Thank you very much, Mr. Chairman.

This is certainly a very active and energetic Committee, and I'm very, very pleased to see that you took the first step in opening up this issue to the public. As you mentioned, I represent the New Jersey Pharmacists Association and also the Garden State Pharmacy Owners, a group, and we stand

as pharmacists and pharmacy owners committed to help the State to coordinate this program.

Unfortunately, I listened very intently to everyone's comments about the Medicaid recipients, and I'm sorry to tell you that even in advance of the Federal mandate later on, in this year's budget, a \$2 co-pay has been proposed for this year's budget. So I think that I would like to join in coalition with the other groups that mentioned opposition to this.

As Assemblyman Payne can tell you, I worked for 14 years in a very urban, Democratic district, and this would mean beneficiaries making the choice between milk, or something, and their prescription medication, even though it's a very nominal amount. So I think that's something we would appreciate your support on looking at that further.

Without going into -- this is such a complex issue-- And as I mentioned before, I served as a Legislative Aide for 14 years prior to becoming a lobbyist, so I understand your concerns relative to constituents. For these approximately 81,000 beneficiaries, it will be very scary for them, because they will have two cards. Before, they had one card. And this is an issue I believe we can all help with that. And hopefully, if everyone lobbies CMS, perhaps we won't have to go that far. But I think that if we do have to take that step, that we can all work together and try to help. And if we can do that, I think that everything should be fine in terms of the benefit.

Kathy Mason and her team have done a fabulous job. They have been proactive in this the very second they heard that this was coming into play. They've been in Washington constantly looking at all the options, and I think

that it's so great that we're here today communicating, because we'll be able to have the information we need as we go further down the road.

So, without further adieu, I just want to mention one area of this whole debate which wasn't mentioned previously, which concerns me greatly. And that is the area of PBM involvement. Because now that the benefit is going to the private sector, pharmacy benefit managers will become a very big part. We earlier mentioned formularies and things of that nature.

I just want to read you something that is very, very scary to me. This past September, the Federal Government filed a lawsuit against Medco Health Solutions, and these are examples of the things that happened. The pharmacists see these things happening with relative to PBMs, but they're very difficult to prove. They were always, before this point -- it was always anecdotal, shall we say. It was very difficult to prove. We would discuss it. But evidently, the Federal Government has investigated this issue and they have alleged these abuses. And it's important for the Committee to hear these things, because we may have to regulate on the State level much more closely these activities in the future. So this is a couple of the highlights from the complaint that was filed against -- in *U.S. versus Medco* this past September.

"Medco Health Solution has defrauded patients, clients, in the United States by canceling and destroying prescriptions, by failing to perform the professional pharmacists services needed by patients and required by law, by switching patients prescriptions to different drugs without their knowledge and consent, by shipping medications and billing patients for drugs they never ordered, by creating false records of contacts with physicians by soliciting and

receiving inducements to favor their products and by making false and misleading statements to the United States about its conduct.

“The primary reason Medco switches drugs is to enhance its revenue, regardless of health plan costs, or of any potential adverse or life-threatening clinical outcomes to patients associated with the switch. Patient and physician complaints about switching prescriptions are routinely ignored. These complaints include the health risks associated with inappropriate drug switches. Medco does not follow up with patients who have been switched to a different drug, and fails to monitor the outcomes of these drug switches. Drug switching, based on undisclosed financial reasons, means danger to health or life of the patient whose drug was switched at the initiation of Medco and results in increased health-care costs, in some cases to patients, and in some cases to the United States.”

So these are just a few of the things that happen. So I think that we need to be vigilant. And this may, indeed, be a topic for future hearings, Mr. Chairman. I want to thank everyone for listening today, and I would be happy to answer any questions.

Thank you.

ASSEMBLYMAN GUSCIORA: Do the members have any questions?

Assemblyman Gregg.

ASSEMBLYMAN GREGG: Just a quick question, a clarification. And I wasn't listening, so it's my fault, not yours. You made a comment about the co-pay change from \$1 to \$2.

MS. CLARK: No. I'm sorry. I'll clarify that. No. At present, there is no co-payment for the Medicaid Program. And the new budget proposes a \$2 co-payment on adult recipients -- pregnant women and children would not be required to pay, just adults, would be required to pay \$2 for their prescriptions if this is adopted in part of the budget.

ASSEMBLYMAN GREGG: In the budget. I wanted to be clear on that, that the Governor's budget is including an increase in co-pays while we're discussing this today.

Thank you.

ASSEMBLYMAN GUSCIORA: Well-noted.

Any other members? (no response)

Beverly, thanks. Thanks for your patience.

**BEVERLY ROBERTS:** Good morning. My name is Beverly Roberts. I direct a program at the ARC of New Jersey called Mainstreaming Medical Care, and I'm very pleased to be here this morning. I agree wholeheartedly with most of the comments that have been made before me, and so I'm not going to read my testimony word for word, since you've heard so much of it before. But I do want to emphasize that the ARC of New Jersey is concerned exclusively with the dual eligibles. That is the population that is going to be very much hurt if we can't -- and from I'm hearing today, we will find a way not to have them be hurt.

But as it stands at the moment, they, as you've been hearing, the dual eligibles do not have any co-pays right now in New Jersey. They do not have any kind of preferred drug list. There is a mandatory generics program that started this past year, but it has a certain amount of flexibility. And for our



consumers, as an example, there is a list of drugs that are exempted from mandatory generics, under Medicaid. So the anticonvulsant medications, the antipsychotic medications, which are of great concern to us, have been exempted. So even though there is a mandatory generic, our folks that need a name brand antiseizure medication can get that under Medicaid just like they always did.

The concern we have is that starting in January of 2006, unless we do what we need to do to fix it, they will lose what they currently have, which is the freedom to get the medications that the doctor is prescribing, and they will have the formulary or the preferred drug list that's put in place. And I understand that probably different PBMs will have different lists and that there were, maybe, over 100 companies that have already submitted to the Federal Government for the drug discount card. So the likelihood is, there are going to be lots of companies that are going to want to get involved in this. And just thinking about the enormous undertaking for somebody that has mental retardation, cerebral palsy, autism, and even-- When we're talking about dual eligibles, they've got Medicare and Medicaid. So these are older people with older parents.

And let me just take a minute to say that in our population to become a dual eligible -- typically they get Medicaid first. So, when they become an adult, because of their disability and their low income, they've got Medicaid. And then, years later, one of their parents either retires or becomes disabled or dies, and then they start to get Medicare. So it's different from other populations where it would be, let's say, on their own work history and then they developed a disability, and that would put them in the Medicare status.

So that's a very large percentage of our folks that do have the elderly parents; parents who themselves are going to have to make some decisions on how to deal with this for themselves. And I'm sure are going to have a difficult time in some cases.

Some of these parents are very frail themselves and have health problems themselves. Their adult son or daughter who is a dual eligible then is going to have to make all of these decisions and figure out-- They may be taking five or seven or eight medications every month and then figure out how does the formulary fit, in addition to the co-pays, which they don't have now. And I agree completely, there is, in the current budget, a proposal for a \$2 co-pay on Medicaid. We are very deeply concerned about that. And we are hopeful that that is not going to go through, because it is a great concern to us.

So, again, we have a large number of these dual eligibles. This is going to be an extremely difficult program for them to comprehend. People are going to fall through the cracks, and it's going to be devastating to them. And that is 100 percent of the group that I'm concerned about.

What I would also like to do is just briefly read to you some testimony from a woman, Darlene LaRue, who wanted to come here this morning. She has cerebral palsy. She is a wheelchair user, and the transportation issue for her to come here and speak to you in person made it so difficult that she asked me to read to you her concerns about this.

"Hi, my name is Darlene LaRue. I live in Hunterdon County. I am one of the 5,300 DDD consumers in New Jersey who receive both Medicare and Medicaid. I had a full-time job, but everyone got laid off. Then I had a part-

time job. People got laid off from that. I've been out of a job for at least three years, so I have to live on disability. I have Medicare and Medicaid.

"I have many disabilities. I was born with cerebral palsy. I am confined to a wheelchair, and I have a little speech problem and a learning disability. About three years ago, I got irritable bowel syndrome, so I have to take two medications for that. One is a prescription medication and the other is over the counter. Then I have psoriasis, and I use a prescription cream for that. Then I have reflux, and I have a medication for that. I just got anxiety and depression about four months, and I have to take two medications for that.

"I live by myself in an apartment. I have to budget month to month. I really don't have much spending money left. I have to take care of myself. My family does not take care of me. So, please, we need the Medicaid. I can't afford to pay for my medication. Please don't take this away."

Let me just see if there is any other comment that I wanted to make. I think just in conclusion, the ARC of New Jersey would be delighted to work with you or any groups that are going to be pulled together to figure out logistically how we can make this work. January of 2006 seems like it's down the road a ways, but it's going to be here before we know it. And we really, really need to put our heads together and find a way to make this seamlessly work so that people are not falling through the cracks.

Thank you.

ASSEMBLYMAN GUSCIORA: Thank you very much, Beverly.

Do the members have any questions? (no response)

Thank you very much.

MS. ROBERTS: Thank you.

ASSEMBLYMAN GUSCIORA: I'd like to call Colleen O'Dell-Multer, a Disability Advocate, the Monday Morning Project; and Edward Goldman, a private citizen from Monroe Township.

Why don't we let Colleen start off then.

**COLLEEN O'DELL - MULTER:** I put the typed testimony before you there. And again, I want to say thank you for giving me this opportunity to speak with you. It's a great privilege to be able to express my views and the views of many, many others here in this fine State of New Jersey who have disabilities.

We heard a lot today about seniors and, indeed, they are a large part of our population. But you also have a very large part of your population who are not seniors but have disabilities, and again, are going to be affected by Medicare and Medicaid changes.

In this written testimony, I had put down about some of the issues, some of the things that we are actually afraid of. You heard today from -- and I learned quite a bit today also, informative on different changes that are taking place. But imagine, again, some of us with disabilities, whether they be cognitive or physical, that all of a sudden are faced with the potential of whether it's Medicaid being cut and drug prices going up and different things. Co-pays, even though in this, I had stated that I really appreciated Governor McGreevey saying that, indeed, PAAD and Senior Gold, that they were not going to be touched. That they were still going to be there. Because again, this was a real fear. I know of even the seniors that have disabilities that are in some of my groups that I facilitate. So there are a lot of things involved here. And again, it is very confusing. And especially, when you see the little things that say more

to come, if you have specific questions about cuts that are going to take place, or maybe about durable medical equipment.

You see I use an electric mobility device. Well, this scooter is how I participate in life every day. This is how I manage to do activities of daily living. This is essential to me. Unfortunately, what is filtering down to people with disabilities and to seniors is, "Hey, watch out, because you're durable medical equipment coverages are going to be cut." Now, right now, this lovely little scooter goes for about \$3,200. And we're fortunate enough with Medicare things to get \$1,800 taken off of that. So that again, through personal resources and family and things, we're able to afford this. Because right now, a manual wheelchair isn't a doable deed for me, with arm strength and things.

And that's how a lot of our citizenry is. This isn't a luxury. This is a necessity, even though some of our HMOs and insurance companies have written and said, "That's a luxury, Colleen. You don't really need that. We have wheelchairs out there that can be used." So again, you go through the process of authorization, of medical necessity. So already, we're facing some of these appeals and challenges, which I heard talked about, for drugs.

I mentioned in my testimony my own personal case. For me to be here today and talk to you, I was granted the privilege of having a drug by a physician that I had to locate that was \$10,000 every three months for this drug. But that's why I'm in the condition -- through God and chemistry -- that I am today, that I can come and talk to you. I have Multiple Sclerosis, and it's a progressive disease. And I have a very active case of it. And this particular drug that I was on, Immuno gamma-globulin, very expensive, very expensive and difficult to get sometimes. But again, a physician at University of

Maryland, a neurologist, said, “Colleen, I think for you, the path that you’re going with your MS, this is the drug for you. But, our big concern is how are you going to afford it at that cost?”

Again, I was very blessed that I was able to get this drug. But, as I heard even some of my fellow sufferers with Multiple Sclerosis, they said, “We can’t even get the injections,” which I’m also on of Copaxone and Evanex -- known drugs that help MS -- we can’t get those paid for. And again, those are like \$5,000, \$8,000 a month we’re talking about here. Again, we didn’t set the rules. We didn’t set the cost on these drugs. This is what they go for. There is no generic. There is none. And to think about us having to go through an appeals process because of a formulary that we would be forced to adhere to that we know that these drugs work for our conditions, that’s a lot of stress. That’s a lot of strain on people who are already compromised, through no fault of their own.

This is a very scary situation that we’re dealing with. Not only for PAAD and Senior, but for all of us there under Medicare, that are sort of being told, well, “Hey, even if you were a retired Federal employee and you have Blue Cross and Blue Shield, you maintained your insurance, you had that nice prescription plan, well, Medicare is primary.” When you have a permanent disability, Medicare is your primary. This is going to be tossed out, and then you’re going to be faced with the formularies and the different things. Well, rightfully so. I think that people with disabilities have a right to be concerned.

And again, as I put at the end of this, the reason that I’m here is to speak for those who can’t speak for themselves. I’m lucky. If I had been here even two months ago, I couldn’t have articulated like this. Part of the disease

is that you can't, even if you know the words you want to say. There is so much damage in the spinal cord and the brain that you can't form the words. They can't come out. I couldn't put six words together in a sentence, and that was just two months ago. So I go from the person that you see here into a paralyzed person that's confined to her bed, that can't always speak. I've lost my hearing twice. And then, again, by God's grace, it came back. And I say, better living through God and chemistry and the drugs that I've been able to repair and come back to what you see now.

But again, every day is a new challenge. And this isn't just me. This is a lot of people and people that I deal with every day out there in Ocean County where I live. Whether you're in Middlesex or Essex or Warren or Hunterdon, we're out there. The Monday Morning Project is across disability groups. So we see it all, and we're exposed to a lot of different disabilities of all ages and what we're faced with. And all these things are scary propositions, because we do know that health care is expensive, not just drugs, durable medical equipment.

Everything has a cost to it. We know it costs the State when you're on these programs. And what I'm hearing some of -- I was sitting there -- is, yes, there is a savings if we're all put on certain programs, if we all go a certain way, that the State is going to have money. And I appreciate that fact because then it can be put back into the pot, and it can serve more people. But I also like to hear that there are some safeguards. That there are some appeals processes that we'll be able to be helped with through these dangerous times that are coming with Medicare, that you all, as legislators-- Because you all have the power and how you influence. This Committee, how you influence who we have in

Washington. The influence you have right here in Trenton on passing bills and looking out, again, for your constituents of older years, as well as those with disabilities.

How important this is. We do follow what you do. We do look at the legislation that you're actively involved in, and we know how important that is. It affects all of us. So, on behalf of myself and others, I want to say thank you for your interest here. And again, for letting me speak that we do have legitimate concerns. And you've all stated it is a problem. The Medicare bill is very complex that we're going to be dealing with and a lot of issues that are going to be faced. Our own, if there are cutbacks in Medicaid, on how we are going to supplement, how we are going to continue with PAAD and the Gold Program. Again, I know there's a lot of work involved here.

But at the end of this, I put my name, address, and phone number, not my e-mail. But again, as a person with a disability, if there's anything I can do, or the Monday Morning Project, to ease any of your process, if you need anything-- I know you have statistics and access to statistics. And some of them I put in here about how many people with disabilities are on Medicaid and Medicare. There's a large faction here of your population. Your constituency have these disabilities. But, if there's anything we can do, please call. Call on me. Call on other people with disabilities. We're on the front lines. We live this every day. We face the pharmacist and the pharmacy bills every day. So we are on the front lines.

We appreciate where you are, too. But again, I appreciate this. And for people with disabilities, thank you very much for your time. If you have any questions?



ASSEMBLYMAN GUSCIORA: Thank you very much, Colleen. I hope you do stay in touch with us as we weed through this whole process.

Assemblyman Payne.

ASSEMBLYMAN PAYNE: It's good to see you again. I think I've seen you a number of times at some of our hearings.

One of the things that -- it's primarily a comment. I've heard the attitude that seems to be expressed, from time to time, is, "Well, it's this or nothing. Isn't this better than nothing?" People have to say, "Well, yes, but it requires a great deal of work to really make it effective." But the attitude I hear coming across sometimes is, "Well, it's better than nothing." The drugs are extremely expensive. The emphasis should, perhaps, be placed on reducing the cost of the medicine, as opposed to the other.

MS. O'DELL-MULTER: Right.

ASSEMBLYMAN PAYNE: But then what may happen then is these pharmaceutical giants that make an enormous amount of money may then not have a friend in high places, you see. So the fact is, that there should be no excuse that we do not provide the kind of medication that's necessary. That people in the dual eligibles, for instance, should not have to worry about whether or not they're going to be able to pay their medication, etc. The fact is that there is money available to do these things. No citizen in our society should have to be worried about whether or not they're going to be able to have the medication to keep them alive, etc. And we have \$87 billion that we can give to Iraq and places like that. There's money there. But the priorities just seem to -- need to be reversed. And we need to look at this realistically. Because what we're seeing is that people will so, too often, make political

statements and question your patriotism if, in fact, we say, "Well, we don't have money, but we have \$87 billion to give elsewhere." But people within our society are suffering and being told, "Well, it's better than nothing, isn't it?" I don't accept that. I don't accept that at all. I don't really believe--

This bill, that so many members of Congress even resigned from AARP because of the support they gave. We know that this is not the kind of legislation that we need to address the problems that we have in this country. But as it's been said, some of us need to stand up and make it clear that we have priorities that go beyond the kinds of things that have been thrown at us. Nobody in our society should have to worry about whether or not they have enough medication to be able to get up and walk the next day. It's asinine. We need to emphasize, I think, our -- as it was mentioned earlier -- to look at reducing the costs of the medication. I think that's one way that we have to go on this whole thing.

I want to thank you for continuing to enlighten us and being able to speak out for those who can't speak for themselves. We know that there are a lot of people out there. And you can rest assured that we're going to do whatever we can -- I certainly am -- to try to see to it that no one goes wanting for the kinds of medication that they need. We'll have to look at this business about the State being able to pay for those who can't pay that \$1 or that \$2 or \$3 that's necessary.

But thank you again for coming.

ASSEMBLYMAN GUSCIORA: Thank you, Assemblyman Payne.

Mr. Goldman, thank you very much for coming.

**EDWARD GOLDMAN:** My name is Edward Goldman. I live in Monroe Township. I hope I can articulate what I'm about to say as well as she did.

I live in an adult community in Monroe Township. And the area that I live in encompasses between 10 and 15 -- 20,000 people in Monroe Township. Actually, the State of New Jersey has become the capital of adult communities, so it's just not a Monroe Township situation, it's the State of New Jersey.

And I agree with Assemblyman Payne. This bill is better than nothing. And one-half of zero is nothing. I don't feel that this bill should have been passed at it stands. Up until December 31 of last year, I was a Canadian affiliate. I was taking prescriptions and working with a pharmacy up in Canada. For various and sundry reasons, I decided -- not because I wasn't successful -- but I felt that I would like to get out of that business. One of the major problems was the fact that I foresaw tremendous problems, due to the fact that companies like Glaxo, Pfizer, Merck are trying to dry up the Canadian market by refusing to ship the pharmacies in Canada, so that they can reship the drugs back to us.

It's sort of ironic that we have to buy drugs from Canada that come from the United States, go to Canada, and then are reshipped back to the United States. It is also ironic that every country that I can mention to you is paying less money considerably -- 20 to 80 percent less money -- in their country for the same drugs that we are paying 20 to 80 percent more than Canada, England, France, and so on down the line.

Now, one of the reasons is that we are subsidizing the world in terms of drug payments. The pharmaceutical companies -- and I have documentation -- are sending drugs to these other countries that have price control. And therefore, since we do not have price control, we are now, as I said, subsidizing the major portion of this money. The cost of research, as it was testified here, is moderate, because there are other means that these companies get their information from in terms of research. However, their program of trying to sell their drugs and promoting the costs of their drugs runs into billions of dollars, billions of dollars. And that's where your major costs for drugs comes from. There is no third side. That's the black-and-white in this, both sides of the coin.

Now, the thing that I can foresee is this: With the privatization of the industry, in other words, eventually as we get into 2006, you're going to see privatization. You're going to see HMOs coming to the forefront and all these other little companies coming in and raising the cost of doing business for the average senior citizen, not only the senior citizen, but we have a lot of young kids out there -- grandchildren, children -- that are going to be forced to pay more money, because there is no control on these pharmaceuticals.

I would dare say, from my own experience, that I was in a -- well, probably in about a five-month period of time, I had been in contact through advertising and personal contact -- everyone was a personal phone call -- that approximately out of the 250 people that I was in contact with, about four of them were involved in that Golden Program for various reasons. They're old people. They're sick people. They're afraid to fill out forms. I had to go over

with my forms, from Canada, and help them fill it out. They're frightened. Some just don't want to go on welfare. I mean, there are so many reasons.

But once this bill goes into fruition and it becomes a bill in 2006, you may be inundated with not 81,000 people, but considerably more people that you hadn't planned on signing up. And then there's the trickle-down effect also. The trickle-down effect is this: That once the drugs start costing the amount of money that we're going to entertain in 2006, that the people that are on the cusp -- the cusp of being low income or poor or whatever you want to refer to them -- they are going to have to spend considerably more money for the same drugs that they're getting now. And therefore, if they're on the cusp, they are going to go into that poverty position, and they're going to be considered a problem in terms of what the State has to do in terms of funding.

So, therefore, I would like to suggest that with the power of your positions that pressure be put on these drug companies to control their prices and that the people that are eligible to sign up for different programs are properly informed how to do it. I think that the most important thing right now is the fact that we need help. And the only place we can go for help is here. This situation that we're talking about right now is nothing more than political issues and monetary issues. The social aspects are really set up in percentages and in dollars and cents and availability. And what we're talking about, honestly, are people like her, like myself. We're real people, and we need help.

I thank you very much.

ASSEMBLYMAN GUSCIORA: Thank you very much, Mr. Goldman.

Are there any questions? (no response)

Thank you.

MR. GOLDMAN: Thank you.

ASSEMBLYMAN GUSCIORA: Okay. I'd like to call Patrick Morrisey from the House Energy and Commerce Committee, and I purposely saved you to the end, because you could hear all our concerns, and you'd be able to address them in one swoop.

Coming from the Rayburn House Office Building.

**P A T R I C K M O R R I S E Y, E S Q.:** Well, thank you, Chairman Gusciora and ranking member Gregg. I appreciate very much the opportunity to be here today.

ASSEMBLYMAN PENNACCHIO: Is the red light on? (referring to PA microphone)

MR. MORRISEY: There we go.

ASSEMBLYMAN PENNACCHIO: There you go. Red is good.

MR. MORRISEY: Good.

ASSEMBLYMAN PENNACCHIO: Rarely.

MR. MORRISEY: Right.

My name is Patrick Morrisey. I'm the Deputy Staff Director of the House Energy and Commerce Committee, and I'm also a long-time New Jersey resident. I lived here most of my life. I did my undergrad work at Rutgers, my law work at Rutgers. And over the past four or five years, I've had the privilege to supervise many of the attorneys who were drafting this new law. And it's really been a labor of love over the past few years. I do appreciate the opportunity to come and talk to you about it today, because there are many misconceptions about how the law currently operates.

I will say that when we were drafting the law we did have New Jersey in mind. And we spent a significantly amount of time working with your Governor's Office; also, with the Pennsylvania, New York, governor's offices as well, because your states are unique in terms of how you currently provide prescription drug coverage for the elderly. So we made a number of changes along the way that we think will be very beneficial for the states.

There's been a lot of discussion about what the law does. You've had a number of very capable speakers come before me. But I'd like to just recap and then go to the question-and-answer period, because I think that may be most productive for the panel. But when you look at the numbers, it's without a doubt clear that this new law will be a good deal for New Jersey. We expect to see 1.2 million Medicare beneficiaries eligible for the new Part D benefit beginning in 2006. If you look at how many individuals are currently enrolled within your PAAD and Senior Gold programs, that still leaves a significant amount of New Jersey's population out of the cold.

Nationally, we're looking at about 23 percent to 25 percent of seniors who currently lack some form of prescription drug coverage. So what that means here, in New Jersey, is that we're still looking at several hundred thousand people who currently don't have coverage. These are people who are going to benefit from day one from the very generous subsidies that we're providing. The subsidies which say that you'll get 75 percent coverage, up to \$2,250 worth of drug expenditures. Also, you'll be receiving subsidies when you hit \$3,600 of out-of-pocket expenditures on your own, and you'll be required to pay no more than \$2 or \$5 worth of co-payments. So that's a very significant benefit.

But there was a very conscience decision when this law was being put together that we would target resources to those who needed it the most. And that means that the benefit is most generous to those who are lower income and those who have catastrophic drug expenditures. So just going through the numbers: For those up to 100 percent of poverty who are dually eligible, that means a co-payment of no more than \$1 and \$3. For those up to 135 percent of poverty, a co-payment of no more than \$2 and \$5. For those up to 150 percent of poverty, 15 percent cost sharing. Now, those are the Federal ceilings.

It's important to note that when we wrote this we had New Jersey in mind, because we meant that that was a ceiling. PAAD has done some wonderful things for the citizens of New Jersey, so we fully envisioned that the State would want to take the bounty that it was realizing, and upwards of \$4 billion and more, and apply even 40, 50, 60 percent. If you apply just a limited percentage of the savings that you're realizing under PAAD, you can ensure that no beneficiary, no beneficiary, will see a diminution in coverage. That means that you can ensure that the beneficiaries today are paying no more than \$1 for their co-pays. You can do that. That decision rests squarely in your hands.

Now, the Federal Government is eager to work with New Jersey, Pennsylvania, New York, and a number of the other states, because there are legitimate implementation issues. You have a unique situation here in New Jersey. And I know that, having spoken to some of the officials over at CMS in recent days and talking with a number of the members of the New Jersey Congressional delegation and also within the key committees at Energy and Commerce, Ways and Means, and Senate Finance, there's a real commitment



to ensure that your unique circumstances are addressed. But make no mistake, the fate of the beneficiary co-payment levels rests squarely in your hands. And so, we'd be happy to, on the Federal level, work very closely with you to ensure that this transition is smooth for beneficiaries.

This is an opportunity for the State to benefit significantly under this new law. It's a very good start for beneficiaries. If you just look at the fact that we're covering up to \$2,250 worth of expenditures, that's -- 65 percent of beneficiaries have expenses of \$2,250 a year or lower. So that means, right away, at 65 percent, you get a very good benefit and will not be exposed to the gap in coverage.

When you further take into account that about 30 percent of seniors today have good employer-sponsored coverage, and most of them will likely retain that coverage under the new law given the special subsidy mechanisms that we put in place, those are people who are going to benefit substantially under this new approach. When you further look at the low-income subsidies, and about 34 percent of seniors nationally will be able to get a good low-income subsidy with no gap in coverage and probably about 80 percent or 75 percent of those will not be subject to the asset test that we've put in. You add that up, and now you're taking another 26 percent of the population.

Now, you add those numbers up and you say, "Well, boy, that's over 100 percent already." The reality is that this bill will be good for probably 90 or 95 percent of the population. And when people focus on the gap in coverage, they said, "Well, why did you do a doughnut hole?" We say that seniors are expected to consume approximately \$1.8 trillion worth of drugs over

the next decade. “Why didn’t you just do a \$1.5 trillion benefit?” The reason is that currently 75 to 77 percent of seniors currently have some third party coverage. So what you don’t want to do from a taxpayer perspective is simply substitute private dollars for public dollars. So that was a very conscience decision.

So we drafted a good benefit which works effectively for those who have expenditures up to \$2,250, for those who have low income, for those who have catastrophic expenditures. And we put good incentives in place to ensure that employers retain the coverage that they currently have. So we made a conscience decision not to spend \$1.5 trillion, because we thought that that would be inefficient and we’d take a lot of private dollars off the table. So that’s why there is a doughnut hole. But, ironically, when we talked about the doughnut hole, it is important to note that for the 25 percent of individuals who currently lack prescription drug coverage, they’re getting a real meaningful benefit beginning in 2006. That’s a pretty good deal for New Jersey and for beneficiaries nationally.

Now there have been some of the speakers who have talked about what Congress has done to address the high price of prescription drugs. That’s a real concern. And we’ve begun to take some steps in this bill to address that. There have been some rules in place for several decades. There’s one law, commonly referred to as the Hatch-Waxman laws, which accelerates the generic drug entry into the marketplace. It relates to how long a drug, a brand product, will be able to stay on patent and what type of exclusivity it will have before a generic competitor will be able to come on line. We changed some of those rules to ensure that generic drugs reach market quicker. That will mean lower

prices for consumers. And that will start to take effect over the course of the next few years.

In addition, we've reformed the way that Medicare currently reimburses for drugs that are paid for in the physician office setting. This is something that is called the *average wholesale price*. The Federal Government and the State Government frequently come up with all these acronyms for how prices are being paid. But this was a very abusive system, and in many cases, we found that we were paying in excess of 86 percent. That was the spread between the acquisition price and what the government was reimbursing. That was a travesty. So we ended that system. And now we're looking to have a more rational way of paying for the drugs in the physician office setting and the hospital outpatient setting.

Are there more things that can be done? Absolutely. And we look forward to working with you to continually addressing these issues. This is the beginning of a long process, but we established some tools. We gave the State Government some flexibility, in terms of how it will design the wrap-around benefit, and we also set up a new Pharmaceutical Assistance Commission to ensure that the Federal Government and the state governments are going to work effectively together to ensure that the benefit is maximized for consumers.

So this is a good law. This is something that we think will be very beneficial for New Jersey seniors. And it would just be a shame if it gets politicized. And once again, I want to say again, that the fate of the co-payment levels rests squarely in this Committee's hands, Governor McGreevey's hands, and the State Legislature's hands. Make no mistake about it, there are a lot of people right now that are saying that this bill will actually

harm people in New Jersey. That's hogwash. And I'm here to answer any charge. And I have the law here (indicating), and I'd be willing to go through and talk about the facts. This is a good bill, but we do want to work to you and make sure it's maximized for New Jersey citizens.

My mom is a senior citizen in New Jersey. She was reading with great interest about what we were doing. She was calling me every week saying, "Patrick, make sure you do the right thing down there." I think we did the right thing. It's not a perfect bill, but it's a good bill. We look forward to hearing your comments.

ASSEMBLYMAN GUSCIORA: Thank you very much, Patrick, for coming up here. We appreciate it, and we do want to work together. And that's part of the mission of our Committee -- is to work well with Congress and make sure that we optimize our Federal dollars. And I promise, as a Seton Hall law student, I won't hold it against you that you went to Rutgers. (laughter)

MR. MORRISEY: We took a tough beating on the hoops -- scored a couple of weeks ago, so--

ASSEMBLYMAN GUSCIORA: Yes. I was enjoying that one. (laughter)

Now, you heard the testimony about the \$30 payment for the temporary assistance cards. What incentive is there for a recipient from PAAD to buy that discount card when we offer a better savings?

MR. MORRISEY: It's interesting, because I think that the clear benefits for New Jersey will be -- in particular, beginning in 2006. This is a very good deal because you're getting the benefits from the dual eligible buy out and also from the displacement from some of your existing PAAD costs. But they'll

also be some savings right away. One of the reasons why a senior may have an incentive to enroll is because they're going to look at an array of drug discount card sponsors, and they're going to be able to shop with their feet. And to the extent that there are some drugs which ultimately are not covered by PAAD, and obviously PAAD goes up to a particular percentage of poverty.

The drug discount card, for example, covers every Medicare beneficiary. That's a significant difference. So a lot of people today in New Jersey will look at these drug discount cards, and it will be a value added.

Now, your State has been well ahead of the curve. Our state's been well ahead of the curve in terms of how aggressive it's been to try to provide benefits for seniors. So New Jersey, with respect to the interim drug assistance plan, probably won't benefit as much as some of the other states out there who really didn't do much for the citizenry over the past couple decades, but they're still going to be able to see, in many instances, that extra \$600 to defray their drug costs. So those who are on lower income who are even paying the \$1 co-pays today or the \$15 co-pays will be able to apply the \$600 toward reducing those co-payments. So it's still good. Is it as good as some other states? Possibly not in this one narrow area. Far, far better than other states beginning in 2006, because of how much you've currently put into PAAD.

ASSEMBLYMAN GUSCIORA: The other thing is, if you could address the issue automatic enrollment. That seems to be a block to the smooth transition. I was wondering what was the reason for not allowing automatic enrollment, particularly in New Jersey's circumstances.

MR. MORRISEY: It's interesting, because we had a lot of discussion with the members on all the committees about whether we should do

automatic enrollment or not, and there was a great deal of debate as to whether the Corzine amendment was the appropriate policy. The conferees decided that it wasn't the appropriate policy for a couple, specific reasons.

Principally, there was a concern that you didn't want to force beneficiaries into a particular program, and that it should always be voluntary in nature. I think that some of the previous witnesses have brought up some good points, because you want to ensure that there's good coordination and it's seamless, so that seniors will be able to access their benefits. At the same time, there is a principle which many members of Congress and most seniors -- about 80 percent of seniors, 85 percent of seniors in the polls that I've seen -- say that an affordable, voluntary benefit was what they were looking for. So I think people were concerned about the automatic features of it.

Having said that, I think that the concerns that are raised are very legitimate. And I know that CMS is looking between now and the time when the final regulations are promulgated, before the discount card gets up and running in June, that some of the concerns to ease beneficiaries into these discount cards is, particularly from states like New Jersey, are addressed. I think that was the main reason why they elected not to do it.

And also some people have focused and said, "Well, what happens in the case of HMOs and other instances?" Well, there, there was a conscience effort to say that you wanted to coordinate care. That to the extent that you're getting your whole Medicare benefit with the inpatient benefits and the outpatient benefits, and now you have a drug benefit, it really wouldn't make much sense to deliver that drug benefit if you're already within a HMO outside

the HMO or the PPO option. So I think they wanted to really emphasize coordinated care.

ASSEMBLYMAN GUSCIORA: Okay. And to follow up from Assemblyman Pennacchio's desire to expand PAAD, what is disappointing from my perspective is that the Federal Government couldn't recognize the PAAD Program and just give us a block grant or some money to help administer it or to expand it on their own, rather than have to do a wrap around on our program. Wouldn't it have been more efficient if the Federal Government would just give us the realized savings so that we could then take over from there?

MR. MORRISEY: One of the critical points that we wanted to emphasize and that the members made a conscience decision on is that they wanted to ensure that beneficiaries were going to be able to receive choice in 2006. They have the option to choose from a stand-alone prescription drug program, a Medicare advantage traditional HMO product, or a Preferred Provider Option. These are programs which are very popular in the under 65 market and that we're trying to inject into Medicare today. And to the extent that the State were to just continue to operate the way it's functioned, that many beneficiaries-- Because PAAD only covers, I believe, it's 300 percent of poverty or it's a little bit lower when you add the Senior Gold. It's still leaving a huge--

ASSEMBLYMAN GUSCIORA: It's 34,000 a year.

MR. MORRISEY: Thirty-four thousand a year. When you look at the percentage of individuals in the State who aren't covered by PAAD or Senior Gold, that still a significant percentage of the population. What are you

doing with those people? You have to set up a viable market and ensure that the insurers are going to be willing to come in and service the entire state. Because if they see that a very attractive percentage of the population has just pulled out and administered by the State and they can't compete with the State, they're not going to come in. So then, the rest of the Medicare beneficiaries in the state are left holding the bag. So that was part of the reason for it. It was to ensure a broad array of choices and that the marketplace would ultimately develop.

But we did spend a lot of time with the New Jersey Governor's Office and the Pennsylvania governor's office. And interestingly, the Pennsylvania governor and many people in that state, had ultimately supported a lot of the work we did in the integration of the benefits. They said that we addressed many of their concerns. So because we made very specific changes at the request of these states. So we think that what we've done will be very effective for the state.

But once again, I emphasize that we remain committed to working with you to make sure that it gets implemented the right way. Because we tried to listen to all the comments that came in and draft the law accordingly. But that doesn't mean that you always get it right. We think it's a very good law. But over the course of the next few years, we think we could probably make it better.

ASSEMBLYMAN GUSCIORA: Oncologists in New Jersey claim that under the new Medicare law payments are going to be cut to them, and that they're going to lose \$500 million in payments to New Jersey. Can you comment on that?



MR. MORRISEY: It's interesting, because this is a charge that we've heard from a number of people across the country. And here is what had ultimately happened. Over the passed five years or so, Medicare had been significantly overpaying for reimbursement of a particular type of pharmaceutical products which were administered in the physician office setting. So if you go to look at the Office of Inspector General or CMS and some of the other -- and the General Accounting Office, they'd indicated that the spreads between the acquisition costs and the Medicare reimbursement price for many products was 86 percent. And that beneficiaries were overpaying to the tune of \$190 million a year.

So what we tried to do is make some modest changes to say that now we're going to start reimbursing based upon some of the existing market prices that are out there, not the fictitious list prices that were being put forth by some of the manufacturers. And as a result of those changes, the current growth rate for Medicare Part B drugs was scheduled to be 28 percent. It's probably going to grow at about a 20 percent or 22 percent rate -- still pretty significant. And, in fact, in 2004, the oncologists will receive an extra \$100 million.

So, when the oncologists talked about losing dollars, what happened is that we're taking away some of the spread that they were used to put into their pocket, but were also providing some additional resources in the physician office setting to defray some of the legitimate expenses that they have to service cancer patients. It's our intent to ensure that cancer care is preserved in the State of New Jersey and across the country, and we think this law reflects the balance of protecting access to cancer care, but also ensuring that abusive practices where the government significantly overpays for products is ended.

ASSEMBLYMAN GUSCIORA: My final question is the comment that the new Medicare bill prohibits drug negotiations with companies or group purchases. What was the purpose of disallowing that?

MR. MORRISEY: It's interesting, because the Congressional Budget Office, and there was a lot of talk earlier in terms of the \$400 billion figure and the score from the Congressional Budget Office. The Congressional Budget Office has indicated that if you were to provide the government with a specific negotiating authority, there would be a negligible impact in savings for consumers -- negligible impact in savings. So when you have a negligible impact in savings for consumers and you're faced with a choice of saying, do you really want the government to make the decisions as to what drugs get covered on a formulary-- Because if the government has the ability to negotiate and ultimately say these are the products which will get covered and these are the prices that you are going to reimburse for, the government decides which drugs are contained on the formulary and which drugs are ultimately in the seniors' medicine cabinet. We didn't think that was a good choice for seniors based upon all the discussions we had with them.

And we also indicated that we wanted to attack the high price of drugs through different ways. So by having plans compete aggressively with one another-- And also exempting these private plans from the so-called Medicaid best price rules -- and these are basically the rules that say, if I, as a private plan, negotiate with a pharmaceutical manufacturer, I have to come back and then give Medicaid a 15 percent or more rebate on top of the good negotiated price that I gave to the private plan. That's a disincentive for the pharmaceutical

manufacturer to negotiate the best rate. And so, that effectively limits how much you can extract from the pharmaceutical manufacturers in savings.

The Congressional Budget Office assumes that seniors will save approximately \$18 billion alone from that new provision, exempting them from the Medicaid rules and saying that competitive structure will be in place. So that's why we did it.

ASSEMBLYMAN GUSCIORA: All right.

Any questions from the members?

Assemblyman Payne.

ASSEMBLYMAN PAYNE: Yes. Mr. Morrissey, your rather polished presentation was very, very well done. I contrast it, however, with the previous people who testified -- Mr. Goldman being one of them, etc. -- where people on the ground who are people actually, not statistics, who indicate deep concern, as many of us do, with this bill. Our senators are concerned with it. Our U.S. senators are concerned with it, etc. We still have this major concern about the dual eligibles, etc., and those kinds of things. We talk about the percentage of people that will benefit from it, but there are those, many, who still will have to look to find out how they're going to be able to cover all their needs as far as prescription drugs go.

And we talk about this as a first step. We are willing to sit down and talk and really tweak this to make it better. How it seems to me that we should do it right the first time, because there were an awful lot of concerns. Not necessarily New Jersey. New Jersey is in a different category -- New Jersey and New York, etc. But across the country, you have many folks who will, in fact, not benefit from this. We also have -- are really not giving enough

attention to the reduction of the costs for the drugs, etc., and we really haven't looked carefully enough. I don't think this administration has not looked carefully enough in that direction for some reason. And I think that we're going around in a very circuitous route in order to arrive at the same kind of savings that we think we can do.

Other countries, as have been pointed out, do not have the same exorbitant costs for prescriptions and medications that we have right here. The very fact that U.S. pharmaceuticals ship to Canada where these same drugs are much less-- Did the administration give any thought to, perhaps, going in that direction, as opposed to the final bill that came out of your administration?

MR. MORRISEY: It's interesting, and I work in the congressional side. I don't work for the administration, though. We interact extensively with them and obviously are -- on the Republican side, our Committee members are strongly supportive of many of the projects the administration is undertaking. But it's interesting, because we've looked very closely at the issue of reimportation and the fact there are some provisions within this bill. Reimportation actually is permitted if the secretary can certify to the safety and cost savings that would accrue.

Now, interestingly, along the way when we were drafting these provisions, I had the opportunity to spend some time with the Congressional Budget Office. That's the organization which is responsible for analyzing their estimate as to what the particular piece of legislation will cost or score. They indicated that if you had a Canada-only reimportation, that that would not result in any real savings for consumers. So that's just one example. So we did take a look at that. That was something that was explored.

ASSEMBLYMAN PENNACCHIO: Why?

MR. MORRISEY: I'm sorry?

ASSEMBLYMAN PENNACCHIO: Excuse me. Just why? Why is that?

MR. MORRISEY: Well, first of all, because the Canadian market is very, very tiny. So, in terms of the prices that would be realized, there's just not that much-- I think it's \$1 billion worth of savings or drugs consumed from Canada, or in Canada, compared to 155 or more consumed domestically in the U.S. There's a sense that given all the additional burdens that would have to be put in place, also, to ensure for the safety within the pharmaceutical distribution trade, that those added costs as well, those burdens, would make it prohibitably expensive. That the net would actually be minimal.

To put it in real practical terms. Right now, it's very difficult to track how pharmaceutical products move from one place to the next. And what a lot of industries are looking at is new technologies to ensure that you can identify when a product is going from one state to the next, or going from a wholesale distributor to a pharmacy or a hospital. Those systems are not currently in place right now. So those are just some of the costs.

ASSEMBLYMAN PAYNE: Those systems are not in place right now. I had sensed, and I feel strongly that if they were in place, we probably would be able to track it. And I'm convinced that it would be much more reasonable for those of us here. We have the ability to track every other thing. I'm sure that we could probably do the same thing. I would imagine that for some reason other countries seem to have the ability to provide pharmaceuticals at a more reasonable rate than we do. And I've heard an awful lot -- we've all

heard an awful lot about the transactions that are conducted in Canada. But you're saying that your data-- And you say you work for the congressional side, the Majority I suppose. The two different conflicting opinions about whether or not we would be able to save or realize significant moneys there is something that perplexes me. I just don't know how, and perhaps you have something that can (indiscernible) me on that.

MR. MORRISEY: It's interesting, because we've begun to, at the Energy and Commerce Committee -- and I know the FDA has done this as well -- we're beginning to look at some of the global pricing systems around the world and how long it takes foreign countries to move products over to generic status. And what we've found is that domestic generic products are actually one of the cheapest in the world. So one of our goals in this new law was to move as many products over to the generic side as quickly as possible. And that's what we accomplished with some of the Hatch-Waxman reforms. What we're going to see is a lot of the block-busters moving off patent -- you know, that extra six months or a year -- before they otherwise would under the current law. That's pretty significant, because there's no way to realize savings better than to incentivize seniors to utilize generic products. They're very safe, they're effective, but they're also a lot less expensive than branded products.

So that was the conscience decision that was made, because then you don't get into the debate about the safety on the reimportation end, because there are a lot of people that are legitimately concerned about counterfeit products which could enter into the pharmaceutical distribution system. So, if you focus on just accelerating generic entry, you get the benefit of the price without the detriment of potential safety concerns.

ASSEMBLYMAN PAYNE: Thank you.

I don't have any more questions.

ASSEMBLYMAN GUSCIORA: Thank you.

Assemblyman Gregg.

ASSEMBLYMAN GREGG: Thank you, Mr. Chairman.

I've served on a lot of committees with you. I don't think I have ever heard you say you're in favor of block grants. I am going to save that one for a long, long time. (laughter)

MR. MORRISEY: Can we bring him to Washington--

ASSEMBLYMAN GREGG: And it is recorded, as I note.

So, as we move--

ASSEMBLYMAN GUSCIORA: It will come back to haunt me.

ASSEMBLYMAN GREGG: It may come back to haunt, and some of my comments as well. But thank you for that comment.

Thank you, Patrick, so much for that incredibly easy to understand explanation. Because as I read some of this information last evening, prior to coming to the Committee, I thought my head might explode on all the details that are included as we're trying to bring a new wave of revenue to the State of New Jersey and how we assimilate it. So I thought I'd just ask a couple of simple questions that I think do need to be asked.

This new Federal program, is there any revenue required from the State of New Jersey at all to receive any of these benefits?

MR. MORRISEY: No.

ASSEMBLYMAN GREGG: So this is purely a new program coming from the Federal Government back to New Jersey with virtually no strings attached?

MR. MORRISEY: I would think of it as--

ASSEMBLYMAN PAYNE: Manna from heaven.

MR. MORRISEY: --the fact that Medicare right now, by virtue of stepping in where the State is currently providing drug coverage for its seniors, now you're going to see that significant drop off in your current expenditures in your budget. So that's how I would look at it.

ASSEMBLYMAN GREGG: Through the Chair, I'll be probably intermingling on the bill and off the bill, but we've been fairly flexible today, and I appreciate that, Mr. Chairman.

When the dust settles, the way I see this, is, we were spending \$500 million a year on PAAD. And as a state that has probably, if not, the number one per capita -- it's probably top, one, two, or three in our commitment to our citizens. And virtually instantaneously we are going to almost double that as we move forward towards 2006. So it does appear, from your testimony, that at the end of this meeting, you really are dropping a lot of pressure on us. Because it's going to fall on our shoulders how we deal with that \$400 million.

I noted some of the questions that the Chairman asked -- the automatic enrollment -- and I that was a question that I had. I think you answered king of the way I expected you to, that ultimately we are one of 50 states. We happen to be one of the different states. Each one of the states may have different views when this is going to be their first program. They may want



different options and choices for their citizens, even though we already have a fixed program that we have to interrelate to.

Dual eligible was another comment that virtually everybody mentioned who testified today. So I kind of go with the ones that get the most attention. Is there anything in the Federal legislation that's giving us all this money that would tell the State of New Jersey that that could assimilate that cost, that increased cost on dual eligibility?

MR. MORRISEY: Well, it's interesting, because if you look at the dual eligible expenditures which will be saved under this bill, by the end of, I guess, by 2014-- It starts out that we're-- Beginning in 2006 -- let's start at the beginning -- in 2006, the State of New Jersey will only be responsible for 90 percent of what it otherwise would have been responsible for under current law. When you move out to 2014, they're only responsible for 75 percent. So every year, you're going to save those dollars.

Now, what you can do with those dollars to the extent-- There's apparently some debate, I guess, in the State about lifting the Medicaid co-payment levels. Someone is talking about that. So I guess the previous criticism that has been made by Senator Corzine and Senator Lautenberg that this bill would hurt Medicaid beneficiaries, I guess, depending upon what the State Legislature will do, number one, you could have an immediate-- It could be kind of a funny situation to see that the State Legislature pushes an increase, then sees a decrease. And obviously, that's something that the State Legislature will have to address. But you can immediately apply those dollars to ensure that you're going to drop down to \$1 or to zero, if you want, on day one. So that's your choice.

ASSEMBLYMAN GREGG: That's in our hands--

MR. MORRISEY: Absolutely.

ASSEMBLYMAN GREGG: --ultimately. And it's not in our hands -- and I want to be clear -- that the State would have to pay for that. The Federal Government is going to pay for that for us.

MR. MORRISEY: Well, you're getting the value of the Federal Government coming in and stepping in and providing that Medicare benefit. You get to decide how much money that you're going to apply to ensure that all beneficiaries receive the same kind of coverage that they're used to today. And my sense is that you can use a portion of your savings to do that. You can use another portion of your savings to expand even further. And maybe you can use a portion of your savings to pay down some of the high bonded debt.

Just as an example, there are so many areas that you can use this for, but clearly, you first want to say, "Let's make sure the beneficiaries are held/hold and that's a decision squarely in the hands of the Legislature and the Governor.

ASSEMBLYMAN GREGG: I might put the debt on another day. We'll be discussing that as we move forward. But I do want to add into that category, because I'm walking through some of the questions. Clearly, there's enough money in the benefit that we have to cover the co-pay issue.

Another question I had is on the discount card where we talked about a \$30 fee, which was a question asked as well. As I remember Kathy's testimony, that we are -- 81,000 of the eligible people -- would save us to the tune of -- my notes say about \$80 million.

MR. MORRISEY: Ninety-one.

ASSEMBLYMAN GREGG: Ninety-one million dollars. Correct, \$90 million. And if you were to waive the \$30 fee, as a Legislature, which we're capable of doing, that that would only cost us about 2.4 million. So of the potential savings of \$90 million, we could only put out 2.4 million and have no costs to those folks when we asked them to make that transition. So we seem to have some money there as well.

The doughnut was another issue -- and we'll use their term. Perhaps, I'd like to call it a life ring, but let's call it a doughnut. That is going to be a situation where New Jersey has another incredible benefit no other state has. Because with this next influx of revenue covering things that we already covered, that we could use that money-- There's nothing in this bill, no language, no prohibition that says the State of New Jersey, the Legislature and the Governor, can not use that extra revenue to close the gap on that doughnut. Would that be true?

MR. MORRISEY: That's correct.

ASSEMBLYMAN GREGG: And the other number that was incredibly compelling to me is that as good as our program is, it is still only ensuring about, or taking care of, approximately 220,000 citizens of our 8.4 million. And this new program -- the one at some point has had some issues in the newspapers -- is going to increase that number to 1.2 million people who will have access to some form of benefit on pharmaceuticals, which is virtually almost an increase of a million people. And the benefits that are articulated in the system today and in the bill that, I guess, we're talking about, is not going to be, as you've used -- and your term was very good -- it's a ceiling on the Federal side. It's not a ceiling on the State side. Again, is that correct?

MR. MORRISEY: That's correct.

ASSEMBLYMAN GREGG: So, if the State of New Jersey chooses to take all of its benefits, all of the increased dollars that we get that are above and beyond that what we've already been covering in our \$500 million, we could conceivably even add more people to it, increase benefits, remove co-pays, and remove any fees that we charge our people now. We have the power to do that?

MR. MORRISEY: You could do all of the above.

ASSEMBLYMAN GREGG: Nothing in the bill prohibits the Legislature and the Governor to act that way?

MR. MORRISEY: Nothing prohibits it. And, in fact, when we wrote the language, we were envisioning that. That New Jersey would come in and-- And that's why it was so perplexing to us to see some members of the delegation say that this wasn't a good deal for New Jersey. We could sit and go through this. This is a very good deal for New Jersey. Obviously, there are always ways that things could be improved. But if you could break down the numbers and you look at the savings from PAAD and Medicaid, anyone who believes that this will hurt New Jerseyans must have an intent that they don't want to apply the dollars back to make sure that co-payments are going to be kept the same. So that would be interesting to ask what their intent is.

ASSEMBLYMAN GREGG: I think an awful lot of very quality people from a number of groups today came with questions, and they should come with questions, because that's what the public should do. Because too often things happen in government and what we say isn't what you get. But I think that the overriding bottomline to today is that there is no question because

of New Jersey's leading the way in pharmaceuticals for its folks, we're going to have tremendous benefits from this if we act according.

So I challenge the Committee. I challenge my colleagues. I challenge people on both sides of the aisle to join me, in any way, because I think all of these benefits should go right back into the folks we've been taking care of. We should ensure, whether it's the Gold Program, the regular program, or the PAAD Program -- all of this should go back where it belongs, because these have been dedicated funds that we've determined our citizens should get. We have an opportunity, a defining moment so to speak, to do the right thing. And too often when these types of revenues come in from another source that we quickly take them to balance budgets or do other things or pay off debt, even though you brought that up.

Again, I think we have a great opportunity here. I'll leave with the last question is -- maybe it's a statement, because I think it's important that the Federal Government-- And I ask you to go back and make sure that this assimilation happens as fast as we can. I think it's incumbent upon the Committee to act. I hope the action does come through this Committee. I asked you last time. I hope that when the spending or adjustments or assimilation or merging of these happen, they happen here, because it is a Federal/State issue. And perhaps, we can have Patrick back as well, as that moves forward to ensure that the Federal Government is doing its part on making it as easy as we can, giving us the appropriate guidelines to make sure that our departments are not handicapped and moving as fast as we can to get the benefits for our citizens, fiscally as well as medically.

Thank you for the -- indulging me, Mr. Chair.

ASSEMBLYMAN GUSCIORA: Thank you, Mr. Gregg.  
Mr. Payne.

ASSEMBLYMAN PAYNE: Just a final comment, on my part any way. And that is, that it has been mentioned that several times because of our PAAD Program and other Gold Program that we're unique, as far as this impact of this legislation goes. Some of us have an interest, however, that for America's people who are in certain categories who will not benefit from this legislation.

Some of us do identify with the National AARP, for instance, that finally was brought to the table, but also, with other, I think, people that whom we respect around the country, many of whom are in Congress and in the Senate, who find very, very, very serious problems with this legislation, and therefore, that resigned as a protest against this legislation, from the AARP. New Jersey is unique, and I think that we do have to look at it from that perspective.

However, speaking broadly, I think that there are many, many very, very serious questions for people, not in New Jersey necessarily, who are developmentally disabled and others -- the dual eligibles, etc. -- across the country, who in fact, are impacted in a much more serious way than others. I think that my concern has been and initially was reading the debate or hearing the debate or listening to the debate on a national level and some of the concerns that existed then still do exist, broadly, when we look at this. I'm sure that you continually run into people in Washington, in the Congress, that still have some very, very, very serious concerns with this legislation. New Jersey, I

will admit, we have been, perhaps, light years ahead of other states in these areas. We will not be impacted in a -- as negative of way as others.

MR. MORRISEY: Assemblyman, I appreciate your comments. And in fact, when we do hear stories from across the country, we want to always take that into account. I just wanted to make the point, though, that we believe that this is a good benefit for all of America, not just New Jersey. It's just that New Jersey has special circumstances, which means that you're better off in many instances than others. This is probably one of the few examples that someone from Washington can come and tell you that, historically we've heard so much about how New Jersey is 49th or 50th in return for its Federal tax dollar.

I've lived in this state for many, many years. I'm sensitive to those issues as well. I'll say that for the first time now, New Jersey really benefited significantly as a result of a new Federal law. So that's just something that I want to emphasize. It's a good law, but New Jersey happens to benefit even more because of its proactive commitment that it's had over the last couple of decades.

ASSEMBLYMAN GUSCIORA: Assemblyman Pennacchio.

ASSEMBLYMAN PENNACCHIO: Thank you, Chairman.

If I may, I think maybe just one of the questions that, if you don't mind, quote the (indiscernible) essence of this bill. (laughter)

ASSEMBLYMAN GUSCIORA: It's your floor.

ASSEMBLYMAN PENNACCHIO: Mr. Morrissey, I am very concerned about some of the testimony from Colleen and especially from my

friends in ARC about dual eligibility and whether or not we can address that as a State to make sure that none of these people pay any co-pays.

MR. MORRISEY: The State would always have the ability. There is no prohibition on the part of the State to come down and to lower co-payments for any of its beneficiaries. So I'm not certain what the State Legislature will do, whether they increase the co-payment levels to \$2-- Let's say that they did that this year. Well, then, immediately the Federal benefit would be lower than what the State does this year. But let's say the State Legislature doesn't act to increase Medicaid co-payments this year. You can still come in, and as part of your amending of PAAD, you can ensure that there is no co-payments paid or a minimal co-pay for all of the dual eligibles. So that's solely within the discretion of the State Legislature. Nothing in the law prohibits that.

ASSEMBLYMAN PENNACCHIO: Thank you, Mr. Morrisey.

I, too, want to echo some of the comments that were made, not only by the people on the dias up here, but also by the people that were testifying about the concerns, making sure that whatever Federal dollars do come in, Mr. Chairman, that they stay within the systems themselves. And that system is to expand, improve the pharmaceutical programs that are in existence, if not to create a greater area where even more additional New Jersey citizens can take advantage of that.

ASSEMBLYMAN GUSCIORA: Our goal is to have you eligible one day.

ASSEMBLYMAN PENNACCHIO: Well, it's not going to be that long, Mr. Chairman.



I have concerns, and I know it has to be done constitutionally, because money goes to all sorts of different places. It's my understanding that even money that comes in from this bill can go to a program, like the post-retirement health benefits program. Am I correct?

MR. MORRISEY: I'm sorry. I didn't--

ASSEMBLYMAN PENNACCHIO: Moneys that are coming in federally with this, can go into the post-retirement health benefits program that the State has?

MR. MORRISEY: Yes. There is-- In fact, there will be hundreds of millions of dollars of savings because we're also paying 28 percent of all employer costs, including State employer costs, from every dollar from \$250 to \$5,000. So all of those savings, once again, will be realized by the State.

ASSEMBLYMAN PENNACCHIO: Well, unfortunately, New Jersey has a history of raiding some of those post-retirement health benefit plans. So we'll get the money that was intended for pharmaceutical--

ASSEMBLYMAN GUSCIORA: Bipartisan.

ASSEMBLYMAN PENNACCHIO: By whoever did it, it was wrong. And to ensure that it doesn't happen in the future, we don't want to see \$300 million going into that fund, one day, thinking it's helping, and then the next day finding out that it goes into the general revenues, maybe, to build an arena in Newark, which coincidentally happens to cost \$300 million.

Now -- sorry, I had to get that statement out.

ASSEMBLYMAN PAYNE: (indiscernible), Mr. Speaker. (laughter)

ASSEMBLYMAN PENNACCHIO: Well, I think we gave you the latitude to talk about Iraq, Assemblyman, and I figured I had to get my dig in. But there's a lot of waste going on.

ASSEMBLYMAN PAYNE: There's a \$300 million tunnel for Atlantic City that I believe -- and I don't anybody ever talked about taking away the State's moneys there. So, we can really go on and \$300 million there. Route 70, etc.

ASSEMBLYMAN PENNACCHIO: One may benefit a lot of people, one benefits the rich, not the owner, but we'll--

ASSEMBLYMAN GREGG: You were doing so good, but just lost.  
(laughter)

ASSEMBLYMAN PENNACCHIO: Okay.

Getting back on this bill, I'm selfish. I'm sorry. I know that we should think of all our fellow Americans and we should be thinking about the impact that this bill has on everybody. But believe me, each and every single representative has their own districts in mind, each and every senator should have had their own State in mind when they voted for this bill. This is a good bill. It's a bill by testimony, by both AARP and Family Services and some of the other people that testified before today, said it was a good bill for New Jersey. It builds upon what New Jersey has. And yet, it's unfortunate that we had our representatives, especially at the U.S. Senate level vote against a bill like this.

It would be nice, Mr. Chairman, if we could have had them testifying before us. If they can't come personally, maybe a written testimony to tell us exactly what they're reasoning was that they voted a bill that would

have enhanced some of the seniors prescription programs that we had. If nothing else, bring in \$4 billion over the next 10 years that could have made us do that ourselves.

ASSEMBLYMAN GUSCIORA: Just all in fairness, I've sent a letter to each one of our congressional delegations. Senator Lautenberg, Senator Corzine, and Senator Pallone responded they wanted to testify, unfortunately which we're going to correct next, we shouldn't have hearings on Thursdays because it conflicts with the congressional schedule.

ASSEMBLYMAN GREGG: Monday is better.

ASSEMBLYMAN GUSCIORA: If it was a Monday, they would have come. So we may visit this issue again.

ASSEMBLYMAN PENNACCHIO: Being that Senator Corzine has been, probably, the most local outspoken person of this bill in the Senate, why don't we see if we can get him, and perhaps he can answer some of our questions?

ASSEMBLYMAN GUSCIORA: He expressed interest in coming. At least, his office represented that.

ASSEMBLYMAN PENNACCHIO: That would be terrific.

ASSEMBLYMAN GUSCIORA: Great.

ASSEMBLYMAN PENNACCHIO: Thank you.

ASSEMBLYMAN GUSCIORA: Okay.

With that, we'll let Patrick go back.

MR. MORRISEY: Thank you.

ASSEMBLYMAN GUSCIORA: But help us with that smooth transition so we'll be seamless. And there are some kinks, I think we can all admit that. If we could work that out, that would be great.

MR. MORRISEY: Well, thank you for giving me the opportunity to be here today.

ASSEMBLYMAN PENNACCHIO: Just in closing, on behalf of Colleen and ARC and AARP, I'm going to be calling you.

MR. MORRISEY: Fair enough.

ASSEMBLYMAN GUSCIORA: Thank you very much, everyone.

Adjourned.

**(MEETING CONCLUDED)**