PX 11

Summary of Legislative Hearing
Transcripts Regarding Vermont Act 80 §§ 1 & 17 (2007)

The following is a summary created by Hunton & Williams LLP of the legislative hearings where witnesses testified concerning Vermont Act 80, sections 1 and 17 (2007).

TAB

January 17, 2007 (CDs 07-07-8) — A
Senate Committee on Health and Welfare

1. Steve Kappel, Vermont Joint Fiscal Office staff member, testifies regarding the role of pharmaceuticals in the health care industry.

2. Robin Lunge and Maria Royle, Vermont Legislative Council staff members, testify regarding drug costs for Vermont's various health programs, as well as current cost savings measures in the state.

January 19 & 25, 2007 (CDs 07-18, 22 & 23) — B
Senate Finance Committee

1. Lunge provides introductory information regarding pharmaceutical spending in Vermont.

2. Kappel testifies regarding pharmaceutical cost drivers and spending, citing statistics from BISCHA and the Medical Expenditure Panel Survey by the Agency for Health Care Research and Quality.

3. Lunge testifies regarding the mechanisms of pharmacy benefit managers.

January 26, 2007 (CD 07-24) — C
Joint Hearing: Senate Finance and Senate Health and Welfare Committees

Lunge and Kappel provide an overview of state pharmaceutical spending, state health care programs, and current Vermont initiatives to reduce prescription drug costs.

TAB

D

January 31, 2007 (CDs 07-21, 07-22)
Joint Hearing: Senate Finance and Senate Health and Welfare Committees

1. Cynthia LaWare, Secretary of the Vermont Agency of Human Services, discusses the agency's programs and initiatives regarding prescription drugs.

2. Sharon Moffatt, acting commissioner of Health, discusses the agency's cost reduction program.

3. Joshua Slen, director of Office of Vermont Health Access, discusses the mechanics of state Medicaid and pharmacy programs, noting that Vermont spent $168,000,000 on drugs in 2006.

4. Rep. Sharon Treat, a Democrat state representative from Maine and executive director of the National Legislative Association on Prescription Drug Prices (NLARx), discusses options for reducing costs of prescriptions drugs including the prescription restraint law.

E

February 6, 2007 (CDs 07-35, 07-36)
Senate Finance Committee

1. Dr. Deborah Richter discusses problems with health care, but does not mention pharmaceutical sales representatives, prescriber-identifiable information, or S. 115.

2. Linda McIntire, Human Resources Department Commissioner, and Cathy Callahan, director of benefits, describe the workings of the state formulary, noting that the list saved the state $2.8 million in 2006.

3. Julie Brill, Vermont assistant attorney general, discusses the pharmaceutical programs administered by the Office of the Attorney General.

F

February 13, 2007 (CD 07-43)
Senate Finance Committee

Lunge discusses a draft of the committee's bill containing Rep. Treat's recommendations.

TAB

February 15, 16 & 20, 2007 (CDs 07-46, 07-47, 07-49-53) G
Senate Finance Committee

1. Sean Flynn, law professor at American University and counsel to NLARx, discusses unconscionable price legislation and the need for restrictions on prescriber-identifiable data.

2. Madeleine Mongan, Vermont Medical Society (VMS) vice president for policy, discusses a resolution VMS adopted on Oct. 14, 2006, which states that "the combination of detailed marketing profiles and the provision of marketing incentives for physicians by pharmaceutical representatives raises the possibility that representatives could exert too much influence on prescription patterns," calling for legislation similar to New Hampshire.

3. Steve Kimbell, lobbyist for IMS Health, discusses the many uses of information aggregated by health information publishers and the likelihood that such data would no longer exist if commercial uses were banned.

4. Brill discusses the lawsuit in New Hampshire regarding that state's prescription restraint law.

5. Julie Corcoran, deputy vice president for state policy for PhRMA, discusses concerns that the bill would limit the ability of the pharmaceutical industry and the FDA to use data to expedite educational information about certain products. She testifies that the American Medical Association's program to allow physicians to opt out the use of their prescribing patterns already addresses concerns about pharmaceutical detailing.

6. Paulette Thabault, Commissioner of Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), discusses concerns that the confidentiality provision would prevent the department's use of collected data.

February 21 & 22, 2007 (CDs 07-54, 07-55, 07-56, 07-57, 07-58) H
Senate Finance Committee

1. Lt. Ed Miller, lobbyist for the Vermont Police Association, testifies regarding police concerns that the definition of commercial purpose would include law enforcement activity.

2. Kimbell discusses the fact that prescriber-identifiable data

TAB

comprises less than 20 percent of the IMS Health business.

3. Harvey Ashman, general counsel to IMS Health, discusses the mechanics of the AMA opt-out program.

4. Mongan discusses anecdotal concerns that prescriber-identifiable data is used to target patients regarding condition-specific medical supplies. Under questioning by committee members as to why the AMA and the VMS disagreed regarding prescriber-identifiable data, Mongan testified that the AMA represents less than five percent of Vermont doctors, while the Vermont Medical Association represents two-thirds of the state's doctors.

5. Thabault discusses the need to "tighten up" the prescription restraint law's definition of commercial purposes.

6. Brill states that the AMA opt-out procedure is insufficient because too few doctors actually use it and that if doctors were to use it, companies compiling prescriber-identifiable data would utilize a number other than that of the AMA.

7. Lunge and Brill discuss changes to the bill that would exempt the BISCHA multi-payer database from confidentiality.

February 27 & 28, 2007 (CDs 07-45, 07-46, 07-47-48) I
Senate Health and Welfare Committee

1. Lunge answers miscellaneous questions from committee members regarding the mechanisms of the bill.

2. Brill discusses the Office of the Attorney General's support for the bill because they think the laws "will very likely be to hopefully reduce -- continue our efforts to reduce pharmaceutical prices here in Vermont."

3. Thabault discusses the need to exempt BISCHA from the prescriber restraint provisions.

4. Corcoran discusses the importance of prescriber-identifiable data and that it has become an integral part of how manufacturers work with the FDA on the pre-marketing and pre-approval of certain drugs.

TAB

J

March 1, 2007 (CD 07-49, 07-50)
Senate Health and Welfare Committee

1. Moffatt testifies regarding the existence of the state's academic detailing program.

2. Mongan testifies regarding VMS's support for the academic detailing provision of the bill and the organization's concerns that prescriber-identified data undermines evidenced-based education. Mongan also stated a preference for leaving the references to patient-identified information in the bill, despite federal laws already on the books.

3. Trinka Kerr, state health care ombudsman (affiliated with Vermont Legal Aid), testifies, voicing general support for the bill.

4. Robert Feeney, director, investor and governmental relations for Eisai Corporation, testifies that losing access to the prescriber-identifiable data would set the prescription drug industry back forty years, noting that the data allows the drug companies to identify patient populations that may benefit from therapy.

5. Kimbell testifies that if the data could not be used for commercial purposes, the data would no longer be collected.

K

March 13-15, 2007 (CDs 07-51, 07-52, 07-53, 07-54, 07-56, 07-57)
Senate Health and Welfare Committee

1. Lunge discusses portions of the bill receiving comment, including the Prescriber Restraint Section. "I don't know that this is really a cost section so much as a confidentiality section, because what it -- and maybe I'm not thinking through the cost implications far enough through the chain of events... So I suppose if you think that this section would reduce marketing in general, that could have a cost impact because it would reduce the total amount of marketing done."

2. Mongan testifies regarding VMS's belief that the prescription restraint law could lower drug costs.

3. Kimbell testifies that no evidence exists that restricting prescriber-identifiable data will lower costs.

TAB

4. Brill testifies that the AMA opt-out system does not prevent health information companies from obtaining prescriber-identifiable data.

March 20 and 23, 2007 (CDs 07-83, 07-87, 07-88, 07-89) L
Senate Finance Committee

1. Brill testifies regarding the Office of the Attorney General's desire to have the committee either re-insert the original provisions that totally ban prescriber-identifiable data for commercial purposes or those suggested by VMS, allowing doctors to opt in or opt out of the usage of their data. Brill further testifies that should the committee adopt the VMS suggestion, an "opt-in" system is preferable.

2. Mongan testifies regarding VMS's support for the bill.

3. Paul Harrington, executive vice president of the Vermont Medical Society, testifies to suggest alternative language for the prescription restraint provision that would require physicians to opt-in to allowing their prescribing patterns to be released.

4. Kimbell testifies regarding the potential loss of data if commercial uses are banned.

5. Susan M. Gretkowski, lobbyist for PhRMA, discusses concerns regarding the adoption of a restraint on prescriber-identifiable information without vetting the issues.

March 27 & 28, 2007 (CD 07-90, 07-117, 07-118, and 07-119) M
House Health Care Committee

Kappel and Lunge provide an overview to the committee of the role of prescription drugs in Vermont.

March 29, 2007 (CD 07-122, 07-123) N
House Health Care Committee

Legislative staff discuss the prescription restraint provision. The committee considers testimony from Treat regarding options for containing prescription costs.

TAB

April 10-24, 2007 (CDs 07-124-132, 135-140, 143, 148, 150, 151, 152, 153) O
House Health Care Committee

1. Mongan testifies regarding VMS's support for S. 115, including the prescriber restraint provision.

2. Brill testifies regarding pharmaceutical marketing, and the legal reasons why marketing could not be banned outright.

3. Kimbell testifies that health information publishers will no longer collect data for non-commercial purposes if commercial purposes are outlawed.

4. Art Woolf, an economist from Northern Economic Consulting, testifies that the data used for health care researchers only exists because it is created for commercial purposes.

5. Randy Frankel, IMS Health vice president for external affairs, testifies about the history and purposes of the collection of prescriber-identifiable data.

6. Thabault testifies regarding concerns that the ban on prescriber-identifiable data without amendment could affect state databases by allowing state agencies to acquire information but not allowing them use of the data.

7. Corcoran testifies regarding the importance of prescriber-identifiable data for pharmaceutical companies' work with the FDA.

8. Ann Rugg, deputy director of Office of Vermont Health Access, testifies regarding her concern that Medicaid claims data containing prescriber-identifiable data is available in public records and as such could be used for commercial purposes.

9. Flynn testifies that pharmaceutical sales representatives use prescriber-identifiable data to influence prescriber behavior. Flynn also testified that the three motivations behind the prescription restraint law are privacy, cost, and public health.

10. Moffatt testifies regarding other provisions in the law and expresses the Department of Health's support for VMS's position on prescriber-identifiable data.

11. Treat testifies regarding various issues associated with the ban on prescriber-identifiable data. Treat also quotes a letter from Dr. Benjamin Schaffer, stating, "This type of prescribing data is rarely used for purposes that benefit the public due to proprietary nature of this data and the high prices charged." [004585].

12. Dr. Carol Boerner, an ophthalmologist, testifies regarding her experience with pharmaceutical sales representatives. "A good rep is absolutely invaluable because when you are in the hinterlands, where are you going to get your information about what's going on with drugs? It's the drug rep." Dr. Boerner testified that, "it's a wonderful idea to not be spying on doctors and having the reps come back and make us feel guilty for not doing what they want us to do."

13. Dr. Elliot S. Fisher, director of the Darmouth Center for Health Policy Research, testifies regarding his concern that precluding the commercial use of prescriber-identifiable data would make it more difficult for researchers to obtain information about trends and practice patterns related to prescription drugs.

14. Dr. Jerry Avorn, a professor of Medicine at Harvard University, testifies that restricting the use of prescriber-identifiable data for commercial purposes would not impact research because that data could be gathered from other sources.

15. Brill cites articles and other publications concerning interactions between pharmaceutical representatives and physicians.

16. Frankel testifies regarding the unique role of the data that IMS collects. He explains that the federal government purchases data from IMS, that shutting down these databases will hurt small companies, and the measure will not reduce costs. He expresses concern that health information publishers were being blamed for the marketing practices of another industry simply because the data they collect is used. Mr. Frankel also says IMS would like to partner with Vermont to allow access to the data for uses such as creating a framework for formularies and counter-detailing.

17. Dr. Frank Landry testifies that he sees "no public good whatsoever for the pharmaceutical industry to have information on my prescribing habits."

TAB

P

April 24, 2007 (CDs 105 and 106)
Legislature Holds Public Hearing

The Senate Health and Welfare Committee and the House Health Committee hold a public hearing seeking input for continuing health reform. No one testifies regarding prescriber-identifiable data, and the hearing focuses on access to care. Dr. Deborah Richter testifies to the need for universal health care; she did not testify regarding pharmaceuticals or the pharmaceutical industry. Dr. Carol Vassar testifies that doctors needed more access to data because most of the data was controlled by the pharmaceutical industry. She also says, "There is absolutely no virtue in pharmaceutical companies doing drug detailing." The thrust of her testimony focuses on the need for campaign finance reform and better care.

Q

May 2 & 3, 2007 (CD 07-163-167)
House Health Care Committee

1. Harrington expresses the VMS's support for the amended version of the bill.

2. Marjorie Powell, senior assistant general counsel at PhRMA, recommends that the committee defer a decision until the First Circuit Appeal of the New Hampshire decision is resolved.

3. Moffatt discusses her support for the amendment as being consistent with the New Hampshire court decision.

4. Chris Winters, director of the Office of Professional Regulation, discusses his concern that the consent provision would create difficulties for those charged with the licensing process.

5. Brill suggests that prescriber harassment creates additional costs, that an opt-out provision would be ineffective, and litigation is still possible with the bill as amended.

6. Kimbell requests that the committee delay passage of the prescriber-restraint provision until the New Hampshire appeal is completed because the findings do not address the problems identified in the New Hampshire decision.

7. Flynn explains that the amendments address the concerns raised by the New Hampshire judge in his April 30, 2007 decision.

TAB A

STATE OF VERMONT
SENATE COMMITTEE ON HEALTH and WELFARE

Re: Senate Bill 115

Date: Wednesday, January 17, 2007

Senate Committee on Health and Welfare

Committee Members:
Sen. Doug Racine, Chair
Sen. Sara Kittell
Sen. Kevin Mullin
Sen. Ed Flanagan, Vice-Chair
Sen. Virginia Lyons
Sen. Jeannette White

Steve Kappel, VFO
Maria Royle, Leg. Council
Robin Lunge, Leg. Council

CD No.: 07-07

- - -

SENATOR RACINE: This is the Health and Welfare Committee. Today is Wednesday --
Okay, start again.
This is the Health and Welfare Committee. Today is Wednesday, January 17, 2007.
This afternoon we are going to talk about prescription drugs and with Robin Lunge and Maria Royle.
MS. LUNGE: I invited Steve to join us to do a quick introduction to some of the pharmaceutical financing stuff including proportions of total health care spending to kind of give everybody a big picture before we start moving into what we've done in this area, but really I invited him so he could show up our Power Point by giving you color Power Point so....
MR. KAPPEL: With those kind words of introduction would you like a color?
MS. LUNGE: Please.
ATTENDEE 1: We don't get to color in ourselves anymore?
MS. LUNGE: I don't know if we can. We're not as sophisticated as Leg. Council with the color.
ATTENDEE 1: (Inaudible).
MR. KAPPEL: That may be the scariest definition of my job. Color copy cost containment?

MS. LUNGE: Yeah.
MR. KAPPEL: It's posted on the web too.
I'm actually happier.
(Background noise from committee).
ATTENDEE 1: Can we have order in this chaos (inaudible).
MR. KAPPEL: I'm actually happier in the chaos.
Okay, as Robin said I'm going to do a very, very fast financial introduction so it just gives you the context of why pharmaceuticals are such an important part of the health care system and why they have gotten so much attention over the last couple of years.
So, on to the second page, this is a chart and I should give credit, all the numbers in this chart come from the Department of Banking Insurance Securities and Healthcare Administration, a/k/a BISHKA from their annual expenditure analysis.
So, important Point No. 1, drugs and supplies is about 15 percent of all health care spending. So, it's almost as big as physicians, the only larger sector of health care spending is hospitals.
Important Point No. 2 is pharmaceuticals are real different from most other kinds of health care service

because of the predominance of out of pocket spending.
So, 180 million dollars is spent by people individually to buy drugs so that's the combination of cost sharing and people who haven't got pharmaceutical coverage. That's a much, much higher percentage than any other area of health care spending.
ATTENDEE 1: How much was it?
MR. KAPPEL: 180 million out of pocket.
ATTENDEE 2: Where did you get these figures?
MR. KAPPEL: This is from BISHKA.
ATTENDEE 2: Vermont has spent 180 million dollars out of pocket money?
MR. KAPPEL: Yep.
ATTENDEE 2: For?
MR. KAPPEL: Drugs and supplies.
ATTENDEE 2: Drugs and supplies. And this is prescription?
MR. KAPPEL: Yeah, predominantly prescription drugs, and just to clarify, this is 2004 so that little asterisk where Medicare is down at the end looks very different this year because this is before Medicare Part B. Remember Medicare Part D is pharmacy coverage for folks on Medicare, so when BISHKA does the 2006 version of this chart it's going to look very

different.
ATTENDEE 3: (Inaudible) continue like all the others.
MR. KAPPEL: It will probably get -- Let me see if I can come up with a good estimate but it will definitely move money from Medicaid and it will move money from out of pocket.
ATTENDEE 3: Will it be larger than Medicaid?
MR. KAPPEL: Not as large as Medicaid. I think Medicaid is going to be the largest. It could get close.
ATTENDEE 2: I'm just trying to understand the 180 million dollars. You know, 16,000 Vermonters are uninsured, so they are spending a lot of money out of their pocket for drugs --
MR. KAPPEL: Yes.
ATTENDEE 2: -- And supplies. But I'm insured so I'm not spending much.
ATTENDEE 4: Yes, you are.
MR. KAPPEL: You're spending deductibles; you're spending co-insurance, and there are a lot of people who have health insurance that doesn't cover pharmaceuticals or that covers pharmaceuticals up to a cap.
ATTENDEE 2: So, I am spending a lot of money

because I spend so much to go to the pharmacy as a co-pay.
MR. KAPPEL: Yeah.
ATTENDEE 2: As a co-pay but it's $66.00 a year for me.
MR. KAPPEL: You have very good coverage then.
ATTENDEE 2: Something like that.
ATTENDEE 4: I picked up prescriptions for my wife last week and my co-pay was $77.00.
ATTENDEE 2: Yeah, and my first migraine prescription of the year is $90 because I haven't met the deductible yet. Then it's $40 every time after that.
ATTENDEE 1: What do you think Vermonters spend for pharmacy, supplies, I guess.
MR. KAPPEL: There will be some Vermonters who spend nothing and some Vermonters who spend thousands.
ATTENDEE 1: Right, I just think that number is high.
MR. KAPPEL: It is, and that's one of the reasons pharmaceuticals are such a topic of importance.
ATTENDEE 1: That's why we're here today.
MR. KAPPEL: So, in addition to the reliance on out of pocket spending, spending on drugs and supplies is going up faster than just about anything

else.
The top graph just compares spending in Vermont so this is total all source spending from 1996 to 2004. And what you can see is it's gone from about 180 million to not quite 500 million in nine years.
ATTENDEE 2: Do we know how much of that is an increase because of increase in the drug prices or utilization or --
MR. KAPPEL: We'll actually get to that in about two slides.
ATTENDEE 2: I'm so sorry.
MR. KAPPEL: It's good to be ahead of me.
(Inaudible speaking among committee members).
ATTENDEE 2: I should have known that.
MR. KAPPEL: The second chart on this page is relative gross year over year the blue bars are drugs and supplies. The red bars are health care spending in total and the yellow bars are inflation measured by consumer price index.
So what you can see is over that same period of time pharmaceuticals were going substantially faster than health care which was growing substantially faster than inflation.
ATTENDEE 1: And the drugs and supplies are included in the all health care?

MR. KAPPEL: Yes. So, in answer to the question it's important when you think about this and what your policy options are to recognize there's really three distinct things that are driving the spending increase. The first one is prices; that last year my prescription for Drug X cost $13.00 and this year it cost $17.00, so that's straight price increases.
The second piece is utilization. I had one prescription last year, I had two prescriptions this year. So, those can happen independent of each other and they both drive spending up.
The third piece which is probably the most complicated to measure is what I'm calling product mix. Product mix is a combination of brand versus generic or different brand drugs or even new drugs so the basket of drugs that I'm buying from one year to the next changes, so each one of those influences total spending and there's a lot of definitional quibbling and a lot of fighting about how much is this and how much is that, but just rough rule of thumb it's about a third each.
ATTENDEE 1: I'm just going by the product then. I would suggest a third of the increase in costs equal going from generic brands but are people going

from brand names to generic.
MR. KAPPEL: It could be generic to brand; it could be over the counter to brand. Someone who is taking aspirin for 10 years and then got switched on to Vioxx.
ATTENDEE 1: Who's measuring that?
MR. KAPPEL: There actually are, some of the pharmacy managers have these tremendous data bases of all the drugs they're buying and they do annual reports on this kind of thing, one of which came out recently and I haven't had a chance to wade through yet, but --
ATTENDEE 1: These are roughly five percent, is that what you're saying?
MR. KAPPEL: The yearly spending is growing at 15, roughly 5; it could be 6, 9 -- no, it could be 6, 6 and 3, depending on who is measuring it. But no one factor completely explained the spending growth. I guess that's the important message that I want to leave you with. That if you control pharmaceutical prices, just prices, you'll have made a substantial impact on spending but you will not completely control spending growth.
ATTENDEE 2: So, do we know what the relationship is between or when PBM came into being and what affect

if any, anyhow ultimately, needs to be cost. Because of PBM, so can we weed out any of that data that looks like the relationship to the cost bearing, or any of the increased costs driven as a result of pharmacy benefit managers or are these costs totally separate or have they kept this increase from being -- less the relationship is.

MR. KAPPEL: Let me look around. I'm not aware of anything off the top of my head but I can certainly do some research. But one thing I can tell you is the rate of growth is slowing a little bit in the last couple of years. How much of that is PBMs, how much of that is better purchasing by the Medicaid program for instance, I'll try to figure up if I can piece it apart but it could be tricky.

ATTENDEE 4: The utilization committee, it may not even make any difference but do we know how much of it is because we are in a society getting older or doing more or that it seems to me that probably it is the availability and our tendency to jump always to the most extensive and pharmaceutical solution to which it becomes more ingrained in us all the time.

I mean, do we have any sense of that, that each of us are sicker, or each of us are older or each of us, just, I'm not going to try warm milk, instead I'm

going to go get a (inaudible.)

(Inaudible comments among panel).

ATTENDEE 4: Anyway -- I'm just curious, do we have any sense of why of that so, maybe it doesn't make any difference.

MR. KAPPEL: Again, it's going to be hard to find but I think there's definitely evidence, people talk a lot about medicalization. I'm always astounded to watch TV and see an ad for a drug where all I know is if I take this drug my life will be better.

They never actually tell me what the drug is for.

(Inaudible comments among panel).

MR. KAPPEL: You know, the flowers, the music, ask your pharmacist if "blurr" is right for me.

ATTENDEE 4: The advertisement.

(Inaudible comments among panel).

ATTENDEE 1: There's a question here. Are there any studies that there is something that you could, you point us to that talks about that because a lot of it is, what people are seeing on TV, and I do know people -- I know quite well who believe it's not everything you see on TV or read in a magazine, and they are also asking for the latest cure-all.

ATTENDEE 4: Can we tackle law and say that it should not advertise drugs on TV?

MR. KAPPEL: I'll leave that one to you.

(Inaudible comments among panel).

MR. KAPPEL: I do have some research on some consumer advertising and I'll bring that in.

ATTENDEE 1: I don't watch TV news much, but I was watching CBS News, but there were six drugs and the sixth one, interestingly enough was heartworm medicine for your dog. It's the same pitch, same company's making the drugs, so...

ATTENDEE 2: My dog will be happier.

MR. KAPPEL: Yeah, the music, the flowers, the open fields.

ATTENDEE 1: Keep your dog happy. Seriously, if we're going to be looking at this, I think that's the intention, the crisis we need to figure out, and may be politically the most difficult thing to do. But what you're pointing out to us, Steve, is even if we level them we'd still be seeking huge increases in the amount of money people are spending on pharmaceuticals. And if we only look in prices we're missing a whole lot of the (inaudible).

MR. KAPPEL: Exactly.

ATTENDEE 1: It may be very limited what we can

do with prices. It may be more than (inaudible) can do with all the other components but if you're going to understand it and to try to do something about it we got to understand all the various pieces of it.

MR. KAPPEL: Exactly.

ATTENDEE 4: Well, we are more limited than we think probably because like the utilization of the meds and stuff when the (inaudible) issue when the room rent is setting up, that crafted this and we, there is the ability to have some input on less expensive, less invasive pharmaceuticals.

ATTENDEE 4: I would like to know why -- you said it slowed down?

ATTENDEE 2: No, we need to be proactive, I think.

ATTENDEE 1: But it's a complicated one.

ATTENDEE 3: I know from my own personal experiences from people like who are looking for pills to cure everything and whether it's I love to eat as much as I want, is there a pill out there to make me lose weight at the same time. They expect patients to be consumers.

ATTENDEE 1: But can we also find out why. He said the rate is slower now, the growth is slower. you're asking why is the growth slower but also what

is, what does he mean by that, is it one percent over last year, I missed that.

ATTENDEE 1: He didn't put a number on it.

ATTENDEE 4: He said the growth is now slowing. The growth of expenditures, not necessarily the growth of (inaudible) so we don't know.

ATTENDEE 1: It's increased and not as great as it used to be but still greater than overall (inaudible).

ATTENDEE 4: I'll follow up with Steve to make sure.

ATTENDEE 1: I'll state one of my (inaudible) here on this issue and in general. He spent a lot of time trying to say to people, (inaudible) we're going to reduce your health care costs but a lot of it is being driven by what we are demanding and what we have come to expect in health care and it's very hard to go back and say -- I did this once in a campaign for public office at a Rotary Club and people were talking about health care costs being completely out of control and I asked give me a show of hands of how many people here have had a hip replacement or somebody in the family had a hip replacement and 20 hands went up; cataract surgery, 20 hands went up.

I mean, we're getting a lot out of this health

care system we never used to get out of it. I pointed that out to them. It's a way to educate people who (inaudible) and (inaudible) what we as a society are asking and those of us around the table are trying to respond to that. I find it's very (inaudible).

ATTENDEE 1: Really.

ATTENDEE 3: We all want everything for ourselves and family and friends, but we want to stretch the system.

ATTENDEE 4: What about the school, high school.

ATTENDEE 1: It's almost the same.

ATTENDEE 5: So, please tell us what we can do.

ATTENDEE 2: Well, we're not quite there yet but we will be.

What I'm going hand out now we are going to talk about some of the Vermont cost containment programs that we've already implemented and then some ideas for you to consider but before we go there we thought it would be helpful just to provide and I won't go through this entire document but this is a document that was recently put out by the Congressional Budget Office which is a unit of the Federal Congress, they're a non-partisan entity that provides fiscal analysis mostly to help Congress with their budget

issues but they do a lot of good work and this is a particularly, I have a bunch of extras with Jan, and go around the room.

There we go, all set. Yeah.

So again, this is just for background information. It's a document specifically on prescription drug pricing in the private sector although it does reference also some of the Medicaid pricing schemes.

So, it's very helpful and I'm going to point out two tables which maybe we could look at very quickly just to kind of refresh our memories. I know some of this might be a bigger picture than you'd like but on Page 5, Figure 2, this is just a table that described the supply chain of drugs from manufacturers to wholesalers, to both retail pharmacies and non-retail providers and consumers and it gives a breakdown of, you know, percentage where the drugs are going through that process.

I should mention, you know, what is really helpful I think in this document, well, it gets very complicated, are the various market transactions that ultimately impact what the final price is. So a lot of that information is in here.

On Page 11, there's a little more specific

information not only of the drugs supply chain but also the flow of funds. So, you can see this is the table that includes the pharmacy benefit manager and what their role is and who they negotiate with, both drug manufacturers, pharmacies, health plans and it starts to get more complicated and as you know, pricing generally is pretty complicated because it's not always transparent and that's been one issue that's been at the forefront at both the national level and the state level.

ATTENDEE 4: So, then within this diagram on Page 11, we may be able to identify cautious -- that cause increased prices overall, right, so he's supposed to save money through your PBM, than the manufacturer must make that (inaudible).

ATTENDEE 2: Sure, yeah --

ATTENDEE 4: -- (inaudible) expenditures.

ATTENDEE 2: It is an inter-related system like every aspect of health care. And then the final, just part of this document is the very last page, it's the glossary of terms, so each of the definitions of prices, like average manufacturer price, average wholesale price; all those relevant terms that come up frequently if you need to refresh your memory.

ATTENDEE 2: The last time pharmacy, one of his (inaudible).
ATTENDEE 4: The pharmacy (inaudible).
ATTENDEE 2: The next thing we are going to hand out, this is now, we're going to get back to the Vermont specific level and I think Robin is going to start and go through, this will begin a description now of her current program and some of our cost containment initiatives and then like I said follow up with some proposal that has been on the table that you could consider.
MS. LUNGE: So, we've already discussed in this committee what prescription drug programs we offer through Medicaid so I won't spend much time on this. But you'll recall that in the Medicaid Program we we offered prescription drugs through Medicaid itself, the Vermont Health Axis Plan, Dr. Dinosaur, which again Vermont Health Access Plan is our plan for single adults; Dr. Dinosaur is our kids' plan. V-Farm which is your wrap-around program for the Medicare Part D drug benefits, and Vermont RX which again provides pharmacy coverage for non-Medicare eligible elderly and disabled individuals and we also have a Healthy Vermonter's discount card which provides the Medicaid price to other Vermonters who do not have

other prescription drug coverage.
ATTENDEE 4: How would I get one of those cards?
MS. LUNGE: You would apply through Vermont Health Access, Department of Children & Families and you'd have to show that you were elderly or disabled, up to 400 percent of federal poverty which is about 45, 4400 hundred dollars, or if any Vermonter with under 300 percent income which is for a family of two, about 3300, you could apply and for both of these programs you either have to have exhausted your prescription drug coverage or have no prescription drug coverage.
So, with Medicare Part D many people will have coverage and less people would be eligible now for Healthy Vermonters than we initially.
ATTENDEE 4: How many people are in that program?
MS. LUNGE: I don't have the current figures but I can get them for you.
ATTENDEE 1: Will you get that for each of those categories?
MS. LUNGE: Yes.
ATTENDEE 1: Great.
ATTENDEE 4: When Steve was here how powerful the fact that the pediatricians in Vermont, maybe

nationally, have said that they were handing out too many antibiotics for ear infections for kids or babies and so they stopped doing it. They stopped more or less, I mean you don't go in, when my kids were small you handed out antibiotics like more readily.
Now, they are very hesitant to give out antibiotics for ear infections or for certain colds and flu and viruses, and I would say if somebody you would find there would be very little antibiotic prescriptions for kids now compared to last year or the year before when they came out with this so I'll keep in mind that the medical community, that they are a very powerful force and they can direct a lot of things other than the insurance companies and that they should hold the power and cut down on drugs and supplies.
(Inaudible comments among committee.)
MS. LUNGE: So, the next slide lists other areas that we spend state dollars for drug purchasing so Cantamount (phonetic) Health of course will have a prescription drug component when that starts October 1, 2007.
The Vermont State Employees Plan has a prescription drug component and teachers and municipal

employees as well.
So, that's just to give you a general sense of all the different state drug purchasing that we do and of course I did not list but should have said Department of Corrections.
ATTENDEE 1: The first (inaudible) at this point.
MS. LUNGE: It's my understanding that currently Cantamount Health will I believe, each insurer will set their own formulary. It wasn't specified in the bill they would follow the Medicaid PDL, and the Vermont state employees looked at it and decided not, I should say, that not the state employees' union, but the Department of Human Resource had a report to help access two years ago on this issued and decided that they didn't think it was feasible for them to follow the Medicaid price as opposed to looking at it in terms of unifying their buying power to doing joint negotiations. So, that is an issue that I think could still be considered.
ATTENDEE 1: So, what does the employees use (inaudible).
MS. LUNGE: No, they use their own formulary; they also have a preferred drug list, but it's a different preferred drug list than Medicaid I

believe.
ATTENDEE 1: Anything else?
MS. LUNGE: I'm not sure, maybe we can try and get more specifics about each of the different groups in terms of exactly what their preferred drugs looked like and that kind of thing. I'll make myself a note. Okay.
So, the next slide looking at some of the cross control programs and preventing our public programs meaning Medicaid and our Medicaid extension programs.
So Medicaid has contained several cost containment strategies, one of which is the preferred drug list that we were just discussing, and I'm going to go into that in a little bit more detail in the next couple of slides.
The other thing I wanted to mention is that Vermont is part of a multi-state purchasing pool where we join together with Maine and Iowa in what's called the Sovereign State's Drug Consortium to negotiate together as three states with drug manufacturers to leverage buying power by increasing the number of lives that we're negotiating on behalf of.
ATTENDEE 1: And this is still with Medicaid?
MS. LUNGE: This is still Medicaid. And currently Medicaid is using a non-profit pharmacy

benefit manager. That was something that was discussed in the legislature a couple of years ago; didn't pass in legislation but OVHA has done that in their own review when their PBM contract came up and we're currently with Med Metrics which is a PBM that was started by the University of Massachusetts Medical School.
ATTENDEE 1: What is there that prohibited them from handing (inaudible) for state employees for example --
Is there, was this stuff only given for Medicaid eligible?
MS. LUNGE: Yes. Medicaid by federal law is required to get the best price or the lowest price in that particular state.
So, for instance the state employees can't get the Medicaid that's priced because the Medicaid would need to get a lower price because it would no longer be the best price.
ATTENDEE 1: How does that price compare to like the federal supply schedule?
MS. LUNGE: It's higher than the federal supply schedule. It's a little bit hard to get the specifics of how they compare in actual dollars because a lot of the pricing information is propriety. We can try and

and get more specific comparisons about that if you're interested in that level of detail about the price comparison, but the Federal Medicaid law specifically exempts federal prices from best prices and that's because they were lower, because it's lower and when they were part of the best price the federal prices went up and the federal employees didn't like it. That's part of the policy reasoning behind that.
So it had been, they were included, not as an exemption for federal programs.
In addition, Medicaid has incorporated coverage of over-the-counter and generic drugs in their preferred drug list so that Medicaid will cover certain of those drugs as a way of decreasing and controlling costs in the Medicaid Program where they are therapeutically equivalent to a brand name drug, but generics often are cheaper, not always, but often.
Also, we've implemented what's called the maximum allowable cost program in Medicaid for generics, which means that we set the maximum allowable price that Medicaid will pay for certain generic drugs.
ATTENDEE 2: In the coverage of generic drugs does it include non-drug (inaudible)?
MS. LUNGE: Right, you mean like Ibuprofen?

ATTENDEE 2: No. St. John's Wart and --
ATTENDEE 4: Other --
MS. LUNGE: Supplements -- not supplements but --
ATTENDEE 1: But there's a lot of ways of treating something and that doesn't have to be a chemical. I mean rosewater for your eye infection because it's all based on rosewater anyway.
MS. LUNGE: I'm guessing no but I don't know that for a fact so I can follow up with OVHA's drug person and ask them that question.
ATTENDEE 4: So, I would think that we would want to move in that direction.
ATTENDEE 1: What's wrong with --
ATTENDEE 4: Well, rosewater, a friend of mine was in South America. Got an eye infection, went to the little woman who gave out the doctor stuff. She gave him rosewater which was unspoiled roses, so it's rosewater and glycerine, sugar, right. And that's what she gave him for his eyes, cured it and came back to the United States; got an eye infection, the doctor gave him a prescription; he went and filled it and 30 dollars for a little bottle like this, he looked at at, what's in it. That's what the basis for it was, it had a few chemical names so I mean, I just think --
ATTENDEE 1: (Inaudible).

ATTENDEE 2: Right.
MS. LUNGE: So, the next couple slides provide you a little more detail on preferred drug lists. So, as we and we've pretty much talked about the main points in the first slide which is that there are federal law and regulations on pricing and prior authorization in Medicaid preferred drug lists, and but a lot of the administration of the preferred drug list is done at the state level, just like with Medicaid in general.
In Part B it will be private insurers setting formularies for each of the Medicare drug plans, and I just wanted to mention because it was in the news that last week the House, the U.S. House passed a bill that would allow the federal government to have a role in negotiating drug prices in the Medicare Part D program That bill that passed is --
ATTENDEE 3: (Inaudible) Whether they do it or not is (Inaudible).
MS. LUNGE: Yes. Right.
MS. LUNGE: So, that bill and I do have a copy of it if anyone is interested does require the secretary to negotiate with pharmaceutical marketers for prices that may be charged to the pharmacy, the PDP sponsors for Part D drugs. It doesn't establish a formulary

or a preferred drug list at the federal level, however, so that's part of, cost containment was not included.
So --
ATTENDEE 4: Can we do it in the state, authorization that we could do that?
MS. LUNGE: No, we don't have authorization at the state level to really do anything in the administration of Medicare. This is a completely federal program.
So, we provide wrap-around coverage at the state level as part of the our Medicaid Program but the feds have full prerogative over Part B.
ATTENDEE 4: So, it's not people in Vermont who are over 65 who are on Medicare insurance? They have gone off and bought Part D insurance, pharmacy insurance from AARP or other companies?
MS. LUNGE: We have some limited oversight in terms of the regulation of the Part D plans in the insurance context but in terms of the preferred drug list or the benefit context, just to be a little clearer, we can't tell PDPs how much they can charge or what formularies they can use.
We can regulate PDPs as insurers like we can regulate other insurers although there are federal provisions that we have to comply with there a
ATTENDEE 4: Did you just read to us that th federal government passed a law saying that all the pharmacy folks Part D passed to find the best price from distributing drugs?
MS. LUNGE: No. The federal secretary of human services has to negotiate with the pharmaceutical marketers for prices that then can be charged by the PDPs but that's all at the federal level.
ATTENDEE 2: I know it was passed by the House.
MS. LUNGE: Yeah, not by the Senate, yes. So, it's pending.
ATTENDEE 4: I'm trying to understand what that means for us.
MS. LUNGE: Well, if the federal secretary of HHS is able to negotiate lower prices than the PDPs currently charge then Vermonters would see savings from that, but at this point it still needs to pass the Senate and then it would need to get, the negotiations would have to happen, so I think it's a little premature to say exactly, you know what...
ATTENDEE 1: Has there been any announcements of all the different Part D plans to show how they bid on, you know, a graph of best prices and FSS and so on and forth where the different Medicare Part D,

how low they've been able to negotiate?
MS. LUNGE: I know there is some information about the PDP pricing. I haven't seen that comparison but I'll ask Steve and we can look for that to see if we can get that.
ATTENDEE 1: Maybe there's no savings, who knows? Maybe there's a lot of savings to be found.
MS. LUNGE: Right, and I think, there certainly is some information on PDP pricing in relation to other pricing and I just, I don't have that off the top of my head. I'll find it.
ATTENDEE 4: That's why everybody passed the supplemental insurance before this legislation, to pay for all the pharmacy if you're 65 and over and they were able to charge with the big money because they picked up all the (inaudible) or most of the (inaudible) charge, so, they must have that information, the insurance company.
MS. LUNGE: They might, yeah.
So, in our Medicaid, Vermont Medicaid Preferred Drug List we are balancing cost and quality in that comparison. We do prefer over-the-counter and generic drugs to brand name drugs which is a common strategy in preferred drug lists as a cost containment mechanism and it's part of being on our preferred drug

list manufacturers agreed to provide the Medicaid program with supplemental rebates.

So, that is one of the other cost containment mechanisms inherent to the PDL system that we have established.

In addition, we do have a prior authorization program in our PDL which allows an individual to get a drug that's off the preferred drug list if there's a medical reason for that.

So, we have, what I do is basically to summarize, so we have what's called an open formulary type of system where you are not restricted to just the drugs on the preferred drug list. You, the patient, can get other access to other drugs through the prior authorization process.

ATTENDEE 4: So, in our Medicaid Program who is negotiating? Do we have a PBM right now negotiating?

MS. LUNGE: Yes. We have a non-profit PBM Med-Metrics.

ATTENDEE 4: Right. And how does that work, how, give me how does it work? So, in that negotiation is for only the drugs that are on the list. Is there any other negotiation beyond that?

ATTENDEE 1: Don't they also allow, let's say you negotiate price and aren't other companies allowed to

match that lower price?

MS. LUNGE: I don't know the details of how we negotiate the PDL but I'm sure that Joshua Slein or one of his --

ATTENDEE 3: I'm sorry, I didn't hear the question.

ATTENDEE 1: On the preferred drug list, okay, if something has been negotiated down, Lipitor say you've negotiated down, it's probably not one of the ones there but just say it is, and whatever the competing drug for that is a higher amount, does the preferred drug list in the state allow the competitor to lower their price within the program or not?

ATTENDEE 3: I guess they can, that's a voluntary measure but that's not on the preferred drug list, it is the preferred drug as far as the agency is concerned.

MS. LUNGE: Right, and I don't know if they have two drugs in the same therapeutic class or not, so that would be a question I think, for more details on that would be Josh Slein, someone in his shop.

MS. ROYLE: I think we did review the formulary periodically and open up the negotiations and try to promote that competition among drug companies.

ATTENDEE 1: Does it go to the pharmaceutical

board?

MS. LUNGE: There's a drug utilization review board which reviews the information and makes the recommendation. The final decision is I think Josh Slein at OVHA.

ATTENDEE 4: We never heard from the pharmaceutical board.

ATTENDEE 5: We did once.

ATTENDEE 1: (Inaudible).

MS. LUNGE: So, I think we'll keep moving because we want to get to your new initiatives as well as our current initiatives.

ATTENDEE 4: That's all the questions.

MS. ROYLE: What we're to talk about next are the strategies that relate to more generally, not just our public programs, but to pharmacies and providers. The first law our program we're going to talk about is our generic substitution law.

What this does is it requires the pharmacist to select the lowest price chemically and therapeutically equivalent drugs. So, if you walk in your pharmacy and you have a prescription, the pharmacist can make a generic substitution if that is cost effective.

There are provisions in the law though that allow the prescriber to opt out and specify that only

the brand name drug, there should be no substitutions and there are also provisions that allow the consumer to get the brand name drug or the higher priced drug provided that he or she pays the difference. So, that's one program.

ATTENDEE 1: Any information on how effective that is? Has anybody ever studied it and saved us X dollars?

MS. ROYLE: I don't know.

MS. LUNGE: I think Steve Kappel is looking at that issue generally in terms of our current cost containment initiatives and whether or not we can find out to do that so we can ask him specifically on this.

ATTENDEE 1: When we talked about things we've already done there's an assumption that they're working.

MS. LUNGE: Right.

ATTENDEE 1: How well, which is most effective and what's the least effective, because if we're going to try something new this year we may as well start with what's standing and works and what doesn't work.

ATTENDEE 4: Right.

ATTENDEE 1: So, to the extent that there's

studies in any of this --
MS. LUNGE: Yeah.
ATTENDEE 1: Maybe you can guide us.
MS. LUNGE: Yeah, and there are several other states that have similar provisions so it's possible in other states it's been studied on a national level so even if we don't have Vermont data we'll try and see what we can find.
ATTENDEE 1: Find one of the things that can work.
MS. ROYLE: I was going to say it's not a bad idea to think about for whatever legislation you consider to put it in an outcome measurement requirement so that it is something up front, you know, that it's going to be studied and that's legislative prescribed.
ATTENDEE 4: Don't we (Inaudible). I mean you were here and you just came back, I'm sorry, but I the pharmacy, (inaudible) the 10 million dollars for the state at first --
ATTENDEE 1: They're also on the preferred drug list.
ATTENDEE 3: I don't know how I'm supposed to say it but I don't know if it has the methodology to put in there to actually figure out whether it would

save that much money or not.
ATTENDEE 3: We booked it, it's in the budget, so.
(Laughter).
ATTENDEE 2: (Inaudible) Organization.
MS. ROYLE: So, the next program is really about drug price transparency. It's a pharmacy drug price disclosure law and what this does is allow consumers when they go into a pharmacy to request the price of a drug so that they can compare it with other pharmacies and when the pharmacist gets the request, he or she is required to provide the usual and customary price which is the price that an uninsured person would pay for the drug and the reason why it's that way is because the pharmacist doesn't know the price by plan, by individual consumer that walks in or the health plan until they actually run the transaction and it comes up in their software but at least having a usual and customary price would allow the consumers to educate themselves and that would be helpful, but when a drug is actually dispensed the information that then should be provided to the consumer is not just the cost sharing amount but the actual price of the drugs and this is mostly kind of education purposes so the consumers are aware, even though they're not

actually paying the full price, the plan is, but they know, have a better sense of where their money is going and what the price of drugs are.
We also wanted to talk about the next slide, the counter-detailing program. What this is, just to refresh your memory, when drug companies hire marketers to do what's called detailing, it's when often they meet with prescribers and basically market their drugs and try to talk about, promote a specific drug, usually a brand name drug. But they don't always provide information about other therapeutically equivalent drugs that are available or generic drugs that might be just as effective and cost a lot less, so the idea behind this program is basically to provide that education to providers so they are not just receiving one-sided information that's trying to steer them away specifically from generic drugs.
So, there was a report, this was OVHA was required to prepare and I think they did the report, it was due a couple years ago, I'm not sure that the program has actually been implemented, so that's actually something to flag.
ATTENDEE 1: What do you mean by counter-detailing? We talked about this for five years.

MS. LUNGE: It's been around. I know.
ATTENDEE 1: I want to actually --
ATTENDEE 4: AHEN (phonetic) is doing some of this through some other trade (phonetic).
ATTENDEE 1: A counter-detail?
ATTENDEE 4: Yes.
ATTENDEE 1: Does somebody have that business card?
ATTENDEE 2: Well, we know what a detailer is. We ought to pinpoint somebody that's actually going to counter-detail even if it's a website (inaudible) because I'd like to know exactly what's going on.
MS. LUNGE: Pennsylvania, the state of Pennsylvania has a statewide, oh, maybe it's not statewide, but they have the gun, evidence based counter-detailing program for physicians and that's run out of their Medicaid office because they are doing it as a way of trying to save money in their Medicaid Program. And so I believe they're rolling it out incrementally and so, there are really counter-detailers. I don't know if they're in the State of Vermont but they are in Pennsylvania.
ATTENDEE 1: Would that report, that was due January 1st tell us anything?
MS. LUNGE: It was supposed to detail all the

parameters of the program, what they're going to do, so I'd have to --
ATTENDEE: It will tell us how many counter-detail there are.
MS. LUNGE: Maybe a counter counter-detail.
MS. ROYLE: I can follow up with OVHA.
ATTENDEE 1: Would you --
MS. ROYLE: Sure.
ATTENDEE 1: Again, if we're going to try new things let's find out maybe we can do small things or (inaudible).
ATTENDEE 2: The sad part of this is when I was in the House when we passed this bill.
ATTENDEE 1: Why is that sad?
ATTENDEE 4: It was a long time along.
ATTENDEE 2: It was at least five years ago.
ATTENDEE 1: Oh, yeah.
ATTENDEE 2: I can't really tell you what we've really done.
MS. LUNGE: We haven't implemented this program yet because I believe OVHA needs funding to implement it and they haven't gotten that funding so it's in Statute but it's not --
ATTENDEE 1: Is that part of the statute that they didn't have to implement it until we gave them

funding?
MS. LUNGE: No.
ATTENDEE 1: We have to go back. It was John (inaudible), and Nancy Chart (inaudible) and it was myself, Tom Koch and Patty O'Donnell on the House side.
ATTENDEE 4: Boy, you got a good memory or you just made it up.
(Laughter).
(Inaudible discussion among committee).
MS. ROYLE: Senator Lieman in the (Inaudible) program does have a counter detail. I think it's in its fourth year, they do a different drug every year so it's based on cholesterol, Nexium-type drugs, depression drugs. They have done four classes of drugs, and they have two counter-details. Amanda Kennedy and Dr. Pinkley, a pharmacist and a doctor who goes out to the office to do a little type detailing presentations to the doctors.
ATTENDEE 1: What other offices (inaudible).
ATTENDEE 4: I think it's pretty small but OVHA hasn't picked up this model. I think OVHA, might tell you what they're doing is retrospective review. They look at the plain data and say Dr. Mondy (phonetic) is prescribing too much. And then they me write a

letter; Scott gives me a call.
ATTENDEE 1: One of the things that Robin and I have been talking about with data mining. Do counter-detailers use data mining at all?
ATTENDEE 4: What's data mining?
MS. LUNGE: No, the counter-detail we talked about that's practices; what is the cheaper drugs, what is the better clinical drugs to use, how you can use a generic drug to treat whatever, the prices, whatever conditions they are working from, but they tell you, talk about that practices.
The data mining, all it does is data mining of all the prescriptions that are written by all the Medicaid professionals and their goal I think is to give every doctor, every primary care doctor a report of all the drugs that they've prescribed, they seem to be not quite getting there.
In other words, a monthly report, this is the drugs you're prescribing, they really aren't there yet.
So, there are other data mining companies but that's for another day.
ATTENDEE 1: So, basically we all (inaudible) good miners go and passed a law and we have all these counter detailers and we met two, so...

ATTENDEE 4: And they are (inaudible).
ATTENDEE 1: We must be funding out though right?
ATTENDEE 4: No, it's grant funded. My hope at least to be outreach education for best practices rather than spending lots of money getting your list of what you're prescribing, or mind turning what you're prescribing telling, you know, I don't like what you're giving out this and this over the quota.
MS. LUNGE: I believe what Pennsylvania has done in their counter-detailing program is a combination where they can review prescribers through the Medicaid Program to see high utilizers of more expensive drugs but then they don't approach the doctor and say you're doing this wrong, they say here's best practice, let us give you some more information.
ATTENDEE 4: Right.
So, I think they try to combine the approaches.
ATTENDEE 1: But the problem is to do the research and go out and find which doctors are (inaudible) themselves.
ATTENDEE 4: I'm sure, right.
MS. LUNGE: Right.
ATTENDEE 4: Well, I mean, that's how drugs are

sold anyway, you bring your dog and your little (inaudible) to the doctor's office and get in and talk with the nurses and hand out chocolates and leave off all your drugs, and the doctor goes, oh, he was wonderful and I like him, and I like his product. That was the old way of selling drugs to the docs.

ATTENDEE 1: I hadn't heard about the dog.

ATTENDEE 4: That's the detail, right. Especially with the allergies --

ATTENDEE 1: Why don't we keep going. Thanks for going astray.

MS. ROYAL: We're withholding cookies and milk people.

ATTENDEE 1: It's a mutiny in here.

(Laughter.)

MS. LUNGE: We can't compete with cookies and milk, is that what you're telling us. Maria and I --

ATTENDEE 1: Keep trying.

MS. LUNGE: Okay.

ATTENDEE 3: Where are we?

MS. LUNGE: We can be pretty quick, how long are cookies and milk available?

ATTENDEE 1: I'll ask Senator Kittell. She seems to be focused.

ATTENDEE 3: Well --

ATTENDEE 4: I wanted to put the insurance thing --

ATTENDEE 3: -- cookies and milk.

ATTENDEE 4: I think it's available until 4:30. The governor is speaking roughly at 3, so --

ATTENDEE 1: You want to hear that?

ATTENDEE 4: I want to put an appearance in.

ATTENDEE 1: Okay.

ATTENDEE 4: So, 4:30.

ATTENDEE 1: It's 3:06 now.

ATTENDEE 4: Right, so I would think that --

ATTENDEE 1: You want to go up?

ATTENDEE 4: I would say shortly I'd like to go up.

MS. LUNGE: Then you'll come back and finish this?

ATTENDEE 4: I would think 15 minutes would be good.

ATTENDEE 1: Only 15.

ATTENDEE 3: Who is bringing the cookies and milk.

ATTENDEE 1: See how quicker Maria and Robin will be after they've been (inaudible) those cookies and milk. Why don't you go now.

MS. LUNGE: I have an appointment at 3:30 so --

ATTENDEE 2: I have an appointment at 3:30 as well.

MS. LUNGE: Let's go and we can do it quick. So, this isn't the section, 40-B drug pricing program. These are programs that are certified by the federal government. They serve vulnerable patient populations, the traditionally underserved people and as such these clinics that are certified by the federal government receive discounted prices on prescription drugs because there has been a push to increase access to be afforded these programs, like FQACs for example, and also to encourage entities that serve these populations to achieve the FQAC status or FQAC look alike status. But, again, just another way to promote access to cheaper prescription drugs.

ATTENDEE 1: Do we know what this one says?

MS. LUNGE: I knew you were going to ask that; I don't know, but we'll look into that.

ATTENDEE 1: I'm serious. As you go through these things, as the basis for what we might want to do.

MS. LUNGE: Yeah, absolutely.

ATTENDEE 1: But I don't want to go and

Senator Mullin) is sitting at a conference tape and feel good what we've done and (inaudible) it's all over, seriously.

MS. LUNGE: Yeah, I think that's a great point.

Do you want to do importation?

MS. ROYLE: Importation, this is sexy and exciting.

U.S. Law regulates a sale of drugs including the importation of drugs and this is the area that many people call reimportation which is technically legally a misnomer, so the gist of this is there's federal law on importation. It prohibits importation except that the FDA has done some guidance saying if you're doing it for personal use we will not enforce it.

It's still illegal but it's not enforced currently by the FDA.

In addition, the FDA has authority to approve importation programs. To date no program has been approved; Vermont applied, we were denied, we appealed and we lost in court.

ATTENDEE 4: Like the Illinois thing?

MS. ROYLE: No. That's next. What we have done on importation is join what's called the I Save RX

Program which was started by the State of Illinois and basically, it's Illinois, the state, does contracts with the PBM in Canada to provide drugs at Canadian prices to individuals and so it's a program that individuals would sign up and through I Save RX to get the drugs, the state itself is not involved in that, the state of Vermont is not involved in that transaction except that we have entered into a memorandum of understanding with Illinois.

Illinois does do some review of the Canadian suppliers so that they feel comfortable with it, et cetera.

ATTENDEE 2: (Inaudible)

MS. ROYLE: How many suppliers?

ATTENDEE 2: No, how many are enrolled.

MS. ROYLE: You know, I actually have been trying to reach the I Save RX people in Illinois and I haven't been able to get our Vermont enrollment numbers but that is something that we are working on getting.

ATTENDEE 2: And what's the test base for the lack of the Pro (inaudible)?

MS. ROYLE: I think it would be a combination of the FDA talking about patent protection of U.S. pharmaceutical manufacturers but also the FDA has

expressed some safety concerns because they themselves don't necessarily inspect the out of country suppliers.

So, there's also some labeling differences for example. The FDA says certain drugs have to be labeled with certain information. That may be different in different countries so if you're getting a drug from another country you may not get the same information on the label as you get here; that kind of thing.

There have been efforts federally to change law on importation in the past and I guess we'll see what happens if anything on that in the future.

As part of I Save RX we did pass an insurance provision which said that insurers in Vermont would cover drugs purchased in I Save RX to the same extent that they provided pharmacy coverage.

Pharmaceutical marketers. So the next two programs are related to drug companies and again they promote transparency.

The first one, the pharmaceutical marketing disclosure law requires drug companies to file annual reports with the Attorney General detailing all the money that they spend on marketing, gifts, so on and so forth and the recipients of that money and this is

just information then that the Attorney General keeps and must keep the proprietary information confidential but it's a way of kind of keeping track of where the money is being spent.

The next program, the marketer price disclosure, this requires when marketers do their detailing and go to prescribers. It requires them to provide average wholesale price of the drug that they are marketing but then also the relationship to other drugs that are in the same therapeutic class, so it's an indirect way of getting kind of to the counter detailing but it's asking the marketer to actually provide that information, so that instantly a prescriber is aware of what other drugs are available and what the pricing schemes are.

So, now we are going to talk about some possible cost containment strategies that reflect proposals that have come up in the past, so most of you all are probably pretty familiar with some of these and the first one we're going to talk about generally is PBM regulations and this is something that's come up, as you know because PBMs do negotiating with drug companies and there has been a push for greater transparency in their practices, so that the health plans that hired the PBM are aware of the rebates that

the PBMs are securing; how much money they are keeping for themselves and how much is being passed on to the health plan and ultimately the consumer.

Sometimes historically it's been documented that PBMs will actually substitute higher priced drugs because they get a bigger rebate from the drug company so the consumer is actually paying more but the PBM is doing that because the PBM is possibly making more money.

So, part of the regulation would require the PBM to have fiduciary duty to the health plan, act in the best interest of the health plan and basically greater transparency, allow for auditing, a whole number of schemes that would promote those objectives.

ATTENDEE 2: Can that be done at the state level or is that federal?

MS. ROYLE: No, that can be done at a state level. Theoretically it can be done without a state law. For example, a state could negotiate a contract with these terms in it, you know, but the idea is maybe there isn't bargaining power for most health plans and if there were state law making it a requirement in business it would be one way of addressing.

And then there's conflicting testimony about

how much money it would save and whether it would actually disadvantage the PBM if they couldn't engage in confidential negotiating. That you'll hear about.

(Inaudible discussion among committee).

ATTENDEE 4: What did we have in statute because I know that the (inaudible) entered into an MOU with a PBM and I was trying to remember if we captured that in state law and offered any direction.

That hasn't happened yet?

MS. ROYLE: I don't think so.

ATTENDEE 1: That's what --

ATTENDEE 4: So, it would be interesting to to know what the --

MS. ROYLE: I can follow up on that and incorporate it in the new contracts with the non-profit.

MS. LUNGE: They just recently changed to this non-profit PBM, I think in 2005.

ATTENDEE 4: But that was an administrative decision.

MS. LUNGE: Yes.

ATTENDEE 4: We haven't offered any direction legislatively.

MS. LUNGE: We had offered direction on OVHA

considering a non-profit PBM, or doing some of their own negotiating, and I don't remember if that was an S-28 but it was definitely an H-524 which was vetoed.

ATTENDEE 4: Yes, vetoed.

MS. ROYLE: So, it passed both houses but it was then vetoed, so it didn't become law.

ATTENDEE 2: There's a preemption issue here, right?

MS. ROYLE: A possible ARISA issue, is that what you're getting at?

MS. LUNGE: I just want to mention there are two states that have enacted PBM regulations, Maine and Washington, D.C., and both laws are both being challenged in federal court. The main law was approved at the First Circuit level; it's been appealed to the Supreme Court but the U.S. Supreme Court has not agreed to review the case.

There's a D.C. case that's been winding its way up and recently at the Circuit level they remanded the case to consider, reconsider the prior holdings in light of the First Circuit case.

If the D.C. case conflicted with the First Circuit case there's a good chance it would then go to the U.S. Supreme Court to resolve that conflict in federal jurisdictions, but that's just to let you know

that there is litigation out there and it's not entirely clear.

ATTENDEE 2: With the Supreme Court makeup, I wouldn't be able to (inaudible) --

MS. LUNGE: What's that?

ATTENDEE 2: Given the Supreme Court makeup.

MS. LUNGE: Oh, I don't know.

ATTENDEE 1: Well, both programs are still operational though?

MS. LUNGE: Neither of the programs have started.

ATTENDEE 1: So that means they are allowed to start.

ATTENDEE 2: Right.

MS. LUNGE: Maine was enjoined in the District Court then but then the First Circuit listed the injunction and I think ruled in favor of the state and summary judgment, so I don't know.

MS. ROYLE: I don't think they've implemented ye because that wasn't that long ago that that all happened.

MS. LUNGE: I'm not sure.

ATTENDEE 1: Was this -- Not being here I'm not familiar with H524. Was this the sum total H524 or --

ATTENDEE 2: No, this was the --

ATTENDEE 1: -- the basis.

ATTENDEE 2: The entire bill.

ATTENDEE 1: So, was it vetoed the bill or was it vetoed because of this provision?

MS. LUNGE: No.

ATTENDEE 1: So, if we wanted to run this thing through again it might -- we're the First Circuit aren't we?

MS. LUNGE: The Second Circuit.

ATTENDEE 1: Oh, the Second Circuit.

MS. LUNGE: So, actually neither of them.

ATTENDEE 4: We can look at the section that says --

ATTENDEE 1: Could we get a copy for that, just that section, 5.1 so we can --

MS. ROYLE: I think S288 was there. It was the one that passed both the House and Senate, but we'll find that --

ATTENDEE 1: And were there objections from the Governor on that provision or was that not part of the C proposition?

MS. ROYLE: I'd have to check, I'm not sure about that.

ATTENDEE 1: Okay.

ATTENDEE 2: Why did we write it if it's all in

there?
(Inaudible discussion among committee members).
MS. LUNGE: So, the next strategy that we're going to talk about generally is the state regulation of drug prices and I'm giving you several different models that are out there. But the first slide there's three different models; the first is the prescription drug sale price program which was in S288 and was considered by the Senate and it is based on some of the provision in Maine RX and Maine RX also established a lot of their pharmacy programs.
At one point there was a lawsuit under Maine RX. This part of Main RX was enjoined and not appealed, so it's not actually implemented in Maine, but what the Vermont version did was allow the state of Vermont to set prices for all drugs if the prices of drugs in the Healthy Vermonters Program did not meet a particular statutory target.
Another model is also from D.C. They just passed last spring I believe an unconscionable pricing law which basically said that if the price that citizens in D.C. were receiving was 30 percent higher than comparable prices in any high income country that the state or the District could step in to determine that an unconscionable price and if the state or the

District then did that the drug company could come back with demonstrated costs of invention, development and production to show that actually the price was

justified. That is also in litigation and hasn't been decided on any level at this point.
ATTENDEE 2: What's your definition on unconscionable?
MS. LUNGE: There is a legal definition of unconscionable in other areas but for instance in many states have unconscionable pricing laws that apply sort of generally and I do have a summary of all the different definitions out there and there's a number of different ways that you can look at it. So if this is something you want to look at, we can review the different models for what you trigger.
ATTENDEE 2: Do they use DVD for the DV model for the comparable (inaudible)?
MS. LUNGE: I'm not sure, I haven't studied it that carefully but I can look at it and see if that's what they used.
ATTENDEE 2: (inaudible) Yeah.
MS. LUNGE: In addition, several states introduced bills with similar provisions; Hawaii, Colorado, sorry about the typo, and New York and

they each looked at the definition of unconscionable slightly differently so there's just three examples of other bills in other states.
The next strategy that has been discussed and this is from the last -- It might have been two meetings ago of NLA RX, the National Legislative Association of Prescription Drugs. There is some discussion as state's implementing State False Claims Act and under the Reduction Act of 2005 it allows the states to be eligible for more money under the Medicaid False Claims Act if the state has a State False Claims Act which meets certain federal criteria and there are models out there and more information at this website I've listed.
The next line discusses something that we touched on already which is prescription drug information and confidentiality. Senator Mullin raised the issue of data mining which is a practice that is sometimes used by drug manufacturers in their marketing so they're able to take data which has been de-identified by patients but still contains the prescriber FDA prescriber number and in some circumstances can actually match up the prescriber number with the doctor and see the doctors' prescribing patterns and then use that in their marketing so they can

decide which doctors are more likely to try new drugs for example or prefer certain plans.
And there is a law passed last year in New Hampshire that prohibits the use of prescription information for commercial purposes such as marketing. There are some exceptions for aggregated data meaning for instance statewide data would be an example of aggregated data and non-commercial uses so one of the things I looked at in reviewing that law was whether or not some of our current initiatives like Vital, the Health Care I.D. Initiative, whether that would be a problem with this New Hampshire law and it would not because it's my understanding is that Vital would not be using any data for a commercial purpose. It would be a non-commercial use.
ATTENDEE 2: (Inaudible).
MS. LUNGE: Yes, and I don't think that would be a problem either because again it's not a commercial use of the data. We're doing it to audit for fraud. And that is also under litigation.
ATTENDEE 2: If there was 2 million dollars to (inaudible) uses in the state (inaudible) to recover money on that (inaudible) or try to recover that is my next (inaudible).
ATTENDEE 4: (Inaudible) I assume it got delivered

to OVHA and they were directed (inaudible).
MS. LUNGE: We can probably track it down.
MS. ROYL: We can track it down.
ATTENDEE 1: I'd like to see us try to recover even if we don't recover the four million at least we're sending a clear message. It might change the practices, you know what I'm saying?
ATTENDEE 4: Yes.
MS. LUNGE: So, the next set of strategies are focused around advertising or other types of marketing, so several states have done bills on restrictions on advertising in media. Vermont had a bill; Massachusetts, Wisconsin. There are some significant legal issues that I don't know in a lot of detail so I'll just leave it that we need to look at those.
In addition, some -- Maine has a bill pending or I don't think it's actually pending yet but will have a bill which has the Attorney General given the ability to enforce federal advertising standards. For instance, misleading advertisements.
Also, there's a report from the New Jersey Public Interest Research Group which looks at the Federal FDA enforcement of misleading advertisements and has some, basically went through all the FDA letters sent out to

all the drug companies over a period of time to talk about what kinds of ads were found to be misleading.
And there is I think the NLA RX is developing a model bill on that issue.
Florida passed some restrictions on electronic marketing through prescribing software prohibiting pop-up ads in the software and then there's a couple of states that passed, Minnesota actually, Minnesota passed a ban on gifts to health care professionals by pharmaceutical companies and in Massachusetts there is a Senate budget amendment which didn't pass the House.
In addition, there are several other initiatives that are considered in this state or other states about strengthening current initiatives that we've already talked about, so for example in 5/24 we included a provision that again works to expand the Medicaid preferred drug list, others in state government or others that state government is buying for, which people commonly refer to as the statewide PDL.
In addition, in the health access report --
ATTENDEE 2: The what?
MS. LUNGE: Statewide PDL, preferred drug list. There was some concern that the standing committees

look at some co-payment issues under Medicare Part D and our wrap program for certain individuals that are duly eligible for Medicaid and Medicare. In particular we have individuals in the choices for care, long term care program which allows people to receive long term care services in their home.
Under Part D people in nursing homes don't have to pay the Part D co-payments but that's not true for people in other long term care and since we now have this waiver where people are choosing, we have people being treated differently because of this.
Also, we've already talked quite a bit about counter-detailing. In H524 there's a required implementation date. In addition, there's a Maine bill which looks at a counter-detailing program and it has a lot more detail than our statute does.
Our statute basically says go forth and do counter-detailing and give us a report. And, that's a summary. That's not the exact text.
Also, yeah, that's the legal terms.
In H524 we also narrowed some of the exceptions in our pharmaceutical marketing disclosure law, specifically grants for continuing medical education are currently exempt from disclosure. The bills removed that exemption so that marketers,

pharmaceutical companies would have to report grants from CME.
In addition we do have a clinical trials bill that passed a few years ago which looked at disclosing that information for public information purposes.
Maine has a bill which kind of takes our bill and moves it one step further and then the next two slides, I don't think we actually need to go over it. What I tried to do was just summarize what was in S288 and what was in H524. Most of these we already discussed with a couple of exceptions that I didn't include in the possible strategies because for instance the non-profit PVM OVHA did that without legislative action and I think the Triple A's are providing information on drug manufacturer programs. The bill has OVHA doing it and then there was some other provisions about FQACs that passed a couple years ago, I think in the budget.
So, that doesn't mean you shouldn't necessarily look at them again but there's been a little bit of action on them and the ones that I mentioned here were things that hadn't moved at all.
ATTENDEE 1: Then you can come back and tell us what measures (inaudible) you can find out there and ready to review H524 and S288 with us.

Can you please let us know --
MS. LUNGE: Yes.
ATTENDEE 1: So, we can schedule you to come back in and talk to us --
MS. LUNGE: Yes.
ATTENDEE 1: -- trying to keep in touch with our counter parts, both (inaudible) and had lunch today with (inaudible) Myers.
(Whereupon, audio ends.)

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Barbara Bullen Stark, Notary Public, Certified Shorthand Reporter and Registered Professional Reporter do hereby certify that I was authorized to and did listen to and transcribe CD 07/07 T1, and CD 07/07 T2, Senate Health and Welfare Committee, Wednesday, January 17, 2007 proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August 2007.

Barbara Bullen Stark, RPR
My Commission #DD320347
Expires July 17, 2008

ESQUIRE DEPOSITION SERVICES
(954) 331-4400

STATE OF VERMONT

SENATE COMMITTEE ON HEALTH AND WELFARE

Re: Senate Bill 115

Date: Wednesday, January 17, 2007

Senate Committee On Health And Welfare

Committee Members:
Sen. Doug Racine, Chair
Sen. Sara Kittell
Sen. Kevin Mullin
Sen. Ed Flanagan, Vice-Chair
Sen. Virginia Lyons
Sen. Jeannette White

Marie Royle, Legislative
Robin Lunge, Legislative Counsel
CD No.: 07-08-T1

- - -

ATTENDEE 1: And we could be the initiative on whatever you want to on the Senate side, so I would like to proceed, continue this discussion with the next step (inaudible). And then at the committee's pleasure, we could proceed. I would imagine the other five members of this committee could perhaps move fairly quickly in trying to advance them and it's already been discussed.

ATTENDEE 2: As much as he thinks that was a small part of but he ordered in a week or two.

ATTENDEE 4: I think that's been part of --

ATTENDEE 1: It's all relative on this one so --

ATTENDEE 4: And then how much of 288, 5.4 was put into the budget?

Was any of this, was any of the pharmaceutical stuff?

MS. ROYLE: A large part of S288 was put in the budget. What you have on your list are just the things that didn't pass any other place.

ATTENDEE 4: Okay.

MS. ROYLE: So, the things that in S288 that were put in the budget even though they weren't designated that way were in what we covered in terms of the current initiative.

ATTENDEE 3: I wanted to get to Senator Mullin's

resolution but he wanted also to come back sometime.

ATTENDEE 1: Since that's an interest maybe what we ought to do is Steve is going to do some research for me and gather a motion rather than me setting it as an individual.

ATTENDEE 2: Okay.

ATTENDEE 1: If we're going to spend time with prescription drugs let's do it.

ATTENDEE 2: Okay.

ATTENDEE 4: Sounds good.

ATTENDEE 2: So, we'll come back to this when they come back?

ATTENDEE 1: Yeah. Basically when we go through it what we can do is we can have a charter; what things we can do and what things we'll need Washington to do, call it a resolution of all things we want Washington to do. They won't listen to us anyway, but we can keep trying.

ATTENDEE 2: It's worth a try.

ATTENDEE 4: Yeah.

ATTENDEE 2: Some people in Washington might listen.

ATTENDEE 4: Right.

ATTENDEE 2: I just don't think, the more power they have. Doug, if you want to continue that

effort.

ATTENDEE 1: I would have more of a chance on (inaudible). We've been setting these resolutions down every year and they never go anywhere.

Now, they can actually go (inaudible).

(Laughter).

ATTENDEE 4: We set a resolution down on the (inaudible) area and that had --

ATTENDEE 1: So, what kind of time frame would you need to come back to us and continue this discussion?

MS. ROYLE: I need to check in with Steve because a lot of the measures of effectiveness would be kind of on end in terms of the cost analysis, so I should try and find out when he thinks he can get the data and do that.

In terms of reviewing 524 and S288, I think we can do that pretty quickly. I mean, we're both familiar with those provisions and we can refresh our memory of the details.

ATTENDEE 1: Why don't we plan to have you back next week and we'll figure on the schedule and give us what you can.

MS. ROYLE: Okay.

ATTENDEE 1: If you can do the two bills that

would be great.

MS. ROYLE: Yeah.

ATTENDEE 1: Kevin, if you can be ready (inaudible) on this and we can start developing that list of the state and federal actions. And whatever Steve can get us on measure effectiveness and that piece of the legislation. And the (inaudible) 2005 report.

MS. ROYLE: Yes, yes.

ATTENDEE 1: So, see what that has to say. Any measures you can get us on what's worked and what hasn't.

MS. ROYLE: Okay.

ATTENDEE 1: That would be very helpful and I'd like to continue this discussion next week.

MS. ROYLE: Right. Okay.

ATTENDEE 2: (inaudible) resolution and email Sharon Freed (phonetic) and ask her about anything --

ATTENDEE 4: I have a meeting at 4.

MS. ROYLE: Yes.

(End of Recording).

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Barbara Bullen Stark, Notary Public, Certified Shorthand Reporter and Registered Professional Reporter do hereby certify that I was authorized to and did listen to and transcribe CD 07/08 T1, Senate Health and Welfare Committee, Wednesday, January 17, 2007 proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 20th day of August 2007.

Barbara Bullen Stark, RPR
My Commission #DD320347
Expires July 17, 2008

ESQUIRE DEPOSITION SERVICES
(954) 331-4400

TAB B

STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: Friday, January 19, 2007

Type of Committee Meeting: Standard

Committee Members:

Senator Ann Cummings, Chair
Senator Claire Ayer, Vice-Chair
Senator Mark MacDonald Clerk
Senator Bill Carris
Senator James Condos
Senator Hull Maynard, Jr.,
Senator Richard McCormack

CD No: 2007 - 18 Track 2

PROCEEDINGS

- - -

SENATOR CUMMINGS: Okay, Robin.

MS. LUNGE: Good afternoon. Robin Lunge from Legislative Counsel.

I have several pieces of paper which I'll hand out as I go. But this first piece of paper, I'm going to attempt to channel Steve Kappel very briefly and talk about pharmaceutical -- he's not here today. That's why I'm attempting to channel him so --

I will mention that he is going to be talking with you about pharmaceutical finance in some detail next week but I wanted to just give you a preview and kind of set the stage for why do we care about pharmaceutical spending in Vermont anyway. So I'm going to go through this fairly quickly. I can guaranty you if you ask me questions, I will not know the answers. I'll try, though. And I can note your questions if you have them for Steve so that he will --

SENATOR CUMMINGS: This is just an overview. We will have lots --

MS. LUNGE: Absolutely. So as you can see

from the first graph which is on the third page, drugs and supplies are approximately 15 percent of health-care spending for Vermont residents. This is based on the BISHCA survey data. And the most recent data Steve said was 2004 although he is getting new data over the weekend so he'll probably give you an updated figure next week.

The next slide is to give you a sense of who pays for pharmaceuticals in Vermont, and it's broken down by drugs and supplies because that's the method used in the BISHCA survey.

FEMALE ATTENDEE 1: What's DME, BISHCA and DME?

MS. LUNGE: DME I think is durable medical equipment.

FEMALE ATTENDEE 1: Oh, right.

MS. LUNGE: And you can see that predominantly the largest source of spending on pharmaceutical -- drug and supplies is from out-of-pocket and that -- what that means it's not -- doesn't mean premiums but it means any co-payments, co-insurance, uninsured folks, all those figures that you as individuals would pay out of your pocket for when you pick up a

prescription.

SENATOR CUMMINGS: And this is prescription, not over the counter.

MS. LUNGE: It's prescription. I don't believe it includes over the counter.

ATTENDEE 1: So it really is out-of-pocket.

MS. LUNGE: Yes. Yep. And then you can see the second -- secondly Medicaid is the second highest payer and then third self-insured employers are third.

You'll notice there's a little star above Medicare. That's because when this data was collected, Medicare Part D had not been implemented yet. So hopefully if Steve is able to get you new graphs next week, you'll see a change -- quite a dramatic change in this graph because there will be much higher spending under Medicare for the Part D program.

SENATOR CUMMINGS: Did you see the Senate allowed us to negotiate the price on the Medicare?

MS. LUNGE: Oh, I didn't hear that yet.

SENATOR CUMMINGS: Yesterday, that was --

ATTENDEE 1: Yeah, the president has vowed

to --

SENATOR CUMMINGS: He probably will (inaudible).

ATTENDEE 1: Same already as our competition.

FEMALE ATTENDEE 2: Yeah. But they've already passed the new freebie trips and stuff. What's the percentage of care to the pharmaceuticals?

ATTENDEE 1: The price ought to go down to --

SENATOR CUMMINGS: Pharmaceuticals are the largest lobby donors in Washington so I'm not sure that will put a lot of profit back in their pockets.

FEMALE ATTENDEE 3: (inaudible) I went to a meeting once with my husband years ago and one drug company rented the entire park system for the evening and took us out to an island to watch a very well known (inaudible).

ATTENDEE 1: You accepted drafts.

FEMALE ATTENDEE 3: Yeah.

MS. LUNGE: So then the next graph is to give you a sense of how fast pharmacy spending is growing, and it starts in 1996 and goes up

through 2004. And, again, this is just Vermont residents so this isn't a national graph. It is Vermont specifically.
SENATOR CUMMINGS: Have you done anything that overlays hospital costs or -- as a percentage.
MS. LUNGE: In terms of growth?
SENATOR CUMMINGS: Yeah, because (inaudible) okay, my sense is it's an inverse curve that (inaudible) --
MS. LUNGE: Oh, I see.
SENATOR CUMMINGS: -- less hospitalization and a lot more Medicaid.
MS. LUNGE: If you increase pharmacy costs, do you decrease. I'll ask Steve that question.
SENATOR CUMMINGS: I'm sure --
FEMALE ATTENDEE 1: I'm sure you're exactly right on that. That is the best (inaudible).
MS. LUNGE: So the next chart shows you the annual growth rates at in health-care spending, and the first line on the left are drugs and supplies. The second line is total health-care spending, and the third line is

inflation. So that's to give you a relative sense of how pharmacy spending growth compares to the health sector as a whole and also to inflation.
ATTENDEE 1: What occurred -- (inaudible) in this graph what occurred in 2004 to cause that spike to surge? Is it increased marketing?
MS. LUNGE: I'm not sure. I can ask Steve if he knows.
ATTENDEE 2: More effective ads.
FEMALE ATTENDEE 2: Yeah.
FEMALE ATTENDEE 4: It will be interesting to trace it from the time we allowed ads.
ATTENDEE 1: Well, I'm not sure that that's -- I don't think they were not allowed.
MS. LUNGE: They were --
FEMALE ATTENDEE 3: Direct to consumer ads.
FEMALE ATTENDEE 2: Yeah.
ATTENDEE 2: But it wasn't a matter of allowed. It was a matter of (inaudible).
ATTENDEE 3: What are supplies?
MS. LUNGE: Supplies would be like diabetic supplies so the needles you use for

insulin shots, that kind of thing.
ATTENDEE 1: It just --
FEMALE ATTENDEE 3: Blood glucose meter reader.
MS. LUNGE: Yeah. I'm not sure it's something like bandages but I'll -- let me ask Steve to specify that. I know that it specifically includes diabetic supplies that you need to inject the pharmaceutical, and I think that's what it's limited to, but I don't know for sure. I may have a misimpression so let me get Steve next week to specify exactly what's in supplies.
SENATOR CUMMINGS: Things you have to use regularly (inaudible). I don't know if Depends is in there.
MS. LUNGE: Yeah, I don't know if that kind of stuff is or if it's just stuff directly related to using a pharmaceutical.
SENATOR CUMMINGS: Oxygen.
ATTENDEE 1: My phone is dead so I plugged it in.
MS. LUNGE: So the last slide just basically gives you a -- a snapshot for next week where -- for where Steve is going to talk

to you in some detail about cost drivers in pharmacy but the point is just to give you a sense that there are three different drivers to pharmacy spending. One is prices which is the change in the amount paid for the same drug over time, whether the actual cost of the drug increases.
The other is utilization, the number in duration of prescriptions, so did I go from taking one prescription the first year to three prescriptions the next year or do I take more of the same prescription for a longer period of time or something like that.
And then the product mix, which means the choices that physicians and patients are making between brand, generic or over-the-counter drugs.
And Steve will tell you that the estimates vary but each factor accounts for approximately a third of the annual increase. And his -- his point in really including the slide I think is to show you that you -- if you -- what the goal is, is to make pharmaceuticals more cheaper for the average Vermonter; you have to attack on the number of fronts at once and any one factor

will only address the situation partially. How did I do?
SENATOR CUMMINGS: Excellent.
ATTENDEE 1: Fair.
MS. LUNGE: So what I'm handing out next is a thick report from the Congressional Budget Office. The Congressional Budget Office is a nonpartisan fiscal office for the Federal Government -- for the Federal Congress, excuse me. And they did a report just this month on prescription drug pricing in the private sector. And we're going to talk again in a lot more detail about prescription drug pricing but there's just a couple of things I wanted to talk about in this report today so that -- again, so that you get more of an overview.
So on page five of this report I'd like -- I'd like to point out figure two. And the point of showing you this graph is to give you a general sense of how drugs move through the supply chain.
So you'll notice that in addition to drugs going from the manufacturers to the wholesalers and then down to retail pharmacies and providers and from there to consumers, they

also go directly from manufacturers to chain pharmacies and food stores with pharmacies. And that's about 30 percent of the dollar sales. And of course from the wholesalers, drugs move through the various retail pharmacies and also directly to hospitals and clinics and HMOs. We're on page five of this report.
ATTENDEE 1: I assume mail order pharmacies have probably picked up a larger percent than the two percent of this thing.
MS. LUNGE: This is a January 2000 report so it also may not -- this is national data, it's not Vermont data, so it's possible that in Vermont that -- that the ratios are somewhat different. And I don't know for sure but I would expect it --
ATTENDEE 1: It's 2000 you say.
MS. LUNGE: The report, its -- hold on just one second -- source is based on data from 2005. The report itself was issued this month.
ATTENDEE 1: Oh, okay.
MS. LUNGE: So the -- so the other purpose of showing you this graph is to just give you a little bit of a sense of where consumers buy

their drugs.
Nationally 43 percent of consumers buy or 43 percent of the dollars of sales is from chain pharmacies and food stores with pharmacies, and 28 percent from hospitals and other providers, and then independent pharmacies is the --
ATTENDEE 1: When they say mail order pharmacies, are these the same -- would a mail order pharmacy be the same as -- what is it is called -- (inaudible) when the insurance company has mail order?
MS. LUNGE: Yes. This is where you as the consumer would get like a 90-day supply through the mail.
ATTENDEE 1: For maintenance drugs?
MS. LUNGE: For maintenance drugs and often health insurers will -- because mail order pharmacies tend to give discounts because it's a bigger purchase I think, they -- a lot of health benefit plans and employers are trying to encourage people to use mail order pharmacies.
ATTENDEE 2: They also have an advantage in that longer prescription.

MS. LUNGE: Yes.
ATTENDEE 1: I mean, typically your co-pay is less.
ATTENDEE 2: Yeah.
ATTENDEE 1: In most cases the co-pay is equivalent to two if you order two months in a row. I mean --
MS. LUNGE: And that's because the insurer is doing that to encourage you, the consumer, to use that mechanism because the drugs are cheaper for them as well.
ATTENDEE 2: And controls --
SENATOR CUMMINGS: That begs the question, where does the pharmacy benefit managers come in.
MS. LUNGE: That is our next chart on page 11. Page 11, number four. And this is meant to give you a sense of the flow of funds and this is -- this example is just for single source, brand named drugs. So these would be brand named drugs still under patent protection with the manufacturer. So only one company would -- is making this particular type of drug that they're showing here.
And, again, the chart is just to give you

a sense that the drugs can flow in a number of -- or the funds, excuse me, can flow through a number of different players. And so you'll notice on the left there's the pharmacy benefit manager kind of between the drug manufacturer and the health plan and also operating with a pharmacy in terms of negotiating payment.

And I'm not going to go into that in a lot more detail because I think we'll talk through the details next week but I just wanted to give you the general sense of you can see from this chart the flow of funds which is the dashed line, the flow of the actual prescription drugs which is the solid lines between the manufacturer, the wholesaler, the pharmacy, the beneficiary, and then the services which is kind of dotted around the wholesaler and the pharmacy benefit manager.

And then I'll leave you to read this lovely report at your leisure.

ATTENDEE 1: And the exam will happen?

MS. LUNGE: Next -- yes, next week you'll have an exam.

So the next handout I'm handing you, I'm going to send you two things right in a row.

You're welcome.

The first is a blue sheet which is an overview of all of our state health-care programs, pharmaceutical and public health-care both. And I'm giving you this because when we start talking about our current prescription drug initiatives which is the second PowerPoint handout that you have, we're going to be talking a little bit about Medicaid. And I don't believe that we've talked in any detail about our pharmacy programs yet in this committee so I wanted to just spend a little bit of time on that so that you understood the lay of the land here in Vermont. But I'm going to start with the PowerPoint slides.

So the first couple of slides are meant to give you an overview of the programs for the ways that the State of Vermont is involved in purchasing prescription drugs. So you can see that a primary way is through our Medicaid program. And there's about 150,000 Vermonters as of 2006 in our Medicaid program. And in -- for both Medicaid, the Vermont Health Access Program and Dr. Dynasaur, all those programs are full coverage health-care programs and do

include farm a pharmacy component.

Also, we have a program called VPharm which is our Medicare Part D wrap program. As I'm -- I think most of you know, Medicare part D is a new prescription drug program through Medicare which started last January in 2006 and provides pharmacy coverage for seniors and individuals with disabilities over -- that last more than two years or individuals who've had disabilities for more than two years.

And we -- when Medicare Part D was inactive, Vermont already had pharmacy programs for this same group of people in place because we had prioritized providing assistance with prescription drugs.

So what we had to do was reassess and look at our pharmacy programs in order to decide what we were going to do now that there's this new benefit available to people. And what we did was decide to keep coverage at the same level that people had prior to Part D. I'm not going to go into the minutia of the coverage under Part D other than to say that there are gaps in coverage. There's a deductible that you have to pay before you get coverage. Then

there's a co-insurance where you pay a certain percentage and the plan will pay a certain percentage, and then there's what's called the donut hole -- you've probably all heard about that -- where there's a big gap in coverage through a certain dollar amount and if you get through that, then there's 95 percent coverage by the plan.

But just to make it a little more complicated, each insurance plan is allowed to cover benefits differently. So that's the standard model but there's a lots of variation there and we in Vermont have -- I think I have it with me. We currently have 51 prescription drug plans in 2007. So there are a lot of different plans out there for people to look at and shop between but --

So back to VPharm. What we Vermonters --

ATTENDEE 1: This is Part D --

MS. LUNGE: That was Part D.

ATTENDEE 1: -- plans.

MS. LUNGE: Yes. So what we in Vermont decided to do is we didn't want people to get worst prescription drug coverage than they had under our state programs through Part D,

because for the most part many people, unless they were very low drug users, would be getting -- paying more under Part D. So we created a wrap around program so that the coverage would more or less stay the same. So that's our VPharm program.

Vermont RX is the name that we gave our prescription drug programs that are the same configuration that they used to be. And these -- that coverage program covers non-Medicare eligible folks. So that's a continuation of our old programs.

And then we have something called Healthy Vermonters, which is a discount card. Healthy Vermonters was based on a Maine program called Maine RX. And it basically allows any Vermonter up to a certain income level to get the Medicaid price on their prescriptions if they have no other source of prescription drug coverage or they've exhausted their prescription drug coverage. So some people have coverage up to a certain amount and then it runs out. So it covers those folks and it's a higher income level for over 65 and individuals with disabilities.

ATTENDEE 2: You don't happen to have off the top of your head have a number for participants.

MS. LUNGE: Oh, participants, I do not but I can bring that next week for you. I can bring it in (inaudible) figures.

So I handed out this two-page -- yours is blue -- chart because it will give you the nitty-gritty details on all our health-care programs but specifically on the pharmacy programs.

So you'll note, for example, that our pharmacy programs that are for non-Medicare eligible people are used -- are called their old names, VHAP Pharmacy, VScript, VScript Expanded. And I'm not going to go through all the minutia of this but on the back there's also an income chart that will show you the premium amount for each group and what the income levels are for one-, two-, three- and four-person households. So if you need more specifics on the programs, this chart is pretty handy for that.

So in addition to our Medicaid pharmacy program, we also will be purchasing -- are

paying for the purchase of prescription drugs through Catamount Health Premium Assistance. In Catamount Health, it will be each insurance company which will set up their -- the specifics of their prescription drug coverage and their formulary, if they have one for that plan.

We also provide prescription drug purchasing for our employees and teachers and municipal employees. And the one group that I should have also added here was the Department of Corrections because they do have some pharmacy coverage for our people under their supervision.

So Vermont has been a leader in general nationally on -- on working towards controlling prescription drug costs. So the main part of my presentation today is going to be going through our current initiatives that we have in place.

Part of what Steve and I will be talking to you next week is we're looking for -- we're currently doing the research on both Vermont evaluation but other states' evaluation of similar programs. So we hope to have some of

that information next week for you.

But first I'm going to start with the Medicaid cost containment strategies. And I'm going to skip over preferred drug lists for now because the next couple of slides are about that.

We currently have joined a multistate purchasing pool. We've been in a multistate pushing pool for some time. We recently switched to a new pool called the Sovereign States Drug Consortium and we're in that pool with Maine and Iowa. And what that program is, is it's a program for the Medicaid agencies for these three states to combine their buying power. So they will enter in joint negotiations with manufacturers so that they can really leverage their -- what costs they negotiate for the Medicaid program. They --

We in Vermont do use a nonprofit Pharmacy Benefit Manager now -- this was also a recent change last year -- and it's called MedMetrics. It was originally established through the University of Massachusetts Medical School. This committee did have extensive discussions on Pharmacy Benefit Managers including asking

the Office of Vermont Health Access to consider switching to a nonprofit PBM, which they did without legislative mandate. So that's something which they sort of heard and did on their own without legislation passing.

In addition, in our Medicaid program we cover over-the-counter and generic drugs through our preferred drug lists and we have what's called a maximum allowable cost program which means that we set the maximum cost that we will pay for generic drugs.

FEMALE ATTENDEE 1: What slide are we on? I'm sorry.

MS. LUNGE: I'm on page two -- I'm actually switching to page three right now. We're going to start talking about preferred drugs.

FEMALE ATTENDEE 2: Okay. You gave us the wrong handout.

MS. LUNGE: Okay. So there are -- a preferred drug list is a mechanism by which states or private companies or health insurance plans try to control the cost of drugs by negotiating with manufacturers and basically saying, if you give us a better price than this

other guy who has a therapeutically equivalent drug, then we'll put you on our preferred drug list. And when you're on the preferred drug list, usually there are things like lower co-pays or financial incentives for patients to buy that drug. So we have used it traditionally in the Medicaid program again as another way to leverage -- leverage buying.

And there is some federal law and regulation on pricing and preferred drug lists including prior authorization in the Medicaid program which I just mentioned. But we do have a lot of flexibility in how we run that program and the administration and actual negotiation happens on a state level.

And I also just wanted to mention Medicare Part D because the way the preferred drug lists work in the Medicare Part D program is they -- each insurer has their own preferred drug list and so each company might have different drugs on their list depending on what happens in their negotiations.

So as you have already discussed, one of the news -- one of the new things that's happening in the Medicare Part D program is

that the Federal Government did just pass this law saying that they would have a role in negotiating drug prices.

I haven't -- I saw the House version and I haven't seen what passed the Senate yet, but if they just voted on the House Bill which is probably I'm expecting what they did, that Bill did not include a federal preferred drug list. So it still would be something left to the private market, that part of it, but -- so it will be interesting to see how that develops and how the Government takes a role in the negotiation without having a preferred drug list.

ATTENDEE 2: How do you mean the private market?

MS. LUNGE: Well, right now, like I said each --

ATTENDEE 1: Yeah.

MS. LUNGE: -- each insurer has their own so they didn't mandate a Federal preferred drug list. So I think that would still mean each company has their own list but just now probably the Feds would get involved in negotiating the maximum.

ATTENDEE 2: So they create their own list.

MS. LUNGE: No, the -- the -- the law did not allow the Feds to create their own list so -- so I'm not sure exactly how the negotiation will -- will kind of play out in that front. It will be interesting to see how that goes.

FEMALE ATTENDEE 2: How much is this going to cost us?

MS. LUNGE: I have no idea. I haven't been following it that closely, I must admit.

So -- and, for instance, other Federal programs do have a federal preferred drug list like I think the Federal Employees. There's a Federal Supply schedule, for instance, which sets drug prices for -- for employees.

FEMALE ATTENDEE 2: Is that the veterans -- the veterans --

MS. LUNGE: I think the VA uses that same pricing.

FEMALE ATTENDEE 2: That's all there is.

MS. LUNGE: So specifically in our Medicaid program, we've tried to balance cost and quality in our preferred drug list. So we

do prefer over-the-counter and generics which in general are cheaper, although not always. If you compare each drug, it's not a hundred percent accurate to say generics are always, always cheaper, but for the most part they are.

And in order to get on to the preferred drug lists, manufacturers would agree to a supplemental rebate on that drug, which means that in addition to setting a lower price we also get this second rebate.

Another piece of information about our preferred drug list is that for individuals who are -- who get their coverage through Medicaid, we do allow them to get drugs off of the preferred drug list with prior authorization from a physician saying that it's -- it's necessary for them to take a different drug. And that's on the list.

And sometimes that's used if someone is allergic to the particular drug that's on the list or I think there's sometimes certain -- even though the drugs are therapeutically equivalent, sometimes one drug works better for one person than another.

So I'm going to move on to our cost

containment initiatives relating more towards pharmacies and providers. And the first of those is the generic substitution law. We have a law which requires pharmacists to select the lowest priced chemically and therapeutically equivalent drug.

And there is an opt-out provision so that the prescriber and the purchaser can choose the nongeneric or the brand name.

In addition, we have a pharmacy drug price disclosure law. That requires that if the individual consumer asks the pharmacy, that the pharmacist will disclose the usual and customary price. And the reason why that particular price was chosen was because the pharmacist doesn't necessarily know the actual cost to the consumer until they swipe the card because each health benefit plan has a slightly different deal. So it would be very difficult for them to give that prior to running the transaction. However, they also need to, on the prescription when it's dispensed, include the actual price of the drug that the consumer is paying, the full price, as well as the cost that the consumer that it sells pays as the

co-payment or whatever. And the point of that was to help in consumer education in terms of giving them a sense of the full price of the drug, not just their share.

FEMALE ATTENDEE 2: I think it's been very effective.

ATTENDEE 1: It does -- it shocks them. It doesn't keep them from getting them.

FEMALE ATTENDEE 2: Yeah.

MS. LUNGE: Well, I think also it depends on what your company share -- your cost sharing is because, for instance, my cost sharing at the state of employees is a percentage so it definitely has an effect for me because I pay -- I can't remember what it is because I don't use it much -- but I think it's like 25 percent. So if it's a higher-cost drug, I pay more, you know. And other people have different arrangements. Sometimes it's a co-payment where you pay the same as long as you're on the list.

So the next initiative that I'll discuss is called the counter detailing program. And detailing is a practice by pharmaceutical marketers of going to doctors' offices and

providing them with information about the drug that they're marketing.

So what this program was designed to do was to provide doctors with information about other therapeutically equivalent or generic versions of that same drug because, of course, the marketer is there to sell their product so they're providing the doctor information about their product. They're not necessarily bringing in information about the competitor's product. But it was thought that many --

Many states are starting to believe that one way of keeping the costs down and sort of addressing the utilization piece of the cost driver that we talked about is to educate physicians about the actual cost because physicians don't always know the cost of the drug they're prescribing. So this was -- this was a method that provides doctors with evidence based research on the therapeutic class of drugs, information about the different costs which are higher costs, and it's really meant to counteract some of that marketing that happens very effectively by some of the drug companies.

FEMALE ATTENDEE 3: Robin, do you know how this works? I mean, do you know what it looks like? I work in an doctor's office. We --
MS. LUNGE: And you've never seen it?
FEMALE ATTENDEE 3: We don't prescribe a lot of drugs (inaudible) but I --
MS. LUNGE: There's a good reason why you haven't seen it. It's not implemented.
And we passed this law a while ago and there is actually a report from OVHA due two years ago, January 1st, 2005, which I do believe we have received. I didn't bring that with me today but I can provide more information on that when we come.
But basically OVHA hasn't implemented the program I think because of funding issues.
ATTENDEE 2: How much was requested or funded do you know --
MS. LUNGE: I don't think OVHA has been including it in their budget request and so I don't think there is a particular line item attributed to it.
What I will tell you is that there is a program -- it's fairly new -- in Pennsylvania that the Pennsylvania Medicaid Office has

started to providing counter detailing. And they started with one drug and they're moving, sort of expanding it as they go and I'm going to try --
I believe a couple of NLARx meetings ago they did a report and they showed their brochures and their educational materials and I believe that they already thought that they were seeing some change in utilization and prescribing patterns. That's what I remember. It was I think at least a year ago.
So I'm going to see if there's any firm data on that, if that was just anecdotal or whether we have any firm data on that from them.
FEMALE ATTENDEE 3: Will we do that or the health committee do that?
SENATOR CUMMINGS: We're going to be looking at prescription drugs and next -- well, the next couple of week we're going to have a couple of meetings with Health and Welfare. And, you know, whatever Bill comes out, it will probably go through both of us so we'll all get a chance to work on it.
FEMALE ATTENDEE 2: This is really a tough

one. I mean, we do mostly birth control pills and antibiotics. I mean, it's such a limited spectrum. And we used to have an idea of what they cost when we give samples to people who didn't have money. Well, now they don't samples because generic are everywhere and there's no incentive to the company of sampling their stuff. But we don't know what anyone is going to pay because it all depends on what insurance they have when they go there and what pharmacy they go to. We can't keep track. It's really impossible. So we could --
SENATOR CUMMINGS: I think we've had Dr. Matthews in a couple of times to talk about, you know, the prescriptions and what they don't tell the doctor. But two of the old ones that -- that have gone off of patent are as good as new ones or you give one of the old ones and something else -- (inaudible) like common things like aspirin do just as well and, you know -- but most doctors are just too busy doing research in medicine not in the price of pharmaceuticals. You know, they're reading in the evening, that's not it.
FEMALE ATTENDEE 2: They use what they

know and they use --
ATTENDEE 2: It also seems like we are throwing more -- sort of like not having regulated tobacco or alcohol, it's and saying okay, we're going to combat it with counter advertising as opposed to -- so we're spending money two or three times as a -- as a culture not necessarily a state. If we just back them off on what they can spend on marketing --
SENATOR CUMMINGS: We would love to do that. I don't know if we can stop the PBM channels from coming in.
ATTENDEE 2: Well, I thought we were going to outlaw Fox first.
SENATOR CUMMINGS: Fox first at least while Bill O'Reilly is there.
ATTENDEE 1: Well, that's news. That's what he's saying. And as people listen to him and watch him believe --
I'd like to go back to the -- there was a report due January 1st of 2005. You just received it?
MS. LUNGE: No, no, we did receive it in 2005. I'm sorry if I misspoke there. It just hasn't gotten any legislative attention than --

well, actually let me take that back because it was in -- this provision, we implemented -- we passed implementation of this in H524, I believe, and -- which was vetoed by the governor. That was the big health-care bill. So we might have looked at the report with H524. I just don't remember.

ATTENDEE 1: Okay. But the counter detailing program is not implemented --

MS. LUNGE: No.

ATTENDEE 1: -- because there's no legislation for it or --

MS. LUNGE: No, it's in statute.

SENATOR CUMMINGS: It's in statute.

ATTENDEE 1: To a level -- who's responsible for implementing?

MS. LUNGE: OVHA.

SENATOR CUMMINGS: And we're going -- we're going to have a meeting -- yes, one -- one -- two of the joint meetings. One is to get a report on things that we've done, what's been implemented, what hasn't, do we have any measure of the success and then we're going to talk to the Administration about the -- you know, the folks that are charged with

implementing about either their successes or their failures.

ATTENDEE 1: Well, then I think I heard Robin say the reason it hasn't been implemented is because they haven't requested the funding for it.

Who instructed them not to request the funding for it?

SENATOR CUMMINGS: That's what --

MS. LUNGE: I don't know.

SENATOR CUMMINGS: That's what we'll find out.

MS. LUNGE: And I don't -- I don't know if they requested one time and got denied and then they didn't request in the future. I don't -- I can see -- it's possible that Stephanie Barrett (phonetic) might know that right off her head, off the top of her head so --

SENATOR CUMMINGS: We did pharmacy in here I think every year for about four years and then last year we did exclusively health care and -- because we felt, you know, we really had done an awful lot in pharmacy. And we're kind of letting the dust settle before we went back, so we're back.

ATTENDEE 2: And this hasn't even (inaudible).

SENATOR CUMMINGS: Right. I think we may found out there are other things that's --

MS. LUNGE: The other thing I would just mention lastly on this -- this particular type of initiative is I do know that AHEC -- do I remember what AHEC stands for, area -- AHEC, Area Health --

FEMALE ATTENDEE 1: It's a new one on me.

FEMALE ATTENDEE 2: No, that's the page --

MS. LUNGE: Right, Area Health Education Centers I think.

FEMALE ATTENDEE 1: Thank you.

SENATOR CUMMINGS: It didn't come out of this committee.

FEMALE ATTENDEE 2: That's the program that pays -- subsidizes people to go into underserved areas in the state.

MS. LUNGE: They might have -- they might do that, too but they had started a small counter detailing program with grant funds. So I'm going to also try and see if I can at least get some preliminary materials on what they're doing for next week so that you can have a

better sense of -- of that and --

I know that there's also some interest in at least Maine and possibly New Hampshire in potentially doing a joint counter detailing program because then it's more cost effective but that's all future.

ATTENDEE 3: Are we going sell antidrug salesmen out with pens, notepads and everything --

MS. LUNGE: They do that. I don't think they have any trips to the Bahamas but they do have -- in Pennsylvania, they do bring the pens and, you know, the little gift things too so they --

FEMALE ATTENDEE 1: The counter detailers?

MS. LUNGE: Yes.

FEMALE ATTENDEE 2: Just to keep their name in front of your face.

MS. LUNGE: So the next initiative that I'll talk about is on the next page which is promoting the 340B drug pricing program. The 340B drug pricing program is a federal program which allows certain entities to get the Federal 340B price for drugs which is lower than pretty much any other price that we can

obtain either through the Medicaid supplemental rebate program on through negotiating on our own.

So certain facilities which are certified by the Federal Government such as -- such as Federally Qualified Health Centers or what are called FQHAC, look alikes which are generally health centers that provide sliding scale assistance based on your income, those type of facilities are meant to serve vulnerable patient populations but anyone usually can go there. You don't have to be a low-income person to go there.

FEMALE ATTENDEE 2: How many of those do we have now? We have two.

MS. LUNGE: We have I believe five if you count FQHACs and look alikes but that's a good point.

SENATOR CUMMINGS: I thought like the end of last year the Feds had authorized --

MS. LUNGE: Another one?

SENATOR CUMMINGS: -- some more and I know Plainfield was trying to get its full -- this would be its third try -- its full status as an FQHAC.

MS. LUNGE: Right. They're a look alike right now I believe. I could be wrong.

SENATOR CUMMINGS: They have been a look alike. They're looking for the -- they're trying for full status because it does -- I think you get better reimbursement.

MS. LUNGE: Well, the main difference is that if you're a look alike, you have to provide the sliding scale fee but you don't get federal funding for that. If you're a FQHAC, you get federal funding to subsidize the sliding scale fee.

So in 524 we had an FQHAC provision that I think maybe even made it into the budget where we appropriated some money to look alikes to help them with the sliding scale fee part of it.

ATTENDEE 2: Now, the 340B, where does that pricing come from?

MS. LUNGE: That pricing is set federally. It's a federal -- I think.

ATTENDEE 2: Negotiated price.

MS. LUNGE: It might be the federal supply schedule price, although I have to double-check that. I -- I used to know this inside and out

when we were doing 524.

ATTENDEE 2: And that supply scheduling prices, where does that come from?

MS. LUNGE: That's federally set. I don't think it's negotiated. I think it's just set but I can check on how --

SENATOR CUMMINGS: It's kind of like the Canadians do it for everyone, this congress gets its prices.

MS. LUNGE: And Steve might know off the top of his head how the federal supply schedule price gets established.

SENATOR CUMMINGS: That's federal.

ATTENDEE 2: But that's the veteran's price.

SENATOR CUMMINGS: Yes, the veterans price.

MS. LUNGE: So the -- the 340B sort of promotion activities that we've done has -- has meant to both increase access to health care in general but also lower the cost of prescription drugs by allowing this cheaper method of getting drugs.

So the next initiative I'm going to discuss is importation also often called

reimportation. And as you know, U.S. Federal law regulates the sale of drugs including the importation of drugs and that's done through the Food and Drug Administration. And what the FDA actually does is approve drugs for certain specific uses by specific manufacturers and they also do things such as prescribe what the labels have to include. They inspect some of the manufacturing facilities. They do all the regulation of that at the -- at the manufacturer.

In addition, we have Federal patent law which allows patents to be obtained by drug companies for certain chemical -- there's probably an official word for it that I don't know -- but chemical combinations that constitute the drug.

ATTENDEE 2: Compounds.

MS. LUNGE: Yeah, sounds good to me. So -- so that also provides some Federal protection on this area. But basically what the Federal law says is that importing drugs from another country, even if it's made by a U.S. manufacturer, is not allowed, period. But there is some guidance on enforcement. And so

Page 42

what the FDA has done is said, we're going to use our discretion to not enforce the law to allow certain quantities for personal use to be brought in by individuals. And it's actually even a little more narrower than that. The -- let me grab my importation file.

So what the guidance actually says is that the FDA personnel can be more permissive, meaning allow the drugs to come in, in the following situations: When the intended use is appropriately identified such as -- excuse me, the intended use is appropriately identified, the use is not for the treatment of a serious condition and the product is not known to represent a significant health risk or -- so that's one situation -- or when the intended use is unapproved and for a serious condition but there's no effective treatment available domestically either through commercial or clinical means.

SENATOR CUMMINGS: That's the Mexican cancer treatments.

ATTENDEE 2: Yeah.

SENATOR CUMMINGS: And the other one is the Pepcid Complete my son takes back to Canada

Page 43

because he can't buy it there.

MS. LUNGE: There is no known commercialization or promotion to persons residing in the U.S. by those involved in the distribution of the product. So it's not distributed here.

And then there's -- there's additional criteria (inaudible). So the importation -- the federal allows -- the federal law is pretty narrow in terms of what it allows. But the -- the FDA also has the ability to approve the importation -- programs meant to import drugs.

ATTENDEE 2: That's not the marijuana.

SENATOR CUMMINGS: No.

MS. LUNGE: No, legal prescription drugs. To date the FDA has not approved any importation programs as they're commonly called.

And Vermont did apply for a program -- to do a program. We were denied and we appealed and we lost. So part of the -- the lawsuit -- the law -- the lawsuit was done by the Vermont Attorney General's Office and it is very discretionary. This type of decision is very discretionary so it's often difficult to win

Page 44

those on appeal.

ATTENDEE 3: The discretion belongs to (inaudible).

MS. LUNGE: To the FDA.

ATTENDEE 3: (Inaudible).

MS. LUNGE: Exactly.

SENATOR CUMMINGS: We're in very high esteem in Washington. This was several years ago we were in high esteem at that point.

MS. LUNGE: So several states and cities have however started importation problems -- problems -- programs and some of them have had problems. They -- so their programs -- and their programs have had problems. Some programs have had their drugs seized by the FDA when they were coming in through the mail. And usually states and cities are doing this as a way of offering less expensive drugs to their employees or their citizens.

Vermont did pass a law to join the I Save RX program. The I Save RX program is a program that was started by Illinois and several states have signed on. It's a program for individuals.

Other than coming into an understanding

Page 45

with the State of Illinois, the State of Vermont has no other involvement in it but it gives access to individuals to use the I Save RX Web sites and the forms to have a mechanism for importing drugs through Canadian pharmacies. I think last (inaudible) they also Irish pharmacies I believe and maybe Australian pharmacies.

The State of Illinois does have some oversight. They go to the other countries sometimes and check out the pharmacy to make sure that the pharmacy meets the Illinois regulatory rules.

SENATOR CUMMINGS: These are pharmacies that also sell drugs to their own citizens?

MS. LUNGE: Yes.

SENATOR CUMMINGS: These are not -- not pass-through black market warehouses.

ATTENDEE 2: Is this another job for the anti detailers?

MS. LUNGE: And the estimates --

SENATOR CUMMINGS: I want to go to Ireland to check out the pharmacies (inaudible).

MS. LUNGE: -- the estimates for savings for individual participants in the I Save RX

program vary between 20 to 50 percent. And I got that from their Web site.

Also as part of that same Bill, we created an insurance provision which would require insurance companies doing business in Vermont to cover purchases through I Save RX if it was something that they included in their plan. So it doesn't increase the coverage. It just says you'll treat this program the same as you would --

SENATOR CUMMINGS: Mail order.

MS. LUNGE: Right. So -- and then I just wanted to mention that at least in the last congress there were some efforts to change some of the rules on importation. And I don't know what's happening currently but I guess we'll see.

One of the things I am trying to follow up with is to see if they can give us some sense of how many Vermonters are using I Save RX. So hopefully I'll have that information for you next week.

In addition, we have two other current initiatives that are really transparency initiatives and those are our pharmaceutical

marketing disclosure and the pharmaceutical marketer price disclosure. We -- the first, the marketing disclosure requires pharmaceutical companies to disclose their marketing activities which includes gifts or certain gifts to the Vermont Attorney General's office. They do an annual report usually in the spring where they list the marketing activities, and that's available on their Web site. And the -- the purpose of that was to just generally have a better sense of what is the marketing like in Vermont. I think it's also by doctor so you can see which doctors receive more gifts or more money from -- from these sources.

There are some exceptions in the law, certain things that don't have to be disclosed. One of those is grants for continuing medical education programs which was something that this committee talked about in H524 when that was in here as well, removing that exception.

The marketer price disclosure looks at direct marketing to a prescriber and basically requires that the pharmaceutical marketer disclose the average wholesale price of the

drug and the price relationship to other drugs in the same therapeutic class. Again, this was an effort to get more information to physicians about --

ATTENDEE 3: Transparency.

MS. LUNGE: -- how much things cost. So that is my summary of our current initiatives.

SENATOR CUMMINGS: We will do much more discussing of average whole price --

MS. LUNGE: Yes.

SENATOR CUMMINGS: -- but there's no -- following S (inaudible) it's very difficult to get -- it varies widely on the same over (inaudible).

ATTENDEE 2: One part -- and I don't know whether you're the right person to ask, but I've never understood other than research the theory why the Feds don't negotiate or won't -- will not pass a law -- or have not passed the law until recently. What's the rational -- do you know the rationale behind --

MS. LUNGE: Well, we do negotiate in some programs.

ATTENDEE 2: Like the Medicaid.

MS. LUNGE: Yeah, and in the VA, for

instance.

ATTENDEE 2: Yeah.

MS. LUNGE: But I think generally -- and there are probably other people who can speak to this in more depth than I can, but I think generally the theory is that we provide patent protection for certain chemical compounds for a certain period of time and that's an intellectual property right that the Feds shouldn't mess around with but also that because the government has such a big market share, that they very much could skew the amount of -- of money that the drug companies would be selling the drugs for. So I think it's sort of an -- I think the drug companies would probably say that letting the Federal Government negotiate or set prices would be unfair to them because they're -- the Federal Government has more authority and power than the drug companies. I think that's what manufacturers --

ATTENDEE 3: The drug companies (inaudible).

ATTENDEE 2: Too big a club now.

MS. LUNGE: Right, exactly, it's too big a

club and that's the -- the counter argument.
ATTENDEE 1: So, in other words, it still doesn't make sense.
SENATOR CUMMINGS: Other countries negotiate or the provinces in Canada negotiate.
ATTENDEE 3: No, I just never heard a good reason other than --
SENATOR CUMMINGS: Yeah. I believe I've also heard that the pharmaceutical companies are the largest spending lobbyist organizations in Washington.
ATTENDEE 3: That, I do know.
SENATOR CUMMINGS: Which might have something to do with it.
MS. LUNGE: So do you have any other questions for me or any other particulars that you'd like me to try to get back to you next week with on any of these programs or any other ideas?
FEMALE ATTENDEE 2: I would be interesting to hear what happened with the counter detailing in Pennsylvania (inaudible).
ATTENDEE 1: We're going the hear from OVHA on that.
SENATOR CUMMINGS: That will all be in a

joint hearing. That's what we're getting set up for. And the other one -- the last (inaudible). Twice now we have attempted to do pharmacy benefit management regulation. It hasn't moved through the other body.
MS. LUNGE: I think it was actually in 524 and got vetoed.
SENATOR CUMMINGS: Yeah. I think that's a Maine statute which is --
MS. LUNGE: The PBM regulation that we passed was based on a statute in Maine which was challenged and that was recently -- it wasn't -- I won't go through all the ups and downs but it was recently upheld by the Federal circuit that Maine is a part of. It was appealed to the Supreme Court and they chose not to review the case. So currently Maine's law has been upheld.
D.C. also passed a PBM regulation law last year. That is currently in litigation. They lost at the district court level. It was appealed to the circuit and the circuit right after it was appealed to the circuit or shortly thereafter the Maine case came down so they sent it back to the district court and said

look at the first circuit case and then give us a new decision. So we -- we're not exactly sure what -- you know, what is happening in D.C.
What I would say in terms of a legal framework, we're not in circuits with either of those places so it would be if we chose to do it and they got sued, it would again be a new issue in the second circuit which is our circuit and it's likely that the Supreme Court would rule on it if there is a split between circuits. So that's all speculation at this point in terms of what would happen.
ATTENDEE 2: You were going to get participants in the programs, a number of participants in various programs.
MS. LUNGE: Yes. I will get you enrollment figures and I think probably also I can ask Steve if he has a cost breakdown, too.
ATTENDEE 2: Oh, we're talking gross dollars because (inaudible) it would be interesting to see.
SENATOR CUMMINGS: And most of that (inaudible) costs --
FEMALE ATTENDEE 2: Which programs?

MS. LUNGE: For the pharmacy programs in Vermont so the VPharm.
SENATOR CUMMINGS: That's it.
(Whereupon, CD 18, track 2 ends.)

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Dona J. Wong, Notary Public, Certified Shorthand Reporter and Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 2007 - 18/T2, the Senate Committee on Finance proceedings held Friday, January 19, 2007, and stenographically transcribed the foregoing proceedings from said CD, and that the transcript is a true and accurate record to the best of my ability.

Dated this 22nd day of September 2007.

_____

Dona J. Wong, RPR, CSR

STATE OF VERMONT

HOUSE COMMITTEE ON FINANCE

SENATE FINANCE COMMITTEE

Date: Thursday, January 25, 2007

Committee Members:

Sen. Ann Cummings, Chair
Sen. Claire Ayer, Vice-Chair
Sen. Mark MacDonald, Clerk
Sen. Bill Carris
Sen. Hull Maynard, Jr.
Sen. Richard McCormack

CD No: 2007-23

Esquire Job No. 928008

- - -

PROCEEDINGS

- - -

(Start of CD 07-23, Track 1 starts mid-sentence as follows):

MS. LUNGE: -- have settled, so there is no case law that's come out of it, so it doesn't give us any real guidelines on the state of the law, but -- and it also generally -- settlements don't necessarily show any admission that someone has done something wrong, just that they didn't want to deal with the lawsuit, so it doesn't give us any information on that in particular, but what I thought was interesting about it was that in addition to some money, the settlements included certain practices.

So in one case that was by the United States against Merck and Merck MedCo, MedCo is the PBM, there were particular drug switch provisions in the settlement that said that MedCo had to do drug switches in particular ways, and I didn't think I'd necessarily go into the details of that, but one of the things that we can look at when we look at the legislation is the law that we are looking at, would that mirror something that this big

company is already being required to do under a federal settlement?

So it's something that they're doing anyway, so it wouldn't necessarily change their current practice.

SENATOR AYER: When you say drug switches, what are you talking about?

MS. LUNGE: If I'm the PBM, and I say well, you asked for Lipitor, but I'm going to call your doctor and say why don't we switch you to this other drug that's therapeutically equivalent?

SENATOR AYER: Not necessarily a generic?

MS. LUNGE: Right.

SENATOR AYER: Okay. Another brand?

MS. LUNGE: Right.

SPEAKER: And it's probably more expensive.

MS. LUNGE: So for instance, the settlement would prohibit this particular company from asking for a drug switch if the net drug cost of the proposed drug is greater than the cost of the prescribed drug, so if it is more expensive, it would prohibit the company from asking to switch the drug if the prescribed drug has a generic equivalent and the proposed drug does not.

So if a doctor says I want you to do this

drug, and what would normally happen is that a generic would be -- it would be switched to a generic. The company can't then say well, we suggest you use this other drug which doesn't have a generic.

Again, this is looking at trying to move costs to lower costs instead of higher-cost drugs.

The settlement would prohibit MedCo from switching or suggesting a switch which is made to avoid competition from generic drugs, or if the switch is made more often than once in two years within a therapeutic class for any patient, so that's to prohibit drugs -- the patient from being asked to switch drugs multiple times in a time period.

The other provisions in the settlements have to do with transparency, similar to what other states have passed in terms of laws.

So an example, the same settlement requires MedCo to disclose to prescribers and patients the minimum or actual cost savings for health plans and the difference in copayments made by different patients; to disclose to doctors and patients MedCo's financial incentives for certain drug switches; disclose to doctors material differences

in side effects between prescribed drugs and proposed drugs; reimburse patients for out-of-pocket costs for drug switch related health care costs; and to notify patients and doctors that such reimbursement is available, et cetera.

So I won't go through the entire list, but -- so I just wanted to mention that there are these lawsuits out there. Some of them are -- are settled, and a lot of the requirements in the settlement are similar to what some of the State laws have suggested.

In addition, some of you, this will look very familiar because we've handed it out in this committee a couple of times before in the past, and this is a brief update of PBM litigation, and this is litigation by -- of PBMs suing states because of regulation passed by the states.

So for those of you who have been on this committee for a while, you'll remember that there-- Maine, the state of Maine passed a law which would require transparency and increased fiduciary duties and there was a lawsuit and that -- that law was initially enjoined at the District Court level.

SENATOR AYER: What does enjoined mean?

MS. LUNGE: Prevented from being implemented, so the Maine law hasn't -- is just actually now being implemented, and it was in litigation for a while.

SPEAKER: (inaudible) pay for it.

MS. LUNGE: Yes. Yeah. There's also some summary information in the firsthand handout.

So as you can see, that happened initially on March 9, 2004.

The District Court of Maine granted the preliminary injunction to prevent temporarily Maine from implementing the PBM law, and then in February of 2005, the U.S. Magistrate Judge recommended a decision in favor of the State of Maine, indicating that there weren't constitutional or ERISA problems with the Maine law, and that recommendation was adopted by the court on April 15, 2005.

That case was then appealed to the First Circuit Court of Appeal.

I should mention that we are in the Second Circuit, so we're not in the same Federal Circuit Court as Maine, which means that the decision in Maine isn't binding on the Second Circuit, but sometimes, circuits do look at what other circuits

are doing. That doesn't necessarily mean they would go the same way, but it is advisory.

So on November 8th, a three-judge panel of the First Circuit Court of Appeals reviewed the District Court's opinion and affirmed it, and that -- that was then appealed to the U.S. Supreme Court, and they chose not to hear the case.

So what that means is that at this point, the Maine decision has been -- the Maine law has been upheld as legal, and I believe they've started working on their implementation.

I don't know the exact status of where they are with that.

SPEAKER: If the Supreme Court chooses not to take it up, does that -- does it now spill out of their First Circuit into the other circuits?

MS. LUNGE: Well, that's a very good question, and it leads me sort of to the D.C. litigation because D.C. is in a different circuit than Maine, so D.C. enacted a similar law, and that's working its way throughout the court.

Generally, the Supreme Court looks at -- will look at an issue if there are different decisions in two different circuits, so if the D.C. circuit ends up going the opposite way from Maine, then

the Supreme Court might change its mind and take the issue up in that case, but at this point, there's no other -- the Supreme Court wouldn't look at the issue until some other circuit had made a decision and it got appealed again.

So did I answer your question at all in English? I felt like I kind of got jargony there.

SENATOR CUMMINGS: Does the D.C. law contain the eminent domain?

MS. LUNGE: That's a different D.C. law.

SENATOR CUMMINGS: A different D.C. law?

MS. LUNGE: Yeah, so what Senator Cummings is referring to is D.C. has passed several pharmaceutical initiatives in the past couple of years.

The one that I'm referring to today is a PBM regulation bill modeled on the Maine law, which is why when that got challenged and went up to the Circuit Court, it happened right after the Maine -- the First Circuit made a decision in the Maine case.

So the Circuit in D.C. said we'll go back and look at the Maine case and make a new decision, and then we'll look at it.

But what Senator Cummings was referring to is

that D.C. had originally -- one of the Council members had introduced a law to allow the City to in the case of public health emergencies, however the City chose to define that, that they could seize through eminent domain, which is the power of the State, the pharmaceutical patent, and then manufacture that or contract with someone to manufacture that drug as a generic at a cheaper cost.

And what happened with that bill, that was how it was proposed initially, and through their legislative process, it got modified into an excessive pricing legislation, which did pass, and that bill basically sets up a structure through which under certain circumstances, D.C. could look at the manufacturer's price of drugs and decide if they were low enough and then change the price or set a ceiling on the price, if under those circumstances, it was found to be excessive.

That is also in litigation, and that's in the court right now, and there's no decision on that yet so...

So the other -- the other point I just wanted to make in terms of the litigation, in the Maine case, the Court of Appeals had concluded that PBMs

were not fiduciaries under ERISA, meaning that Maine -- that left it open for the State of Maine to create the fiduciary relationship.

SENATOR CUMMINGS: I just want to check.

MS. LUNGE: Yeah.

SENATOR CUMMINGS: Does everyone know what ERISA is on the committee?

MS. LUNGE: ERISA is basically a federal law which talks about -- and this is -- it's a big law, so this is a really big generalization.

SENATOR AYER: But just as it applies to this.

MS. LUNGE: Right. As it applies to this, it regulates health benefit plans and says what states can and cannot do in that area, so for instance, we also -- we often refer to self-insured employers as ERISA plans, because ERISA says that we, the State, can't tell an employer what they can do or not do in terms of their health benefit plan, so if the employer chooses to be self-insured and offer that plan themselves, we don't have an ability to regulate that.

SENATOR CUMMINGS: We can tell insurance companies what they must include --

MS. LUNGE: Yes.

SENATOR CUMMINGS: -- in a plan that is sold within the state.

MS. LUNGE: Yes, but we can't tell employers what they can offer or not offer to their employees under ERISA. And it -- it also governs like pensions and other types of employee benefits.

SENATOR CUMMINGS: It just makes our life much more difficult.

MS. LUNGE: So the other case that I just wanted to mention is that in December of 2005, a jury in Ohio held that MedCo, which is a large PBM, did have a fiduciary duty under ERISA to one of its clients.

So you can see that -- I just raise that mostly to show you that the legal issues in this area are still very much open. There's not a lot of case law from the U.S. Supreme Court in this area giving us definitive answers, so legally speaking, what you -- what we can, we as Leg. Counsel, can give you is basically our best guess or our legal opinion on and descriptions of what other courts have found, but it's not an area -- it is a new area, so there's not going to be a lot

of definitive answers in the legal realm often to legal questions that come up so...

Questions for me?

FEMALE SPEAKER: There you go.

SPEAKER: In 1998, when we failed to pass and Maine passed its pharmaceutical bill, and then the industry began to challenge in court various provisions of it, the statement was often made that the industry would come in and say the way to save money is to negotiate this or negotiate that or to do it in bulk and follow this procedure and that when the states followed the industry's advice and did the things the industry were suggested, then industry would go ahead and sue the State court for having infringed upon them (inaudible) and would sue the states in court.

Was that a claim just pulled out of thin air, or is that, in fact, something that was taking place and continues to take place?

MS. LUNGE: Well, I actually wasn't here when you all -- in 1994, so I don't know really.

SPEAKER: '98.

MS. LUNGE: '98.

SPEAKER: But we failed to pass pharmaceutical legislation in every year, but that

was the year we were conspicuously failures.

MS. LUNGE: Right, so it's a little hard for me to comment on, you know, sort of industry's motives or the industry's, you know, representations to the Legislature because I just don't know. I don't know.

SPEAKER: Fair enough.

MS. LUNGE: But I think that it's fair to say that there has been lots of litigation in the area of pharmaceutical legislation when new initiatives or states have tried cost containment measures.

I think it's a fair statement to say that usually, there are lawsuits after either Vermont or Maine has passed kind of a new initiative in this area.

SPEAKER: So it was 2000 that we were more conspicuous.

MS. LUNGE: Yeah, and -- oh, and Senator Ayer, you had asked about the generic drug law.

From the statute, it looks like we originally had something about generics in 19 -- as early as 1977, but I think the current incarnation was 2001, so that's when the -- I think the mandatory substitution.

SENATOR CUMMINGS: We do did a pharmaceutical

one. I think it was the year before I came on this committee that was struck down.

MS. LUNGE: Yes.

SENATOR CUMMINGS: Because Maine's passed, and they're almost identical laws, but they put State money into it, and we didn't. There was a balance or something.

MS. LUNGE: We had -- their law -- there's a Maine -- there's a bunch of actually Maine initiatives that were all under the umbrella Maine RX, and that I think Maine RX is actually their -- their version of our Healthy Vermonters Discount Card, so we did have a number of -- they did Maine RX. We did Healthy Vermonters. They did Maine RX Plus. Then we had looked at doing Healthy Vermonters Plus I think, so -- and that litigation was about providing this discount card to uninsured individuals who weren't officially signed up for Medicaid, but allowing those people access to the Medicaid price, and that has been in its current incarn -- we sort of fixed some legal problems, some issues with it, and now, that's operating. We do have that running in both Maine and in Vermont.

The other piece of that though in Maine RX

was a price regulation piece, and that was enjoined by the court, and it was not appealed, so the initial court did enjoin it, and Maine didn't appeal it, so we don't know more.

SENATOR CUMMINGS: We initially looked at price setting --

MS. LUNGE: Uh-huh.

SENATOR CUMMINGS: -- in this committee and this body, and I believe we -- I know we passed it out of here usually on a future date, if failure to reach a certain level of pricing.

Can you tell us a little bit about the legal issues we ran into with that one?

MS. LUNGE: I think that -- I haven't actually reviewed the Maine case on that recently, but generally speaking, there's an issue around the commerce clause.

I think any of the excessive pricing, the eminent domain and that particular price regulation bill, the commerce clause is one clause of the Constitution that will come up because Vermont under the commerce clause, we're allowed to regulate commerce in our own state, but we can't tell people what they can do in New Hampshire or in New York or Massachusetts.

So I think when Sharon Treat talks to you next week, she'll probably talk about this type of -- if you ask her questions about it, she can give you a lot more information.

But some of the newer legal thinking in this area is that it's possible that it could be found permissible if the State was very clear that it was only looking at prices, comparable prices in state.

For instance, Wisconsin has an excessive pricing law that they call a price gauging law which says that people have -- within the state have to get comparable prices on pharmaceuticals. And that was actually upheld in Wisconsin. I haven't studied that case in depth, which I can certainly do if that's something you're interested in me learning more about to educate you about that issue.

And then there are also some cases in other states like the Maine case that said that Maine was overreaching in setting its -- its law.

And one of the issues in the D.C. case, in the D.C. excessive pricing case, one of the benchmarks they had in their law was looking at other countries, and then there was an argument

that that would violate the foreign commerce clause, which quite frankly, I'd didn't even know existed, but having to do with the states, or in that case, the District's ability to compare against foreign countries' pricing so -- and again, that's still in process. There's no definitive case law in that case yet, but that's certainly an area we can give you more legal background on if you're interested in the landscape there, and again, it is a new area, so there's not going to be an answer of if you do it this way, it's going to be a hundred percent, you know, unassailable in court. There will be a range of well, this court said this, and this court said that, and probably none of them are in our Circuit, so it's all advisory.

SENATOR CUMMINGS: Questions from the committee?

Okay. We'll get into this in more detail. If anything comes up, just give Robin a call, and she can explain it.

MS. LUNGE: Great.

SENATOR CUMMINGS: But we have -- I think this gives you -- we have done several pharmacy bills. Some of them, parts of them have made it

out of this building.
MS. LUNGE: And I think we probably went a little faster than we thought we would, so if you did want to walk through some of the pharmacy provisions from previous years, I can go make copies of those and do that this afternoon and do that also if you'd like to keep plugging away. I just need a few minutes to -- you'd have to take a break.
SENATOR CUMMINGS: If we do that today, it will probably get us out earlier tomorrow. Right?
SENATOR AYER: We went over that.
SENATOR CUMMINGS: Okay. All right. Therefore, let me get this copied, 15 minute break, but first, Jan Kennedy has a guest, a very brave guest.
MS. KENNEDY: Thank you, Madam Chair.
For the committee, since it's a new year, I'm Jan Kennedy, and I have a sole proprietor lobbying firm out of South Burlington, JB Kennedy Associates.
Today, I have with me a very -- as the Senator said, a brave guest, Andy, Andy Friedell, who is a government relations person with Medco, which is a PBM, and he --

SPEAKER: Which we've heard about.
MS. KENNEDY: Well, you've heard pieces of the story, so Senator Cummings kindly offered the opportunity for Andy to say hello to you today.
We do understand that there will probably be another time for him to come back and talk to you or someone else in the company in more depth.
So thank you. This is Andy.
SENATOR CUMMINGS: Okay. Andy, if you could just introduce yourself to the rest of us.
MR. FRIEDELL: Sure, yeah. My name is Andy Friedell. I'm Director of Government Affairs at MedCo.
I don't think it's being brave because I'm actually, you know, very proud of coming to work. We do help millions of Americans have affordable access to prescription drug care and, you know, I'd like to make myself available to the committee as you look at these issues and answer any questions you have.
I can do it now if you have time or at any time at your availability. We can do one on one or anything.
One thing I would say, you touched a little bit upon transparency, and the questions you asked

about transparency, is it available to customers or not?
The way our industry works, it is a very competitive industry. The Federal Trade Commission found out there's about 40 to 60 PBMs in the marketplace today, and when one of our customers puts out a bid because they want to get their drug benefit managed by a Pharmacy Benefit Manager, they set out the terms that will be met on their bid, and they spell it out in an RFP that they release. It's a very thick document that gets into details about how rebates will be shared, how interchange programs will work, things like that.
Companies like mine and our competitors all look at those bids and determine if we want to compete and make an offer on that bid, and we come to the table.
If we're not able to do it, certainly our competitors will, and right now, about -- I think about 70 percent of our business, and I think this is true across the industry, is transparent in that our customers have full access to understanding their rebates, pass-through of the rebates.

The 30 percent that does not, they've made that decision, and it's a business decision on their part because if they get the rebate, then they are budgeting on that rebate being there, and as you know, it may not be there.
A drug like Vioxx goes off the market. That rebate evaporates, and if they're counting on that rebate as part of their budgeting, suddenly they could be left with --
SPEAKER: Who is "they"?
MR. FRIEDELL: I'm sorry. The employers or the managed care companies, the people who are our customers who are paying the bills for an individual's drug benefit.
So if they're counting on that rebate, and it doesn't materialize, then they've got a budget shortfall, so a lot of times, some of our customers will tell us, you keep the rebates, and you give me a discount, a deeper discount across all the services I'm buying from you, and that way, then we are at risk for the rebate. If we lose the rebate, then we're out the money, but we still owe them the guaranteed discount.
It's just a matter of how some of our customers want to structure their contracts.

Some of the legislation that you've seen basically says the State is going to step in and say this is the kind of contract you'll have. It's a one size fits all, and everybody will have this kind of contract, and that's not how it works today in the --

SENATOR CUMMINGS: We did allow in our legislation, they just, you know, the option for just this is what I want, and I want it, and I don't want to with rebates.

MR. FRIEDELL: Uh-huh.

SENATOR CUMMINGS: We did hear that testimony.

MR. FRIEDELL: But anyway, like I said, I want to make myself available for any questions you have about MedCo, in specific, switching programs and the litigation that were mentioned, anything now or at any time. I'd be more than available.

SENATOR CUMMINGS: I think once we start into the minutae --

MR. FRIEDELL: Sure.

SENATOR CUMMINGS: -- of PBMs and really, we'd, you know, love to have you come back. We like charts, simple.

MR. FRIEDELL: Yeah. Actually, I do have a one-pager. This is -- the General Accounting Office did do a study on PBMs. This is a one-page summary. I have the full report I could leave to your counsel if that's --

SENATOR CUMMINGS: Okay. Yeah. We -- we try to keep at least one copy in here. We have a library.

MR. FRIEDELL: Yeah.

SENATOR CUMMINGS: So we'll have it here.

MR. FRIEDELL: This is the General Accounting Office's report on PBMs.

The Federal Trade Commission was also asked to do a report on PBMs. It's a little thicker, but they're both very positive, and I have summaries of the Federal Trade Commission's report as well.

SENATOR CUMMINGS: Robin probably wants those.

FEMALE SPEAKER: Robin may have seen those.

MS. LUNGE: Thank you. Okay.

MR. FRIEDELL: Thank you, folks.

MS. KENNEDY: And also, Andy is planning on staying over and will be around the cafeteria tomorrow morning if any of you have any questions

for him.

MR. FRIEDELL: Please.

MS. LUNGE: Thank you.

SENATOR CUMMINGS: Okay, committee, it's twenty after. Does that give you enough time?

(End of CD 07-23, Track 1.)

* * *

(Start of CD 07-23, Track 2.)

FEMALE SPEAKER: Okay, we're back.

MS. LUNGE: Here you go. So what I am handing out are the prescription -- the most recent set of prescription drug provisions that passed in H-524, which was the Green Mountain Health precursor to Catamount that was vetoed by the Governor, and you'll see at the top, there's a summary of the provisions and then the actual text of the bill, and I just -- since I know you haven't looked at much language yet, I wanted to just remind people that the headings, like the Pharmacy Best Practices and Cost Control Programs, are just headings for the bill to provide sort of guidepost markers of different parts of the bill. They're not actually law. They won't go into the statute books or anything like that.

SENATOR CUMMINGS: What's the difference

between session law and --

SENATOR AYER: You know, I still don't know that.

MS. LUNGE: Well, we can do that. We can do that, so there are -- we have two different types of ways that we pass law. One is called session law. Session law -- and I don't know if I have an example in this particular bill, but session law is something that comes out in those white books over at the end, and it doesn't go into the green statute books.

Normally, session law, you put something in session law if it's a temporary, of a temporary nature.

SENATOR CUMMINGS: Like budget.

MS. LUNGE: I'm going to deal with the budget differently so...

SENATOR CUMMINGS: Budget isn't in session law?

MS. LUNGE: It is, but it has special provisions.

SENATOR CUMMINGS: Okay.

MS. LUNGE: So for instance, let's say we wanted a one-time report or we wanted to set up a summer study committee.

We would put that in session law because ten years from now, we don't need it sitting in our statute books that in 1995, we had a summer study committee on prescription drugs.

SENATOR CUMMINGS: And it would consist of, and they will be paid such.

MS. LUNGE: Exactly.

SPEAKER: How about laws that have sunset clauses?

MS. LUNGE: Laws that have sunset clauses can go into statute and often do go into statute.

What would happen is --

SPEAKER: What happens when they're --

MS. LUNGE: Repealed?

SPEAKER: -- they're put in the book in the back?

MS. LUNGE: The publisher would update the statute and note that that law had sunsetted, and it was no longer in effect, so the publisher would do that as part of the yearly revision of the statutes with new law.

The budget, as Senator Cummings mentioned, is in session law because it is of course the budget for one year.

The budget also has a provision in the front

which says that anything in the budget bill only lasts during that fiscal year, so if you put something into the budget bill, if it's not codified in statute, it goes away at the end of the year. It's no longer binding law.

That's distinct from regular session law, which is still binding law for more than one year. It's just not the type of law that you would need to refer to over a long period of time.

SPEAKER: Is there subjective judgment involved in that?

MS. LUNGE: There is to some degree.

Usually, that's a judgment that we at Leg. Counsel make.

For instance, we happen to put the Mental Health Oversight Committee in session law, and originally, the Health Access Oversight Committee was in session law, but the Health Access Oversight Committee lasted for ten years, so last year, we put it in statute because it's clearly not going to go away.

It was originally designed to do one thing, and over time, it evolved, so it certainly is -- is something of a judgment, and sometimes, we don't quite get it right, and then we have to

revise things later on.

SENATOR AYER: Sometimes in the budget, we have things -- well, the State of Vermont will pay such and such $35 a year.

MS. LUNGE: Uh-huh.

SENATOR AYER: And it's not changed, so how do you -- how do you know -- I mean, we had some nursing home rates and things like that. If that's only in session law, how does it last forever?

MS. LUNGE: Well, usually, that kind of thing, it's built into the budget, and really probably, you should have somebody from JFO go into the minutae of how they build budget.

SENATOR AYER: Uh-huh.

MS. LUNGE: But I think the way they do it is they have something called steady state, which means the budget without any policy changes, and so each year's budget is built on what last year's budget had been built on, so if it's a new initiative, that will be put into text, so that it shows the change from last year, but then if that's an ongoing initiative, it would be inherent to the budget the following year.

That's my understanding, although I'm not a

budget girl so...

SENATOR CUMMINGS: We'll have staff -- actually, Steve's going to be here tomorrow. Tuesday, right? We'll go through the general fund and the ad fund. We're going to talk a little bit about what happened with the ad fund over the last two years, and you can ask him how he does that because we don't do budgets.

MS. LUNGE: And often, that kind of rate setting is done through procedures at the agency level too, so for instance, with nursing home rates, there's federal law about how you do nursing home rates for Medicaid, for instance, and they have a whole set of State regulations that deals with that, and when they want to change that, they would have to do that through a regulatory process, as opposed to our process so...

So -- so you'll notice the first example is an example of changing a statute, so you can tell that it's a statute because the Sec 20 refers to the section of the Bill H-524, and I just excerpted it and didn't change any of that, so that's why we're starting with Sec 20, and you can see that this amends a current statute because it

says 33 VSA.

VSA is the notation we use for Vermont Statutes annotated, so any time you see 18 VSA, 33 VSA, 1, 3, whenever you see that VSA --

SENATOR CUMMINGS: That's the number that's on the book.

MS. LUNGE: That's the green books. That's the statute.

Yep. That's the volume number, the title number, and then 1998 is the section number, so statutes are organized by volume or title. Then there are chapters, subchapters and sections. So in this case, we're amending just one particular section of statute, so that's what we've reproduced.

And the Pharmacy Best Practices and Cost Control Program is the name of the initiative that we did in Medicaid on pharmaceutical cost containments.

This is where we've established the Medicaid P.D.L., for instance, so -- and I'll also just mention that I haven't revised -- since I just cut and pasted this out of the old bill, I haven't revised it to reflect any new changes in the statute, so if you do take up some of these same

issues this year, it may look different than what you're seeing right now.

So any language that has a line through it means it's a strike-through.

Any language that has no -- so for instance, 1998, Pharmacy Best Practices and Cost Control, that's current law. You can tell it's current law because it's just stated there. There's no strike-through or underline.

The strike-through means we're crossing out current law. The underline means we're adding new language to current law.

So in addition to changing an old name, the first substantive thing this bill did was to clarify that we would use the statewide preferred drug list and then direct the Director of OVA, the Office of Vermont Health Access, that's the Medicaid office, to work with and encourage all health benefit plans in the state to participate in the Medicaid preferred drug list by inviting representatives of each health plan in the state to participate as observers or non-voting members in our Drug Utilization Review Board.

Our Drug Utilization Review Board is the committee that Steve had mentioned earlier that's

made up of some doctors, some pharmacists, some people from OVA, a bunch of -- I don't remember the exact composition right now, but that board looks at safety and efficacy and makes recommendations to Joshua Slen, the Director of OVA on what drugs should or should not be on the preferred drug list.

So this basically invites the health benefit plan representatives to participate in that process as a way of encouraging them to align their individual preferred drug list with the Medicaid preferred drug list so that we have a uniformity in that and can increase the negotiation power some.

So the strike-through is the current language on the preferred drug list which directs the Medicaid office and the Commissioner of BISHCA to implement a preferred drug list as a uniform statewide preferred drug list, so that is current law, and that's something that hasn't happened for a number of I think practical reasons.

And you'll also notice that current law directs the Commissioner of Human Resources to use the preferred drug list if participation in the program would provide economic and health benefits

to State employees, and then there's other language in there which was designed to protect I think State employees, and we've -- in the last version of the bill, we took all that out because it wasn't happening, so I think the -- the approach had shifted some to say okay, we're going to try and get people to use the same preferred drug list on a voluntary basis by involving them in this committee.

And then you'll see in 3, on the second page, that we also direct the Medicaid office to pursue strategies designed to negotiate with pharmaceutical manufacturers on behalf of individuals who are under the supervision of corrections, the division of mental health, so people who receive services through mental health or who are in the Vermont State Hospital or through D.C.F.-- that would be children in State custody, individuals who get prescription drugs through one of our Medicaid programs that we talked about the other day, and you can see the list is here, and workers' comp.

So we direct OVA to pursue strategies to try and negotiate on behalf of all these different people who the State purchases drugs for, and so

that was sort of a new approach that was taken because the old approach of just saying go forth and do a unified preferred drug list hasn't accomplished what you set out to accomplish.

You'll notice the next change is in Subdivision 4.

This subdivision sets up an evidence-based research education program, and we haven't really talked much about this yet, but this is also referred to as counter-detailing.

Detailers are folks who work for the drug companies and go out and market drugs to doctors.

So in current law, we've directed OVA to set up an evidence-based research education program to provide information and education on prescription drugs to physicians, pharmacists and other health care professionals who prescribe, and to the extent possible, the program should inform prescribers about drug marketing that is intended to circumvent competition from generics, and also, other educational materials. So that one piece was specified.

We again asked them to come back to the Senate and House Committees on Health and Welfare, as they were then called, no later than

January 1st, 2005, and I am trying to hunt up a copy of that report for you by tomorrow. I haven't gotten it yet, but I'm looking for it.

And then as I think I may have mentioned in this committee, this program hasn't started yet, so one of the initiatives that this committee had pursued before was to set an implementation date, which at the time, the future was July 1st, 2005.

This bill's a couple of years old, so if that was something you wanted to do, we'd obviously update that date. So that was another initiative in this bill.

On the next page, you'll see that this bill also directed the Medicaid office to negotiate a contract with a Pharmacy Benefit Manager that would further the goals of transparency, safety, quality and cost effectiveness and would consider both proprietary and nonprofit PBMs, as well as the a feasibility of a state-run PBM.

Now, I think as I mentioned when I was here last time, OVA has renegotiated their PBM contract, and we currently -- our new contract which happened last year is with a non-profit PBM, so they pursued -- I think they took this language from the previous bill seriously, and sort of

looked at other alternatives when they did renegotiate their contract, so that's -- they're currently with Metrix, which is a non-profit.

9. This would direct the Medicaid office to provide information on programs offered by pharmaceutical manufacturers that provide prescription drugs for free or reduced prices.

Many drug manufacturers offer programs to give you free drugs or reduced prices.

I don't know the details of those. Each manufacturer has their own program.

I do know that the area agencies on aging are helping people apply for those programs, so they--if that's something you're interested in getting more information, that might be a source of kind of what do those programs look like? How different are they from one another?

And I know that there had been some effort I believe for manufacturers to kind of create a website that people could apply for multiple programs through one place, and I'm not real up to date on where that -- I think that happened. I'm not real up to date on the details of that.

Number 10. Another new initiative was to create a plan to encourage Vermonters to use

Federally Qualified Health Centers, FQHC's and FQHC look-alikes.

I am going to bring you a list tomorrow of our current facilities that meet those criteria, and the purpose of this was to focus on participants in the Medicaid and Medicaid waiver pharmacy programs, State employees, individuals under the supervision of corrections and individuals receiving workers' comp benefits to see how we could improve the use of FQHC's by those folks because of -- I think we mentioned -- we talked about this brief, the 340B pricing, which is available through the FQHC's, and that's a much lower price than even the Medicaid price, so that would be a way of providing access to pharmaceuticals that are at a lower price for these groups of people that the State is contributing funding.

SPEAKER: What is an FQHC?

MS. LUNGE: An FQHC look-alike is -- well, let me start with an FQHC.

An FQHC is a federal designation that a health center can apply for from the federal government, and if they meet certain criteria, and I can't really tell you the details off the top of

my head, but if you meet certain criteria, including providing services at free or reduced cost for lower-income people on a sliding scale level, if you meet the criteria, you can get federal money to do -- for the sliding scale fee, so it's usually targeted towards allowing greater access at a lower cost, and the other big federal perk you get is the 340B pharmacy pricing.

Now, an FQHC look-alike is a health center that looks like an FQHC, but has not yet met all the federal criteria to get the federal designation, so they still offer free or reduced care, but they don't get the federal subsidy for that. They do get the 340B pricing.

Is that clear as mud?

My understanding is the main difference is that the FQHC's get federal subsidies to assist in the sliding scale fee.

The FQHC look-alikes don't, so they would be giving free or reduced care, primary care.

SPEAKER: Is that a legal term? I mean, it's in the statute?

MS. LUNGE: Yes. It's a legal term.

SPEAKER: It is a legal term now, but I mean...

MS. LUNGE: It's a federal legal term.

SPEAKER: It is?

MS. LUNGE: It's in federal statute, yep. So it refers to a specific federal designation.

The next part of the bill is the PBM regulation part that we've started discussing today, and this would create a new subchapter in Title 18.

SENATOR CUMMINGS: Robin, before you go --

MS. LUNGE: Yes.

SENATOR CUMMINGS: -- I've been summoned to the Speaker's office.

MS. LUNGE: Okay.

FEMALE SPEAKER: So I'm going to leave Senator Ayer in charge, but before I left, because it's going to come up on the floor tomorrow, there were a whole bunch of transportation bills that came in. I was notified that of the three, they'll have the second reading tomorrow.

The question is do we want to take them in, or do they affect the -- because one of them requires no title if it's over fifteen --

SENATOR AYER: The boats.

SENATOR CUMMINGS: The boats, and then this is from Bonnie Rutledge, and the impact would be

less than a few thousand dollars, so unless someone strongly objects, I'm not going to ask to have the bill come in.

The same would be for the medical marijuana bill. It will have diminimous effects, and so that was it.

And I'm going to go. I'll let you continue. This is a discussion of broadband, so I'll let you know what we find out.

Okay?

Claire, you're on.

SENATOR AYER: I was just thinking about the boat though. The whole Mosquito Control Program is funded by boat registrations, the entire program until they pass the new budget.

SENATOR CUMMINGS: Oh, those mosquitoes are in trouble now.

(Multiple speakers, inaudibly.)

FEMALE SPEAKER: Well, the Governor put it in the budget (inaudible).

SPEAKER: And so are the access areas.

SENATOR CUMMINGS: We are doing -- we are doing that though.

SENATOR AYER: Are they?

SPEAKER: Boat registrations.

SENATOR AYER: Okay.

SENATOR CUMMINGS: But we can ask to have a committee. There's some serious concerns.

SPEAKER: It looks like we're going to lose some money.

SPEAKER: Maybe we can add some.

SENATOR AYER: Go ahead, Robin. I'm sorry.

MS. LUNGE: Okay. No, that's okay.

So this is the PBM part of this bill that had passed in previous years, and you'll see the first section is a definitions section, and it defines several terms, including beneficiary, which means an individual enrolled in a health plan in which coverage of prescription drugs is administered by a Pharmacy Benefit Manager and would also include that person's dependent or other person who gets health coverage through the primary policy holder.

Health insurer, we use a definition existing already in Title 18, so that's the first reference, and we also add into that term for clarity that this would include the State of Vermont and any agent or instrumentality of the State that offers, administers or provides financial support to State government. It would include Medicaid, VHAP, and the pharmacy

assistance programs, as well as any other Medicaid waiver pharmacy program that we're offering.

Health plan means health benefit plan by an insurer doing business in Vermont.

Pharmacy benefit management is an arrangement for the procurement of prescription drugs at a negotiated rate for dispensation within Vermont to beneficiaries or the administration or management of prescription drug benefits provided by a health plan for the benefit of beneficiaries or any of the following services regarding the administration of pharmacy benefits; mail service pharmacy, claims processing, retail network management and payment of claims, clinical formulary development, rebate contracting and administering and then certain patient compliance and generic substitution programs and disease management programs.

Pharmacy Benefit Manager is an entity that performs pharmacy benefit management, as we just discussed it, and it would include a person or entity acting for a PBM in a contractual or employment relationship in the performance of that management for a health benefit plan.

9472 would establish the required practices,

so this would be what the State would be requiring pharmacy benefit managers to provide as part of their management.

So the first is that the Pharmacy Benefit Manager is required to discharge its duties with care, skill, prudence and diligence under the circumstances then prevailing that a prudent Pharmacy Benefit Manager acting in like capacity and familiar with such matters would use in the conduct of an enterprise.

So that is the standard of care essentially that we're -- or the fiduciary duty standard that we would ask the company to perform its duties with.

Also, provide all financial and utilization information requested by the health plan relating to the benefits of that health plan's beneficiaries, and all financial and utilization information relating to services to that health plan, so that lets the health plan have information relating to themselves or their beneficiaries.

A Pharmacy Benefit Manager providing information may designate the material as confidential, and the information designated as

confidential and provided to the health plan may not be disclosed to the health plan without consent of the PBM.

So again, that's the confidentiality protection for the PBM.

Now, the exception to that would be a filing in court under a consumer fraud provision or, of course, if the court were to order something for good cause.

Notify -- another duty, notify a health plan in writing of any proposed or ongoing activity, policy or practice of the PBM that presents directly or indirectly any conflict of interest with a requirement by this part of the law, and then also, adhere to the following list with regard to dispensation of substitute prescription drugs.

So we talked a little bit about when -- that some of the laws set up rules for when PBMs could substitute or request, I should say, a substitution of a drug so that's what this is -- these two things are about, so with regards to substitution, when the substitute drug costs more than the prescribed drug, the PBM must disclose to the health plan the cost of both drugs and any

benefit or payment directly or indirectly made to the PBM as a result of the substitution, so that the health plan knows Drug A costs this amount, Drug B costs this other amount, and how much is the PBM getting for selling A versus B?

Transfer in full to the health plan any benefit or payment received by the PBM as a result of a prescription drug substitution, so passing on any rebates to the health benefit plan instead of maintaining the rebates at the pharmacy benefit level, so that's as a result of the drug substitution or the result of substituting a lower-price generic or therapeutically-equivalent drug for a higher-priced drug, if the PBM derives any payment or benefit for the dispensation of prescription drugs in Vermont based on volume of sales, so a volume discount for instance, for certain drugs or classes or brands, that that payment would also be passed on to the health benefit plan unless the contract between the PBM and the health plan provides otherwise, so the law still allows for people to contract around this provision if they decide to structure their relationship that way.

Disclose to the health plan all financial

terms and arrangements of any kind that apply between the PBM and the drug manufacturer, including formulary management and drug switch programs, educational support, claims processing, pharmacy network fees and data sales fees.

A PBM again can designate the material as confidential. And there's a prohibition against the health plan disclosing that information except in the two circumstances we just talked about, so it's the same language as previously.

Compliance with this section of the law is required in all contracts in the State of Vermont, so that would be contracts for pharmacy benefit management by a health plan in this state.

9473 describes the enforcement of the provision, so if there's a violation, how does -- what happens?

So in addition to any remedy already established under Title 18, a violation of this subchapter would be considered a violation of the Vermont Consumer Fraud Act, which is an existing law, and all rights and remedies available to the Attorney General and private parties to enforce the Consumer Fraud Act are available to enforce provisions of this subchapter.

So basically, what this section does is say in addition -- it just makes it clear that it could be a violation of the Consumer Fraud Act if you violated something in this part of the law.

In connection with any action for violation of the Consumer Fraud Act, the Commissioner determinations concerning the interpretation and administration of these laws and any rules adopted under this section carry a presumption of validity. The Attorney General and the Commissioner shall consult with each other prior to the commencement of any investigation or enforcement action.

So again, the Commissioner in this paragraph refers -- would refer to OVA I think. Let me just double check that.

Oh, under Title 18, I believe it's the Department of Health, so that's something we should probably clarify, actually, is what Commissioner do we mean? Because it's not clear if we mean health or elsewise, and actually, it may be BISHCA, now that I think about it. I have to look at which section of the statute, so I think it's BISHCA, but I think that should be a little clearer.

So there's a consultation between the A.G. and BISHCA, and BISHCA has the authority to enforce the violation under another current provision that they have enforcement power under.

So the next section is a standard section we put into law when it affects contracts to make it clear when the law would apply to contracts, so it would specify that this would apply to contracts executed or renewed on or after September 1st, 2005.

Obviously, that would be updated, and for the purposes of this section, a contract executed pursuant to a Memorandum of Agreement prior to September 1st, 2005 is determined to be before that date, so that's just a clarification so people know when the law would apply to them in their contract negotiations.

The next section changed our pharmaceutical marketer disclosure law.

We talked about this a little bit previously, that we have a law that requires drug companies to disclose certain marketing activities.

What you see here is the repeal of an exemption, so they have to disclose marketing activities except -- and then there's a list, and

you'll see one of the things they currently do not have to disclose are grants for continuing education medical programs, so this would require them to disclose grants for continuing medical education programs.

We also add that disclosures of unrestricted grants for CME programs shall be limited to the value, nature and purpose of the grant and the name of the grantee. It does not have to include individual participants in that program.

SENATOR AYER: Well, what's a grantee if that's not the participant?

MS. LUNGE: Well, let's say -- I think it -- it's a good question, but for instance, if I was UVM, and I was putting on a CME --

SENATOR AYER: Uh-huh.

MS. LUNGE: -- if I got a grant from a pharmaceutical marketer or a pharmaceutical company -- excuse me.

SENATOR AYER: Uh-huh.

MS. LUNGE: I, UVM, would be disclosed, but you Clair Ayer, who happened to sign up for the UVM conference wouldn't?

SENATOR AYER: Okay.

MS. LUNGE: So you're the -- it would be the

Page 50

person actually getting the money, not necessarily the people who sign up for the program.

The next part of this bill was a provision on pharmacy discount plans.

You'll remember we talked a little bit about the Healthy Vermonters program, and that is again the discount card that allows certain uninsured Vermonters under certain incomes to get the Medicaid price, which is a lower price than you would get as an uninsured person walking into the pharmacy.

So the first -- Ann mentioned the different lawsuits in this area, and at one point when we passed this program, we assumed that we might need a Medicaid waiver in order to implement a slightly higher income limit.

We went from 300 percent of poverty to 350 in doing the Healthy Vermonters Plus Program.

The way the law after -- the law got clarified through these cases, and again, I haven't read them recently enough to be more specific than that, and I can certainly -- if this is something you decide you want to look into, I can give you the specifics of it, it became clear that Maine has implemented their program without

Page 51

needing a Medicaid waiver because you're not actually using Medicaid funds to pay. There's no -- the state's not contributing necessarily Medicaid funds to this program because what we're insuring is that you get a particular price at the pharmacy. The State isn't subsidizing the purchase in any way.

So what this does is simply change our current language to say we don't -- you know, we can implement it without the waiver, so it would -- because right now, this program is not implemented, and even though the law has directed the Agency to seek a waiver, I don't believe they actually have applied for the waiver, although I'm pretty sure they did not include it in the global commitment waiver or in any of the recent waiver amendments that they filed, so I don't think the Agency has sought to pursue this.

The next section is a price disclosure and certification provision, and this would add a new provision to law which would require the manufacturer of drugs dispensed in this state under a health program directed or administered by the State so that, for instance, would be Medicaid.

Page 52

It would require the manufacturer on a quarterly basis to report the pricing, the following pricing for the drug using the national drug code number to the Office of Vermont Health Access for each drug that Medicaid has paid for, so this would give OVA more information.

So the first price is the average manufacturer price.

Steve talked about that a little bit earlier, and the best price, which Steve sort of talked about a little earlier when he said that Medicaid is required to receive the best price, and that's the federal citation about how the best price is determined.

The pricing information required under this section is for drugs defined under the Medicaid Drug Rebate Program and would be submitted to the Director after the drug company has made a similar submission to the federal government in accordance with federal law, and when a manufacturer reports the average manufacturer price or best price, the President or its CEO of the manufacturer would certify to OVA on a form provided by OVA that the reported prices are the same as those reported to the federal government for the applicable rebate

Page 53

period. So that would require the CEO to actually say okay, this is exactly the same as what we reported, the best price to be to the Feds.

Information submitted to OVA under this section would remain confidential and would not be a public record, and disclosure may be made to the office -- by the office to an entity providing services to the office under this section, as long as that disclosure doesn't change the confidential status.

So for instance, if OVA needed to tell someone they were working with the price, that's okay, as long as that person is also required to keep it confidential, so it maintains the confidentiality of the information, but allows OVA the ability to pursue what it needs to pursue in the administration of the Medicaid program, and the information may be used by that entity only for the purposes specified by the office in its contract with the entity.

Data compiled in aggregate form by OVA for the purposes of reporting are public records, provided they do not reveal trade information protected by State or Federal law.

So there is some public information about

general aggregate numbers, but not the details of who -- each drug company's price for a particular thing.

So the A.G. also has enforcement authority under this section through the Consumer Fraud Act.

So that's what was passed in H-524.

SENATOR AYER: Any questions from the committee?

SPEAKER: That's a good rundown.

MS. LUNGE: Thank you.

I would have had to go a little faster.

(End of CD 07-23, Track 2.)

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Katherine W. Milam, Notary Public, and Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 07-23, Tracks 1 and 2, the Senate Committee on Finance, Thursday, January 25, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 7th day of April 2008.

_____
Katherine W. Milam, RPR
Esquire Job No. 928008

STATE OF VERMONT

HOUSE COMMITTEE ON FINANCE

SENATE FINANCE COMMITTEE

Date: Thursday, January 25, 2007

Committee Members:

Sen. Ann Cummings, Chair
Sen. Claire Ayer, Vice-Chair
Sen. Mark MacDonald, Clerk
Sen. Bill Carris
Sen. Hull Maynard, Jr.
Sen. Richard McCormack

CD No: 2007-22

Esquire Job No. 928009

- - -

PROCEEDINGS

- - -

(Start of CD 07-22, Track 1.)

FEMALE SPEAKER: Senate Committee on Finance, January 25th, 2007.

(End of CD 07-22, Track 1.)

* * * * *

(Start of CD 07-22, Track 2.)

SENATOR CUMMINGS: And this is starting our work on prescription drugs, and by the time we're finished, we may all need some.

SPEAKER: Do you have samples? We are going--

SENATOR CUMMINGS: Yes. I mean I've set agendas where it says drugs in House Chamber. They're doing drugs upstairs.

So anyway, Steve Kappel is here to kind of walk us through cost drivers, spending.

MR. KAPPEL: And a little of everything.

SENATOR CUMMINGS: And a little of everything. This is our kind of intro -- and you're also going to do introduction to pharmaceutical pricing.

SENATOR AYER: You can't just say, Who knows?

SENATOR CUMMINGS: A.W.P.

SPEAKER: I was actually going to say, How much do you want it to be?

SENATOR CUMMINGS: Okay, so this is just -- I'd say at least half this Committee has not done prescriptions before, so this is our kind of introduction as to what they are, what the cost drivers are.

SPEAKER: Okay, good.

SPEAKER: There are more if there's not enough.

MR. KAPPEL: Okay. Steve Kappel from the Joint Fiscal Office. We'll do a fun-filled world-wind tour through the exciting world of pharmaceuticals today and also a little bit more tomorrow. There will be lots and lots of stuff today particularly, so as usual, I make my plea, if I say anything that makes no sense to you at all, please stop me. If you have questions, certainly stop me because we'll be doing a lot of stuff quickly.

Okay. The big question first, why drugs? Why -- what's all the interest in drugs? And I think it really comes from two major places.

The first is even compared to underlying

health care spending growth, pharmacy spending is even faster, and we'll talk about that in some more detail in a minute.

The second thing is there's a lot more use of what's called out-of-pocket spending for pharmaceuticals. People tend to pay more cash, less kinds of insurance coverage, so because of that, they're much more directly affected by the cost of drugs than they are affected by the cost of a stay in the hospital, for instance, and that out-of-pocket spending includes some health insurance that just simply doesn't cover drugs at all, a lot of cost-sharing requirements. There's more and more of high copays for drugs in an effort to control costs.

Lately, there's been things like caps on coverage, so you have drug coverage up to $2,000 a year, and then it ends, and of course, the uninsured, who get to pay cash for everything.

In the credit where credit is due department, I'm going to use numbers from three sources. Any Vermont specific numbers come from the Department of Banking, Insurance, Securities and Health Care Administration, hereafter referred to as BISHCA to avoid ever having to say that again.

BISHCA does an annual expenditure analysis which looks at all of the health care spending in Vermont two different ways: Where the money comes from and where the money goes. It's probably one of the really useful basic sets of numbers we've got about health care.

National numbers come from two sources. The first is the Centers for Medicare and Medicaid Services, the famous CMS. No one ever figured out where the second "M" went. We won't go there either.

The second is what's called the Medical Expenditure Panel Survey. This is something another federal agency called the Agency for Health Care Research and Quality does periodically, and it basically is a very detailed tracking of a large number of individuals' health care spending, so they ask people to keep journals and write in the journal what drugs they're taking, how much they pay for them, when they go to the hospital, when they go to the doctor, so it's a great use -- a great source of very basic spending information, but it's national, not state-specific.

Okay. Next chart, just to put things in

perspective, the red bar is what's called drugs and supplies in the BISHCA expenditure analysis.

What you can see from that is drugs and supplies are probably almost as big a spending area as physicians and second only to hospitals. Everything else is smaller, so drugs are a major chunk of health care spending in this state.

To make the point about out-of-pocket spending, the next chart compares health care spending by source of funds, so this is what percentage of spending is out of pocket for all health care, what percent of spending, out of pocket for drugs.

What you can see there is all health care out of pockets less than 15 percent of spending. Drugs and supplies, it's over 35, so again, much heavier reliance on direct cash payments for drugs.

Everything else, insurance and Medicaid, the share of spending that's out of pocket is similar, or the share that's paid for is similar. Sorry. I'm not entirely coherent here, but I'll get there in a second.

The asterisk next to Medicare, up until last year, Medicare did not pay for drugs at all, so

that's why there's nothing there from 2005.

Starting last year, Medicare Part D, which is the new Medicare benefit that covers pharmaceutical drugs, that moved a lot of spending over to Medicare, so the next time BISHCA does this analysis, things will change quite a bit.

The second part of the equation, rate of growth in spending. The chart there shows rate of growth for drugs and supplies, all other health care spending and CPI in Vermont for the last nine years.

What you can see is by and large, drugs and supplies are growing much faster than health care, which itself is growing much faster than CPI.

SENATOR CUMMINGS: What happened in '05?

MR. KAPPEL: Ah, I'm glad somebody asked that. I'm not sure.

Sometimes BISHCA has methodology changes that make numbers change. Sometimes they have sources of data that only come out every two or three years, so sometimes, you'll see year-to-year patterns that look a little peculiar.

Look more generally at kind of the overall pattern. Rate of growth is probably --

SENATOR CUMMINGS: Yeah, I mean I don't think

we've done that good of a job.

MR. KAPPEL: Well, it's still running about 50 percent higher than health care spending, which is running about twice CPI, but the drugs look like they're slowing. And we'll talk some more about that in a second.

One of the consequences of drugs growing a lot faster or drug spending growing a lot faster than health care spending as a whole is the share of our health care dollar that goes to drugs and supplies is going up.

So in 1996, it was a little over 10 percent. It's now about 15-1/2. So drugs as a share of spending is going up.

The next graph on that page, this is historical and projected national growth and prescription drug spending, so this is one of those numbers from CMS. Some pretty dramatic shifts going on.

I'm not sure what happened in the early 90s. We need to try that again sometime soon.

But what you can see is things peaked around 2000 and have been coming down pretty substantially, and what the Feds are projecting is a much more moderate rate of growth going into the

future than what we've seen in the past several years.

SENATOR AYER: Is that total?

MR. KAPPEL: Yep.

SENATOR CUMMINGS: Yeah, but I'm just looking at -- you've got a pretty consistently-erratic pattern, and all of a sudden, it's going to level out. Are the Feds planning on doing something?

MR. KAPPEL: No. This is just the way the Feds model things. They wouldn't model that year-to-year twitchiness.

SENATOR CUMMINGS: Is that called wishful thinking?

MR. KAPPEL: It's called averaging over the long run.

SENATOR CUMMINGS: Okay, yeah. So if you average this, yeah, you could get a fairly flat line --

MR. KAPPEL: Yeah.

SENATOR CUMMINGS: -- which would in no way show the radical ups and downs.

MR. KAPPEL: Yeah.

SENATOR CUMMINGS: Okay.

MR. KAPPEL: But what they do when they create these projections is they do look at

historical stuff, but they also look at things like what new drugs are in the pipeline? How are the demographics changing? How will Part D affect aggregate spending? And Part D will affect the total spending to some large extent, so they put a lot of things in the pot, stir it up a few times and come out with a nice straight line.

SPEAKER: But it's still above 8 percent?

MR. KAPPEL: Yeah, so it's still also above underlying health care spending.

SPEAKER: And it's still projected.

MR. KAPPEL: Yeah, and that's way above CPI. Okay. Any questions on that stuff? Good.

SPEAKER: Maybe we could follow the Governor's lead and put a cap on prescription drug bills.

(Multiple speakers, inaudible)

MR. KAPPEL: Okay, onward.

SENATOR CUMMINGS: Onward.

MR. KAPPEL: Drug spending in the U.S. population, so this is MEPS data.

So among the 300 million of us, about 64.4 percent had some expenditure on drugs in 2003, so about two-thirds of all Americans buy drugs of some sort.

SENATOR CUMMINGS: These are prescription drugs?

MR. KAPPEL: Prescription drugs, yeah.

Two statistics, mean and median. Let's take a brief detour and talk about why those are so different.

Mean is just the plain old average, so you add up everybody's spending, divide by the number of people, you get the average.

Median is the spending level at which half the people are above, half of the people are below.

When you see mean a lot higher than median, what that means is there is a small number of people spending a whole lot of money, so those guys are contributing disproportionately to the average, and what you can see is the next statistic down, the 10 percent of Americans who consume the greatest number of prescription drugs account for about two-thirds of all spending, kind of a classic health care pattern, highly concentrated.

SENATOR CUMMINGS: That's the expensive end.

MR. KAPPEL: Yep. The top 30 percent, almost 94 percent of all spending, and pretty much the

bottom half probably have one or no prescriptions a year, so the guys for whom there are substantial drug spending, it's very, very significant amounts of money.

Another way to look, top selling drugs. This is a really interesting thing to look at. I've got a summary on this slide, but there's also on the last page of the handout, for those who like lots of little numbers, this is a sheet of the top ten pharmaceuticals by total sales by just dollars in the United States, 2000 to 2004.

A couple of real interesting things to notice here, Lipitor has stayed in first place, but has almost tripled from 2000 to 2004, so about 3.3 billion to 9.3 billion.

Lipitor alone is 4.8 percent of all drug spending in the United States.

SPEAKER: How much? 4 point?

MR. KAPPEL: 4.8 percent of all drug spending.

SENATOR AYER: Didn't they -- I think they changed some therapeutic numbers there which could account for that.

MR. KAPPEL: That could be.

SENATOR AYER: I think they did.

MR. KAPPEL: The next biggest spender in 2004 was also a statin. Statins are those drugs that lower cholesterol, so if you kind of look down the right side of the page, I just listed what kind of drugs each one of them is. And it says a whole lot about America.

Cholesterol, cholesterol, anti-acid, anti-acid, anticoagulant, asthma, hypertension, antidepressant, painkiller, heart drug, anti-acid.

SPEAKER: We don't eat right.

MR. KAPPEL: We don't eat right. We don't live right. We may have some responsibility for our health care spending.

SENATOR AYER: Isn't -- didn't we learn that Nexium -- isn't Nexium the purple pill that was a (inaudible) drug, and there was another drug that proceeded it before? It was (inaudible) exactly the same thing.

MR. KAPPEL: I think Prilosec was the --

SENATOR AYER: Was it Prilosec?

MR. KAPPEL: -- the one before it. What the manufacturers will sometimes do is just slightly change --

SENATOR AYER: Yeah.

MR. KAPPEL: Come out with a new drug on

patent because --
SPEAKER: It's to extend their control.
MR. KAPPEL: Yeah.
FEMALE SPEAKER:
SENATOR AYER: Look at the difference in the prices though. It's amazing, going from the first two years of Prilosec and the last two years of Nexium.
MR. KAPPEL: There's all sorts of interesting things going on, but the other thing to take a peak at is that bottom line number, $190 billion on drugs.
SENATOR CUMMINGS: Billion?
MR. KAPPEL: Billion.
SENATOR CUMMINGS: Yes.
SENATOR AYER: Can I ask another question?
MR. KAPPEL: Please.
SENATOR AYER: These drugs down here that don't have columns all the way across, did they drop out of the market?
MR. KAPPEL: They dropped out of the top ten.
SENATOR AYER: Oh, the top then.
MR. KAPPEL: The data I had just had the top ten, so they're still around. They're probably just a little lower down the list.

SPEAKER: To have been replaced by something else.
MR. KAPPEL: Yeah, and one of the things they've been replaced by -- we'll talk about it in a little more detail is Celebrex, which is an interesting history in itself.
FEMALE SPEAKER: Yeah.
MR. KAPPEL: Next chart, top of page 6, again just trying to give you the big picture, this is a table of pharmacy spending by medical condition, so let's look at hypertension.
The first column is total health care spending for that condition, so about $38 billion.
Of that 38 billion, 22 billion is prescribed medications, so hypertension is particularly dependent on pharmaceuticals for its treatment.
The condition itself is about 3.9 percent of all health care spending, but it represents about 11.5 percent of all pharmaceutical spending.
And then the last column, 58 percent of all the costs for hypertension are pharmaceuticals. So a lot of stuff on that page. Does that make sense?
SENATOR AYER: That's percentage of total care?

MR. KAPPEL: Yep.
SENATOR AYER: For that diagnosis?
MR. KAPPEL: Yep. So the 22 million on prescribed medications is 58 percent of the 37 or 38 billion in total spending on treating hypertension, so that's a particularly dependent diagnostic category on drugs.
Just for contrast, look at heart conditions, second one up from the bottom. That's the biggest category for total health spending, that 90 billion, much, much less reliant on pharmaceuticals, a lot more hospitalizations, things like that.
SPEAKER: What's hyperlipidemia?
MR. KAPPEL: High cholesterol.
SENATOR AYER: High cholesterol.
SENATOR CUMMINGS: I think Senator Ayer (inaudible) tutorial on medical terms.
SENATOR AYER: Well, that's about all I know anymore. Things have changed.
But you know, it's interesting, heart conditions, most people who are treated for a heart condition also have a diagnosis of hypertension, a lot of them.
MR. KAPPEL: Yep.

SENATOR AYER: So it's not, it's not that there's a huge -- that it's disproportionate. It's reasonable.
MR. KAPPEL: Yeah, I'm sure the line between us is not perfectly clear.
SPEAKER: Are beta blockers considered heart condition pills?
SENATOR AYER: Yeah.
MR. KAPPEL: Beta blockers I think are congestive heart failure, but also, hypertension.
SPEAKER: Well, that's what I'm getting at is I'm thinking if you're taking a beta blocker for hypertension, does that show up as a heart condition?
MR. KAPPEL: The way MEPS works, they actually have the diagnoses that you in particular have when you respond for surgery.
SPEAKER: So it's not just the drug. It's why the drug?
MR. KAPPEL: Yes.
SPEAKER: So you can be multiply diagnosed then?
MR. KAPPEL: Yeah. Okay?
The next way of looking, brand and generic, and we'll have lots more conversations about this.

Just as a way of stepping back, brand drugs, one company has a patent. They and they alone can sell that particular formula. When the patent expires, the drug is then available for generics to be sold. Generics are identical to brand drugs in the active ingredient, but they're not necessarily identical in all the other stuff that makes the medication. So the stuff that makes the pill may be different, but the active ingredient is the same.

SENATOR AYER: When did -- I'm just seeing the percentage in these sales numbers. When did we put in the generic legislation? When did we pass that, that the doctor has to write no, brand name only, no substitutions for all drugs?

I'm just wondering if it coincides with one of these big pills.

MR. KAPPEL: I don't think it would have that big of an effect.

SENATOR AYER: You don't think so?

MR. KAPPEL: I think it slows things down, but if you look at the next chart, in fact, the next chart just divides nationally brand and generic spending, so between 1999 and 2003, brand name spending rose from 75.5 billion to 141, about

an 88 percent increase.

Generic spending rose just slightly faster, so generic share of total spending went up slightly, but not that dramatically, and a lot of states have had things like mandatory generic substitution and things like that, so I think what it probably does is slow the growth down a little bit, and we'll talk -- if we can get a little further on into exactly the effects of generics on drug spending, but I don't think you could point to a single year and say that was what happened that year.

Okay. Cox 2 inhibitors, cyclooxygenase I think is its name. Anyway, Cox 2 inhibitors were first developed as an analgesic, a painkiller that when they were developed, it was believed had a big advantage over things like aspirin and the other NSAIDS, nonsteroidal antiinflammatories because they reportedly produced a lot less, a lot less gastrointestinal problems. Aspirin, in particular, has a problem with causing stomach bleeding, so the Cox 2 inhibitors came on the market with what everyone thought was a lot of protection against that problem.

They came on the market in 1998, and what you

can see is what's really striking about new drugs coming onto the market.

1997, total spending on these NSAIDS, this whole class of drugs was about 3.2 billion.

By 2003, other than the Cox 2 inhibitors, spending had fallen very slightly to about $3 billion, so that's constant dollars there, so we're controlling for inflation.

Spending on the Cox 2's was 5.5, so what you see is not that the drug is doing a whole lot of replacing. It's adding a whole lot of costs, and there may well have been consequences outside drug spending, like reduced hospitalizations for ulcers, things like that, but the effect within the pharmaceutical spending is just to drive spending up, leading to the next slide.

What does drive health care spending up? What drives pharmaceutical spending up? The big three: Prices, utilization and intensity.

Prices are the amount you pay for the same product over time. Utilization, just how much of the product you buy, and intensity is the mix.

The best way to think about this is when you go grocery shopping, your spending from week to week on groceries can change because the store

raises all its prices.

It can change because people are coming over for dinner a couple of times this week, so you're buying more groceries. That's utilization, or you can change because you've gotten tired of store brand, and you've decided to start buying some of the fancy brands of things. That's intensity.

The exact same things happen in health care. Exact same things happen in pharmaceuticals.

Someone going from aspirin to a Cox 2 inhibitor like Celebrex, spending goes up, even though utilization may be exactly the same, and prices may be exactly the same. That's the intensity piece of the equation, so three of those actually contribute to the spending growth.

And cleverly enough, the next slide is well, how much does each one of them contribute?

A lot of studies have looked at this question. They've really had very similar results.

The one I picked is one by Express Scripts, which is one of the big PBMs, and they do an annual report on drug spending within their business, so this may not be the perfect representative of the entire universe of drug

spending, but I think they do a pretty good job, and they have done this consistently for several years, so it's a nice time series. They break things down a little more detailed than I do.

So the next slide down the top half is the way they present spending growth, and then I folded it into the way I'm doing it.

So inflation, the price thing pretty much going up about 6 percent a year, so this is the exact same market basket of drugs year over year over year. The costs go up about 6 percent.

Units per script, they break that out separately. I would call that a piece of utilization.

That means last time, the prescription was for 30 pills. This time, it's for 40 pills, so that's a utilization measure.

Brand and generic, real interesting thing going on there, has a negative effect, so this is the consequences of people moving from brand to generic, so that has been the one thing that's going down, and in some ways, they even --

SENATOR AYER: This is the impact on total spending?

MR. KAPPEL: Total spending by Express

Scripts.

SENATOR AYER: Okay.

MR. KAPPEL: So what they're seeing in their business is everything else is pushing their spending up, but movement from brand to generic actually pushes it down about 2 percent a year, and that effect's actually been growing, so again, this is the good news consequences of people starting to push harder and harder to switch from brand to generic.

Therapeutic mix, that's that idea of what kinds of drugs am I putting in the basket?

So Express Scripts adds all of those up and calls that cost per script, so each prescription that they pay for, all those factors stirred together is going up about 7.3 percent a year.

Utilization, which they break out separately, is going up about 5 percent a year, so combine the cost per script and utilization, and you get what they call the same drugs growth, which is up around 13 percent a year.

What they do that's really handy is they add on top of that a calculation of the effect of new drugs coming onto the market.

That alone adds another historically about

one percent, but you can see the rate of drugs coming on the market starting to slow. That's why the impact of new drugs on their spending is going down.

SENATOR AYER: Would you tell me again what inflation is, and is that in costs or in general or price?

MR. KAPPEL: Inflation is -- let's identify the hundred drugs we buy the most.

SENATOR AYER: Uh-huh.

MR. KAPPEL: How much did those hundred drugs cost last year? How much do they cost this year?

SENATOR AYER: Who was the PBM? Express Scripts?

MR. KAPPEL: Yeah.

SENATOR AYER: Okay.

MR. KAPPEL: But they still --

SENATOR AYER: This is what they paid?

MR. KAPPEL: Yes.

SENATOR AYER: All right.

MR. KAPPEL: But it's still -- the price is for the same product over time. Okay?

Let's look a little more closely at prices because prices get a lot of attention.

No news to anybody. There is huge variation

in prices. There is dramatic differences in both brands and generic, the U.S. compared to almost every other country. Almost always, brand prices are higher in the U.S. than any other country, and interestingly, typically, generic prices are lower in the U.S. It's hard to put those two together, but I think in some ways, it's market versus protection because you get two different effects going on.

What's even more dramatic is among the payors, the V.A. always get held up as the guys who get the best deal.

The V.A. typically pays about 45 percent of list price for drugs. Medicare, about 60 percent, and PBMs about 80 percent.

So how does the V.A. get such great prices? They combine two tricks.

The first trick is there is a statutory cap that they live under, that a lot of federal programs live under that guaranties them they will pay no more than -- I don't remember the exact number, but no more than I believe 40 percent discount.

The V.A. then starts from that point and negotiates downward because the V.A. is a closed

system, and the V.A. has complete control over what drugs its physicians prescribe.

The V.A. can do what's called moving volume really dramatically, so the V.A. goes to manufacturers, and they say, We're a really big purchaser, we can buy your drug, or we can buy your competitor's drug. What kind of deal will you give us?

And that's one of the basic models in most pharmacy cost containment is coming to manufacturers with that ability to move volume. And we'll talk about that in a second. That is the inducement for manufacturers to negotiate. You have to be able to show them you can take your volume and go somewhere else with it.

How do pharmaceuticals move through the United States? Everything starts with the manufacturer, but there's a couple of different ways things go.

About 60 percent of drugs go through wholesalers. And I think Robin and Maria gave you out -- gave you the C.B.O. report a couple of days ago.

That's where this graph comes from, but that goes into a lot more detail, but the important

thing to understand is there is purchasing through wholesalers, but there's purchasing directly from manufacturers, and a lot of it depends on how big you are and what kind of volume you're buying in.

Big chain pharmacies probably buy directly from manufacturers. Local pharmacies probably buy from wholesalers, and there is some price consequences in that, and then it all eventually comes down to us paying the bills.

Now, the magic world of three-letter acronyms. The critical three that we'll have to learn to understand pharmaceutical pricing, AMP, WAC and AWP.

The first one, average manufacturer price. This one is a real number. This one is reported to CMS by manufacturers. It is the amount, on average, that they receive from wholesalers and retailers to purchase their drugs, so this is real green dollars.

One of the reasons it's reported to CMS is it's used to calculate Medicaid rebates. And we'll talk about those in a minute. The value of those rebates is excluded, so this is the money -- this is really what manufacturers get for their drugs.

Wholesale acquisition cost, this is the manufacturer's list price, so this is what the manufacturer says it charges wholesalers to buy the drug.

Of course, it's a list price, and nobody pays it. It's probably close to what wholesalers charge to retailers.

It's always funny when I call something a wholesale price and it reflects retail.

The third one, AWP, average wholesale price. Again, this is a list price. This is supposed to be what wholesalers charge retailers for the drug. It typically isn't. It's typically much closer to the actual retail price, but AWP is real important because that's how a lot of state Medicaid programs pay for drugs.

Vermont, for instance, pays brand name drugs, pays pharmacists 11.9 percent below AWP, plus a dispensing fee.

So Medicaid, in effect says, Give us a discount off your acquisition cost, but we'll make up for that by giving you a fee to fill a prescription, so what Medicaid is trying to do is to pay the cost of the drug, as well as it can be estimated, what the retailer really paid for the

drug, and then a markup because of the labor involved in actually filling the prescription.

A lot of criticism of AWP. A lot of people believe it's subject to manipulation because it is something manufacturers put out as a list price. So a lot of concern. There may be movement away from AWP, particularly by Medicaid programs in the future.

Again, I'm starting to run out of voice, so stop me if there are questions.

Let's talk about rebates for a second.

Rebates, real standard idea. It's a way to lower your prices without actually lowering your prices.

Car dealers love it because they can say we're still charging $25,000 for the truck, but we're giving you a $5,000 rebate, so we haven't actually lowered the price, but you're paying $5,000 less.

But we can change that, take the rebates away faster, so they're really viewed as something different from price reductions.

In Medicaid, rebates exist under federal law. The Omnibus Budget Reconciliation Act of 1990, OBRA '90, one of those things you throw around

when you want to show everybody you know a lot about pharmacy pricing. Basically, what OBRA '90 did was it guaranteed Medicaid would get the same price as the best deal the manufacturer gives any private purchaser.

So if a manufacturer enters into a special deal with Rite-Aid, Medicaid is guaranteed to get that same price.

It's a really interesting process because in order to protect the proprietary contracts that manufacturers have, the calculation of rebates is done by CMS inside a locked room with the lights turned off.

Actually, I don't know if the lights are turned off. I just threw that one in.

SPEAKER: Odds are.

MR. KAPPEL: Odds are the lights are turned off, so the State gets a check from each manufacturer.

CMS says we owe you $1.3 million. Here's a check for $1.3 million. So the State really never knows what the best price is. The State just trusts that the process works and it has gotten the best price for each individual drug.

Again, a lot of concern because of the

secrecy of this process, and there's really no very effective way to audit it, so it's pretty much a "trust me" process at this point.

SENATOR AYER: Madam Chair?

SENATOR CUMMINGS: Yes.

SENATOR AYER: What happened to the PBM bills that we worked on? Did they go down with the whole health care bill? I don't remember.

SENATOR CUMMINGS: They did not make it through.

SENATOR AYER: Okay.

SENATOR CUMMINGS: Parts of prescription drug regulation were attached to the budget two years ago.

MS. LUNGE: The PBM, the PBM piece of the bill was in H-524, which was vetoed by the Governor.

SENATOR AYER: Okay.

MS. LUNGE: So that was -- that did pass the Legislature as a whole through that bill.

SPEAKER: If I'm understanding correctly, the rebates aren't figured into this price, are not figured into this?

MR. KAPPEL: Now, which price are you asking about?

SPEAKER: Well, the calculation for Medicaid. They subtract it out as part of this guaranteed, that Medicaid will get the same price for each drug as the lowest price, or is it -- are the rebates in there or not?

MR. KAPPEL: That's how -- the rebates are the mechanism by which Medicaid is guarantied that lowest price.

SPEAKER: Oh.

MR. KAPPEL: So Medicaid pays the pharmacist something above that best deal.

SPEAKER: And then a rebate comes out of the black, dark room.

MR. KAPPEL: Right. Yeah, but I think an important point there is that the pharmacist gets something more than Medicaid's ultimate cost for the drug because of the rebate.

So one of the things -- when we talk tomorrow about controlling costs, one of the things we'll look at is the difference between controlling costs by reducing what you pay the pharmacist and controlling costs by reducing what you ultimately pay the manufacturer, and those have different effects.

Take rebates one step further. Several

Medicaid programs, including Vermont, have gone one step further, and they've gone beyond the guaranteed rebates.

Because Vermont has a preferred drug list, because we have demonstrated we can move volume from one manufacturer to another, the State has managed to negotiate rebates, supplemental rebates, so above and beyond that base rebate, with several manufacturers, and I believe the last number I saw was last year, we got about $10 million in supplemental rebates, so beyond the roughly 40 million in guaranteed rebates, we've negotiated more.

One of the most effective things we've done to control Medicaid pharmacy spending is those supplemental rebates.

Rebates are also a tool used by Pharmacy Benefit Managers. Same basic idea.

Manufacturers pay rebates primarily on the demonstration of being able to move volume, but again, we're into the kingdom of secrecy, so one of the concerns we've had with PBMs is if the State of Vermont is a customer, can the State be guaranteed it's getting the full benefit of whatever rebate is being paid by the manufacturer

Page 34

to the PBM? And that one is still very much up in the air.
Okay. Almost done.
Today was designed to kind of give you the basics.
Tomorrow, what I'm going to talk about is much more specific: Tools for controlling pharmacy spending, things like preferred drug lists, lots of the other things Vermont has done, and then we'll try to work through those and figure out how well they work, and there's a lot of challenges in figuring out how well a particular cost containment strategy works, especially in a state like Vermont that's been very creative and probably has eight or ten different things going on at the same time.
So we'll talk about what we do and don't know about how well preferred drug lists work, counter-detailing, marketing disclosure, all the things we've done.
So at that point, I'd be happy to take questions. I'd be happy to stop talking.
SPEAKER: Obviously, age is a major factor in how this whole thing is skewed.
MR. KAPPEL: Yep.

Page 35

SPEAKER: Especially on the front end here where you're talking about medians.
SPEAKER: I resemble that remark.
SPEAKER: But in the end, it doesn't necessarily affect total cost because we've got to deal with it.
MR. KAPPEL: That's a great point. There are two different things that are both called cost containment. One is, one isn't.
When one payor figures out a strategy to make another payor pay more of the bill, that's cost containment for that one payor, not for the system as a whole.
Containing costs in the system as a whole needs to reduce spending for everybody.
SPEAKER: Units, how has the growth been, just plain old numbers of pills, as opposed to dollars?
MR. KAPPEL: Well, that's what's handy about that Express Scripts study.
SPEAKER: Yeah.
MR. KAPPEL: Because inflation is dollars per script for the same prescriptions. The combination of units per script and utilization, which is number of scripts written, duration of

Page 36

script, things like that, that's the volume increase, independent of price, so that's the "I was on two prescriptions last year, and now, I'm on three" spending increase.
I saw one of those ads on TV that said, "Ask your doctor if such and such is right for you," and I called and asked. Didn't know what the drug did, but I just had to call and ask.
SENATOR CUMMINGS: He told you you weren't menopausal.
MR. KAPPEL: Well, not yet.
SPEAKER: I'm looking at the V.A. as the sort of 800-pound gorilla for negotiation purposes.
MR. KAPPEL: Yep.
SPEAKER: Do you know how many people they buy drugs for, how many people?
MR. KAPPEL: Wow, that's a good question. Let me find out.
SPEAKER: Okay.
SENATOR AYER: He wants to know how many Vermonters buy here.
SPEAKER: Well, what I'm thinking is just for, you know, comparison, they probably have -- there are probably more people getting V.A. benefits than there are the population in Vermont.

Page 37

SENATOR AYER: Do all the retired national legislators also get that too? They get -- don't they get V.A. prices, our Congressmen and our Senators?
SENATOR CUMMINGS: I think Congress does.
SENATOR AYER: And when they're retired, don't they get that for life?
MR. KAPPEL: I don't believe they get quite as good a deal as the V.A. because there's a thing called the federal supply schedule.
SENATOR AYER: Oh.
MR. KAPPEL: And that's the federal cap, but the V.A. negotiates down from that, so that's where the V.A. gets the best of all worlds.
SPEAKER: I'm just wondering, do you have any thoughts, if they -- it seems it's pretty easy to understand how they can negotiate the prices down because, you know, they offer quite a nice market.
MR. KAPPEL: Yep.
SPEAKER: And so they can sort of tell them well, if you want us as a customer, which will be lucrative because of the deal we have to get, if the thought occurs, why doesn't just the State of Vermont do the same thing?
MR. KAPPEL: There's actually been discussion

of that, and there's been a lot of difficulty in figuring out a way for the State of Vermont to consolidate all of its purchasing under one roof.

SPEAKER: And move the drugs.

MR. KAPPEL: Yeah. I think trying to consolidate State employees, teachers, IBM all under one buying process, no one has quite figured out how to do that yet.

SPEAKER: Okay. It doesn't seem so terribly different. Maybe I'm naive.

MR. KAPPEL: I think I'll defer to the lawyers.

SPEAKER: Yeah.

MR. KAPPEL: On why that may be a little trickier than it first looks.

SPEAKER: And, Steve, you may actually address this later today or tomorrow, but I'm not going to be here tomorrow, so I just want to ask a question.

How are the preferred drug lists developed? I mean, I know that the State of Vermont is trying to remove Lipitor from the preferred list, but it's a drug that so many State employees are dependent on.

MR. KAPPEL: Uh-huh.

SPEAKER: How -- how is a preferred drug list developed? And is it just really the choice of the -- the buyer of the insurance plan, or is it the PBM, or is it a combination?

How do they -- how do they come up with a preferred drug list?

MR. KAPPEL: Well, let me start conceptually with how a preferred drug list gets built, and then we can talk about specific instances.

Every one of the PBM -- every one of the preferred drug lists I'm aware of starts with a professional review panel of some sort, prescribers and pharmacists, so fortunately, they keep people like me out of the room until -- to further the discussion.

They will look at categories where "A," there's a lot of spending, and "B," there are therapeutic alternatives, so two different beta blockers, two different calcium channel blockers, two drugs that pharmacologically do the same thing, and the professionals will review those two drugs for safety and efficacy.

Assuming they're comparable in safety and efficacy, then they bring the numbers guys in the room, and they say, Which one of these can you get

us a better deal on?

So the ideal is two drugs, equally safe, equally effective. You simply go with the one you get a better price on.

The challenge in a lot of cases is that idea of efficacy because there's almost no head-to-head testing of therapeutic alternatives. The whole FDA process -- this is something really important to understand, the FDA process evaluates against placebo, so as long as the drug has an effect different from the placebo, and as long as it's safe, of course, it can be approved.

FDA never says Celebrex is better than Vioxx, Vioxx is better than Celebrex.

So one of the challenges in preferred drug lists is incorporating any information you can find about that efficacy piece.

There is an interesting program which I can talk about a little more tomorrow as well at Argon State Health University where they're trying to do exactly that.

They're trying to say let's go beyond safety. Let's go beyond price. Let's look at efficacy because if a drug is 5 percent more expensive but 30 percent more effective, that may be an

investment. We may want to go with that on our preferred drug list.

I believe a lot of PBMs start with kind of their base preferred drug list, but for large influential customers, they'll go change it.

SPEAKER: Say that again.

MR. KAPPEL: Express Scripts, any of the big PBMs probably have their kind of generic preferred drug list. They've gone through this evaluation process. They know who gets the best deals from manufacturers. You know, their clinical review guys have done that job, but for a really big customer who comes to Express Scripts and says that's nice, I want to make a couple of changes to your preferred drug list for my beneficiaries, Express Scripts would probably do it.

SPEAKER: Just the size?

MR. KAPPEL: Standard size and influence, but they would also make sure that the buyer recognizes that the prices would probably not be quite as good because of that.

SPEAKER: It's kind of shoving the beneficiaries, the people that are using them aside, and we'll figure this thing out amongst ourselves, whichever -- okay, I understand.

SENATOR AYER: But when people choose their pharmacy benefit managing program, they look at what's -- it's like buying an insurance program in some ways. You look at, you look at what's available at what price to figure out what your numbers are. It's like buying insurance.
SPEAKER: No, but if the buyer of a specific PBM or insurance plan, whatever says, Well, I like this preferred drug list you have, but I want to take this drug off because we have a large utilization of that particular drug, and I'd rather put that into the non-preferred list so that I can charge more copay for that, that's -- that's what I'm getting at.
SENATOR AYER: But it's like all the insurance though, you dicker by how much you're going to buy.
SPEAKER: Yeah, but you and I at the bottom of the chain, we're at the bottom.
SENATOR AYER: Oh, yeah.
MR. KAPPEL: Yeah, but let me draw one distinction.
SPEAKER: It's not about us.
MR. KAPPEL: But just something to keep in mind, there's open formularies and closed

formularies.
Closed formularies, you take the drug on the list or you get no drug at all. Vermont doesn't have those. Medicaid in particular doesn't have those.
Open formularies, this is the preferred drug. If there's medical reasons, if you and your doctor have tried the preferred drug, it doesn't work, then the insurance will cover the alternative.
SPEAKER: On the aforementioned, you take this, or you don't take anything at all, do you pay the difference for the extra, for the higher (inaudible).
MR. KAPPEL: Probably on a closed formulary, you would pay the whole price.
SPEAKER: Even if you and your doctor have determined that it's not (inaudible).
MR. KAPPEL: Closed formularies are pretty rare, for that reason.
SENATOR CUMMINGS: Okay. Other questions?
MR. KAPPEL: Okay. I'll be back tomorrow.
SENATOR CUMMINGS: Ready?
MS. LUNGE: Yeah. I'm Robin Lunge, Legislative Counsel. Sorry. I'm jumping right in

before clarifying who I am, for the record.
Just to answer a couple of questions that you asked Steve slightly differently, you had asked about the statewide preferred drug list.
We do have language in our current statute directing the agencies to look at that.
There was a presentation by I believe it was Cindy LaWare when she was at personnel or Human Resources. Now, she's someplace else, but that she did to the Health Access Oversight Committee two summers ago indicating that the problem that she felt the State had with joining the Medicaid preferred drug list was that the State couldn't get the Medicaid price, which is accurate, but I think that it's a good question for you to explore with the Administration in terms of what they see as the problems of negotiating together.
Even if they end up getting slightly different prices at the end, it seems like there's still the opportunity to be able to negotiate together, and I don't really understand the practical difficulties there, and I don't really see that as being legal problems to that so...
SPEAKER: Thank you.
MS. LUNGE: You're welcome.

And also, you had asked about the preferred drug list and how it's built.
When Administration comes in next week, I believe Ann Rugg will be here from the Office of Vermont Health Access, and she is very involved in the Medicaid preferred drug list, so I think she'll be able to answer very specific questions in terms of Medicaid and how that list is built if you want to explore that more with her.
So a slight shift of gears to PBMs, Pharmacy Benefit Managers.
I'm going to hand out -- actually, I'll keep one for myself before those go. Thank you.
This is a few fast facts and best practices that were developed by Prescription Policy Choices, which is the policy arm of the National Legislative Association on Prescription Drugs.
They're actually a separate organization, but they were spun off from that organization.
To just give you sort of their take on PBM issues, they include some citations to some of the lawsuits that I'll briefly be talking to you about this afternoon as well, so I won't go through this in a lot of detail, but I thought you might find it helpful as background information.

So we've talked a little bit, but I wanted to start with the basics of what is a Pharmacy Benefit Manager?

Pharmacy Benefit Managers came about in the 1980's to apply managed care principles to drug benefits of health plans, so they -- a couple of examples of things that they do are develop provider networks, so they develop networks of pharmacies for health benefit plans, and they also develop a preferred drug list, so they manage the pharmacy benefit plan, or they can manage the pharmacy benefit plan for the health insurer or the employer. They'll create formularies or preferred drug lists.

They negotiate with pharmacies about being in the network.

They can also negotiate with drug manufacturers on prices. They can run the automated process for coverage decisions at the pharmacy.

And I think that that's some variation from contract to contract that they have with different health benefit plans, but that's sort of a general description of some of the services that they can provide for benefit plans or employers.

In addition, the four largest Pharmacy Benefit Managers operate their own mail order pharmacies as well.

So what I wanted to then start talking about was a little bit of what are the issues that states have identified around Pharmacy Benefit Managers?

Why have states felt it was necessary to pass legislation in this area?

So we've talked a little bit about rebates in the Medicare context, but PBMs also can receive rebates from drug companies, and those are sometimes called market share payments or formulary payments. Those are two different types of payments.

They're usually described as a percentage of the wholesale price, multiplied by the quantity of a particular drug that is dispensed. And there are some states who have argued that these rebates that the PBM negotiates should be passed through to the health benefit plan or the consumer and that that doesn't always happen.

So that's one of the reasons that states have looked into this area because the PBMs are getting rebates, and those rebates aren't always passed

through to the consumer.

SPEAKER: Do the PBMs have to say I'm getting a rebate, but I'm not passing it through, or they're allowed to just be silent?

MS. LUNGE: Well, currently, actually, as you will I think remember from previous years, one of the purposes of some of the PBM regulation that passed previously in this state was to increase transparency and provide more information from the Pharmacy Benefit Manager to the health benefit plan.

I think the PBM would say that there's a lot of information that they have that should be kept confidential.

The counterargument is that should be confidential from the general public certainly, but the person you're contracting with should know what price you're receiving, what rebates you're receiving in case there's potential conflicts of interest.

So I think it depends. The answer is it depends on the specific contract that a plan would have with the PBM, but I think it's not always the case that that information is available to the person contracting with the PBM, so the employer

or the health benefit plan.

SPEAKER: This is -- I mean, this is -- the grocery industry does a lot of the same thing.

The grocery industry, if you're dealing with a -- if you're a manufacturer and you're dealing with a wholesaler, grocery wholesaler, they would prefer things not to be on the invoice. They want things off the invoice.

SPEAKER: Shelf space.

SPEAKER: So they don't have to -- so they don't have to show that to their customer as being on the invoice, so what they do is they want a rebate, so they'll ask for a sliding fee for the warehouse. They'll ask for a shelf space allowance for the shelf. They'll ask for a position allowance to where on the shelf you want it, or they'll ask for an allowance if you want to be on an end cap.

It's just -- it's unreal.

MS. LUNGE: So some of the other issues that have been raised in this area are that there are occasions when a PBM might receive a higher rebate on a single-source brand name drug, as opposed to a generic or multiple source drug, and there are -- there's some who would argue that this

Page 50

would give the PBM incentives to sell the newer or higher-priced drugs versus generics.

In addition, there are -- the negotiations that the PBM has with the plan are different from their negotiations with the pharmacy, so -- and the plan doesn't necessarily know about the details of the negotiation with the pharmacy, so the amount paid by the health benefit plan may not or may be the same amount as what is paid from the PBM to the pharmacy, so if there's a difference in that price, some states have found that they would prefer that more of that -- that cost differential be given to the benefit plan and passed through to the consumer, as opposed to being profit for the PBM. So that's another reason why some people are looking at this area.

SPEAKER: It's conceivable that the PBM can get a better price than --

MS. LUNGE: The health benefit plan.

SPEAKER: -- the health plan.

MS. LUNGE: Yes.

SPEAKER: One could be number one and number two, and the other could be number two and number one as far as pricing goes.

MS. LUNGE: Uh-huh, and I think part of the

Page 51

issue is that because everything is -- is confidential, you just don't know if you're getting a good price or a bad price in relation to what the PBM is buying, is paying for it.

In addition, there are -- often, PBMs are allowed to request switches and drug substitutions to a different therapeutically-equivalent drug, and there's been some argument that PBMs could be switching people to drugs that give them more profit than another drug, and also, the use of PBMs of their own mail order pharmacies. There could be other markups involved in the PBM using their own mail order pharmacy so...

SENATOR CUMMINGS: Didn't you find some issues around both the mail order and the negotiations with the local pharmacist? If you are the PBM, the State of Vermont in this town, and you say pharmacy, and the testimony we heard was we will pay you two dollars for this prescription. They're charging five dollars to the State employees or whoever their contract is, major employer. They get to pocket that difference, but the pharmacist -- oh, and pharmacists, you can only sell a 30-day supply, so people have to come back with a copay.

Page 52

However, if you go to their website, you could get a 60-day supply for the same copay.

One concern for the pharmacist is that when you -- especially in small areas like this where you are the PBM for a major employer, which means a major chunk of their business, we have an awful lot of clout, and the employer does not know or may not know what's going on.

MS. LUNGE: So there are of course pros and cons to every piece of legislation and different approach, and I think, just to summarize those two camps very briefly, I think the states where they've passed PBM regulation, there's been an argument that in order to address these issues, we should increase transparency, increase State involvement through a regulatory model and that that will achieve savings, because if health plans know what the PBM -- if they have more information, they can do a better job negotiating, and then that savings can be passed through to the consumer.

The other side of the argument is of course that we should let competition in the marketplace do that kind of thing, that regulating could actually increase prices and that competition and

Page 53

letting things work through that way is really a better way to go.

So that's a very broad brush sort of summary, but I think those are the two sort of extremes of the argument in terms of which way to go.

So the PBM legislation in other states has focused on transparency and fiduciary duty.

I'm going to be going through our version that has passed, that passed Vermont previously tomorrow in more detail, but I wanted to give you just some general concepts to start.

So what's transparency?

Transparency is basically allowing for more free disclosure of information between the PBM and the health plan.

I think most of the legislation that has passed in other states does not allow for public disclosure, recognizing that there are some trade secret issues and confidentiality issues, but that there should be disclosure under confidentiality restrictions to the PBM's customer or the health plan or employer that they're contracting with.

Usually, those are focused around financial and utilization information relating to the benefits to beneficiaries enrolled in the health

plan, so if I'm the Medicaid program, I would want from the PBM specific information about the Medicaid recipients and the financial information between the Medicaid program and the PBM. So that's one piece.

The other piece would be providing information to the health plan about the financial terms and arrangements between the PBM and the drug manufacturer and also the PBM and the pharmacy networks, so that I, the health benefit plan, know that if my enrollee gets a particular drug through my program, I know what I'm paying versus what the pharmacy's paying and what the price differential there is and how much profit is going to the PBM versus the pharmacy, versus me versus the consumer.

The other piece of it is fiduciary duties, and at least in Vermont, we structured the fiduciary duties modeled on existing fiduciary duties in a federal law called ERISA.

We used an objective prudent PBM standard as the standard of care that the PBM would need to use.

And just generally, a fiduciary duty means that the PBM has a duty to the health plan as its

customer to act in a good faith manner.

In addition, that standard would include passing through payments or benefits that the PBM received from drug companies to the health plan to the consumer and specifying some details of when drugs could be substituted and general standards for that, and also, notice to the health plan if there are potential conflicts of interest that that the PBM might have.

(End of CD 07-22, Track 2.)

CERTIFICATE

THE STATE OF FLORIDA,)
COUNTY OF BROWARD.)

I, Katherine W. Milam, Notary Public, and Registered Professional Reporter do hereby certify that I was authorized to and did listen to CD 07-22, Tracks 1 and 2, the Senate Committee on Finance, Thursday, January 25, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 7th day of April 2008.

_____

Katherine W. Milam, RPR
Esquire Job No. 928009