TAB C

STATE OF VERMONT

S.115 - Prescription Drugs, Regulation

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APPEARANCES:

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Job Number: 894085

PROCEEDINGS

CD2007-24_Track 1

MS. LYONS: Go ahead.

MS. LUNGE: You start.

MR. KAPPEL: Okay. I'll start. With the Obligatory, Steve Kappel. And --

MS. LUNGE: Robin Lunge.

MR. KAPPEL: From wherever we're from this week.

MS. LUNGE: The pink lady.

MR. KAPPEL: From across the way.

So, this is either part two of a two-part presentation, or the second presentation, we're not sure which, about pharmaceuticals and various things thereof.

I brought copies of the handout from yesterday for folks who weren't in Finance. So, I can circulate a few around.

(Whereupon, copies of handouts were distributed, after which the following was had:)

MR. KAPPEL: And then before we --

UNIDENTIFIED ATTENDEE: We saw this one too.

MS. LUNGE: You did see some of these slides, yes.

UNIDENTIFIED ATTENDEE: Okay. We've seen some of them.

MR. KAPPEL: Parts of them.

UNIDENTIFIED ATTENDEE: Okay. All right. Sorry.

MR. KAPPEL: And then the other thing I have before we start the presentation is, there were a couple of numbers questions. So, I have here a sheet, which on one side is enrollment in all the state pharmacy programs. And on the other side are the ever popular FPL stuff. So, if you ever wondered what the family poverty level for 185% of poverty in a family of three in 2007 you will now know.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: Okay. Onto actual content. Today's presentation.

UNIDENTIFIED ATTENDEE: May I ask a question about the family poverty level?

MR. KAPPEL: Oh, sure.

UNIDENTIFIED ATTENDEE: You give monthly and yearly. Are there federal programs that use one and then a different then for the other?

MR. KAPPEL: No. They all use yearly, but some people think monthly.

UNIDENTIFIED ATTENDEE: Oh, okay.

MR. KAPPEL: So, a lot of people would ask, well, what is that for monthly wage?

UNIDENTIFIED ATTENDEE: Oh, okay.

MR. KAPPEL: So that's why I just do it both ways.

UNIDENTIFIED ATTENDEE: All right.

MR. KAPPEL: So, the main topics of today's presentation will be, how do we save money in pharmacy programs and to what extent have we evaluated how well we've done that?

So, bottom-line, in order to achieve savings, you have to affect one of the three big drivers of pharmaceutical spending, which is utilization, intensity and prices. So, any -- any approach you're contemplating has to affect at least one of those. And it's actually better to affect more than one. Because what will frequently happen anywhere in healthcare is, you control one of them and the other one pops up to offset it.

UNIDENTIFIED ATTENDEE: Define intensity.

MR. KAPPEL: Intensity is the mix of different drugs that you're buying. So, the example that probably makes the most sense to people, prices. You buy the same groceries every week. The store raises its prices. You're spending goes up, even though you're buying the exact same basket of goods.

Utilization. You're having some friends over for dinner one night, so you buy some more groceries. So that's, utilization's a measure of how much you're buying.

Intensity's the mix of things you're buying. So,

you may switch from store brand tomato juice to fancy PhD organic tomato juice. That's a change in intensity. More to the point here, if you switch from aspirin to Celbrex, that's a change in intensity. And that switch can increase spending. Even if utilization stays exactly the same, one pill a day, prices stay exactly the same for both products.

UNIDENTIFIED ATTENDEE: Okay. Thank you.

MR. KAPPEL: Ways to achieve savings, as far as prices; you can reduce reimbursement. If you're the government, you can reduce reimbursement by law. If you're not the government, you can reduce reimbursement by negotiation. Or, you can increase rebates. And we'll talk a little more about rebates. Or, a third option, you can purchase internationally.

Important distinction; where exactly the savings are coming from. When the state, for instance, chooses to save money by reducing how much the Medicaid Program pays a pharmacy, the savings in that case come out of the pharmacist's pocket. If instead the state pays the pharmacist exactly the same thing, but manages to obtain more rebates from the manufacturer, then the savings comes out of the manufacturer's pocket. Real different consequences, local economy.

Important point to understand, how this stuff does

savings, you have to move volume in order to do this. If you go to a manufacturer and say, I'd like a bigger discount, please, the manufacturer's likely to say, oh, that's very nice, thank you for your time. If you go to a manufacturer and say, I can move half of the business you currently get over to your competitor, then the manufacturer's a whole lot more likely to start talking discount. So, any way you want to reduce prices, unless you're the state and can do it directly, you have to be able to demonstrate that you can move volume around.

So, how do you move volume? Couple of really simple ways; a preferred drug list. One of the basic ideas behind a preferred drug list is, you steer people to one or more therapeutic alternatives. When manufacturers see preferred drug lists actually working, their market share starts to decline, their market share starts to increase, then they're a lot more interested to talk about price.

You can further move volume when you start consolidating your purchasing, so when state programs start mixing. If, for instance, the state employees and Medicaid use the same preferred drug list, that increases the affect of the list because you're buying for more people. Get even bigger state programs and private programs within Vermont; get really big multi-state purchasing agreements. So, when several states get

together and talk to manufacturers, manufacturers tend to pay a lot of attention.

One thing you'll hear a lot of discussion about right now is, in Congress there's discussion of whether they will change the Medicare Part D Law to enable the government to negotiate directly with manufacturers. There's been a lot of difference of opinion among economists as to whether the government negotiating for what is a huge purchase will actually be able to negotiate better deals if they don't have a preferred drug list. If they say, we're just negotiating for all of the same drugs that are being sold now; I'm not sure what manufacturer's incentives are to give them better deals. But that's the thing that's gonna play out in Congress.

Savings on the utilization side; a couple of ways of doing this. Some states have things like brand name limits in their Medicaid Programs. So, this says, doesn't really matter how many drugs you actually need, Medicaid will only pay for three or five brand name drugs a month. So, it tends to truncate those folks who are taking lots and lots of different pharmaceuticals.

UNIDENTIFIED ATTENDEE: That seems a rather arbitrary way to -- to cut down on -- on costs. I mean, it's you're only allowed three, what are you supposed to do for the -- for everything else that you need?

MR. KAPPEL: It's certainly not a way I would ever recommend.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: But some states do have that.

UNIDENTIFIED ATTENDEE: That just -- That seems bizarre to me. But, anyway. We probably see stuff like that, caps or rebates.

UNIDENTIFIED ATTENDEE: Don't health insurance policies do that? I mean, you get something.

UNIDENTIFIED ATTENDEE: I don't know.

UNIDENTIFIED ATTENDEE: Get care up to so many thousand dollars and then --

UNIDENTIFIED ATTENDEE: They cut you off in dollars, but not the number of brand name.

UNIDENTIFIED ATTENDEE: Yeah. But most of them have to be generic.

UNIDENTIFIED ATTENDEE: Right.

MR. KAPPEL: Yeah.

UNIDENTIFIED ATTENDEE: If it exists.

MR. KAPPEL: Generics or you just do without.

UNIDENTIFIED ATTENDEE: Or, if it exists.

MR. KAPPEL: Yeah.

MS. LUNGE: Yes.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: Okay.

UNIDENTIFIED ATTENDEE: I wasn't asking you to defend it.

MR. KAPPEL: Not a problem. I wasn't going to.

Other way to achieve savings and utilization is what's called prior approval. So, this is a process where for certain drugs, typically a focus process, a third-party manager of benefits typically has to approve the prescribing of that drug for that person. There'll be questions like, why does the person need the drug, what evidence do you have that the person has the condition the drug is designed to treat? It's just kind of a little way to step on the brakes slightly.

MS. LUNGE: We talked about this a little bit in terms of our current Medicaid preferred drug list. Because we -- why we have a preferred drug list, you can access drugs off the list with prior approval or prior authorization. So, it's the same sort of concept.

MR. KAPPEL: You can't have one without the other. But I think putting both together is probably the best way to approach it.

How to achieve savings in intensity. A lot of interest in this area right now, some pretty straightforward ways, mandatory generic substitution. So, just saying unless, as Vermont does, the doctor says

specifically fill the brand, pharmacists are required to substitute generic drugs where they're available.

Changing position behavior, a lot of this going on. Counter detailing. This is typically a process by which an academic group or some other credible organization goes into physician offices in an effort to offer a different opinion from what the marketing folks do.

Other kinds of feedback; sometimes docs just get reports how their prescribing patterns are different from their -- their compatriots.

Other way to do savings in intensity, change patient expectations. There's been a lot of discussion about the pros and cons of direct to consumer advertising. Clearly, direct to consumer advertising has an affect on patients. I would argue, the pharmaceutical manufacturers know this or they wouldn't do the advertising. So, one possibility, with some Constitutional questions is, to ban direct to consumer advertising.

UNIDENTIFIED ATTENDEE: Used to be banned.

MR. KAPPEL: Yes.

UNIDENTIFIED ATTENDEE: Or was it -- Was it voluntary or not done?

MR. KAPPEL: I think it was -- Do you know?

MS. LUNGE: I'm not positive. But if it was not allowed, it was at the federal level.

MR. KAPPEL: It was federal law.

MS. LUNGE: And so there is federal law right now about what's allowable in advertising. And there are other options on the advertising front included that aren't quite as -- go this far.

UNIDENTIFIED ATTENDEE: Okay. How does the state do that?

MS. LUNGE: Ban direct. Well, that's where we get into the Constitutional questions.

So, --

UNIDENTIFIED ATTENDEE: The commerce clause.

MS. LUNGE: Yeah. So, --

UNIDENTIFIED ATTENDEE: Even if you could -- Even if you could do it Constitutionally, I don't know how stop various cable signals and magazine subscription sales.

MS. LUNGE: I think it's usually combined with some sort of right of action by the Attorney General to enforce it. So, they can sue.

UNIDENTIFIED ATTENDEE: Is anybody trying this?

MS. LUNGE: You know, I should -- I think Sharon Treat can talk to you a little bit more about that next week when she's here.

I haven't -- I can't recall off the top of my head if what other states have done in this area. There certainly has been action in other states in terms of, for

instance, Maine has a proposal that allows the Attorney general to pursue violations of the federal law relating to misleading advertisements, which is sort of the next step down from this, in terms of giving AG's enforcement in advertising areas. But I can double-check on that.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: Two other ways to deal with intensity, as we discussed before, preferred drug list and prior approval. I think the main advantage of those two is, they can affect more than one of the three variables; they can affect both prices and intensity. So, again, tools that affect more than one thing tend to work better.

The interesting challenge we face is, to evaluate the savings. Vermont has done lots of things. Other states are doing lots of things as well. It's hard to get real good credible evaluation of different programs. And we'll talk about why that is.

Probably two different ways of evaluating savings, one of which is to have a comparison group. So, for instance, subject half of Medicaid to a preferred drug list, the other half of Medicaid not, and then compare the drug spending. It's probably the gold standard, because it most clearly defines the effect you're trying to test and isolates all the other effects away from that evaluation. But it's almost impossible to do in an

ongoing program. I don't think it -- You wouldn't do that kind of a laboratory model in an ongoing assistance plan.

The other big way is historical. Much easier to do, because you've got last year, this year, kind of spending comparisons. The limitation to historical is, it's much harder to look at the effect of your specific program as compared to all the other things that are going on.

Couple of other ways people have taken, and we'll have some examples of these in a few minutes; surveys, surveys of beneficiaries, surveys of prescribers. How have your prescribing patterns changed as a result of our program kinds of questions. Are you aware of, are you more likely to kinds of questions. But, again, those are once removed from what you really want to examine.

Last couple of issues, establishing causality. Again, this is the problem of we have our program, the feds are doing something else, there's more broad system changes going on that nobody quite knows the reasons for. So, isolating what we're trying to look at gets tricky.

There's also a question of scope. When you evaluate the savings in a pharmaceutical program, do you look at just the savings inside the pharmacy budget or do you also look at potential what are called spillover effects? Have I saved $100 million dollars in my pharmacy program to

increase my spending on physicians by $120 million? Gets a lot more complicated, but it's probably a more valid way to do an evaluation, if you can figure out, again, all the causal effects.

So, to give a little structure to the rest of the presentation, we started making a list of all -- Yes.

UNIDENTIFIED ATTENDEE: Excuse me. I think stepped out for just a second. I apologize. You may have talked about this.

Included indirect effects, like increased physician costs in prescribing. What are the costs like? And if you already went through this in great length we'll talk later.

MR. KAPPEL: No. No problem. I'm glad you asked.

Let's suppose you do something to reduce your pharmaceutical spending, like that three- prescription limit kind of program. And in response to that, people get a little sicker, so they go to the doctor more, they go to the hospital more. That's the spillover effect I think we need to be concerned about, depending on what kind of program we do.

UNIDENTIFIED ATTENDEE: So, it's costs for physicians, not physician's, apostrophe S, costs?

MR. KAPPEL: Yes.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: Yep.

UNIDENTIFIED ATTENDEE: Thank you.

MR. KAPPEL: Mischievous apostrophe needs to move around.

Vermont has done lots and lots of things; the quick list; preferred drug list; multi-state purchasing; non-profit pharmacy benefit manager; some coverage for over the counter drugs where they are prescribed by the physician; generic substitution laws; price disclosure; counter detailing; marketing disclosure; promotion of the use of 340B providers, we'll talk about that in a second; and re-importation, in particular, the I Save Rx Program.

So, given all of the things we've done, one of the evaluation challenges is, all the things we've done. We can say the aggregate, we've had all these neat effects on spending, but we -- it's much harder to say, and 20% of the effects is because of this and 5% of the effects is because of that.

UNIDENTIFIED ATTENDEE: We know one of them that didn't do anything, counter detailing.

MS. LUNGE: Because it hasn't been implemented.

MR. KAPPEL: Well, it has the potential to. The law's in place.

MS. LUNGE: Right.

UNIDENTIFIED ATTENDEE: That's quite a disclaimer as we start through these. But keep going.

MR. KAPPEL: I'm always pleased to explain how little I know.

So, evaluation of preferred drug lists; probably the most mature. Just as a reminder, preferred drug lists focus on therapeutic categories where there's lots of spending and multiple brands, so there has to be a choice. Not much point in having a preferred drug list when there's only one drug in the category.

There's a professional review trying to look at safety and ethicacy. And then once the alternatives have passed those tests, the accountants come in and they start looking at prices. So, two drugs, equally safe, equally effective, the preferred drug list is going to try to move people toward the one that costs less.

One issue we'll talk about a couple of times is, the ability to compare ethicacy. Because the FDA approval process just looks at whether the drug works better than a placebo, there really isn't a good way of testing whether Celebrex is better than Viox or Viox is better than Celebrex.

There is one program out in Oregon that's starting to do this, and it's actually being supported by I think seventeen other states at this point, trying to actually

give states information on head-to-head comparisons; this drug is 20% more effective than this drug. Which makes the preferred drug list process a little better informed, because then you can think about whether it's a good or bad investment, a 5% less for a drug that's 20% less effective. You could integrate the ethicacy information more clearly.

Couple of things that have been done about preferred drug lists. There was a JFO report four years ago now, looked at the ethicacy of Vermont's preferred drug list a couple different ways. One of which was to look at a few categories and look at the spending year over year in those categories where the preferred drug list had kicked in, and there was substantial savings. They looked at antacids. I don't remember the other three categories, but it was very clear and obvious that the PDL had reduced spending in those categories.

The other thing, the secondary consequence of preferred drug lists is, supplemental rebates. So, this is the ability of the state Medicaid Programs to go to manufacturers and say, we've got this preferred drug list, we'd love to include you, how much of a rebate will you give us in order for us to do that? In 2006, we got about $10 million in supplemental rebates. So that's direct, off of the top, savings in the state program.

MS. LUNGE: Can I ask you a question before you move on? So, --
MR. KAPPEL: Does that follow our protocol?
MS. LUNGE: Yes.
MR. KAPPEL: Okay.
MS. LUNGE: So, in terms of savings, is there a way to -- to sort of suss out how much is the PDL itself and how much is multi-state purchasing?
MR. KAPPEL: This one, I believe, was before the multi-state.
MS. LUNGE: Okay.
MR. KAPPEL: I don't think that's real clear as soon as you start integrating.
Couple of other states have also evaluated the preferred drug lists. Florida saved about $81 million, much bigger program, so about 4% savings. And that was a study done by their own Office of Public Policy and Government --
MS. LUNGE: Accountability.
MR. KAPPEL: -- Accountability. Something like that. OPPAGA.
UNIDENTIFIED ATTENDEE: Sounds like a Florida town name.
MR. KAPPEL: Nowhere near as catchy as JFO.
Indiana, they estimated about 12.4 million savings.

Interestingly, offset by a reduction in rebates of about 3.5 million. So, they saw a smaller but still substantial savings. That reduction in rebates, something I don't think a lot of other states have thought about. When you move people away from the real high priced, high rebate drugs, onto drugs that are lower priced but carry a lower rebate, you give up some of those savings. So, what Indiana did was, net the effect to come up with that roughly $9 million savings. And they did specifically look at that spillover effect, was there increases in other kinds of health services, and didn't see any at all.

UNIDENTIFIED ATTENDEE: Now, for both Florida and Indiana, given the size of those two states, that doesn't seem like a lot of money to me. Dangerous for a politician to say. Any amount of money is not a -- doesn't look like a lot of money. But for the size of those states, that wouldn't seem to be significant.
MR. KAPPEL: It sort of depends on how you define --

UNIDENTIFIED ATTENDEE: I mean, 12 million in Indiana.
MR. KAPPEL: You're talking about one or two percent of your spending. Which is, when you look at a billion dollar program, not a whole lot of money. But when you

look at how tightly Medicaid tends to get managed every year, --
UNIDENTIFIED ATTENDEE: You'll take it, yeah. It's just not dramatic, I guess, is what I'm saying.
MR. KAPPEL: Yeah. Yeah. There's no -- Nothing I can foresee that's gonna do the 33% reduction in drug spending. I can't imagine a way of doing that. So, in effect, what you have to look for is, --
UNIDENTIFIED ATTENDEE: So, looking for a percentage point here and a --
MR. KAPPEL: -- a lot of percentage here, percentage there, kind of programs.
UNIDENTIFIED ATTENDEE: -- and a percentage point there. And pretty soon it starts to add up.
MR. KAPPEL: Yes.
UNIDENTIFIED ATTENDEE: You got two percentage points then.
MR. KAPPEL: Yeah. Vermont's pharmacy spending is probably around a hundred and -- was around a 150,000 million before Part D. And Part D took a whole lot of that away.
UNIDENTIFIED ATTENDEE: Okay.
MR. KAPPEL: Evaluation of generic substitution. One of the nicer ways to look at this, we talked yesterday and it's in the handout, about the Express -- Oh, boy.

Oh, boy. It is Friday afternoon, isn't it? -- the Express Scripts Drug Trend Report. So, this is an annual report that that particular PDM does on its own book of business. But they -- What they report is, a pretty substantial downward pressure on growth directly as the result of switching from brand to generic. And that effect grew from about 1.4% of trend to about 2.7 over the last five years. So, a definite reduction in growth, and that reduction itself is growing. So, I think that's pretty good news.
Counter detailing in Vermont.
MS. LUNGE: So, as we've discussed in -- in both of the committees, as you know there is language in our current statute which requires OVA to do an evidence-based counter detailing program that I don't believe has been implemented at this point. We have requested the 2005 report. And I think it may be in my E-mail this afternoon, so I can get that for you next week. And that report was requested from OVA to describe how they would proceed with that program.
There's also a question, -- And I apologize. I can't remember who asked it.
-- as to whether or not OVA had included in their budget request, money to implement this program. And I did talk with Stephanie and Maria at the Joint Fiscal Office. And,

basically, our -- our budgeting processes, in order for us to really determine that, we'd have to physically go back through the files. So, we haven't determined that yet. But they're -- OVA's gonna be here next week, so that's certainly something that you can ask them as well.

UNIDENTIFIED ATTENDEE: So, why hasn't this moved along more quickly? Was it not required, or, they just not getting to it? What's the story?

MS. LUNGE: It was required. It was a shall in the statute.

But I think you really should ask OVA about that. My understanding is, because there was no money budgeted for it. But -- Which I think is why someone asked, well, did they ask for it? And I don't know. So, I think that's something you should discuss with them?

UNIDENTIFIED ATTENDEE: Is the AHEC and the OVA effort connected? Because after I asked the question in our committee, --

MS. LUNGE: Yes.

UNIDENTIFIED ATTENDEE: -- Blair pulled me to the side and referred me to a report, which I still haven't had time to read. But --

MS. LUNGE: I -- I did look up some information about AHEC and what they're doing on counter detailing. And I do have a handout for you on that.

Would you like to hand that out for me?

(Whereupon, copies of handouts were distributed, after which the following was had:)

MS. LUNGE: And it -- From what the information that I've been able to get so far, it doesn't look like they're necessarily connected. The statute did not make any connection.

But AHEC, which is the Area Health Education Centers, which is affiliated with UVM, does provide a one-hour case based interactive session at a doctor's practice. And they have a team of a clinical pharmacist and a physician providing the evidence based information to doctors. And in 2006, they have three areas that they are providing education on, management of hypertension, cholesterol and heartburn.

So, we do have a small counter detailing program operating in Vermont through that operation. And I think it's -- I'm still trying to track down exactly if that has any connection with what we had asked for, a statute, or if it's completely separate and AHEC just decided it would be a good opportunity for them.

MR. KAPPEL: One of the most comprehensive evaluations of counter detailing was done in Pennsylvania. Pennsylvania has a program called Independent Drug Information Service. And it's designed specifically to do

an education program directly to providers, a credible program by professionals, in the hopes of changing their prescribing patterns.

So that was the goals of the evaluation. Do behaviors change, do the way docs write scripts change? And, interestingly, they specifically asked, can the changes be attributed to the program? They used a provider survey, asked a lot of questions about how the providers value the program; do they find it helpful, is it informative, is it credible? But they didn't really determine anything about specific outcomes. They didn't report anything about behaviors changing or money being saved.

Marketing --

UNIDENTIFIED ATTENDEE: They didn't find any evidence? Does that mean it doesn't exist? Or, --

MR. KAPPEL: They weren't able, based on their survey, to identify it. I think the --

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: -- survey was a good try, but it definitely didn't get them where they wanted to go.

UNIDENTIFIED ATTENDEE: But did they come to the conclusion that it's not saving any money?

MR. KAPPEL: No.

UNIDENTIFIED ATTENDEE: Or, are they just saying they couldn't figure it out?

MR. KAPPEL: They couldn't conclude either way.

UNIDENTIFIED ATTENDEE: Either way. Okay.

MR. KAPPEL: But what they did conclude was, the doctors found the program helpful and useful.

UNIDENTIFIED ATTENDEE: Okay.

MR. KAPPEL: So that was enough for them to keep going.

UNIDENTIFIED ATTENDEE: Did they save any money?

UNIDENTIFIED ATTENDEE: Clearly, it blows my --

MS. LUNGE: We don't know.

UNIDENTIFIED ATTENDEE: -- prescribing habits. Thank you.

UNIDENTIFIED ATTENDEE: But this was desperately needed.

MS. LUNGE: I can call Pennsylvania and see if we can get more information on that. But at least the materials that we were able to find, that were publicly available, didn't really address the -- the cost savings issue. It just addressed more physician participation and satisfaction with the program.

UNIDENTIFIED ATTENDEE: Made everyone feel good.

MR. KAPPEL: Marketing disclosures. This has actually gotten a lot of attention in the Medical

Journals. Journal of the American Medical Association, New England Journal of Medicine, have both written on this. JAMA specifically cited the Vermont program as a good start. But JAMA pointed out there really, again, is no concrete evidence that these have an affect.

So, there's a report filed with the Attorney General's Office. The most recent was June 2006. It's very informative, which companies are spending how much money kinds of things. But once more, you've got information, but you haven't got a real good evaluation tool.

340B providers.

MS. LUNGE: So, --

UNIDENTIFIED ATTENDEE: For Finance, tell us what 340B is.

MS. LUNGE: 340B. I can do better than tell you. I have a chart.

There are two terms that we use in this area, FQHC and FQHC look-alikes.

UNIDENTIFIED ATTENDEE: Those we know.

MS. LUNGE: And those particular entities are able to get what's called 340B pricing.

340B refers to some section of federal law. But, basically, you can see from this very colorful chart, which Steve will go through in more detail, where 340B

pricing compares to other pricing.

So, 340B is the red, small but low line, on the back page of your handout, your PowerPoint. Which is what -- And because it is one of the lowest costs available, that is one reason why there -- many states have focused on trying to increase the number of federally qualified health plan look-alikes that are able to obtain this pricing for their patients.

So, the handout that Steve just passed around is a list on one side. The first two boxes are the FQHC's and the FQHC look-alikes in Vermont. We have five FQHC's, each with multiple sites.

It's on the back of this.

UNIDENTIFIED ATTENDEE: Do you have more of them?

MS. LUNGE: Were there not enough? I'm sorry.

MR. KAPPEL: Oh, there's plenty.

MS. LUNGE: Sorry. So, -- So, you can see from this list exactly where each of the five FQHC's are and where their additional sites are. And it gives you everything, including their address and phone number. And then it also shows you our two look-alikes, one of which in Lamoille County has five sites in total.

So, on the front of that page, it compares the differences between FQHC's and FQHC look-alikes, which was a question yesterday from Senate Finance. And I won't go

through this in detail. But it gives you a very nice snapshot of all the different benefits that the health center gets with this designation and the differences between the two types of entities.

So, the other handout that I wanted to --

UNIDENTIFIED ATTENDEE: Excuse me.

MS. LUNGE: Yes.

UNIDENTIFIED ATTENDEE: How do -- How does Section 340B result in lower --

MS. LUNGE: Drug prices.

UNIDENTIFIED ATTENDEE: -- lower drug prices?

MS. LUNGE: It's set by federal law. So, federal law, in Section 340B, is the section of the federal law which discusses the pharmacy pricing for this particular program. So, it gets the cheaper, I believe it gets the cheaper prices, because the federal government has set it at a particular level.

UNIDENTIFIED ATTENDEE: So, they've set what they -- what they will pay to the pharmaceutical companies.

MS. LUNGE: I believe so. I -- I can double-check and do more research on exactly how that works.

UNIDENTIFIED ATTENDEE: Why didn't they do that with Part D?

MS. LUNGE: Hold on. Let me channel to Congress. I don't know.

UNIDENTIFIED ATTENDEE: That was a huge debate. That was more of a rhetorical question.

But what I'm hearing is, when they choose to for limited populations, and whether it's -- whether it's the FQHC's or the Veteran's Administration, they'll negotiate like on other areas they're reluctant, for broader populations, --

MS. LUNGE: Right.

UNIDENTIFIED ATTENDEE: -- they have been reluctant to do that for whatever the reason might be.

MS. LUNGE: Right.

UNIDENTIFIED ATTENDEE: But they have been willing to do it in certain -- for certain distinct populations.

MR. KAPPEL: Well, it's actually a combination of setting a statutory cap and then even negotiating below that, which is how the VA gets the best prices around.

MS. LUNGE: So, while I don't -- I wasn't able to at this point find Vermont's specific data. Which doesn't mean it's not there. I just wasn't able to spend enough time looking for it to track it down, if it exists. I was able to find a NCSL brief from last January, which talks about community health centers in general. It doesn't have specific finding on drugs. But it did find -- It did review studies on this type of health center, and found that money invested in health center reduces Medicaid

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expenditures and national healthcare spending. And then there's some specifics about that on the -- on the second page. So that gives you a little more information about this type of entity and -- and some of the studies that have been done on that area.

Next, I also said I would follow-up on our I Save Rx Program. This is our program that we joined that is run prescription drugs through Canada, Europe, and Australia, and New Zealand. And I was able to get our cumulative numbers through December 2005, which are 242 enrollees and 752 orders that have been placed through that web-based service.

Now, on their website, I Save Rx estimates savings of 25 to 80% from U.S. retail prices, depending on the medication. I don't know the specifics for our 752 orders, 'cause I wasn't able to obtain that information.

But there are additional reports on the I Save Rx website, including a report on potential savings to the Illinois Retiree Program, if they used the program for those folks. And also reports on the safety and ethicacy kind of questions that come up often when people are discussing reimportation. And so they have one on Canada, one on Europe, and one on Australia/New Zealand. So that's a little more information about I Save Rx than we had the last time we talked.

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UNIDENTIFIED ATTENDEE: When will we get information through the end of '06? This looks like a very small -- small program at the moment.

MS. LUNGE: Let me just double-check. I didn't --

UNIDENTIFIED ATTENDEE: We predicted that.

MS. LUNGE: I'm sorry. That's '06.

UNIDENTIFIED ATTENDEE: We predicted that.

MS. LUNGE: I made a typo there. It should be '06.

UNIDENTIFIED ATTENDEE: That should be '06.

MS. LUNGE: Yes. I apologize for that. Thank you.

UNIDENTIFIED ATTENDEE: Yeah. We had started it at the '05 session.

UNIDENTIFIED ATTENDEE: Oh, okay.

MS. LUNGE: Right. We passed it in '05, so I think.

UNIDENTIFIED ATTENDEE: So what -- Ken, why did you predict that it wouldn't be -- it wouldn't be a larger program?

UNIDENTIFIED ATTENDEE: Because it's not easy. It's not easy. People -- To make something easy for people to get cheap drugs, it has to be not something that they do out of the ordinary. You know, when people are used to going to the doctor, getting the prescription, going to the pharmacy, you know. And that's -- that's the reality.

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UNIDENTIFIED ATTENDEE: Rather than going home and going to a website.

UNIDENTIFIED ATTENDEE: Yes.

MS. LUNGE: It's --

UNIDENTIFIED ATTENDEE: There was some outreach. But, you know, you almost have to question whether we even get our moneys worth on that. So, --

MS. LUNGE: It's also, I would mention, because it is a mail order service, it's mostly -- it's -- I think it's only --

UNIDENTIFIED ATTENDEE: Maintenance.

MS. LUNGE: -- maintenance medication that people use it for.

So, if you, you know, need penicillin or, you know, some sort of antibiotic, you wouldn't use this for that.

UNIDENTIFIED ATTENDEE: Okay. It's limited too.

UNIDENTIFIED ATTENDEE: Yes. And they don't do any -- Yeah.

MS. LUNGE: And there's certain categories of drugs, --

UNIDENTIFIED ATTENDEE: Drugs.

MS. LUNGE: -- which they don't provide because of either FDA restrictions or concerns about that.

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UNIDENTIFIED ATTENDEE: You can't get Oxycoton that way.

MS. LUNGE: Right.

UNIDENTIFIED ATTENDEE: Thank you.

MR. KAPPEL: Okay. Lastly, the triple, colorful graph, which despite it's garish colors, is not something I did.

This graph was done by a guy named Bill VanOssen (Phonetic), who is probably one of the smartest guys nationally on prescription drug pricing. He's done a lot of presentations for NCSL and knows this stuff better than almost anybody.

So, this graph has a couple different things. The heights of the bars are the relative prices that each different pricing system pays. So, what you can see is, preferred PBM's and other private insurance typically pay about 80% of retail; Medicaid, about 60%; FFS is the Federal Supply Schedule, about 51.7. And then the 340B's and the VA negotiate down from there.

The width of the bars gives you his estimate of the market share that each one of those entities has. So, what you can see is, about 25% of customers pay cash; the lion's share, about 60%, gets that discount. And the guys who get the really big discounts are not necessarily big market share organizations. But despite that, they're

able to negotiate pretty substantial discounts.
UNIDENTIFIED ATTENDEE: Steve, the argument, 'cause we keep hearing the argument, that if we do anything to PBM's it'll cost money. Is the argument that the manufacturers can afford to give these small groups big discounts because the big groups are paying more? And so, if we equalized it, the argument might be that we'd bring everybody maybe to the yellow line or slightly above, but the Veterans and everybody else would come up. Is that -- If we went national.
MR. KAPPEL: Wow. That's a tough one to answer.
UNIDENTIFIED ATTENDEE: The leveling effect.
MR. KAPPEL: Clearly, you wouldn't get everybody down to the VA.
UNIDENTIFIED ATTENDEE: Down to the purple.
MR. KAPPEL: I think part of the question is, where that line winds up in part is how you implement that line, and in part, what your expectations are of the manufacturers. Because I think you can sort of average this out if you assume they're going to keep their current levels of profit and current levels of investment, things like that.
UNIDENTIFIED ATTENDEE: And marketing.
MR. KAPPEL: If you start pushing it down below what's the weighted average of these, then you're gonna

start eroding either their profits or their investment, or some combination of the two.
UNIDENTIFIED ATTENDEE: Do we have any indication where foreign sales are at, where their pricing is at? Canada, England.
MR. KAPPEL: Well, I think Robin's I Save Rx numbers were saving 30 to 80%.
MS. LUNGE: Depending on the drug.
UNIDENTIFIED ATTENDEE: On the drug.
MS. LUNGE: So, it -- it -- it -- I think there's a lot of variation, depending on --
UNIDENTIFIED ATTENDEE: Oh, yes.
MS. LUNGE: -- what drug you're talking about.
UNIDENTIFIED ATTENDEE: Where it's manufactured.
MR. KAPPEL: The international comparisons, lots and lots of folks have gotten their PhD's doing that kind of analysis. And it's --
MS. LUNGE: And they're not sitting here today.
MR. KAPPEL: And they're not sitting here, neither one of them.
But I think it's another one of those places where evaluation gets a little tricky, because the discount you report depends on what basket of drugs you buy. There's not kind of this standard market basket of drugs that everyone uses to compare different pricing in different

countries.
UNIDENTIFIED ATTENDEE: Okay.
MR. KAPPEL: There's even some counter-argument, because the U.S. pays lower prices for generics than a lot of foreign countries, whether you offset your savings in brand with having to pay increase generics or whether you just say, we'll buy brands there and generics here. I think it's -- it's clear that prices are lower internationally, but exactly how much gets much more subtle.
UNIDENTIFIED ATTENDEE: But I know you can't buy Pepcid Complete in Canada.
UNIDENTIFIED ATTENDEE: You can't?
UNIDENTIFIED ATTENDEE: Can't.
MR. KAPPEL: And that -- that's our presentation. We'd be happy to take questions.
Okay. Either we were perfectly clear or it's Friday afternoon.
UNIDENTIFIED ATTENDEE: You were perfectly clear.
MR. KAPPEL: And it's Friday afternoon.
UNIDENTIFIED ATTENDEE: I think you've run us through this basic thing a couple times, so we're starting to grasp it.
UNIDENTIFIED ATTENDEE: What were the other two of the next step above -- two steps above VA for?
UNIDENTIFIED ATTENDEE: To the right.

black and white.
MR. KAPPEL: Yes. FSS is Federal Supply Schedule and 340B is what we just talked about.
UNIDENTIFIED ATTENDEE: Okay.
MR. KAPPEL: Okay.
MS. LUNGE: Thank you.
UNIDENTIFIED ATTENDEE: Thank you.
(Whereupon, the foregoing proceedings were terminated.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF SEMINOLE

The foregoing transcripts were transcribed to the best of my ability from a digital recording of the proceedings identified at the beginning.

RICHARD CASTILLO
Registered Diplomate Reporter
Notary Public,
State of Florida at Large
Commission No. DD 609499
Expiration: February 25, 2011

TAB D

STATE OF VERMONT

SENATE COMMITTEE ON HEALTH AND WELFARE AND FINANCE

Re: Senate Bill 115

Date: 1/31/07

Type of Committee Meeting: Joint Meeting with Finance

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

CD No: 07-21/T1, T2
07-22/T1

PROCEEDINGS

CD 21/TRACK 1

ATTENDEE 1: This is a meeting of the Senate Health and Welfare Committee and the Senate Finance Committee joined here in room 11. Today is Wednesday, January 31st, 2007.

(Conclusion of CD 21/TRACK 1.)

PROCEEDINGS

CD 21/TRACK 2

ATTENDEE 1: Okay. We're going to start off. This is our joint meeting on -- today's topic is impact and evaluation of Vermont's initiative and we've got (inaudible) administration come in to talk to us about what we have done and what their impact has been and we're going to start with Secretary Cynthia LaWare.

MS. LAWARE: Good afternoon. It's nice to be here. What I thought I would do today -- for the record, Cindy LaWare, Secretary of the Agency of Human Services. Get back into the swing of things. What I'd thought I'd do this afternoon is just take a very brief moment and review the prescription drug issues that are involved -- that we're involved with at our agency.

ATTENDEE 2: Excuse me, could you put the microphone up a little more.

(Static.)

MS. LAWARE: Let's try this again. Why don't I start over. For the record, Cindy LaWare, Secretary of the Agency of Human Services. It really is a pleasure to be here and

I thought I would begin and give a brief overview regarding prescription drugs and the programs and initiatives that we are involved with at the agency, and then I would ask the Acting Commissioner of Health, Ms. Sharon Moffatt, to speak to the programs in her area, and Joshua Slen, who's the director of OVHA, to speak to the programs that he manages.

With that said, it's, you know, no surprise to anyone that prescription drugs are a major, major health issue nationally. There's certainly an issue with Vermont and I don't think there's anyone that's not concerned about the direction that things are headed. Certainly medical professionals are, the pharmacists are, consumers and insurers are all very, very concerned. I think the pharmacists clearly are concerned about the cost of doing business and I think they're also very concerned about the impact of recent reimbursement protocols from private payers as well as insurers.

There's also no doubt in my mind that everyone has the same goal in mind and I think that we are trying to provide clinically appropriate coverage and access to clinically

appropriate medications at the most effective cost, and that -- that's a challenge.

Now, as I mentioned, I'll discuss the I-SaveRX program and we could start right there. I think as you all recall, the I-SaveRX program began by legislation in the 2005/2006 season.

In essence, it is a program that would -- it was designed and developed by the State of Illinois and it's a program that would allow residents to purchase less costly brand drugs from outside the country. And they worked closely with Canada, Ireland, as well as the United Kingdom, and there may be a few other countries that -- I know they were looking into Australia and a few other countries as well.

Now, it was in the spring of 2005 that we signed an MOU with Illinois to participate specifically in the program. And then we began to work -- we, the Agency of Human Services -- to work diligently with a variety of our partners, those including AARP, the Vermont Coalition for Disability Rights, area agencies on aging, to create a communication plan so we could get the information about this program out to Vermonters so that they could make some informed decisions

about whether they wanted to participate or not.

And the communication plan that we established, we certainly developed a Web site first and foremost, we -- in consultation with Illinois and our community partners, we created various pieces of descriptive material, fliers and the like. The Department of Health distributed the information through all their district offices. Our Department for Disabilities Aging and Independent Living, working through their network distributed the information to the area agencies on aging, adult daycare centers, anywhere that we thought that folks would have an interest in having access to this particular program. We worked closely with the Vermont healthcare ombudsmen and their hotline had information about the program and directed them to where they could get either a hard copy and/or the Web information. AARP, Vermont legal aid offices. So we really did -- the Bi-State Primary Care Association. So we covered the waterfront in that regard.

Currently, Acting Commissioner Sharon Moffatt is a member on the joint work group which is, I would say, in some respects, a governing

body for I-SaveRX. There is a representative from each state that participates and they review the program, how it's working, and they also review any additions or deletions to the prescription drug list. So Sharon is participating in that on a regular basis.

We also receive monthly reports from I-SaveRX so that we have an understanding of the actual impact that this program has had on the residents of Vermont. And the most recent report that we've received is as of December 31st of '06. And that indicated to us that there were 242 enrollies, Vermont enrollies, and those enrollies had placed 752 specific orders for drugs. So it has been up and running for a little while and you can see the participation level.

ATTENDEE 3: When -- excuse me. When did you say this started?

MS. LAWARE: In '0- -- the spring of '05.

ATTENDEE 3: So in two years you have 242 enrollies signing up?

MS. LAWARE: Yes.

ATTENDEE 3: How would you characterize that, successful, unsuccessful --

MS. LAWARE: Weak.

ATTENDEE 3: -- too soon to -- weak?

MS. LAWARE: Weak. Very weak.

ATTENDEE 3: Thank you.

MS. LAWARE: And I think that there was a lot of discussion in controversy around the program relative to reimportation of drugs.

ATTENDEE 4: (Inaudible) comments (inaudible).

ATTENDEE 5: Yeah.

ATTENDEE 4: Can I just ask what -- I -- you referred to a document. Is there a document that's been passed out? Because we haven't seen it down here. You stated as you can see, and I didn't know if there was something you handed out.

MS. LAWARE: No.

ATTENDEE 4: Okay.

MS. LAWARE: Sorry. You can see just from the figures.

ATTENDEE 4: Okay.

MS. LAWARE: I apologize.

ATTENDEE 4: Figures.

MS. LAWARE: I think there certainly was some concern. There was a tremendous amount of

debate when we were discussing the program during that session as to the legality of the program. I think there were additional issues relative to how quickly the drugs might be able to cross the border. And, you know, all of my sense is that it's those kinds of questions and concerns that may have impacted our -- the choices that our residents made as to whether to participate in the program.

And I think the other thing that's very important to understand is this is really for brand drugs only. You can purchase generic drugs in the United States for much less money than you could even go to Canada and purchase a brand drug for. And I think there's no doubt that everyone, consumers as well as physicians, are much more in tune with the cost of prescription drugs, and I believe that the generic script writing is increasing every day. And that could be another reason why the participation might be lower.

ATTENDEE 5: You might have said this and I missed it. When you said that you thought it was weak, do you -- do we have a sense of how many people in Vermont would -- because people with coverage -- with prescription coverage can't

access this, right, it's only for people without prescription coverage?
MS. LAWARE: No, no. People with coverage can access it.
ATTENDEE 5: Oh, they can?
MS. LAWARE: And then they submit a claim through their insurance company.
ATTENDEE 5: Okay. (Inaudible.)
MS. LAWARE: It would depend on the coverage --
ATTENDEE 5: Right.
MS. LAWARE: -- because in recalling some of the testimony as, you know, I recall talking about, let's say, the state employee plan --
ATTENDEE 5: Uh-huh.
MS. LAWARE: -- the prescription drug benefit under the state employee plan at that time was so generous that very quickly it wouldn't make any sense for a state employee to use this program because they would have received 100 percent coverage for any drug that they needed. So it also depends on the coverage that someone has.
ATTENDEE 5: (Inaudible) 242?
MS. LAWARE: If it helps one person.

SENATOR RACINE: How much did it cost to set this up?
ATTENDEE 6: How much did it cost to what?
SENATOR RACINE: Set this program up. I'm just wondering on a cost per person (inaudible) what it's cost the State to provide this benefit.
MS. LAWARE: There were no additional funds appropriated to set this program up. It was the cost of developing the Web site, developing --
SENATOR RACINE: Somebody did that.
MS. LAWARE: -- the marketing materials. It was absorbed in our department and I don't have an absolute cost associated with it.
SENATOR RACINE: Okay. So we don't know how many -- one person spent a week setting it up or six months setting it up, we don't know how much those materials cost us?
MS. LAWARE: I don't have that number today.
SENATOR RACINE: I'm just wonder- -- I'm just trying to get a sense. I'm not trying to put you on the spot.
MS. LAWARE: No, I understand.
SENATOR RACINE: Just trying to get a sense of where -- one of the things we're trying to do here is see what's working and what's not, and if

things aren't working then we would want something else. If there's a reason this one's not working, then -- if it can be fixed, I think we'd want to know that too so we can fix it.
But just getting a sense of the cost with your 722, I would like to continue, but the questions are going to be what's wrong with it and can it be made right.
MS. LAWARE: Other -- other questions regarding I-Save?
ATTENDEE 7: Well, actually to follow up to what Doug just asked, Senator Racine has asked, in the budget adjustment, does AHS got anything in there for -- anything at all in the Budget Adjustment Act? I assume you must.
MS. LAWARE: Anything at all in the Budget Adjustment Act?
ATTENDEE 7: Under Agency of Human Services.
MS. LAWARE: We are not asking for any general fu- -- any additional general fund money, but there is a variety of adjustments that we need to make --
ATTENDEE 7: Okay. Are there any that are targeted to replace ones that were used on this program setting it up?

MS. LAWARE: No.
ATTENDEE 7: Okay.
MS. LAWARE: Thank you very much.
ATTENDEE 7: Are you done?
MS. LAWARE: Yes.
ATTENDEE 8: Oh, (inaudible) ask my question, then. What are you -- how are you responding to what you characterize as weak participation? Are we going to redouble our efforts, are you going to back off, are you going to recommend to the legislature that this one just be forgotten? Where do we go from here or do we accept this and look at other things? I don't know where to go.
MS. LAWARE: Well, we still believe that the program is not legal.
ATTENDEE 8: Oh, okay.
(Static.)
ATTENDEE 8: I might agree with them, but I doubt it. But given that, does that mean there's no -- there- -- there's no continuing effort to make this work? I just -- I don't know what that means.
ATTENDEE 6: Did you say not legal?
MS. LAWARE: Yeah.
ATTENDEE 8: Yeah, that's what she said.

(Inaudible.)
MS. LAWARE: Well, I haven't been arrested yet and, you know, the authorities are -- there's considerable debate as to whether sponsoring organizations were going to run into any particular issues if they were sponsoring programs of this nature. There was -- I think maybe Springfield, Massachusetts, was one of the first cities that sponsored a reimportation program. I know Burlington has done so.
It is my understanding that none of the programs had taken off and we're the be all and end all panacea to the escalating cost of prescription drugs that folks thought they were going to be. And, again, I think it is because generics are much less expensive.
ATTENDEE 9: So assuming you still think it's illegal, that would be the Administration's position?
MS. LAWARE: Yes.
ATTENDEE 9: And I wasn't here, so I'm not aware of the history, but I assume that means the governor did not sign this into law, is that correct, or did he sign it?
ATTENDEE 10: Yeah.

ATTENDEE 11: Yes, he did.
MS. LAWARE: I believe he signed it.
ATTENDEE 9: He did sign it even though he thinks it's illegal. Okay.
Now, my question still remains, because of your position that it's illegal, does that mean you aren't committed to trying to expand it or are you trying to expand it and expand participation or is it just on life support now?
MS. LAWARE: We are not aggressively selling the I-SaveRX program.
ATTENDEE 9: Okay.
MS. LAWARE: We are providing information through the networks that I have mentioned before so that if people do have an interest in the program we can be responsive to give them as much information as possible.
ATTENDEE 9: Okay.
ATTENDEE 6: And what -- if I'm remembering it correctly, that some 40 percent of healthcare dollars are spent with prescript- -- prescription (inaudible) -- no -- yeah, sensory pharmaceuticals, drugs.
MS. LAWARE: I don't have that percentage off the top of my head. Maybe Sharon or Joshua

would be closer to that.
ATTENDEE 6: Okay.
ATTENDEE 12: Now, so the issue of legality obviously goes beyond the state. It's not something that would be under consideration in this state, but it's a federal issue. But one of the concerns that's raised consistently about reimportation is the quality of the drug for treatment. And are there any indications that the drugs that have been received in this program through reimportation are any less medically effective than those that are purchased in the United States?
MS. LAWARE: I have not been made aware of that. You know, I think there are also issues associated with drugs that need to be temperature controlled and I think that -- when we started out you have the whole gamut of drugs and then if you begin to chop off all the generics -- and then again, nothing that is a narcotic can go across a border and then temperature-controlled drugs cannot go across a border. Then you really do get down to a much smaller group of pharmaceuticals that could potentially be involved in this program.

But I've not heard of anything. And in cases where shipments have been delayed, then I-SaveRX and the distributors out of Canada or the other countries I know have been replacing the orders if there's any question.
ATTENDEE 13: What -- you said Illinois started this. What other states did you say are participating in this?
MS. LAWARE: There's Illinois, Wisconsin, Kansas, Missouri, and Vermont.
ATTENDEE 13: And do you have any information on participation rates in those states? I see somebody nodding (inaudible).
MS. LAWARE: I don't have any here, but we have access to that information.
ATTENDEE 13: And do you have any -- do you know enough about the numbers to know -- to make any judgment on whether their enrollments have been stronger than ours based on a per capita basis, I guess?
MS. LAWARE: I'll say it's my recollection, the last time that I looked at all of the numbers, that they were disappointing as well --
ATTENDEE 13: In all states.
MS. LAWARE: -- but whether they were as

disappointing in other states, we can get that information.

ATTENDEE 13: Okay. Maybe we could find the state that's the least disappointing and find out what they are doing to market this program so if this legislature wants to do something more aggressive with this program, and we could provide construction to the administration on other things, that could be done.

MS. LAWARE: I'd be very happy to get that information.

ATTENDEE 13: Thank you.

ATTENDEE 14: My question is along the same line, but what did you do -- you said you're not doing anything aggressively to market this now and so what you did before was aggressively marketing would you say? Before you made -- were notified through the channel that you had at your disposal.

MS. LAWARE: Well, I -- certainly I believe that we are trying to get information proactively into the hands of those that we believe would be most able to take advantage of the program. So to that extent, yes. We clearly didn't go knocking door to door nor did we put ads in

papers and whatnot.

ATTENDEE 14: Right. Nor on public service announce- (inaudible) --

MS. LAWARE: Right.

ATTENDEE 14: -- TV or nothing in the paper, it was just through the clients that you -- the channel you usually go through?

MS. LAWARE: Yes.

ATTENDEE 14: Health Department.

MS. LAWARE: Area agency on aging, senior daycare centers.

ATTENDEE 14: Right. Thank you.

ATTENDEE 15: Do you think the Medicare Part D had any impact, though?

MS. LAWARE: I think Medicai- -- Medicare Part D impacted a whole host of things, but --

ATTENDEE 15: Well, we indicated --

MS. LAWARE: -- clearly if --

ATTENDEE 15: -- this Part D wasn't in effect.

MS. LAWARE: We could clearly go back and look at the numbers and see if there was any major shift in the numbers as we brought that program on-line.

ATTENDEE 16: Thank you.

MS. LAWARE: Thank you very much.

ATTENDEE 17: Thank you.

ATTENDEE 18: I've got people in order, but do you want to do a deliberate order (inaudible) Sharon Moffatt in that order. Do you guys have a different --

MS. MOFFATT: I guess it doesn't matter. We don't have a strong feeling that maybe I can follow up on --

ATTENDEE 18: Okay.

MS. MOFFATT: -- what this --

Hello. Sharon Moffatt, Acting Commissioner of Health. Actually what I hope to do is touch on a couple of different things a little bit more on the program that Secretary LaWare was speaking to. I also want to bring your attention to a study you asked us to do last year in terms of a drug repository and what the benefits of that might be. I'm also prepared to talk to you about how we actually fund our immunizations in the state because I think there's some opportu- -- more opportunities, but I also want to have you understand what's also coming at us from another expense. So those are the things that I could particularly be able to speak to you today about.

The program that Cindy was -- Secretary

LaWare was just speaking to, I say -- in September 19th of 2006, the Illinois state auditor actually released a rather scathing -- and rather is my word -- scathing report on the state's administration of I-SaveRX. And in particular what they felt was that the program was illegal, so that's also another point if we -- if you would like us to get that further documentation of the audit done by the Illinois state auditor.

In addition, their other comment was it was also very, very low enrollment. I think for the whole community of Illinois or whole state of Illinois it was in the low 3,000s, so certainly under 5,000. So again, for the administrative cost and then the enrollment they actually felt, you know, it was -- they really questioned it.

Also -- and again, we can get you this further documentation if you'd like, but in November of this last year the Rutlin Harrell (phonetic) actually did a limited survey and actually based on their survey results they indicated that I-SaveRX actually charges two and a half times what it would cost to pick up the same generic drug at Wal-Mart.

So as you can see there's certain areas that we need to keep on our radar screen and I'll get that further documentation to you in that regard.

ATTENDEE 19: How about your local pharmacist?

MS. MOFFATT: We could also --

ATTENDEE 19: Are we talking Wal-Mart's $4 generics?

MS. MOFFATT: Right. That's what their -- that's what Rutlins compares -- we can get you actually their report and their survey results and also you have further information on that particular --

ATTENDEE 19: You said the health department took it out of the newspaper or did you collaborate that and send somebody out or is this just a newspaper article?

MS. MOFFATT: No, this was a newspaper article that was brought to our attention.

ATTENDEE 19: (Inaudible) not anything official from the State Department --

MS. MOFFATT: Not anything that we had done. So I'm just referencing two other points of information that we can get you and further documentation to Secretary LaWare's statement.

ATTENDEE 20: Does this run out of your department or the secretary's office?

MS. MOFFATT: The secretary's office -- we -- what our role in the health department has been is to be on these joint work groups and on -- particularly what we do is myself and also Dr. Cortloff (phonetic) and actually now Dr. Don Swartz (phonetic), who's our medical director, actually participate in these costs. Usually the costs are around what the formulary is, is really whether -- are there new medications, prescriptions being added to the list, do people agree that they should be added to the list. And also that's the level that's being done and that's where a lot of that committee work is done. Less on the outreach aspect.

Yes, sir.

ATTENDEE 21: Yes. How much time is put into all that, just upkeep?

MS. MOFFATT: From sitting on the phone calls or whatever, it's probably an hour a month at the most that, you know -- and if we were looking at a more expensive person that might be one of our medical physicians, so it would be the time devoted to that.

I'd also -- will mention that AARP actually in the initial outreach, they also sent out a flier and did some -- and again, no cost to us as an organization, but they were a partner in the early outreach in terms of this, so . . .

ATTENDEE 6: What do you think auditor (inaudible) would find -- do you think he'd find things consistent with the --

MS. MOFFATT: Oh, I dare not guess, but he may benefit significantly by looking at the state auditor in Illinois' report and see if there was a mutual agreement in terms of that.

ATTENDEE 6: (Inaudible.)

MS. MOFFATT: That's true, he may want to do his own separate audit.

Shall we move on to another topic?

ATTENDEE 22: Yes.

MS. MOFFATT: Okay. I apologize. I don't have copies for everyone here because I -- this is a report that we did, and let me just pass around what copies I do have. This is a report actually requested of us last year by the legislature. It was to look at drugs in medical supply repository. The notion behind this, if you will, and the discussion that happened in

committee asking us to actually do this study was -- and again, I apologize that I didn't make copies for the whole committee or whatever.

(Inaudible.)

MS. MOFFATT: I also would say that any of the legislative reports are actually up on our Web site if people need to get easy access to them.

I'm not going to go through this whole report, but I wanted -- I'm sorry.

ATTENDEE 23: I saw this (inaudible) last year. Can you just give us --

MS. MOFFATT: Give you a grounding?

ATTENDEE 23: Yeah.

MS. MOFFATT: Okay. This came from the notion of were there medications -- it came from two places. Were there prescriptions that were being put into landfills and actually creating a toxic situation, so it came from that aspect. Or also creating a situation where drugs that were not used could be diverted if they were thrown away, so there's that aspect. And then another aspect of it was could these drugs be recycled. And I mentioned drugs and pharmaceuticals in particular, so this study that we were --

initially there was some talk to actually pilot a program. And based on what we understood was happening in other states, we were actually cautioned not to go out and immediately do a pilot because the first thing you do is a study and present to you the study and then actually decide where we want to go next and on your advice. So that's essentially the essence of where this study came from and all.

So -- and we were asked to look at other states that may be actually tackling this. We were also asked to look and coordinate across other parts of state government. So our medical practice board, OVHA, obviously public safety, and also the Department of Aging and Independent Living were key partners that were specifically needed to outreach.

And I'm not going to go through all the detail of this, but I think what's probably most important for me to do is bring you to the last page, page 14, which is our findings and recommendations. And then I'd be happy to speak to whatever point.

As far as the costs that we looked at, it de- -- depending on the state, they had spent

from zero to set up the program to as much as $400,000 to set up the program. Most of the states are voluntary in nature. So, for example, in Maine, what they've done is more of a collection so it's not going into the landfills and it's also not getting diverted, if you will. They have not gotten into the recycling of the drugs.

Yes.

ATTENDEE 24: Testimony judiciary that if -- when you die in Florida that the police arrive and confiscate your medications. What's that about?

MS. MOFFATT: That's further supported in here. Now in some states, and Florida I believe is one of them, they confiscated -- or -- if you will, maybe that's not right -- quite the right word, but they actually take that drug so it can't be diverted, but then because it hasn't been used and they -- many states have actually -- are recycling it. The package has to have not been opened, so it can't be a partially used bottle, whatever -- the blister pack can't be opened and all. The pharmacy board actually will then, you know, okay whether it can be recycled

and then it's used and put back into the -- particularly the state stream to help reduce Medicaid funding.

What -- and I just want to be careful not to jump to conclusions, but basically what we're seeing from other states, there's probably a lot of good reasons to do this from rec- -- from a collection and diversion place. We would probably want to go very, very cautiously if we were to talk about trying to reclaim and recycle these drugs. In particular, the states that have recycled them is often in nursing homes where the drug -- or in a hospital setting where it's been under the control of a healthcare professional and is able to be reclaimed in that situation, not from individuals' homes or donations of that sort and all.

But I just wanted to -- want again to make the committee aware of one other study. So we're real cautious going forward and we're happy to talk to you further about this if you should want us to consider piloting it. I think from a diversionary place there's probably some real wisdom here. Beyond that, I'm not sure that we're going to see some significant savings in

that area.

ATTENDEE 6: You stated that the only drugs that you can do that with, and maybe I misunderstood, it sounded like even the diversion and not necessarily the recycling, but the diversion or just moving it from the waste stream would be only those that are blister packed.

MS. MOFFATT: Oh, I apologize. Only the blister packed or the unopened, you know, totally sealed would be for recycling.

ATTENDEE 6: Okay.

MS. MOFFATT: But in Maine, for example, it's similar to how we do in Vermont, have a -- you know, a pla- -- a paint -- if you want to drop off your house paint, there's recycling centers around that kind of move around the state. That's essentially how Maine is. They've had little activity in the first run with that. They believe it's just more informing they've got to do.

That's a situation where you take it from your home and instead of necessarily putting it down the toilet or in the wastebasket or whatever, you just drop it off at the site and then it's disposed of.

ATTENDEE 6: Right. I guess the question -- even if you -- let's say we were going to go to a recycling mode, let's just say it assumes we figured that part out, how would we do that? Because it seems to me there'd be very few drugs that are -- I have a maintenance drug that I -- and it's not a blister pack when I get it, and I get a three-month supply. It comes in a package via the mail.

MS. MOFFATT: Right. It doesn't have to be blister packed for it to go to a recycling center, to be taken into a waste center.

ATTENDEE 6: To go -- I'm talking about if we decided to recycle the drugs.

ATTENDEE 25: Use reuse instead of recycle.

ATTENDEE 6: Reuse. Okay. Reuse the drug.

MS. MOFFATT: Reuse. Okay. Reuse. Okay.

ATTENDEE 6: We try to reuse the drug.

MS. MOFFATT: Right.

ATTENDEE 6: Very few are blister packed or sealed when you get them in a tube.

MS. MOFFATT: Right.

ATTENDEE 6: I mean, you can get them in a bottle --

MS. MOFFATT: Right.

ATTENDEE 6: -- and you just open it up and use them. There's no seal on it.

MS. MOFFATT: Well, and that's exactly your point, I mean, that's where it's certain to have the savings and given the administration and oversight -- because you then have to have it overseen by usually a board of pharmacy. There'd be very few -- there would be a limited number of drugs --

ATTENDEE 6: Right.

MS. MOFFATT: -- even in a nursing home or hospital setting that would be able to be used. So again, I think the study speaks more to that that, you know, if you can keep your costs down, if you could do it in a very controlled way, you may be able to get some benefit. I'm not sure in the volume in Vermont that we would be able to take care of that, but again, we're very open to talking with you further around this. I'm just not sure that this is a magic bullet, if you will.

Shall I move on?

ATTENDEE 26: I would like that.

MS. MOFFATT: Okay. The next area, and I do have enough copies of this, and this is to start

the discussion around immunization funding. What -- and again, I'm going to just step back a little bit because I'm not sure that everyone understands how currently immunization funding has occurred in our state. And I'll -- what you have is -- oh, I apologize.

So for well over 20 years in our state we -- and by -- I say we, let me back up and say the health department has an advisory board around immunization, particularly children's immunizations, and on that board sits representation from the world of family practice, nurse practitioners, and pediatricians. That is our Vermont essentially immunization advisory board.

So as a new vaccine becomes available at the national level, there is a national advisory board. They determine who the children should be that -- and whether it should be a recommended vaccine. Then that comes to our state and we essentially bring that group together to help us make that decision, should it become part of Vermont's package, if you will, available vaccines.

Actually, the advisory board worked

extremely well until several years ago when we had a shortage of the flu vaccine. We brought them together and they actually helped us figure out how we could redistribute and get to the gaps in the state. So that's a place where policy decisions around vaccines are made.

And actually Dr. Cortloff, our state epidemiologist, who actually oversees our immunization program, he's the one that actually conducts and oversees and chairs those -- that advisory group.

Over 20 years ago we as a state made a policy decision to have universal access. By that I mean that any child walking into any pediatric care provider setting would have a vaccine available to them and that that healthcare provider would not have to go to the refrigerator and figure out, well, this is my shelf for BlueCross vaccines, this is my shelf for state vaccines or whatever, that it would be one fridge, all the same vaccine, everybody would get the same access.

ATTENDEE 27: (Inaudible) that's all free.

MS. MOFFATT: And actually virtually all children's vaccines are (inaudible) free, other

than some of the flu vaccines for children, but that's a discussion for another day, right?

So that's been the policy decision and I will tell you in our state that's been a high -- a reason one -- for years we've actually had very high vaccine rates because any door was open and people didn't have to worry about how they were going to bill.

The health department actually receives federal funding and there's two streams of federal funding, and this goes into it in more depth. There's the Vaccines for Children program, that's funding that comes from the Center for Disease Control, comes to the state. We essentially purchase that vaccine that we need to take care of all children birth to 18. And then we actually have a distribution center that we're responsible -- we actually store it in the health department. We then distribute it out through our district health offices throughout the state and then they move it out to the actual healthcare providers based on their orders or sometimes it goes directly to them. For example, in Burlington it goes directly to the healthcare providers wherever.

We then have a whole quality program around the safe storage of that. One of the things that's really critical in vaccine storage is the temperature, and that's one of the issues actually facing Vermont right now. We've actually long been one of the leaders in children's vaccinations. We're not -- once you look at chicken pox, and in part because chicken pox has to be frozen it can't be in one of those stacked refrigerator -- freezer and refrigerator because the temperature changes, so then you have an unusable vaccine. So in our state some providers have chosen not to vaccinate for chicken pox, have children go elsewhere for that. So we've got some work to do in that area. Discussion for another day. So from a funding place, the VFC program, the federal program, has long carried Vermont in terms of getting its children vaccinated.

There's also a section 1 -- 1 -- 317 federal funding available. That funding can be used for adults also. In our state, though, we prioritize that 317 funding to go first to children. So it's only when there's money left over that we've been able to use it for pneumococcal for adults

and all. So the 317 funding has been level funded for several years now and currently we're ver- -- continue to be very concerned that that funding is not going to be changed.

There are -- you have private insurers that are also paying, and also Josh will speak to the Medicaid's program. This is where -- before I tell you where we are, let me just go -- and I think the graph shows this. The cost to vaccinate children has grown exponentially, and there's a smaller graph, but the larger one I think shows a better picture of this. And I can actually provide you with a few copies in color and try -- I think it would explain it a little bit better and all. I think, though, graphically what this shows is the enormous expense of now vaccinating a child from 20-odd years ago when we decided as a state to go universal vaccine. So we're starting to hit a significant wall around how we vaccinate and paper vaccine for our children.

Let me also emphasize, the $894 figure here, no, that does not include the now HPV vaccine for cervical cancer, which on the market is $360 for the three-course dose, so -- no, I'm sorry.

That's -- that's for one vaccine. That's for one vaccine, it takes three courses. So this doesn't represent what that potentially could mean.

Where we are right now -- and we have an immunization study that we've just completed. We're going to be working -- and Josh Slen and I have already started working this and we've already worked -- I'm sorry.

ATTENDEE 6: The cervical cancer vaccine, are you getting a lot of resistance from, you know, extreme right religious right type --

MS. MOFFATT: I will say no, we haven't, and actually we have a cervical cancer report. I didn't bring that with me today. Actually there ha- -- there -- I will say we have not had that type of call come to the health department, and even as that cervical cancer study was done, there was lower concern that -- because the focus was cervical cancer protection. So most individuals -- and there was quite an array of individuals as part of that cervical cancer study, and as they explored that did not find that to be the case. But perhaps others of you have heard --

Yes.

ATTENDEE 27: I have a question about the cervical cancer vaccine. It's a three-part vaccine over a year or so, is it, or year and a half --

MS. MOFFATT: That's the ideal, yes.

ATTENDEE 27: So is that window -- does the state cover people who get that vaccine --

MS. MOFFATT: It's not at this point a recommended or required vaccine, HPV. And that's something in the next several months that I think as a state -- and I believe there is actually a bill that Representative Barnard (phonetic) is putting forward to have that public policy discussion about should it be a recommended or required vaccine. But at this point it isn't, so what you're finding is individuals, their insurers are actually vaccinating if the child and the parent actually request it. And Josh can speak specifically to Medicaid and how they're managing at this point. But at this point it's not required.

ATTENDEE 27: When is the age -- (inaudible) is it 15 or is it 18?

MS. MOFFATT: FDLE allows it from 9 to 26. The national advisory recommends 11- to

12-year-olds. So it -- I guess what I wanted to finish with is just the next step. So one of the things that not only Josh and I are doing with Medicaid and state funds, but also working with the primary provide- -- insurers in the state. BlueCross BlueShield and MVP in particular have come to the table to see if we could work out and be wiser in how we use our resources to purchase vaccine.

Let me make it clear, in some states you'll hear, in Rhode Island, North Dakota, and also in New Hampshire, they have a waiver on their CDC grant which allows insurers to buy on the CDC rate. It is the absolute lowest rate available. That was an old waiver they got under the cover. We weren't able to use that.

But Vermont also uses a Minnesota purchasing agreement that actually has a very low rate also. Not as good as the CDC rate, but lower. And actually I would say on comparison, actually very, very competitive if not lower than what even BlueCross BlueShield can buy through their marketing or purchasing ability.

So that's the discussions we're in right now, is to see whether -- as we could bring our

resources together if we could be wiser in how we purchase vaccines in the state. So (inaudible) -- and beyond that I don't have a lot more detail for you today.

ATTENDEE 28: Just one question about the federal funding, the level funding. Where does that -- where does that emanate from? Is that a CDC or is it a --

MS. MOFFATT: It's through CDC -- CDC is the -- it's health and human services.

ATTENDEE 28: (Inaudible) making in Congress?

MS. MOFFATT: Yes.

ATTENDEE 28: (Inaudible) from? Okay.

MS. MOFFATT: Yes.

ATTENDEE 29: Yes. On the graph here, 2006, is there a reason why they're stacked in the order they are or is that just when they came on?

MS. MOFFATT: Usually it's when they came on and all, so you can see how we've continued to add on in terms of the number of vaccines that we have available for children which is certainly the good news.

ATTENDEE 29: Yeah. We're getting different -- so it's stacked by priority of importance.

MS. MOFFATT: We -- I think we'd end up -- we'd end up with the exact same cost --

ATTENDEE 29: (Inaudible) cost as much as -- the stack look any different or did we bring them on as we thought that this was the more important that we had or --

MS. MOFFATT: Usually it was exactly how they rolled out into the market as it became available, you know, essentially where we are with HPV. It's brand new to the market. And it's not unusual with any of these vaccines. We were actually in this situation about ten years ago with Hepatitis B, when we as a state made a -- tried to make a decision of should the Hepatitis B vaccine be available and be required for entry into 7th grade and at that point we as a state made that policy decision that it would be required for entry. That was about ten years ago with Hepatitis B, so it's kind of -- each vac- -- usually they're not so maybe contentious as Hepatitis B and potentially HPV could be, but we've got more talking to do together to get to that policy decision.

ATTENDEE 30: (Inaudible) prepared to go forward (inaudible) the fact that (inaudible) get

to buy three immunizations (inaudible) signing yesterday (inaudible) report back when we served on that committee in Bloomsburg (phonetic) we (inaudible) --

MS. MOFFATT: I'm working --

ATTENDEE 30: -- any type of town (inaudible) list or --

MS. MOFFATT: -- working on that right now with Susan and actually trying to make sure that coordinates also with Medicaid, so that -- but again, as far as children we certainly would hope that we would be able to support exactly what we're doing (inaudible). I think ultimately what we want to aim for is -- and actually (inaudible) Hall speaks to this and I -- you know, I think we need to recognize how significant the recognition was around immunization as a prevention tool and that we needed to invest in that area.

ATTENDEE 31: What's the timeline for us getting the list?

MS. MOFFATT: I would think within less than a month and maybe even sooner than that.

ATTENDEE 32: (Inaudible) is there disagreement on which ones should be offered or --

MS. MOFFATT: No -- I think -- I will tell you one of the stumbling blocks is HPV, whether that should be in or not and what that would do. I think we're right now looking at modeling in terms of, given the resources, what would that do, and you are essentially weighing HPV against other adult vaccines. So that's the, if you will, touchstone force right now.

ATTENDEE 32: Okay. Thank you.

MS. MOFFATT: Certainly. Thank you.

ATTENDEE 33: Joshua, are you next?

ATTENDEE 34: First time he's ever testified below the (inaudible.)

ATTENDEE 35: He had it, I saw him bring it in.

MR. SLEN: I left it in the back.

Good afternoon. I'm Joshua Slen, I'm the director of the Office of Vermont Health Access, and Ann Rogue (phonetic) is our pharmacy director and she's not here with me today, but she would be happy to come if there's questions that I can't answer or there's items that are additional items that you'd like to talk about with her.

I have in boxes, and we can give them to you or not, our Medicaid generic reimbursement study

which we did this year. And it's a rather thick study and so if some of you want it and some of you don't, we're happy to give you them, they're right here in the boxes. But we also brought a copy of our preferred drug list. This is by drug all of the drugs that we're actually managing on that preferred drug list since it was one of the items that you asked for us to talk about.

Again there's an enormous amount of detail in this document. We have copies of it here enough for the committee, and if not all the committee members don't want copies today, we're happy to make those available to the members of the audience also, but --

ATTENDEE 36: (Inaudible) try to get just one copy for our committee library.

MR. SLEN: That's absolutely fine, and we're happy to give those directly to staff if you'd like and have them put in your library.

ATTENDEE 36: (Inaudible).

ATTENDEE 37: I think it's a good plan.

ATTENDEE 36: I'm trying to save --

ATTENDEE 37: (Inaudible.)

ATTENDEE 36: Yeah. We have a larger plan.

MR. SLEN: I can talk for quite a great deal

of time about the Medicaid program and I don't want to do that, and also on the pharmacy program.

ATTENDEE 37: Sounds like a threat.

ATTENDEE 38: Please don't.

(Static.)

ATTENDEE 39: We have a phone conference at 3:15.

MR. SLEN: Okay.

ATTENDEE 39: We're hoping to get a break, but I don't think we're going to get a break.

MR. SLEN: Well, Senator, I think that's up to you and the other members.

ATTENDEE 39: (Inaudible).

MR. SLEN: What I'll do is give a brief overview of the different things that we're doing, a very brief overview, and then I'll answer questions instead of spending a lot of time with a lot of detail.

ATTENDEE 39: (Inaudible) healthcare industry (inaudible) finance this morning, do you have any assessment as to how successful this is, how much money are we saving?

MR. SLEN: First of all, there's been a lot of changes to the pharmacy program over the last

several years and the newest change was in last January when the Medicare Modernization Act started covering drugs for elderly and disabled folks across the countries and in Vermont also. That moved about 30,000 people off our pharmacy programs and had a dramatic change in our total spending and the composition and the types of drugs that people were buying on -- that the Medicaid program was paying for. So --

ATTENDEE 39: Did that loss of monies have any effect on our ability to bargain with the now 30,000 less people? Did that diminish our ability to bargain with pharmaceutical companies for better prices because (inaudible)?

MR. SLEN: I can talk a little bit about that. We -- we have changed our supplemental rebate pool that we participate in and we currently participate in -- it's called the SSDC, which is the Sovereign States Drug Consortium, and it includes Maine, Ohio, and Vermont at this point in time, and there's several other states that are considering joining it.

That's a supplemental rebate grouping that we use to poolize Medicaid lives across multiple states in order to negotiate rebates beyond what

are the OBRA rebates or the rebates that are required for participation in the Medicaid program across the country.

So we receive rebates that amount to something north of 20 percent on average of the price of drugs through the OBRA program, and then we receive an additional -- additional rebates. Last year we received $10.4 million in supplemental rebates through the SSDC. So -- and that was formulating more than the year prior, so just as a --

ATTENDEE 40: What happens to the rebate when you get the rebate, where does it go?

MR. SLEN: It offsets our spending, so we offset it in our system against the actual spending for drugs. In comes in --

ATTENDEE 40: Does it stay in the pharmaceutical?

MR. SLEN: -- it come- -- no, it comes in and it's deposited through the -- I'm sorry?

ATTENDEE 40: Go ahead.

MR. SLEN: It comes in and it's deposited into our healthcare fund, so it goes into the Medicaid program. It doesn't actually sit in a pharmacy-only bucket. We don't have such a

bucket for money.

In state fiscal year 2006 we spent $168,000,000 on drugs.

ATTENDEE 41: 168-?

MR. SLEN: $168,000,000, yeah.

ATTENDEE 42: In '06?

MR. SLEN: Yeah, in state fiscal year 2006.

ATTENDEE 43: (Inaudible).

MR. SLEN: The total budget in the state fiscal year 2006, I apologize, I don't have it in front of me. Something just south of a billion dollars, a little south of that, a billion.

ATTENDEE 43: 168- in drugs only.

ATTENDEE 44: (Inaudible) ask you a question, when you were talking about the drugs and this $10,000,000 coming from supplemental and there's overall a 20 percent discount because of the programs we're in, did you say that 20 percent was a discount?

MR. SLEN: From the over 90 rebates, the rebates that we've received from the negotiations that the federal government does with all drug manufacturers, we received a discount off the -- what would be the price we would pay without the discount of about just something -- just over 20

percent on average across all. For some individual brand drugs we may receive discounts of 70, 80, 90 percent. But we don't -- on average it's just over 20 percent.

ATTENDEE 44: So then I guess my question, then, would -- you know, having been around -- or on committees discussing the -- all the ABCs of the drugs, but our pharmacists in Vermont are not necessarily involved in all of this; is that right? I'm trying to look at this $10,000,000 and did any go back to the pharmacies in Vermont? But not everybody gets their drugs from our Vermont pharmacies. Is that what you do? Because we're talking all about the OBRA Medicaid drugs, right? And that's Vermont pharmacists.

MR. SLEN: Senator, the rebates accrue to the state.

ATTENDEE 44: Yes.

MR. SLEN: So we pay -- at the pharmacy we pay average wholesale price minus 11.9 percent for a brand-name drug at the pharmacy currently and we pay a $4.75 dispensing fee for when our pharmacist dispenses that drug. That's our pricing methodology for brand-name drugs at the pharmacy.

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We then -- we then send a file that allows us -- that goes through our system and goes out and we get out to CMS and we get a rebate that comes back in, retrospectively, of course, for that list of drugs that we dispense. And so all of those drugs get allocated out by manufacturer and go to each individual manufacturer for a check, then it then comes back to the state and offsets future spending.

So it doesn't actually get -- there's two separate distinct processes.

ATTENDEE 44: I don't see it, though. I have heard in the past from the local pharmacies -- I don't know how to put it, but they -- you know, guess what Medicaid or OBRA did to us now, or that they're -- they don't seem to get -- they do a lot -- they have to follow a lot of rules and they don't seem to get any reimbursement for the amount of work that they're out there doing.

MR. SLEN: Senator, I'll get to that. We have a rather lengthy study that was done on reimbursement and dispensing fees at the pharmacy level and I'm happy to talk about that at length today. It -- as it -- let me just run through a couple of other things because that's a meaty

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subject in and of itself.

Last summer we did a study about generic dispensing and it turns out that in Vermont just over 62 percent of all of the drugs that Medicaid pays for are generic drugs. So more than half of all of our prescriptions that we pay for are generic drugs.

Another statistic that's important in concert with that one is that when a generic equivalent's available, 98 percent of the time a generic is what we fill. And so that means that only two percent of the time when there's a generic available is there a physician override that says, no, give them the brand anyway. That's a pretty high -- that's a pretty high percentage. It's a very high percentage actually.

Vermont has had a preferred drug list since 2002 and on our preferred drug list -- that's managed through a group called our drug utilization review board, which is made -- composed of doctors representing several different specialties as well as pharmacists. And that drug utilization review board manages our preferred drug list with the help of the

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pharmacy team within the Office of Vermont Health Access and our pharmacy benefit management company, which prior to 2006 -- calendar year 2006 was First Health.

We did a procurement and First Health was not the successful bidder on that procurement and we currently have MedMetrics, which is a company affiliated with University of Massachusetts. It's a non-profit pharmacy benefit manager and they have been active since January of 2006 in managing our pharmacy spending. The total -- the total contract costs over a three-year period for that MedMetrics contract are $1.1 million less than what the three-year bid by First Health was for the same period.

ATTENDEE 45: And what is the total? What do we pay them?

MR. SLEN: I apologize, I don't have my -- yeah, I have my budget document in my bag, so I can answer that question for you, but I don't have it on me right this second.

When Medicare came in -- when Medicare came in, about half of the individuals with disabilities that were on our caseload moved over to Part D and almost 96 percent of the elderly

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that were on our caseload moved into Part D. And so when you think about the caseload in Medicaid and who's left, you know, who are we paying for drugs for, we're paying for medications mostly for adults under the age of 65 and kids and some -- a few -- some disabled folks that are still on the caseload also, but mostly adults and kids, that's it.

ATTENDEE 46: Is that why it's skewed to about 50 to 60 percent of drug costs as opposed to the 48 percent that occurred?

MR. SLEN: Yeah. The fact is that the individuals that moved off tend to take more -- have more prescriptions and different types of prescriptions. We don't prescribe a lot of arthritis medicines to kids, for example, and we have more kids than anyone else on the program now.

So Medicaid -- so, for example, the Medicaid program pays for a lot of labor and delivery. We pay for a lot of labor and delivery charges and the medicines associated with pain relief for that procedure in the hospital and afterwards. And that's just a demographic in reality.

One of the other things that's happened as

we've managed the preferred drug list over the last year or so is that the drug utilization review board put in some additional edits into the new system that our MedMetrics contractor is utilizing and we've actually seen a dramatic reduction in the total number of prior authorizations that have been requested. And the reason for that is, one, because we have fewer people on the program, but it's even -- it's been more dramatic than even that. And one of the reasons is because the system that we're utilizing with the new vendor is an actually more efficient system at identifying specific instances where age and gender and diagnosis would allow an override automatically. And so our system is more efficient today, much more efficient than it was a couple of years ago. And that's not just a vendor -- a new vendor issue, that's also a change in the system overall.

So overall the vendors have gotten better at, and we've gotten better at, detailing the pharmacists at the -- at the point of sale and making sure that as many transactions can go through as possible. And so we've actually -- we've actually dropped from 42,000 prior

authorization requests down to 20,000 prior authorization requests.

To put that in context, on an annual basis we process almost two and a half million pharmacy claims, and so we're talking about very small numbers that are actually requiring some sort of action by a physician and/or pharmacist in the form of overriding.

ATTENDEE 47: Do you keep track of any mistakes or blocking people or any of the problems in the system? I mean, there was one, I think, a year ago --

MR. SLEN: There's always -- in any large system like this there's always some problems, if you will. There's always some things that are not going exactly according to plan. And those often have to do with new formulations of drugs that don't have the right edits put on them when they get entered in the system right away.

ATTENDEE 48: When they don't have the right what?

MR. SLEN: When they don't have the right edits on them, and so -- an edit is a -- it's like a little wall in the system so that you -- that says you can't prescribe this to someone

under 18 because clinically it's inappropriate. And so when you have a new formulation that, say, takes two drugs that used to be only available as two separate pills and squishes them together and says now you can have it, you know, this new formulation for whatever the price is -- and that happens continually.

The manufacturers are every month coming out with new formulations and new varieties, fast-dissolving pills, liquids, gels, all kinds of things. And as those new formulations come out, in order to actually allow them to be purchased at the pharmacy counter, there has to be all of the appropriate edits in the system.

And so what I was responsive -- I was attempting to say was that sometimes, you know, a large system like this, those edits don't all get put in place correctly. And so there i- -- it's a -- it is a system that is constantly being overseen and we have to be continually right on top of.

But I'm not aware of any specific individual beneficiary case where there was a problem that I could talk about right now.

ATTENDEE 49: No. That's the one I was

thinking of. And then the only other one I was thinking of was people getting told that they don't have coverage any more. There was a couple of situations that I've run into and then they -- we call -- a lot of them call and call and then they say, oh, yeah, that was a mistake.

MR. SLEN: I encourage all of you to contact me or my office -- Stephanie Beck, who's back here and is our legislative liaison -- with any of those individual issues because there are -- especially in the pharmacy area.

As you know, the state of Vermont has expanded pharmacy benefits pretty dramatically. We cover individuals up to 225 percent of federal poverty with a pharmacy benefit. And even with Part D, we're wrapping individuals, meaning we're provi- -- we're paying all of -- for drugs that are not covered by the federal program and we're paying for cost sharing for that federal program for individuals that were on all of our programs in the state prior to Part D coming into place. And so we're still the secondary payer for the vast majority of individuals that were on our programs before.

ATTENDEE 50: Josh, we've only got a couple

minutes left and I'm looking at the PBMs and just wondering in -- who negotiates the drug price with the drug manufacturers for our prices? Does your office or does the PBM do it? And what role does the PBM play in (inaudible)?

MR. SLEN: Senator, the formulary -- the preferred drug list that we work off of was developed by our drug utilization review board. The pharmacy benefit management company, First Health previously, MedMetrics today, provides staffing and staff reports and expert testimony to the board to help them identify what agents are appropriately placed on the preferred drug list and what formulations might be restricted in some way.

ATTENDEE 50: So they have an advisory, but an expert opinion advisory role in the development of the preferred drug list.

MR. SLEN: That's correct. And now Vermont has what you can consider a mature preferred drug list. So we're not adding new classes and wholesale like states that might have just started a year or two ago creating a preferred drug list. What we're doing really is managing a preferred drug list that's been functional in its

current form for a long time. We did add, for example, mental health drugs by act of the legislature to the preferred drug list last year and we grandfathered everyone that was on medications to stay on those medications without being subject to the preferred drug list.

We've been tracking as individuals have come on to see how many overrides were requested from the preferred drug list for mental health drugs and they have not varied from that very small percent across all drugs that we've been talking about which tells us that at least at this point that new folks that are coming on are being able to find the medicines they need on the preferred drug list, which is a good thing.

ATTENDEE 51: Along that same discussion line, have you or anyone within your agency asked the drug utilization board to remove or add a specific drug from the preferred list, either remove one or add one to it?

MR. SLEN: Senator, on a monthly basis -- and I don't attend all of the monthly meetings, but on a monthly basis there are drugs that come -- that may come off of the preferred drug list or be added to the preferred drug list, and so

there is significant movement in that list over, say, a 12-month period.

ATTENDEE 51: No, I don't want -- I think you're misunderstanding me. You have a drug utilization review board which is, I assume, a separate board that does the reviews, all additions or removals, deletions from the preferred list. Have you or anybody in your agency asked, requested of the drug utilization to take and remove a drug or add a drug to the preferred list?

MR. SLEN: Senator, the drug utilization review board is an advisory review board to me, to the Office of Vermont Health Access, so that's exactly what we do --

ATTENDEE 51: Okay.

MR. SLEN: -- is we come to -- with a package for this month that gets sent out several weeks in advance of the monthly meeting and -- for the board members to review and then we provide presentations at the board for drugs that should -- for discussion about taking them on or off of the list as well as all the formulation and other --

ATTENDEE 51: Let me -- let me just -- a

very popular drug, Lipitor, is that on the list?

MR. SLEN: I don't know the answer to that question directly. You probably do.

ATTENDEE 51: I don't. I'm asking. It's a popular drug.

MR. SLEN: Senator, I can -- let me not try to answer that question while I'm sitting here. Instead, I will make sure I pull the preferred drug list that has all of the preferred agents on it and I'll let you know.

ATTENDEE 51: Okay. What would be the reasons why a drug might be removed from the list?

MR. SLEN: If there was an equivalent, a drug in that same class, therapeutic class, that was providing a significant cost discount to the state of Vermont, we would -- we would remove potentially as long as the drug utilization review board felt that it was clinically appropriate to do so. We would remove the more expensive agent and place it on the non-preferred list.

So remember the preferred drug list is a cost control mechanism that has to be done in a clinically appropriate fashion. So the reason

for all the medical and pharmaceutical folks on the board is to make sure that nothing is done that's clinically inappropriate.

Meanwhile, placing a drug as a preferred agent on the preferred drug list has a significant impact on the number of -- on the percentage of the market that that individual drug will have in a state like Vermont. And so that's why a preferred drug list brings manufacturers to the table to negotiate supplemental rebates with the state.

ATTENDEE 52: Okay. (Inaudible).

ATTENDEE 53: So going back to the MedMetrics and First Health, can you talk a little bit about how -- because I can't remember or maybe I never knew -- how we went from First Health to MedMetrics. Was it a bid process? We saved $1.1 million and then at some point would it be helpful to look at what exactly it costs us to gauge the PBM?

MR. SLEN: It was a full bid process. It was a full procurement process following all of the state's procurement guidelines, an RFP process, request for proposals process. That took a better part of a year to do. And the

ultimate where it was the best proposal -- the best price and best proposal for support. And I'm happy to provide you the cost and breakdown for the new contract.

ATTENDEE 53: Okay. (Inaudible) just one -- is there an incentive within the contract for a savings for the state?

MR. SLEN: There are a number of different incentives in the contract, and so I'm happy to talk about those.

ATTENDEE 53: Okay. Okay.

MR. SLEN: What we didn't get to, and I know you're out of time, and I apologize, is this reimbursement study, so I'm happy to talk about that at another time. I'm sure that others in the industry will be talking to you about their reimbursement study also, if they haven't already, and we're happy to come in -- Senator was saying to your committee if that's where that will be discussed, and go through it in more detail.

ATTENDEE 54: Thank you.

MR. SLEN: Thank you.

(Conclusion of CD 21/Track 2.)

PROCEEDINGS

CD 22/TRACK 1

ATTENDEE 1: Yeah. Okay. Okay. And Senator Racine is here and Robin has passed or is passing out your document, I believe, I'm looking for it here and -- okay. We have that. So the floor is yours and I think we're looking for your advice for things that have happened elsewhere in the nation and things that Vermont might consider as part of our ongoing effort to control the cost of prescription drugs.

MS. TREAT: Okay. Well, thank you very much for the opportunity to testify, and I want to say thank you to Senator Cummings (phonetic) and Senator Racine and it's always a pleasure to return, even if telephonically, to my home state of Vermont.

I have put together a kind of a laundry list and I know there's going to be some repetition. Your staff was very helpful in sending me the materials that they've already distributed and I know there will be some overlap. And I have tried to tailor this to the programs you already have, but I have to say that I've heard of other

(inaudible) and wasn't able to fully (inaudible). I may talk to you about plans that were already done, but I tried not to do that. But as long as you understand that right from the get-go.

ATTENDEE 1: Okay.

MS. TREAT: What I've done is kind of come up with a list of actually 11 or 12 policies that I've broadly grouped into certain categories, and I thought I'd just run through them. You know, I have some thoughts (inaudible) I think some of them are more successful and less successful than others. I haven't gone into a lot of detail about the cost savings, but I know you have a separate presentation on that. But you're welcome to, you know, interrupt at any time. It's a little weird by telephone, so -- but, you know, I'd appreciate if you'd stop as I go along and -- you know, if things need clarification.

ATTENDEE 1: Okay. And -- if --

MS. TREAT: So I don't know what -- you know, how you want to run this.

ATTENDEE 1: Okay. I think we'll probably end up interrupting you a couple of times as hands go up. It would be helpful if you know anything about savings of individuals and which

is the most successful just to kind of indicate that as you go through the programs --

MS. TREAT: And I do have some separate documentation, some of which I've provided already to your staff about some of these programs. (Inaudible) you know, sending the 25-page documents.

ATTENDEE 1: No.

MS. TREAT: Already I believe it could be longer.

So anyway, the first thing I started talking about here are pricing provisions. You know, it -- Vermont really was a leader on this early on when they (inaudible) and those of you that were in the legislature at this time may recall that the original version of Maine (inaudible) Vermont (inaudible) actually established prices for medication in the state and it evolved into a discount drug program basically referencing (inaudible) on a large (inaudible) pool as well as in Maine a provision that connects the Medicaid preferred drug list to the Maine RX program in that it's an opportunity for the state to put drugs on the preferred drug list or rather on the prior authorization list should a company

not be willing to negotiate with a company good prices to benefit not only the Medicaid program, but also the discount drug program. And I know that you have a healthy Vermont (inaudible) program, it does not have that leverage provision in it, but you do have the (inaudible) for that kind of approach.

There are other states that have taken a crack at this pricing issue with some different legislation, and I want to state right off the bat that there are some complex legal issues here. It's not entirely clear how far states can go with all of this. And those issues are being worked out in the courts right now, although there are certainly measures that states have taken in other states that have not been challenged. I also don't know to what extent they've actually been implemented.

Just right off the bat with the Maine RX approach in terms of the leveraging provision has been upheld in Vermont including (inaudible) Supreme Court. Other approaches that are on the books right now include the District of Columbia which has a law which provides for judicial remedy including damages and injunctive relief

where a drug price is in excess of 30 percent over (inaudible) income. That is a law that has been on the books for a couple of years now. It's been going through the court system what was initially enjoined by the District Court in the District of Columbia, the federal court there, and it's now on appeal. And actually we've submitted a (inaudible) that. It is something that might -- our view is that it might be possible to draft a law that takes this approach that is perhaps better drafted.

There are some problems with the way this law was drafted. It only applies to patented or brand-name medications, so there was a question -- legal questions right off the bat. So that -- it takes the reference price that you would look to to find out whether either the drugs are overpriced to prices in other countries, only it doesn't look to prices within this country. And it doesn't have a very good (inaudible) showing.

I mean, you could come up with a law that looks particularly at drugs that benefitted, let's say, people who have cancer or who are in a life or death situation where the drug price is particularly high. And perhaps a targeted

approach to this, you know, might have a different legal consequence if it were challenged.

I can push to the Colorado type (inaudible) statement that (inaudible) and this is just one example of it. The thing about these laws is they're mostly focussed on their payment situation, you know, so outlying activity that were (inaudible) prices that -- in a state of emergency. So it's a very limited provision, but it does give you an example of some of the legal approaches that the states have been taking and those weren't generally challenged.

Pennsylvania has a really interesting law which is still -- and the courts are implementing and also what I would call reference pricing law where they pick a price -- in this case the federal supply schedule was used by the medical administration as a reference prices of -- price that -- their price, I guess you would say, in the case that (inaudible) is going to come up with an appropriate price for medication based on, you know, all the prices out there, you're looking at what's there, the most fair price and the federal supply schedule (inaudible). They

also have an intent to back out the costs that are marketing and advertising as being not an appropriate price -- part of the prices charged to their state's revenue.

They're, as I said, in the process of implementing that. They've just come out with rules about advertising and marketing. It's something that they feel that Vermont's already done. Obviously Vermont's way ahead in that regard in terms of having that information if you were interested in following along with something that West Virginia has done.

The Maine RX law actually has a very specific provision separate from this leverage provision I'm talking about which actually does say that the state has authority to go in and require prices to come down to a fair level, that level being around what the price for Medicaid is.

And this provision, however, is a wonderful provision on paper, but has never been implemented. It was enjoined initially at Maine RX litigation and what happened is that the state I think in part confirming those resources in terms of legal research versus the financial

resources decided to focus on the issue that they felt was most important which was upholding the discount drug program itself and kind of let this law go and said they just didn't even appeal the decision that -- that section of the law where it's unconstitutional, the ruling of the court based on commerce clause, which is that the state really didn't have jurisdiction over the drug company that's outside of the state.

And that's an issue that's being litigated in other contracts around the country right now. The jury's still out on whether or not a state can take this approach. And I (inaudible) to the Wisconsin law which has been on the books and not been challenged as far as we know, and that takes a very similar approach to the Maine RX law. So there may be another approach to looking directly at prices, you know, that may well be upheld. But again, this is all areas where it would be sure to be challenged by the industry I would suspect if you put one of these on the books. But there may be ways to address it and ways that can be more rather than less places to be upheld.

And then I just recently put something down, this -- I happened to have just gotten elected

myself back to the legislature, (inaudible) myself, so I thought you might be interested as well, but it was something I learned about by (inaudible) that apparently (inaudible) have been made. I even have insurance where your co-pay is actually more than what the drug costs, and they charge that. So it's a way of just kind of going in and regulating that and addressing the co-pays. So that's the pricing stuff that I wanted -- maybe I should just pause to see if anybody has any questions on any of that.

ATTENDEE 1: Any questions? I don't see any hands, so keep going.

MS. TREAT: Okay. Well, keeping on our focus on price, as you all know I am sure, there's a great deal of discussion out about price (inaudible) and being able to make good choices, states having information. So this has been reflected in the pharmaceutical area by state laws and other programs, many of them implemented through the AG's office and, quite frankly, the (inaudible) summary of this information is in the report of your own Attorney General that (inaudible) has help put together, which he's apparently been updating right now.

But these states have set up a program where people can log on to the Web and find out what the prices are in other states and different (inaudible) at different pharmacies. (Inaudible) it's a good way to find out what's going on in different pharmacies and help people price compare. It does not get at the core issue of pricing set by the manufacturer, but it does help people -- if you do have prices there between pharmacies, it does address that.

One of the issues is -- is that -- and I know (inaudible) some states haven't wanted to do this, is that it basically encourages people to go to several different pharmacies to get their several medications. Because what often happens is that the same pharmacy doesn't necessarily have the low price for all of the drugs you're taking, you know, there might be three different pharmacies with a lower price depending on how many drugs you're taking. Which means that if there's drug interaction or things like that or you're taking drugs together you shouldn't, the pharmacist you go to might not know that.

Now, when you deal with that, if you were interested in the whole electronic record push

right now to make sure that those records can, you know, be electronic and can be shared, and that would be one way of addressing this issue if you wanted to go with a -- the pricing.

There's other kinds of disclosure. I mentioned that -- a Maine law which requires the retail price to be printed on the receipt. And you may have something like that, I'm not sure. But it's yet another way to continue to (inaudible) the actual cost of drugs and so that if your co-pay is $40 but the actual cost of a two-month supply is 400, that would be on the receipt and you would find that out.

And then the third disclosure provision that I've mentioned is one that actually is my favorite right of the state senator, I put in in part because of discussions with the attorney general of the state of Maine, which like I believe Vermont has been involved in a series of investigations and also lawsuits for pricing fraud essentially under the Medicaid law where -- as I know you all know, where the state's supposed to be getting the corporate best price under Medicaid and, in fact, we're not being that -- not given that price. And there's private

companies that provide this information to go through (inaudible) from the drug companies. And basically this provision requires the drug companies to ensure that the information that the states are getting is, in fact, accurate.

And I mentioned AWP, I know that there's some changes to how pricing is going to be recorded. The Maine law includes a whole panoply of these different pricing mechanisms. And it -- basically if there's violations of this, those violating it would be rife for perjury as well as the other (inaudible). So it gives the attorney general additional legal fire power essentially. And hopefully you'll do fine with that in the first place so that you won't be ending up in a (inaudible) situation (inaudible). So that's my discussion of disclosure and I think I'll pause and see if there are any questions here.

ATTENDEE 1: Okay. Any questions at this point? Okay. None. All right.

(Static.)

MS. TREAT: Vermont has been the leader in this, you're the first state and for a long time the only state to require disclosure of marketing and advertising spending. Since then we've been

joined by Maine and West Virginia. Maine (inaudible) come out with its regulations and it's going to be enforcing it now. West Virginia is in the process of it (inaudible) weeks. But there's a lot of other issues (inaudible) if you wanted to and I know your focus is on pricing and, you know, there's reasons to do -- to focus on advertising and marketing which are related to the cost of drugs (inaudible) that are perhaps unrelated to that.

But there certainly is a belief among many states that has focussed on addressing advertising and marketing that their -- their concern is about health and safety, their concern is about privacy, and their concern also is about making sure that people aren't -- and doctors aren't being directed to prescribe the absolute most expensive drug which may not be a (inaudible) drug because of the intensity of advertising and marketing. So there is a link to -- you know, whether we can come in with the numbers on that, that's another question.

That said, the big hot issue right now which is pending in a court near you, (inaudible) on Monday is the New Hampshire (inaudible)

prescription confidentiality law that -- restricting you of identifying information -- doctor or patient identifying information from being released to pharmaceutical companies and other companies for the purpose of marketing that can still be used or carrying out clinical trials, research, assessing Web (inaudible) properly or whether they're (inaudible) or, you know, cost-controlled Medicaid program, any of those (inaudible) to be used for. But aggregate data have been still used for marketing purposes, but what is not allowed is a retailer coming into an office with a profile of a doctor saying that that doctor has prescribed X, Y, and Z, and then targeting their marking towards that doctor's prescribing practices.

This is in the courts right now. I would say there's at least ten states that have pending legislation on this issue, and I believe Vermont is one of them or will be soon if you do not have a bill yet. So that is happening. And, you know, I have all the briefs on that. We actually submitted, I think, a brief, but a big part of (inaudible) actually was the focus on the effect of this marketing on the state costs for the

prescription drugs program.

The second bill relates to something that Florida enacted. We -- I mentioned electronic prescribing and electronic records. There's a huge push to do that not only in (inaudible) prescription drugs, but also health care generally. It's the big new thing. (Inaudible) make health care better for everybody, et cetera, et cetera, and I believe that you've also done something in this area (inaudible) but I think that's part of your focus.

Anyway as -- particularly if they're making more restrictions on what retailers could do, for example, like the New Hampshire law, there's going to be a real shift towards marketing to doctors and others through electronic means.

So this Florida law is one example of that standing (inaudible). It may not actually be a (inaudible) but perhaps it needs to be. I get e-mails from a lot of pharmaceutical blogs and this is a hot topic right now, this whole shift towards electronic prescribing, electronic everything, and I think you're going to see a lot more marketing and advertising that's done in that way. And this might be good to have a

heads-up on so that any laws that pass, you know, look at that issue as well as this more traditional means of marketing that we're more familiar with.

Another area would be misleading advertising, which really goes in large part to help (inaudible) standard people can say whether they're really good or not so good standards, but there's a lot in those standards that address misleading advertising and they address adverse effects of what's fully communicated to not only medical providers, but also direct consumer advertisers to consumer patients.

FDA does very little enforcement of those and often it's (inaudible) less statistics from all of that. As a consequence to that, Maine has a law in 2005 which adopts as part of the Maine law the FDA misleading advertising standards and gives to the AG authority and to others under the AG Unfair Trade Practices Act, to go into court and -- false advertising or get payments in full.

One of the issues around FDA enforcement is that frequently it doesn't really happen until a lot of advertising has already run its natural courses. It only goes for a certain number of

months and then they're on to something else. And what seems to be the case is that the FDA, by the time they get wound up to do something about it, pretty much the advertising campaign's over. So this gives explicit authority, still the AG may already have that authority and probably may do as well under the Unfair Trade Practices Act on misleading advertising, but this makes it very specific authority which they were quite happy to have. It hasn't yet been used by anybody to go after anything.

I then have listed on your handout, it's -- one, two, three -- four (inaudible) unsuccessful pieces of legislation that I just thought were interesting focussing on this whole issue of advertising and marketing. I think one of the legislators, and some of you may be among them, who would just like to ban the whole practice of the drug consumer advertising program. There is questions about whether that can be done, which is why Maine, for example, would not be (inaudible) for now. But these are some different measures that different states have looked to to see whether they can (inaudible) the lines maybe in terms of addressing advertising

and marketing.

And then finally what I've listed here is a whole -- a number of things that focus on the activities of drug (inaudible) dealers who the salespeople come into the offices, provide information about the latest and greatest drugs, and also provide some (inaudible) gifts and payments in various forms. There is, of course, a variety of industry and doctor standards that have been (inaudible) and say we're not going to get into a conflict of interest situation, we're not going to take this and that. But from all the reports (inaudible).

Interestingly there is a law on the books which was passed in 1993 in Florida that bans gifts to doctors or pharmaceutical companies. There's a bunch of exemptions to this law, it's not written in (inaudible) like I think and it's not really clear that's ever been implemented. It hasn't been challenged from the courts as far as we know, so it appears to be a good law on the books and a model for (inaudible) to look at.

Massachusetts last year in its -- the Senate version of the budget passed the more stringent version of this gift stand, and -- but it didn't

make it through the final budget after consultation with the House.

I have drafted, working with the Massachusetts folks this year, a bill which we felt pretty good about that if you were interested in this would be a model bill you could take a look at that would -- it's actually the clearest reading of the Massachusetts version (inaudible) but it's a tighter version than the Minnesota one, and it might be something you'd like to look at.

The other area where states have attempted to do something but not successfully so has been legislation that would set registration provisions or (inaudible) provisions, sort of an education criteria for drug retailers. And that hasn't gone anywhere. And I actually sat through one of the hearings on that and the entire room was filled up with hundreds of retailers. And I think that's a pretty powerful lobby. But anyway, those haven't gone anywhere, but there's been interest in doing something in a number of states, and I've listed a couple where that legislation was not successful. So there you have advertising and marketing, and again I would

pause and see if there's any questions on that point.

ATTENDEE 1: Questions? Don't -- don't see any.

MS. TREAT: Okay. I hope I'm not putting anybody to sleep here.

ATTENDEE 1: Oh, no, everyone's awake.

ATTENDEE 2: No, it's great.

MS. TREAT: You can't tell when you're on the phone. All right. Well, this leads naturally from the detailed discussion to my next section which is what I call communicating effectiveness (inaudible) evidence.

One of the things that -- you know, response to all of this heavy-duty marketing, some of which is misleading, all of it's expensive and it's definitely effective in shifting prescribing practices and also what patients ask for. It states that (inaudible) is something they can do to counteract that.

Now, you have a wonderful provision in your log that says that you have the authority to do a detailed program to provide evidence-based research, get it out to doctors and other medical providers about, you know, (inaudible)

information that wouldn't be -- this is the best drug but (inaudible) newest drugs but here are all the options, here's what they cost, here's the medical and the clinical evidence, here perhaps are some alternative (inaudible) drugs also that involve exercise, diet, et cetera, et cetera.

And I know that there's a small effort going on in Vermont right now. I wanted to mention that I have been working with an organization called The (inaudible) Foundation, it's a (inaudible) has spun off from our group which is focussed on working with legislators and (inaudible) choices is really working more generally on prescription drug issues. And my colleague, Ann Wolf (phonetic), is there and has been in active communication with doctors as well as health people in Vermont, New Hampshire, and Maine, and there may be a more (inaudible) to see if there's some interest (inaudible) a state-to-state (inaudible) detailed program. And there's tremendous interest in the New Hampshire, we know, in doing this that really came out of the whole confidentiality bill debate and discussion.

And so I just wanted to put that on the table. And, you know, the big difficulty with doing (inaudible) detail is you have to come up with a pot of money in the first place in order pay for these trained, you know, pharmacists, nurses, doctors to go out into the countryside and the cities and meet with people and talk to them, you've got to have money to prepare the materials.

However, Pennsylvania is doing this in a big way. They've already prepared a lot of materials, they have the model, they're evaluating that, and I think we -- and I speak because I live in north Pennsylvania myself -- we're in a great position to perhaps take that information and those materials and run with it and do a bunch more (inaudible) they've already put in the original cost, quite frankly. And I think there's some -- you know, potentially there's money available for this.

I don't know if Vermont was a party to the Bayer drug settlement which just came down which was related to marketing, the corporate marketing. I know Maine was, there was $200,000 that went to Maine because of that. It's

supposed to be used to address issues around marketing. That would be a perfect pot of money to put into teaching appropriate -- maybe spending on the pilot level to actually do this. Obviously you already have the authority.

So I'm a big fan of this. In a way it seems like it's a little frustrating to put state money into something to counteract all of the private sector stuff that's going on that you can't get rid off, but Pennsylvania believes -- and based on some clinical data that Jerry Abrams (phonetic) has put together, they believe they could actually save money ultimately. The real challenge is getting off the ground and funding it in the first place because there will be (inaudible) later on because it's going to totally shift the prescribing pattern. And that is what the evidence has shown.

ATTENDEE 1: Okay. Sharon, I do have a question.

MS. TREAT: Sure.

ATTENDEE 1: And I (inaudible), see if she can hear you. If not, I'll repeat it.

ATTENDEE 3: Does this help? Can you hear me, Sharon?

MS. TREAT: Not very well.

ATTENDEE 3: The question is --

ATTENDEE 1: Come on down.

ATTENDEE 3: I'm sorry?

ATTENDEE 1: You can come on down.

ATTENDEE 4: I can do the question from here.

ATTENDEE 3: Okay. My question is, Sharon -- can you hear me now?

MS. TREAT: Yes.

ATTENDEE 3: That's my first question. My second one is, is if Pennsylvania's done all the work on all these drugs, what does Vermont have to spend money for? Can't we just do what they do and use their stuff?

MS. TREAT: Well, the biggest expense is you need to take the salary of the people who actually go do this. So even -- and I'm not sure that they've actually entirely done all of the materials, but there's -- they've done a lot. But essentially you're going to have to pay the salaries of the people who are going to go out and meet with these doctors and other medical providers. And that's actually one of the reasons I thought -- and this comes from the fact that in part I'm familiar with the territory,

like my parents live right across the river from New Hampshire, they live in Vermont, and the closest drug store is across the river.

So, you know, I think there might be some real (inaudible) by doing a regional program, you know, that -- in a sense you want to look at documents from a medical center in New Hampshire, but it's still (inaudible) I believe that are associated with Vermont as well on that (inaudible) because people in Vermont go there for their medicines. So, you know, I think there could be some of the same that we've done in that (inaudible) level. So -- but that's where the costs are primarily. But --

ATTENDEE 1: Okay. We have a follow-up.

MS. TREAT: Yes. Well, just quickly I should tell you in addition to the drug settlement money, again, I mean -- again, I don't know Vermont's situation on this, but Maine has a Fund for a Healthy Maine which is a track of government money, most of it goes to health care. Some of the stuff there -- if you really did save money, you'd have a revolving loan essentially that would (inaudible) and get repaid as they make payments.

ATTENDEE 5: When I looked at the written materials, Sharon, it shows a Web site for this process or this service, and I had the idea it was something that a doctor or a nurse or whoever the prescriber is could log on to check out the stack that wanted to prescribe or whatever it is. Is that something that we could -- and then of course we'd have to pay our share of the staffing, though, but is that something that's been looked into?

MS. TREAT: Yes. I mean, currently there's a possibility in the future -- if you go to (inaudible) down the page (inaudible) that the Oregon Effectiveness Review Project, which some states belong to and they get all -- complete access to the materials. And also what Maine's doing as part of the misleading advertising law that they have, it gave the AG authority to enforce misleading advertising standards.

Also at the request of the Department of Health and Human Services, it required that department to set up a public and provider education program. It's funded through (inaudible) drug companies and one reason it's been slow getting started is states have been

rather reluctant to (inaudible). However, they are just about -- according to (inaudible), she sets up this program, they're just about to go out with an RMP to do a (inaudible) education program that will also have a Web portal to these clinical trials information and other information that would be helpful.

I think that's great. I do think and I believe that many (inaudible) were (inaudible) from Harvard Medical School among other, in fact, (inaudible). His words will show you that, you know, every opportunity to deal with research on the Web and click on something is not the same as (inaudible) someone coming into your office, having a relationship with you. I mean, retailing works. And even if they're not giving away free gifts, you know, from that drug retailer, what they've found is that there's a law to benefit and it's essentially more effective. Because your (inaudible) is in the office and, you know, giving someone a Web site to click onto is good, but it's not going to counteract the detailing in the same way.

And the other thing that we're finding in Pennsylvania is that it's a real value to having

this relationship with the provider, particularly for the Medicaid program. I don't know how it is in Vermont, but one of the things we haven't talked about yet is a preferred drug list and things like that. At times a contentious relationship between doctors and the Medicaid program is partly around fees.

But in any event, one thing that they've -- a real benefit they've found is that this has been a real positive relationship between the Medicaid program retailing, you know, aspect and the doctors, kind of -- you know --

ATTENDEE 1: Sharon, one of the things that was brought to our attention by staff is that right now we can, you know, know differences in price, but that there is -- don't have any studies that tell you differences in effectiveness. It might be worth 10 percent more to have a drug that is 40 percent more effective. And he thought there were trials underway or studies underway to that. Do you know anything about that?

MS. TREAT: That would have compared one drug to another?

ATTENDEE 1: For effectiveness.

MS. TREAT: Yeah. I mean, (inaudible) this gets into a much larger question about who's doing all of these clinical trials and what are they trying to prove. And, you know, usually they're done by drug companies that would like to get their drug on the market and they're essentially testing out the drug, I guess.

ATTENDEE 1: Right. Yeah. And that's -- yeah, that's what he said, that it reduces heartburn, but does it reduce it as well as or less well than the more expensive drug?

MS. TREAT: Right. And, I mean, that's a problem that I don't know that Vermont's going to be able to solve because unless, you know, you've got one pot of money I don't know about to independently fund this sort of study --

ATTENDEE 1: He thought that there were some studies underway. Robin looks like she knows more than I do.

MS. TREAT: But I think that's more (inaudible) I think that Congress is actually -- or the FDA is starting to look at this issue more directly at things that need to be done. I mean, it's just that there's so many tremendous shifts over the last 10, 15 years from --

ATTENDEE 1: Okay.

MS. TREAT: -- you know, a lot of the independently done clinical studies having it largely being done by interested parties and it (inaudible) look at.

ATTENDEE 1: Robin just pointed out it's on your sheet under RN evidence-based --

MS. TREAT: Yeah. And again, that -- a number of states have joined that as -- in addition to the evidence-based and the information could be used in a variety of ways. It could be used to help draft what you put on your preferred drug list, what do we (inaudible) entire authorization forms. You know, PO can be based on what you're giving those rebates for or they could be based on what you think is the best drug.

This Oregon (inaudible) though, getting information to states and others who have bought into their program to identify what is the best treatment and the best information including the best clinical trial information. So that's something that, you know -- and (inaudible) encourage that, I think, but it is a cost until that information is available without paying

anything for this certain amount of freeloading going on.

But I think (inaudible) also it's talking (inaudible) detailing that North Carolina is a state that has viewed the Oregon information in a program that did (inaudible) they tried to provide information to doctors and their offices. So it could be used to help any effort in that.

ATTENDEE 1: Okay.

MS. TREAT: Okay. So I've already mentioned the posting of clinical trial results in the Maine law that said that these clinical trials need to be posted. People are sometimes confused. This is the only state in the nation that does this now. There is posting of the fact that the clinical trial is done, and that's a law that, you know, this is ongoing. There's somewhat incomplete compliance with that law. What the Maine law does, though, (inaudible) is the results need to be posted even when they're bad results so that the clinical trial might be ended because the results are not positive results to that particular drug.

ATTENDEE 1: Posted where?

MS. TREAT: It's posted on the Internet.

ATTENDEE 1: On the Internet. Okay.

MS. TREAT: Everybody can get these -- the notes, whether you're in Maine or not obviously. And the state is going to develop a Web site (inaudible) so that there'll be a people-friendly way of accessing the information.

But I will tell you this is a very complicated thing. I have actually submitted two or more sets of comments on the state's rules. If you are interested in pursuing this, I would suggest not copying the Maine law verbatim because there are problems with it in that it was the first law that was drafted and those that drafted it weren't that familiar with clinical trials and the lingo as they should have been. So there's information that probably should be posted that's not posted because the Maine law is stating the -- there is a difference between states.

ATTENDEE 1: Okay. We'll learn from your experience.

MS. TREAT: Yeah. So the next thing, Part D, everybody's big headache. You know, Vermont is usually like just about the best of anybody on this in terms of providing wrap-around. This is

not a cost to you, this is a cost to expenditures. But I did want to mention that I'm not entirely clear on whether or not you're doing all of the things that you might want to be doing around making sure that people access (inaudible) Part D who need it and who are eligible for it. And (inaudible) with a Maine program (inaudible) this, that and the other, and I'm not sure that's true. But I did want to mention that I think they are doing a lot that would be worth looking at if you are not doing it. And that includes, you know, signing people up -- the state signing people up for the subsidy and for (inaudible) programs and specifically enrolling them in the programs that are appropriate for them, as well as helping them with their appeal if they're denied medications or denied the subsidy. And so I don't know.

ATTENDEE 1: I think we're being told we do. There's people pointing to themselves and saying that's what they do.

MS. TREAT: What's that?

ATTENDEE 1: There are people in the audience saying that's what they do, so I think that Vermont does do that. I know we have a

healthcare ombudsman that also -- that does that, so . . .

MS. TREAT: Good. And also one other -- this is another one actually that I am personally putting in, but at the request of our insurance bureau and just -- it may be that I think there may be other states that states want to be taking a look at.

Part D, as you know, not all (inaudible) is a private insurance product. There have been problems with how that product is marketed and just -- and, you know, whether or not you're fully regulating everything you can do. And then to put these questions here because there's lots of writing and (inaudible) what states can and can't do -- can't do.

But I've been able to put in a bill dealing with entirely a growing practice in this state which is that insurance agents use the Part D marketing as an opportunity to market everything else that they have like their life insurance. And that includes cold calls to people as well as (inaudible) somebody to sit down (inaudible) Part D stuff.

And so our insurance bureau has asked that

we put in a bill (inaudible) the Unfair Trade Practices Act and that may be something that you would be interested in in the consumer protection provision.

ATTENDEE 1: Okay. We will definitely check with our insurance representatives on that one.

MS. TREAT: So --

ATTENDEE 1: If it's a practice in your state, I'm quite sure it is in ours too.

MS. TREAT: Yeah.

ATTENDEE 1: That's -- otherwise (inaudible). Okay.

MS. TREAT: So next on my list is purchasing pools. I mentioned (inaudible) you are a member of this. The only thing I would say here is -- I mean, what I don't know is -- purchasing pools are effective in dragging down prices in part because you have a large group of (inaudible) and in part because you have to balance if the drug company's participating in a rebate situation. Because you can, you know, say, well, you're not -- we're not going to, you know, have your drug (inaudible) there may be things that Vermont could be doing that would make that more effective in terms of how your preferred drug

list works. I just don't know.

And the other question would be whether everybody -- all the different programs within the state are benefitting from this negotiating authority or not and -- you know, including whoever's buying the medications for the state employees, for the teachers, for the town, all of that. So that's the only (inaudible). I know that you're doing a lot already, maybe there's not much more that you could be doing, but those are two areas where, you know, perhaps there's additional savings that are possible.

ATTENDEE 1: Okay.

MS. TREAT: Okay. Same thing with generic, when we -- you know, I just didn't have time to know everything you're doing about generic. So again, there may be things that could be done related to your preferred drug list and other policies that you have that would encourage generic use more than you are right now.

So I've listed a number of things that (inaudible) there's lots of savings that can't be seen in here. You know, a lot of these states weren't doing much to start with, so by doing more small changes in generic policy they've --

I don't know what that beeping is.

ATTENDEE 1: I don't know either. Sounds like a --

(Static.)

MS. TREAT: -- changes in their policies, but (inaudible) seniors with Florida they've saved, you know, really some money. I just don't know whether there's anything to review, but I think that we look at that and particularly right now with so many of the really big blockbuster drugs that are prescribed a lot, going by the patents, you know, that's -- some of them like right away, that's something to pay attention to to make sure you have policies that allow for and encourage people to switch over to the generic right away.

ATTENDEE 1: We've got another question.

ATTENDEE 6: Do we have a short list of those biggies that are going off patent?

ATTENDEE 1: Can you get us a short list of those biggies that are going off patent?

MS. TREAT: I can't off the top of my head.

ATTENDEE 1: Okay. No, I just --

MS. TREAT: But there are lists out there we could (inaudible).

ATTENDEE 1: We will find them.

MS. TREAT: You could do that in that e-mail I'm sending (inaudible) yeah, you can probably just go to the Generic Drug Association's Web site, but I could help you with that.

ATTENDEE 1: Okay.

MS. TREAT: Okay. So then my next category is avoiding the middleman. This is always a good policy, mind you. And again, I don't know whether that's an issue with Vermont. I know that some states purchasing -- purchase not (inaudible) the middleman such as a PBM to do the negotiating. So I guess that's good, but, you know, you might want to consider having overall PBM transparency (inaudible) legislation. Maine has a law, (inaudible) has a law, there's laws in South and North Dakota. We do believe that there is cost savings out there.

Essentially by getting rid of the middleman you're getting complete transparency around how much money you're actually saving with any rebates being passed through of those savings and all of that. If you're not avoiding it, then you can pass legislation that says here's how we deal with PBM.

ATTENDEE 1: We have actually passed that legislation twice but it hasn't made it past that committee. I think it's -- and it hasn't made it through the other bodies, it's just made it through the Senate.

ATTENDEE 7: It passed it by 24 actually.

MS. TREAT: So, you know, I mentioned here, I mean, just to be really clear about -- there's a lot of things being said about Maine like all the PBMs are leaving the state and all this, and I just -- we have no evidence of that, but I get these e-mails because, you know, Indiana just had a hearing on what was said. I don't believe it's true.

But the way the Maine law is set up is it's really hard to know for sure what's going on because the law is really about (inaudible) contract law. There are some PBM regulatory laws that are more about giving an insurance commissioner authority to go in and get information or to regulate PBM kind of like in insurance companies. The Maine law and the D.C. law and actually the North and South Dakota laws also are more saying this is about what should be in contract between PBMs and those parties which

would be health plans or states that contract with them or employers, you know, the contract has to have certain things. Well, the contract is between those parties, it's not between the parties and the state.

So the state has been gathering information about whether everyone's complying with those contracts or whether, you know, there's PBMs that are leaving the state or anything like that, they don't really know. So I would just put that as (inaudible). We don't really know. But I will say this, that the Maine law is good law, at least in the First Circuit which is where Maine is. This case was decided in (inaudible) terms. I mean, it could not have been a decision that would better put the state of Maine (inaudible) law and the PBM industry was unsuccessful in getting the Supreme Court to take the case and review it and reverse it. Well, they didn't even take the case.

In D.C., the law like Maine was initially ruled unconstitutional. That court has been asked to look at its decision in light of the Maine law and has been sitting on it for quite some time and we haven't had a decision out of

that court. We don't know what's happening there.

So there are very legal complicated questions here that involve (inaudible) dealing with the employer being health care. And there (inaudible) issues at first impression illegally and they go to a lot of questions on how far states could go on some of this stuff. This is one of the areas where that is certainly the case. So that's my PBM discussion.

ATTENDEE 1: Okay.

MS. TREAT: On 340B, I know I appeared before the finance committee last year and mentioned a number of things that could be done under the 340B pricing. (Inaudible) Public Health Act. There's policies that -- there's a couple different ways to look at that. One is to expand the clinic in -- the ability of clinics (inaudible) to provide pharmacy services essentially, which we'd have as lower 340B pricing, I believe, that you -- that's actually something that you've had a report on and are working on.

The other side of it is to see if there's particularly high cost (inaudible), example which

would be HIV medication, hemophilia (inaudible) medication, drugs that are particularly expensive that if you have someone going through a 340B certified clinic, which could also be many hospitals in many states, then they have access to these lower costs. And also if the state is paying the (inaudible) rate, they have access to these costs, you know, just generally. So that's the information that (inaudible) provided that to the finance committee last year. There may be some savings opportunities there.

And I noticed that there was a conference coming up very soon sometime in February that looks like it's going to go into vast detail on this. There might be something that if you were interested (inaudible) staff or someone from the agency would be interested in going and listening if there's anything else you could be doing.

ATTENDEE 1: Okay. Questions?

MS. TREAT: A study here called the claims act on --

(Static.)

ATTENDEE 1: Okay.

MS. TREAT: Okay.

ATTENDEE 1: Okay.

MS. TREAT: So False Claims Act. What we're talking about here is Medicaid and Medicare products. You know, sometime when people think about Medicaid fraud they think about an individual patient going in and getting (inaudible) that they are not allowed to have for (inaudible) purposes. But it turns out that the bigger issue is one that many states have been involved in litigation against various healthcare providers, the bigger issue is things going on with those providers charging prices that are over the price of the (inaudible) charge, for example.

In the case of a pharmaceutical company, many of these marketing and misleading advertising cases have involved False Claim Act cases. False Claim Act is something I'm (inaudible) on the federal session books that's actually passed back (inaudible) from Abraham Lincoln to deal with fraud that was happening during the Civil War. And it's kind of a weird (inaudible) because it's like a whistle-blower in that it protects the whistle-blower to report things. It actually has a kind of weird secret process for a little bit before the government

decided we'd better not be one to jump into the case, and especially brought by private persons.

The thing about this is that if you have a law that looks a lot like the federal laws and meets strict criteria, if you enter into one of these case (inaudible) that has a settlement that (inaudible) and I know if Vermont's been real active in a lot of these cases, you will be eligible for additional federal money when that case is settled if you have a law that meets their criteria. And most state laws deal with the legal (inaudible) as such do not meet these criteria.

So I wanted to mention this. This was something you might want to do because since you're bringing these cases anyway, you would be eligible for more money as a result of (inaudible) that came down. So that's something you might want to look at.

Then finally I'm not going to talk about it as much, I know that (inaudible) talked to everybody about those, but trade issues actually could have an effect on what you are able to do or not able to do.

And what I sort of left out of this

discussion is all the programs around importing drugs from other countries, which you have already done. It's -- it's (inaudible) you're -- with these programs, so I haven't really gotten into any more detail on that. But I guess you could certainly lump that in with the trade discussion as well. So that's not really, you know, a way to save money on the trade issues, but it's something to be aware of so that you don't lose money if you're told that you can't have a preferred drug list or something like that.

ATTENDEE 1: We're actually going to be back on Friday here in (inaudible) and people on the trade issues.

MS. TREAT: Right. So that is my presentation.

ATTENDEE 1: Okay. Thank you very much. I don't see any other questions. Very comprehensive and I think it's a world that we need to start looking at and we hope to be talking to you in more detail once we've kind of honed in (inaudible.)

SENATOR RACINE: Okay. This is Doug Racine, Sharon, I'm the new chair of the Senate Health

and Welfare Committee and I just wanted to thank you. This was, as Ann said, very comprehensive and I think it gives us a number of areas that we can pursue. This was sort of put on the back burner the last couple of years because we've been focussing on cap amount within our blueprint for chronic care management. But we want to move it to the front burner this year. So you gave us a great start and I thank you for that.

MS. TREAT: Great. Thank you. I appreciate it.

ATTENDEE 1: Okay. Thank you. Bye.

CERTIFICATE

STATE OF FLORIDA,)
COUNTY OF DUVAL.)

I, Cristina S. Holmes, Court Reporter and Notary Public in and for the State of Florida at Large, do hereby certify that I was authorized to and did listen to CD 07-21/T1, T2 and CD 07-22/T1, the Senate Committee on Health and Welfare and Finance, January 31, 2007, proceedings and stenographically transcribed from said CDs the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 22nd day of August 2007.

Cristina S. Holmes,
Notary Public - State of Florida
My Commission DD 475618
My Commission expires 10/8/09

TAB E

STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: February 6, 2007

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: CD 2007 35

Esquire Job #928010

PROCEEDINGS

- - -

CD No: CD 2007 35

SPEAKER 1: -- at one time, and then I just got treated by another surgeon, and he says, you know, I am out of here.

MS. RICHTER: Was he a general surgeon?

SPEAKER 1: No, (inaudible) the second one, and general was the first one.

MS. RICHTER: Yeah, because general surgeons are sort of in the bind that we are in. They are being devalued and --

SPEAKER 1: We lost -- medicine lost a good man.

MS. RICHTER: And that's the problem, that's happening all the time. Retlin (phonetic) is having a severe problem.

SPEAKER 1: Yeah.

MS. RICHTER: Northeast Kingdom is having a severe shortage. So there are certain areas that are actually being affected more than others and really need not be. I mean this need not happen. I think this premature retirement can be stopped.

As far as, you know, getting and

recruiting docs to come here and practice here, I think we are sort on somewhat of a right track. The AHAC has an initiative of going -- where they are trying to encouraging students to practice in rural Vermont, and we actually just had one float in to our office that's going to do that. So that is actually promising. But when you have so many doctors that are now dissatisfied and thinking of retiring early, we are going to have a crisis in another five years, if you don't already consider it a crisis.

SPEAKER 3: I don't know if this is (inaudible) here, but I know in Maine -- Maine, over the years, actually a high school classmate of mine was married to a Physician's Assistant, and he then lived in rural Maine, and the communities that he was actually working in actually paid for his medical to go back to school to become a doctor, as long as he agreed to stay, and are we doing that here?

MS. CUMMINGS: I had a neighbor who wanted nothing more than to come back and be a pediatrician in Vermont, and she went to -- I think it is called -- she went to a school in Maine, and Maine made her such an offer that she

could not afford to come back and practice.

SPEAKER 1: They pay for your education.

MS. RICHTER: Yeah, I mean there is a rural initiative that is doing that, but we have not invested in that.

I mean I think that is certainly worthy, because what you find is that when you recruit from rural areas, rural people tend to stay rural, just like urban tend to stay urban, black tends to stay black.

I mean that's why minorities are recruited, because they tend to then practice in minority communities. Same thing in rural, and that would be certainly in our best interest to do that, but I think there is other things that we should try do in the meantime to keep docs from retiring early.

I am terribly worried about my own practice, where two of my partners are 63 years old, and they have had it up to their eyeballs, and most of the time -- you know, when they first started, they would have probably practiced until they were about 75. That's not going to happen. Within two or three years, they will retire, and we will not be able to replace them, because we

will never be able to reimburse at the rate that other places around the country are.

SPEAKER 4: How much retirement, say, 60 on is in fear of liability?

MS. RICHTER: I am not sure. I don't know what the answer to that is.

SPEAKER 4: Because it would strike me as that is an added variable.

MS. RICHTER: It is. I mean it is an added -- if you consider the malpractice premiums and such, although they are not that tremendous for primary care, it is one of the issues, but most of the issues right now, the docs that I talked to, most of them, especially the ones that are disgruntled, who have been in practice for a while, it is because of the second guessing.

You know, they say it's that steady drip, drip, drip of asking me to provide documentation of something that I already did for the patient, and now you are taking time away from the patient so I can show you that I did this.

MALE ATTENDEE: So malpractice is another part of the (inaudible).

MS. RICHTER: Yeah, it is part of it, yeah.

MS. CUMMINGS: Where do they go?

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MS. RICHTER: Well, I will tell you, some of them in here talked about one woman who is now in law school. Some of them went to other places. Some of them -- yeah, one said practice closed and moved out of Vermont. Some went to other states where they got paid more. One actually said that, I have actually made that phone call, and I am moving out of state where I will see a 70 percent pay increase and substantial reduction in hours. This is on page seven. I am retired from clinical practice. This person was in the military.

People are, you know, either retiring early and finding some other way to make a living or just retiring.

MS. CUMMINGS: It's not the money?

MS. RICHTER: It's interesting, because there are some docs that actually can't afford to retire, can't afford to. They want to, but they can't afford it.

So you have got sort of a disgruntled group in that respect, too. One doc has been practicing for 30 years and can't, you know -- actually, in the eastern part of the state, and can't afford to retire, but wants to.

So, you know, if you add all these

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together and the fact that, you know, we really probably need 20 or 30 more primary care docs in the state, and that we may end up losing that amount, we are going to have a tremendous problem in a few years.

MS. CUMMINGS: I am watching the clock, and I think I said before you came in some of us have -- one of us has been summoned to the Speaker's office at 3:00.

MS. RICHTER: Oh, okay.

MS. CUMMINGS: I thought it was 2:00, but it looks like we have got a 15-minute interval, so Sandra Ayre will take over.

MS. RICHTER: All right.

MS. CUMMINGS: And I will -- yeah, I think we are just going to --

SPEAKER 3: What happened to our break?

MS. CUMMINGS: We are not finished yet.

MS. RICHTER: Are you union or what?

(Inaudible.)

MS. CUMMINGS: Well, we have to be out by 6:00.

MS. RICHTER: I think in terms of recommendations, though, in case you want to know --

MS. CUMMINGS: Yes, I think --

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MS. RICHTER: Instead of hearing from just me, I am one practicing doc in the state, you need to really hear from docs in the trenches.

What we heard last year, there was maybe testimony on -- I think on one day hearing from six docs. I actually happened to be one of them, but there wasn't enough input from people who are in the trenches, and you need to hear from these folks. It isn't just me. It isn't just a handful of us. There is basically a major disaffection with the ways things are going right now, so I would say if we involve the docs that want to be involved, we actually have 170 that responded with personal information, contact information, to us that wanted to be involved in the process.

I think we need hearings at the state level to hear from these docs, to find out what would make their lives easier, what could make things better, and then we have to stop before we add more work, which I would sort of single out the Catamount disease management piece, the blueprint for Health adds work to our load without even assessing if there is enough hands to do the work, and we need to stop that in its tracks and reassess. Let's do things that help primary care,

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not hinder them.

MS. CUMMINGS: This community really isn't the appropriate one to do that.

MS. RICHTER: I know that. I already talked to Senate Health.

MS. CUMMINGS: It needs to be either Health or probably the Healthcare Commission.

MS. RICHTER: The Commission, yeah.

MS. CUMMINGS: And I will be willing to do everything I can to get that hearing. I assume it will be an evening meeting.

MS. RICHTER: It would have to be.

MS. CUMMINGS: I think part of it is I hesitate to ask doctors --

MS. RICHTER: I know.

MS. CUMMINGS: -- because they have a practice.

MS. RICHTER: Me too. I know. I mean that's why we did this. We wanted to hear at least what they had to say.

I mean the other thing we are going to do is, we are going to assemble sort of a democratic process for primary-care physicians to be able to respond to various aspects along the way.

If you suddenly start discussing some measure that you are going to implement, that we

then feed it back to them and say, what do you think of this, does this make sense to you, and if not, what would you recommend that we use to contain cost.
MS. CUMMINGS: I think some just like to think the Medical Society does that for them. I think we are having some doubts.
MS. RICHTER: Yes, I think they are not addressing primary care as much as they do the specialties.
SPEAKER 3: I think the emergency room would be a plum assignment in today's era, because it's --
MS. RICHTER: Yeah.
SPEAKER 3: -- more organized by hours and it probably --
MS. RICHTER: It's guaranteed pay. As far as the paperwork hassles, they are very minimal, except you have to write the chart for seeing the patient, yeah, that and locum tenens.
A couple docs talked about locum tenens. Locum tenens are basically temporary placements. You go and work for a year, but you get a salary. You have no paperwork as far as any kind of administrative stuff, and it's much more satisfying for some of these docs, but that's not

the answer.
SPEAKER 3: (Inaudible) travelling nurses.
MS. RICHTER: Yeah, but it is not the answer, you know.
SPEAKER 1: How would you get a random sample of the primary cares so that you get maybe a happy doctor out there?
MS. RICHTER: Well, there probably are some happy doctors. I mean we only heard from -- we're assuming we only heard from about half of the docs. I am either assuming the other half are happy or --
SPEAKER 3: No time.
MS. RICHTER: Or whatever, yeah.
Some of them -- actually, we even after the deadline for this, we started getting -- we continued to get about a dozen more that came filtering in.
But I am sure there are some happy docs out there. I don't happen to know very many of them, but I am sure there are. You know, I think most of us are happy with what we do. What we don't want is the baloney that does nothing for the patient and does nothing to contain cost that is being imposed on us, because people are trying

to contain cost and think that this will do it.
The other thing is when you see the insurance companies who send these different correspondence, it saves them money, but it doesn't save us money, and it doesn't save the system money.
SPEAKER 3: Puts it on you.
MS. RICHTER: Pardon me?
SPEAKER 3: Puts it on you.
MS. RICHTER: Yeah. So I mean, each of these -- this is a different formulary for each -- I actually just took two of them. This is for MVP and this is for Medicaid. They are all different. So if you want a (inaudible) hypertensive, it may be covered on MVP. It is not covered under Medicaid, etcetera.
So every time I get in the habit of prescribing a sort of class of drugs, I may or may not be able to and have to sit down and look it up, or sometimes you have to call them and find out what they cover and what they don't. Everyone is different.
SPEAKER 3: That's the problem of first (inaudible).
MS. RICHTER: Yes.

But we also have the disease management, you know, that are calling our patients and sending them letters, like this patient ended up being accused of having congestive heart failure, and was told to go to a Web site and that he would learn how to manage -- he could learn how to manage his congestive heart failure. And he actually called me after a month, and it turns out that he didn't have congestive heart failure, so he spent his entire Christmas being frightened, depressed, trying not to dwell on my prospects, as my wife emphatically stressed lastly, I should have confided in her in this immediately, but I couldn't face this over the holidays, so I tried to swallow it.
Maybe it's the guy thing about being a stable provider and protecter. Now the terror is subsiding, and I am really angry about being subjected to this. My kids were home from college, and this was Christmastime.
So that's not the only one. I mean I have had people accused of having depression or one patient diabetes that she didn't have, called me hysterically.
The problem is that they are overseeing --

they are going aside from what the doctor is recommending, and they are not necessarily --
MS. CUMMINGS: These are by the insurance companies?
MS. RICHTER: Yeah.
MS. CUMMINGS: Oh.
SPEAKER 3: Oh, yeah.
MS. RICHTER: They are calling patients without asking the doctor, and this one was an insurance company, and I actually have the Web page that this gentleman was in. It says, Hello, Mr. Jones. It time to manage your congestive heart failure. He was -- he was mortified.
SPEAKER 5: They respond to gestures? I don't think so.
MS. RICHTER: Isn't that awful?
SPEAKER 5: (Inaudible.)
MS. RICHTER: Oh, yes. I mean this -- the reason that this can happen is for some reason you went into your doctor one time with a cough, they -- the claims -- they use claims data, and the insurance company may see that as you have pulmonary hypertension, because people with pulmonary hypertension have coughs. So they will pull in all those people that had a cough, and

they send you a letter saying that you are at a higher risk and you need to get a flu shot, because you have pulmonary hypertension, scaring you to death.
And that -- there are -- I have numerous examples. I am just one doc.
MALE ATTENDEE: Do they extrapolate from the pharmaceuticals they are taking?
MS. RICHTER: As far as -- you mean as far as what your disease might be?
MALE ATTENDEE: Yeah.
MS. RICHTER: Sometimes, yeah.
MALE ATTENDEE: In other words, there are drugs to be taken for hypertension, specifically heart medications.
MS. RICHTER: Right.
MALE ATTENDEE: So there are people taking them --
MS. RICHTER: Absolutely.
MALE ATTENDEE: -- who don't have heart conditions?
MS. RICHTER: Right. Absolutely. That happened with one of my patients who was not a diabetic, and I put her on a drug used for polycystic ovary syndrome and diabetes, and they

said, well, she must be diabetic, wrote her a letter, scared her half to death, told her she could go blind, her kidneys could fail, her feet could fall off.
You know, it is really unnecessary, and it is not helping the care. If it was, we could probably put up with it, but it is not. And it is adding to the burden, and it really needs to stop. And I would urge any of you if you have any connection with the Catamount, that we stop that process and take a look it, and how we can make this a positive thing instead of a negative thing.
I mean the disease management and the chronic care model could be good if you integrate some of these measures into primary care.
So, anyway, any other questions?
MS. CUMMINGS: Thank you very much.
MS. RICHTER: Okay.
MS. CUMMINGS: Committee, we have Linda McIntire.
Committee, we have a break until our next witness at 3:15. Can you be back at 3:15?
Be back in 11 minutes.
(Thereupon a break was taken.)
MS. CUMMINGS: To resume, are you all set,

Linda?
MS. McINTIRE: Thank you very much.
I am Linda McIntire, Commissioner of the Department of Human Resources. And I understand that you have some questions about the PDL that we have for our formulary and our healthcare plan.
Our prescription drug benefit is the biggest part of our health plan, which is something that we negotiated with the union, and the present formulary was actually negotiated before I became commissioner. Actually, the contract was signed the day that I accepted this job March 4, 19 -- 2005.
So I would think it would be beneficial for the committee to hear from my Director of Benefits, Kathy Callahan, and she is with me, and Harold Schwartz, the Director of Fiscal Information Management for my department. The two of them really were involved with the negotiations with the union, and they know the formulary inside and out. So I think it would be really more appropriate to turn the chair over to the two of them, and I think they can provide the answers that you are looking for. Okay.
MS. CUMMINGS: Thank you.

MS. McINTIRE: Do you want to sit here together?
MS. CALLAHAN: I could probably manage it. Hi, everybody. Kathy Callahan. Nice to see you.
I may be calling to Harold on the sidelines, but right now --
Under --
SPEAKER 6: He is used to that.
MS. CALLAHAN: I have some copies here --
Yes, there are some committees that if Harold says it's okay, it's okay. So I don't know about (inaudible).
SPEAKER 6: If the girl thinks it's okay, Linda thinks it's okay.
MS. CALLAHAN: Yeah, well, she made some improvements.
Thank you for inviting me here today, and the request was testimony on the State's preferred drug list, how is it working, can you quantify any savings, anything else you think the committee should know about the prescription drug plan and any other information you would like to share.
So I thought it might be useful if I gave you a quick overview of the plan as it stands now,

and a little bit of history of what it used to look like and what it does look like.
Presently we have 22,400 plan members, and this includes the state employees and retirees, and their covered dependents.
For the year 2006, plan members filed 33,637 -- that's a typo. I apologize. 333,637. We goofed, in case you had the other two numbers. And the total cost of our drug spends for 2006 was 21.1 million.
Now, of that total number of prescriptions, 140,225 were for brand name drugs, and those cost 16 million. And the remaining 193,232 prescriptions were for generic drugs, and the cost of those was 5.1 million.
So I think you can see that generics are a lot more cost effective, and they represent about 58 percent of our drug spend, which is pretty good.
Some of you may know that we use a pharmacy benefits manager named Express Scripts, and through Express Scripts the plan provides prescription drug coverage through both retail pharmacies and mail-order home delivery.
Retail pharmacies in Vermont are

nationally contracted with Express Scripts for retail prescriptions, and then Express Scripts provides mail-service prescriptions through its own dispensaries around the country.
On our behalf, Express Scripts obtains and passes along manufacturer pharmaceutical discounts. They don't pass all of the discount along, but they pass some of the discount along, based on the size of our plan and our market share, and these discounts are based on a drug's average wholesale price, otherwise known as AWP.
The discounts vary between their retail network and their mail-order pharmacy, and the mail order discounts are generally the deeper discounts.
The plan's current contract with Express Scripts guarantees the following discount levels: At retail, brand name drugs are average wholesale price minus 16 percent, and there is a $1.20 dispensing fee. And generic drugs are average wholesale price minus 51.5 percent, plus a $1.20 dispensing fee. And through mail service, brand drugs are AWP minus 24 percent, and generic drugs are AWP minus 54.5 percent, and there are no dispensing fees at mail order.

Plan members may obtain short-term drugs or 30-day fills through retail. Long-term maintenance fills, these are generally 90-day supplies, are available either through retail pharmacy or the mail service home delivery, whichever one an employee chooses.
MS. CUMMINGS: Your plan does not -- I'm sorry.
SPEAKER 7: No, go ahead, you are the chair.
MS. CUMMINGS: -- doesn't make it so our local pharmacists have to defer to some mail order person in Illinois?
MS. CALLAHAN: That's correct, they don't. You can do it either way you want.
SPEAKER 7: I guess my question is the follow up of that, that is, if you choose the retail typically -- I mean I don't know how this plan works, the plan that I happen to belong says it is -- if I order a maintenance drug through the mail order, I get -- I get the equivalent of two months of co-pay.
MS. CALLAHAN: Yeah.
SPEAKER 7: And it's either way for whether it's retail or not, the co-pay is basically the same?
MS. CALLAHAN: One co-pay. It is one co-pay.

SPEAKER 7: It is the same co-pay?
MS. CALLAHAN: It is the same co-pay.
SPEAKER 7: Yes.
MS. CALLAHAN: Yes. So there is no disadvantage. Members aren't disadvantaged if they go to retail. They will generally pay more, though, because the discounts are greater at mail order.
SPEAKER 8: We have a percentage co-pay, so they are paying the same percentage, so if it is 10 percent, they are paying 10 percent of the cost.
SPEAKER 7: Oh, okay, so the co-pay --
SPEAKER 8: 10 percent of the smaller number.
MS. CALLAHAN: Is a percentage.
SPEAKER 7: Under, okay. So it is not a co-pay of $5, $10, $20.
SPEAKER 8: It is a percentage co-pay.
SPEAKER 7: It is a percent co-pay?
SPEAKER 8: Yeah.
MS. CALLAHAN: Yeah.
SPEAKER 7: And it is a percent of the --
MS. CALLAHAN: Cost.
SPEAKER 7: -- the final cost --
MS. CALLAHAN: Right.

SPEAKER 7: Okay.
MS. CALLAHAN: And that really goes to my next point, that for longer-term maintenance medicine, it is more cost effective to both the plan and the members if they use the mail service delivery.

The impact of the January 1, '06 change to a PDL or a preferred drug list plan, prior to that, prior to 1/1/06, because employee benefits are a mandatory subject of collective bargaining between the state and its union, the state does not have the unilateral right to just change the plan. So we did bargain with the union in 2005, and the parties agreed to change the structure of the prescription plan and to use a PDL for the first time, and that went into affect January 1st of 2006.

The plan designed prior to the PDL in 2006 was that there was a $25 annual deductible. The plan paid 80 percent, and the members paid 20 percent, and that was for any prescription drug. There was a low member annual out-of-pocket cost of $300. That means that the plan paid 100 percent after that $300 in drug costs.

The changes that we made in January 1st of 2006, we implemented a preferred drug list on a

three-tier formulary basis. The $25 annual deductible remained in place, and the cost shares under the plan changed, and it changed from the state paying 80 percent and the member 20 for any drug to the state paying 90 percent and the member 10 percent for generics. The state retained its 80 percent cost share, and the member the 20 percent cost share on preferred brands, and then for non-preferred brand drugs, the state paid 60 percent, and the member pays 40 percent. And in addition, the member out-of-pocket maximum was increased slightly to $475.

So why is a formulary plan important, and what were the changes that occurred? Generally, a formulary plan incites (phonetic) members purchasing decisions, which we have seen going on in our experience. It drives market share to the preferred brand, and it incites members to use generics where available.

The 2006 savings based on our change to the PDL plan were 2.8 million based on an overall drug spend of 21.1 million.

The plan's 2006 drug spend would have been 2.8 million higher if we had not changed to a PDL plan. The savings came primarily from a higher

generic fill rate. And based on the new PDL plan, more members chose the lower cost generic drugs at a low 10 percent co-pay, which is kind of a win-win for everybody. I know mine -- when -- you know, when I go for a 30-day fill, my out-of-pocket is 58 cents or something, which is almost unheard of, because of the cost of the generic is low, and my 10 percent is pretty small.
MS. CUMMINGS: Okay. So we did save some money.
MS. CALLAHAN: We did. It's money not spent, money --
SPEAKER 7: Can you join the life of the contract? Typically, it is a two-year contract; is that not right?
MS. CALLAHAN: It is -- no, it is a two-year contract, with a possible two more years extension.
SPEAKER 7: Okay. I am talking about the overall contract with state employees.
MS. CALLAHAN: Oh.
SPEAKER 7: State employees.
MS. CALLAHAN: The labor agreement.
SPEAKER 7: The labor agreement is a two-year contract?

MS. CALLAHAN: Right.
SPEAKER 7: Is the PDL -- I don't know how to say this? Is this part of the contract, the PDL? I mean what drugs --
SPEAKER 8: Does it coincide with it?
SPEAKER 7: Yeah.
Does it coincide with that two-year window? In other words, you have two-year labor contracts. Is the PDL, a two-year PDL?
MS. CALLAHAN: No. The change to the PDL was permanent, and it was negotiated in the last contract.
SPEAKER 7: All right.
MS. CALLAHAN: And the state and the VSCA have agreed to get together and talk about changes within PDL.
SPEAKER 7: How does that happen? That's my question. How does changes within the PDL happen?
MS. CALLAHAN: Okay.
SPEAKER 7: Is it unilateral? Does the state say this is it, or is there --
MS. CALLAHAN: No. We have something called a benefits advisory committee, and the state and VSCA get together and talk about -- at least quarterly, and talk about anything related to the

benefit plans. And we have language in the labor agreement that said that we will discuss the PDL at least once a year. And Express Scripts then comes forward with their proposed PDL changes, and they only do this once a year essentially. So the formulary is not changing every quarter or every month or anything like that.
If a drug goes off patent, it will be a generic at the time that that occurs in mid year, and that is all to the good of the member. But if there are going to be any drugs that come on or go off the PDL, that's an annual thing.
SPEAKER 7: But you are not bound to the labor contract in order to switch the drug benefit around?
MS. CUMMINGS: You could take things on and off. That's not written in the labor contract.
MS. CALLAHAN: That's correct.
SPEAKER 7: But that has to be in conjunction with the union, right?
MS. CALLAHAN: Yes, it does.
SPEAKER 7: In other words, both sides have to agree to that?
MS. CALLAHAN: We do, and we work pretty closely together on that.

SPEAKER 7: How does -- how does -- how do you decide something that might come off of the PDL and become a non-preferred versus preferred or vice versa?
MS. CALLAHAN: Well, we take the counsel of the PBM, not to throw too many acronyms around. Express Scripts --
MS. CUMMINGS: Pharmacy benefit --
MS. CALLAHAN: -- benefit manager --
MS. CUMMINGS: -- we are going to do a lot of work on PBMs.
MS. CALLAHAN: Yeah. And they have what they call a pharmacy and therapeutic committee. They study the drugs coming into the Pipeline, and they determine which ones are medically advantageous and which ones cost a lot. And their first cut is medical necessity or medical efficacy.
SPEAKER 7: Who sits on that board?
MS. CALLAHAN: That is a board of physicians and pharmacists from all over the country. It is a private, independent board.
SPEAKER 7: I just want to be sure it's not insurance guys --
MS. CALLAHAN: No, it is not.
SPEAKER 7: -- making those decision.

MS. CALLAHAN: No, it is not. They don't work for ESI at all, which is a good thing.
Yeah, it is a private, independent group of doctors and pharmacists who are brought in and do their thing under cover of night -- as we all joke -- and then fade away. But truly speaking, they are an independent group, and they make this recommendation.
Now, they send us the recommendation. We talk about which drugs -- this year not more than a handful of drugs were added or subtracted. You know, when you think of all the drugs on a formulary list, there aren't many that change.
MS. CUMMINGS: How much transparency do we have with the PBM? Do we know if they are going to put something on or off, if they are getting paid for market share for that particular -- those are stories we have heard about pharmacy benefit managers, that they get a bonus if they increase the market share for a certain pharmaceutical. Do we know if that's going on, or is this just again --
MS. CALLAHAN: I don't --
MS. CUMMINGS: -- you get a percentage of the average wholesale price discount -- I think that's

what went on there, a discount from the average wholesale price.
MS. CALLAHAN: Yeah.
You know, it's hard to use the word transparency and PBM in the same sentence.
MS. CUMMINGS: We are finding that.
MS. CALLAHAN: Because I think it might take, you know, the CIA to ferret out true drug pricing.

SPEAKER 7: I don't even think they could.
MS. CALLAHAN: The answer is --
MS. CUMMINGS: This is worse than the CLA. I am still trying to figure that out.
MS. CALLAHAN: It is not all that transparent, but a lot of common sense goes into it too from our prospective. We question their thought processes and their choices and their recommendations. We don't just say okay.
MS. CUMMINGS: Okay, that's --
MS. CALLAHAN: Okay.
SPEAKER 7: Madam Chair, I think it would be equal as a group if we could, for instance, maybe see what the current PBM is and what the PBL is -- what the proposed PBL is, just so we can kind -- I mean, I happen to know -- I worked for a

pharmaceutical company years ago, and I happen to know a little bit about these things, and I worked for a wholesaler as well at one time. And I would be curious from my standpoint so I can understand better, you know, what's going on. I mean, I don't know what some of the companion drugs are from different companies. You know, Merck had one, Pfizer had one, the same -- they treat the same thing. And one may be on this year, and all of a sudden, there is a push by the PBM to take that one off and put --
MS. CUMMINGS: Yeah, that's --
SPEAKER 7: That's what you were saying.
MS. CUMMINGS: But that's our negotiating thing.
SPEAKER 7: Right.
MS. CUMMINGS: Is that if you give us a lower price, you will be on our list and we will deliver to you at X market share.
MS. CALLAHAN: We don't get hurt by their decisions actually, if you want to think of it that way, because they are making decisions in their own financial best interest, and that interest is passed on to us.
SPEAKER 7: But when does the patient's best

interest come into play?
MS. CALLAHAN: Well, it is important to know that on a preferred drug list, there are always choices. It's never the one -- that there is only one choice of a drug in a category. There are generic choices. There are brand choices, and there is at least one brand choice in every therapeutic group and two in many.
So we have -- let me back up and say that we have what is called an open formulary or a broad formulary. There are three kinds of formularies, and we have the one that's the most broad. Some are much more narrow, and they are really more restrictive. They are designed to have people pick just whatever there is, but we have a lot of choice in ours.
MR. SCHWARTZ: There is a couple of protections for the patient employees. One of the protections is: If the person cannot take a particular drug that's -- that is a preferred drug, and they have to take the non-preferred drug, the one where the co-pay is 40 percent, if there is a clinical reason for it, not just the doctor says I like that drug, yeah, there is on opt-out, so they would end up -- the doctor provides some

information to the PBM, and they would pay a lower percentage co-pay on it.
The other --
MS. CALLAHAN: An override.
MR. SCHWARTZ: The other sort of safety net for the individual is there is a maximum amount out of pocket, so they wouldn't pay more than a certain amount of money. So their decisions -- you know, there is a certain tunnel of decisions that they can make, but at a certain point in time, they are not going to pay any more than X amount.
MS. CALLAHAN: I think it is important what Harold brought up, being able to take drugs and get a medical override. And that was part of what we negotiated with the union when we put this thing in.
MS. CUMMINGS: Okay. So we have got an override, and we are still saving significant money.
MS. CALLAHAN: Yeah.
MS. CUMMINGS: And I am not going to get into drug formularies. The Health Committee does that.
We don't do pills (inaudible), you know, in efficacy and all the recognized (inaudible), we are really kind of looking at the money.

So any other questions from the committee?
Okay. Thank you. That told us what we asked.
MS. CALLAHAN: Great, thank you.
MS. CUMMINGS: Committee you've got ten minutes. I am going to give you -- I assume you didn't get any break while I was gone.
MALE ATTENDEE: No, we didn't.
MS. CUMMINGS: You get another ten minutes, because Julie is not here yet.
(Thereupon, a break was taken.)
MS. CUMMINGS: Thank you. We can't do this too well. Rachel will be sorely depressed that we survived without her.
MALE ATTENDEE: We went through two breaks.
MS. CUMMINGS: We went through two breaks, that's what happens when Rachel is gone, we get two breaks.
MS. BRILL: Good afternoon. My name is Julie Brill. I am from the Attorney General's office, and I specialize in consumer protection and anti-trust, among other things, and pharmaceuticals is one of the areas I spend a lot of time working on.
I would just like to take a minute to

introduce Anna Lav (phonetic) to you. Anna is a MPH candidate down at Dartmouth, and he mastered in public health. And he is doing an internship with me this semester. And he has got great credentials and has been incredibly helpful. He formally worked with Consumer Reports' version of health watch or health report, so he has got a great background for this kind of work. And so I am very pleased that he is here. And he has been sitting here this afternoon, so I just thought I would let you know who he was.
MS. CUMMINGS: That's helpful, because we -- up to a few minutes ago, we were really crowded. And I -- we just assumed that some people -- never sure the people come or if they just -- we had -- I saw, by the name tags, I gather the L&As were here today. There were a couple of L&As in, and so it's been a --
MS. BRILL: Interesting, and I am sure they came here just to hear what you guys had to talk about.
I thought I would talk about the five things that our office has been responsible for in terms of doing the pharmaceuticals. I wasn't talking about enforcement matters.

You heard the Attorney General last week talk about the kind of cases we bring under our general consumer protection jurisdiction, for instance, the Betty Call (phonetic) case that you were just mentioning. We had a large Neurontin settlement. We had -- this year will be another banner year, I think. I think in 2007 we will have a large number of settlements again this year.
But instead, I thought I would focus on the programs that we administer that deal with pharmaceuticals you all have basically given to us to deal with.
One is the gift disclosure law, which is a law that requires pharmaceutical marketers, basically the manufacturers, to report to us about payments that they make to prescribers, and we do a report on that issue.
The second is the price disclosure law, and I will explain that all to you in a minute.
MALE ATTENDEE: What's the first one?
MS. BRILL: We call it gift disclosure. Unfortunately, these two laws have very similar names, so -- it's called the gift -- colloquially, it is called the gift disclosure law, but it

refers to any payment, like a consulting fee, travel, any meals, anything like that.
The second one is a price disclosure law, and they are different. And I will explain those in just in one second. And then we have been doing things related to retail prices, and you all passed a law related to retail prices, and then we are working on a Web site related to that. So I wanted to let you all know about that.
I thought I would give some information about the counter detailing that we did fund at UVM and Dartmouth through the Neurontin Grant Program. Bill Strull (phonetic) mentioned that when he was here, so I thought I would give you a little more information on that.
And finally, I thought I would talk about the 2005 report that we did, which I have enough copies for you all, and I can hand that out.
I think you might find this interesting. It has got some very interesting topics in it, and we are doing an update on this now, so we can talk about that.
So those are the areas I thought I would cover briefly today. I know it's the end of the day, and you guys are probably exhausted, so I

will try to go quickly, unless I go too quickly.
MS. CUMMINGS: The protam (phonetic) has told us to plan on midnight, so --
MS. BRILL: Midnight today?
MS. CUMMINGS: Midnight every day, so --
MS. BRILL: Oh.
MS. CUMMINGS: So we are wearing the calluses up here gradually.
MS. BRILL: I certainly will not work you until midnight.
MS. CUMMINGS: I have to work my other job at 6:00 o'clock.
MS. BRILL: Don't worry. We will be out of here well before then.
Okay. So let's talk first about the gift disclosure law.
What you all decided several years ago, probably in around the 2002 time frame, was that you wanted to know and you wanted to have reported to the public gifts that were made by manufacturers to prescribers, because you wanted to find out what was influencing prescribing decisions and whether these gifts were out there as one of the mechanisms for influencing prescriber decisions.

So prescribers are required to report to -- I am sorry, not prescribers -- the manufacturers and marketers are required to file a report with our office every year.
And it's actually a very detailed report, and it's all computerized now. And we get probably 10,000 or more pieces of information about various gifts and payments to various prescribers in the state.
We pull that information together and we put out the report. And we have now done three reports, and we have discovered that, you know, on average, Vermonters are receiving on the order of one to $3 million. Vermont prescribers are receiving one to $3 million per year in terms of reportable payments.
There are exceptions that do not have to be reported, payments under $25, discounts and rebates. We actually had a debate in the legislature about whether those should be recorded or not. You all decided they should not be recorded. Certain types of CMEs do not have to be recorded, things like that.
FEMALE ATTENDEE: What are CMEs?
MS. BRILL: Sorry, Continuing Medical

Education.
FEMALE ATTENDEE: Oh, education.
Sample drugs, right?
MS. BRILL: Sample drugs do not have to be reported, that's right, that's right.
Although, there is an intellectual debate about whether that influences prescribing decisions.
As you can imagine, if a doctor has a bunch of samples, you know, will the doctor more likely prescribe that for a consumer who may or may not be able to pay? But that is not part of our report. Consulting fees are, and that's a big area that we deal with.
So I thought what I would hand out, this is the guide that we give to manufacturers of what they have to report to us. Just sort of describes generally our view of the law.
And this is the last report that we did. This is the 2006 report. All of this information -- I have got plenty for the people that are here, but all this information is available on the Web. (Inaudible) report. Frankly, we would like to -- I will give it to you.

MS. CUMMINGS: That's another report?
MS. BRILL: These are two different documents.
Frankly, we think that this database that we have is an extremely rich database, and has a lot of great information in it. And we would like to start doing more with it, but we are a little bit hampered in terms of the amount of data that we can match up with this data. So we want to work with folks over at OVA to get more data to help us enrich this report, and we are going to be working on that this year.
MS. CUMMINGS: I was wondering. You collected all this information. Is it telling us anything?
MS. BRILL: Well, it does -- it tells us some things, but I think it could tell us a lot more.
In other words, right now what it tells us is, you know, the total amount of payments that are made, which in FY05 was $2.17 million. And we can see the rates at which these payments are changing, which is interesting. But what I would like to see is looking in specific categories of drugs, whether individuals who receive these payments are influenced in terms of the rate at which they prescribe certain drugs versus other drugs. I think that would be a much richer --

MS. CUMMINGS: I think that sounds like a Ph.D. thesis.
MS. BRILL: Well, we actually talked about the type of person that we would need to help us analyze the data, because OVA does have a tremendous amount of data, but I do -- I do think that would make this a really rich report, and frankly, I think it would be helpful for you to know whether, for instance, who are prescribing for Medicaid patients, are some doctors prescribing certain drugs, maybe more expensive drugs, and they also happen to be doctors who are receiving consulting fees, things like that. I think it would be a very helpful thing to know.
So we would like to enrich this report. It will take a lot more work on our part, and it will take cooperation from OVA, and I am sure we will get it. We just need to get their attention on the issue. But in the meantime, it is a very rich database.
You all, at our request, allowed manufacturers to declare that certain payments would be trade secrets, and the reason we asked you to do that is so we wouldn't be subject to a constitutional challenge on this law. And in

fact, we have not been subject to a constitutional challenge, but we -- it's resulted in some litigation on the part of consumer groups. Some consumer groups have sued us, and then also sued the manufacturers, because we were not giving them data that the manufacturers were declaring which was trade secret.
So we have been working on that issue. We have been working on that lawsuit. It has not affected the functioning of the law, the administration of it or the report. I just thought I would let you know that that's been happening too.
MALE ATTENDEE: What kind of gifts would (inaudible).
MS. BRILL: Well, the argument is, and I think that that has been asked just that way by some people, that a manufacturer's marketing plan can be easily discerned and figured out if you know which doctors they are seeking expert opinions from, which doctors they are consulting with those kinds of things.
We in Vermont have actually a very broad trade secrets law. It covers quite a bit. And what we didn't want to do is wind up in a

situation where the manufacturers could enjoin this law, basically stop it from functioning at all, because they would have said it was taking their intellectual property, their (inaudible) property in terms of their marketing plans.
MS. CUMMINGS: That was the same argument we had with transparency and PBM.
MS. BRILL: It's similar, yes, similar, similar.
So we actually asked to have that in there in order to protect the law. That was --
MS. CUMMINGS: Now the other side is suing you.

MS. BRILL: Yeah, we are dealing with it. We are okay. We are dealing with it, and I actually think that's going to be worked out between the consumer groups and the manufacturers. I think the manufacturers will just give them the information they are seeking.
MALE ATTENDEE: And they don't want to shut the operation down?
MS. BRILL: No, no. They definitely don't want to shut this down. They definitely don't want to do that.
So that was -- I can go into greater depth

about this, but I thought I would just move along.
MS. CUMMINGS: Any questions from the committee (inaudible)?
MS. BRILL: I think it is a great law.
Actually, one thing I will say, it is one of the -- there are several of them on the books in other states, but this one is the most advanced and the one that has been functioning the longest.
And I go to some conferences where the manufacturers ask me to talk about this law, and the industry asks me to talk about this law. And there is a lot of concern out there in the industry that states are enacting all sorts of different laws with different requirements.
And my response is, well, Vermont was first. Vermont is working well. We would be very happy to cooperate with any other state, to tell them what we are doing and give them our guidelines.
The difficulty is that in most other states, it's not the Attorney General that's administering the program, it is someone else. So it has been -- it has been hard to coordinate with other states, but there is sort of an interstate issue here.

No, that's good, and do you have the other one?
MALE ATTENDEE: I don't know, this one?
MS. BRILL: That's okay. We were just talking about the gift disclosure law, and this I haven't handed out yet but you can take one.
MALE ATTENDEE: That's okay.
MS. BRILL: So the next law that I thought we would talk about is the price disclosure law. This one has been interesting.
MS. CUMMINGS: Has been a little more difficult?
MS. BRILL: This one has presented some issues that we are working on.
MS. CUMMINGS: Well, it had issues when we cast it. This is one of the things that sounded so simple.
MS. BRILL: I think it is one of those things that sound really simple and it is a great idea, and it is the execution of it that has been interesting.
What this law requires, rather, the one that we just talked about requires the manufacturers to report to our office their gifts. And we have this huge database, and we put a

report together.
This is a different law. This requires the manufacturers, when they go into a doctor's office, to detail, that is, to market a product, what you all had said you wanted the manufacturer to do was to simultaneously give the doctor some information about relative price so that there would be some understanding about, okay, we are hearing the wonders of this new drug, drug A, which is supposed to be this brand new thing, but how does it stack up in terms of price for other drugs in the same therapeutic class. That was the concept you all had asked us to work on.
MS. CUMMINGS: I was thinking of the one that said that the pharmacies had to reveal the retail price.
MS. BRILL: We are getting there.
MS. CUMMINGS: Okay. That's the next --
MS. BRILL: That one hasn't actually -- I don't think that one has been that difficult, but maybe you have heard things that I haven't heard.
MS. CUMMINGS: No, just I remember it was very difficult to do.
MS. BRILL: It was difficult to come to a solution, but the solution is actually -- that we

did come to was simple.
MS. CUMMINGS: Yeah.
MS. BRILL: This is different. This deals with detailing and giving the doctors and prescribers some relative information about pricing for drugs in the same therapeutic class.
We have heard some complaints from nurses. The information needed to be given to any prescriber is detailed, and a lot of times it appears that the nurses are receiving this information and they are complaining, because they are saying they are getting a stack this big, you know, a stack of materials, and they are not reading it, and they want something that's simpler.
And we have been in discussions with various members of the industry, as well as various consumer groups, to try to figure out a more elegant way to do this disclosure.
What I passed out for you is the guideline that is currently in operation. In fact, I think we have a meeting Friday to continue some discussions with the industry on this.
One of the things that I am thinking would be much simpler is just requiring an average

retail price for other drugs in the same therapeutic class. The manufacturers can go to drugstore.com or whatever source they want, as long as it is the same source, they can come up with an average price of other drugs in that therapeutic class, and they can disclose the price of the product they are marketing. One page, I want it to one page.
The industry has said, Well, gee, why don't we just disclose it on the Web? Why do we have to even hand out anything to the doctor? And I think I have been resisting that, and the reason is because I think the legislature generally wanted the doctors to receive something at the time when they receive information about the wonders of the new drugs. That was the intent that I recall during the debate, and so we are sticking with that. We are sticking with the desire to give the doctors something simultaneously at that meeting.
MS. CUMMINGS: So you know that this is at or above, below the average price?
SPEAKER 9: Who is policing this?
MS. BRILL: We are.
SPEAKER 9: How do you know that at the time --

MS. BRILL: Oh --
MALE ATTENDEE: Julie is very busy.
MS. BRILL: I am very busy. I am going all -- no.
SPEAKER 9: It just seems --
MS. BRILL: We have not heard of lack of compliance in terms of people not giving the information out. What we have heard in terms of complaints is that the nurses, as I mentioned, think that the information is not helpful. They have complained to us about trying to make this more helpful. So what we have been focused on is thinking about the different ways we can make this information more helpful to them.
MS. CUMMINGS: Sounds like we told them to give information, and they are giving you --
MS. BRILL: Exactly, exactly. They are in -- I am not aware that anyone is out of compliance. There may be some companies out of compliance, but I think the better thing for us to focus, in the Attorney General's Office, our attention on right now is making this a better program so that it works better for the prescriber. That's why we really want to get it to down to one sheet.

MS. CUMMINGS: (Inaudible.)
MS. BRILL: Yes, exactly.
MS. CUMMINGS: (Inaudible.)
MS. BRILL: So as I said, we had meetings. I had meetings with various people down at Dartmouth who are thinking a lot about this in terms of trying to come up with creative ways to do this, and we are also meeting with the industry so that effort will continue.
Retail prices -- unless there are more questions about this one, the giving information to doctors as we are -- as they are being detailed.
Retail prices, yes, a couple of years ago, we came in here and we said we wanted the pharmacies to do Web disclosures, and the pharmacies really resisted that.
MS. CUMMINGS: I would say it started out with putting back the signs --
MS. BRILL: It may have started out that way.
MS. CUMMINGS: It started out with the sign.
MS. BRILL: That's right. And no ever liked that sign. Just to give -- you, who are not on the committee, Vermont, years ago, required a poster or something similar to that in all the

pharmacies that listed the retail prices of a certain number of drugs, like 100 of them or so. The problem was the posters were being crossed out all the time with new prices being added. It was a mess. The pharmacies hated it. I don't think consumers ever really looked at it. So we -- that was then -- I think it was the Health Department and not AHS, but it was some state agency. Again, I believe it was the Health Department. It could have been the Pharmacy Board. One of them said they were going to no longer require that.
We felt that something needed to be disclosed to consumers. If it wasn't going to be the poster, then let's have the pharmacies do a Web disclosure. They very much resisted that in this committee, if I am recalling. So we said, okay, let's require that when a consumer requests the retail information, that they will get it -- that they will be given it by the pharmacy; in other words, you go in and you say what's your retail of Lisinopril, the pharmacy will tell you their retail price of Lisinopril or whatever the drug is.
MS. CUMMINGS: The problem is that when they got into their computer, they had to put in all of

your information and they had to go -- to get to that price, if you asked --
MS. BRILL: Right.
MS. CUMMINGS: -- they had to actually input your prescription, and then --
MS. BRILL: And they weren't giving the price.
MS. CUMMINGS: Yeah. And then if you say, oh, because there was a study done and there was a wide swing.
MS. BRILL: We did that study.
MS. CUMMINGS: Yeah.
MS. BRILL: We did that study. Your memory is great on this one. We did that study. We passed it out to you all. We said, Look --
MALE ATTENDEE: Who is (inaudible).
MS. BRILL: Look at the difference in price --
MS. CUMMINGS: If I were knitting, I would remember more.
MS. BRILL: That's right.
Look at the difference in price. In fact, I could have brought you that study. I didn't bring that, because it has been a few years since we have done that one. But there was a wide disparity in price, and therefore, we said we need to have some disclosure.

The pharmacies did say they had some trouble, because typically they liked to give the consumer what the consumer's price would be.
MS. CUMMINGS: Right.
MS. BRILL: So if you were on Cigna, it would be different than if you are on Medicaid, etcetera, etcetera.
We said just give them the retail price. Cash customers, give them the cash price, and that's the law that you all enacted. So if a consumer goes in and asks for the cash price, you know, not on any program or anything like that, just what will it cost me to buy this product cash, they have to tell the consumer what that price is.
During that debate, you remember there was a lot of discussions about whether this ought to be put on a Web site, and who ought to be doing that. In -- since that discussion, again, over the last couple of years, a number of Attorneys General around the country have instituted retail Web -- retail price Web sites. So that a consumer can go to their Web site, plug in a drug, one of say 50 or so, and get -- get the retail price.
So we thought that was a great idea. We

have actually been working on developing that Web site for probably on or off two years.
It has been interestingly complex to get it right. We have really been striving to get it right. And we are probably going to be launching that within a couple of months. We will invite you all to the launch. You can see it work. It is actually very neat. It is a very, very neat site.
And while the percentage of consumers that are buying drugs at, you know, cash retail is shrinking, especially because of Part D, you know, consumers who are now on Part D as seniors no longer need to pay cash, because they are all -- most -- the vast majority of them are on Part D.
There is also this other element at the other end of the spectrum, where you have Wal-Mart, and Kmart and these other stores who are now doing the $4 generics, so we still think there is a strong market for cash, especially at the generic level.
MS. CUMMINGS: Is there a concern about price gouging with that? I know -- remember we did a whole thing on unfair competitive practice?
MS. BRILL: Predatory pricing you mean?

MS. CUMMINGS: Predatory pricing. I heard that, and said that's the death now for your local pharmacists.
MS. BRILL: Well, we have not heard that complaint. That doesn't mean that isn't a concern by the pharmacies with respect to that issue, but they have not come to us, and they could come to us, because, of course, we enforce the predatory pricing law.
MS. CUMMINGS: Well, who wants to go out there and say you want to stop people from getting $4 drugs?
MS. BRILL: Right.
$4 generics?
MS. CUMMINGS: Yes.
MS. BRILL: And it really is very good for consumers. It really is terrific. And you know what Wal-Mart did is they took a number of drugs, not as many as it seems, because there are all sorts of numbers and dosages -- you know, there was one drug that had five different dosages that was on the list five times, but it became a loss leader for them. They would get somebody in the store, and then the person would buy all sorts of other things.

It probably is a phase that ought to be watched in terms of predatory pricing, but we -- like I said, that would be the sort of thing that I think the industry, if it were really concerned about that, would at least come to us and say, you know, Attorney General, you should really be looking at this, and we just haven't heard that.
So that's what we are doing with respect to retail pricing. You know, again, the Web site will be something that we are hoping will be very helpful. We know that in other states, consumers love them. I mean if they are not paying cash --
(Thereupon the CD ended.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Sara Glazer, Notary Public, do hereby certify that I was authorized to and listen to CD 2007-35, the Senate Committee on Finance, Tuesday, February 6, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the beat of my ability.

Dated this 7th day of April 2008.

_____
Sara Glazer
Esquire Job #928010

STATE OF VERMONT

SENATE COMMITTEE ON FINANCE

Re: Senate Bill 115

Date: February 6, 2007

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: CD 2007 36

Esquire Job #928011

PROCEEDINGS

CD No.: CD 2007 36

MS. BRILL: -- in terms of best dealing with pharmaceutical companies, but we were very pleased that both Dartmouth and UVM submitted application for money under this national program, and this money comes as a result of a settlement with Pfizer over some inappropriate marketing that it was engaged in back in the late 90's and early 2000's.

So that's something that we are very involved in, in dealing with that program, and actually, we are about to launch a consumer grant round where consumer groups are applying to educate consumers about pharmaceutical projects -- excuse me. Pharmaceutical efforts and marketing direct-to-consumer advertising, that kind of thing. And we will be awarding a grant probably -- one or more grants in a few months.

So the -- the last thing I thought I would talk about, I think Bill Strull (phonetic) also mentioned that in 2005, when he was president of the National Association of Attorneys General, we

did a report on pharmaceutical pricing, and this is the report, and it is actually, I think, still, even though it is -- almost two years old, it has a lot of interesting information in it.

So we did bring one copy for every member of the committee, and I thought I would tell you that we are working on updating that now. Probably will come out late spring, early -- early summer. But this report has a section on research and development, and what kind of -- what costs are added to the price of prescription drugs as a result of research and development, and is that rational or irrational. It talks about direct-to-consumer advertising. It talks about marketing to doctors. It talks about international pricing and how other countries do pricing in pharmaceuticals.

We brought in national and inter -- actually, international experts to a conference that we had in January of 2005, and they spoke on all these different issues. And this report is a culmination of that conference and what was said and talked about. But also, at the end of the report, we have a list of the kind of efforts that other -- that states generally, including Vermont,

are involved in to deal with pharmaceutical pricing.

There is a chart in back, and you know, we have worked with Sharon Shreet (phonetic) to keep that as up to date as we can. And I actually do have a new chart that I am working in terms of current efforts that states are involved in.

So there is some pretty high powered thinkers that are described -- their thoughts are described in this report dealing with, as I said, like I said, research and development. We have Marsha Angel giving a -- wrote a piece in here. She is a doctor at Harvard Medical School, and someone who has written a lot about research and development. She actually has a book on it. We have got -- we had Jerry Avorn (phonetic) and Jerry Casamer (phonetic). These are leading thinkers on marketing to doctors, leading national thinkers.

So, anyway, you know, when you are having trouble going to sleep some night as you are sitting in a hotel room up here, maybe it will be something that you might want to look through.

MR. MacDONALD: (Inaudible.)

MS. BRILL: What did you say, Mark?

MR. MacDONALD: (Inaudible) prescribe this.

MS. BRILL: That's right. The (inaudible) prescribing for insomnia.

MR. MacDONALD: One page takes a long time.

MS. BRILL: It is thick, but actually it does have a lot information.

SPEAKER 4: It has got lots of pictures.

MS. BRILL: We tried to make it with some pictures and wide space.

Anyways, as I said, we are updating that. That's a new effort that is underway.

SPEAKER 4: I don't know that I have seen that.

MR. MacDONALD: Why don't we wait? I think they are just trying to hand these out.

MS. BRILL: No, no. These are a hot commodity. You can sell them on a E-bay for a lot of money. No, just kidding.

SPEAKER 4: Inaudible.

MR. MacDONALD: Inaudible.

MS. BRILL: The update that we are working on will be different in the sense that we will really be focusing in the version on what states are currently doing, and making recommendations of what states ought to be doing. This is more descriptive of some of the problems that are out

there with respect to pharmaceutical pricing, so to give you background and an overview, and then at the end it talks about what states are doing, but it doesn't focus on that. So we are going to pick up where that one left off.

SPEAKER 4: You should probably develop a reading list for members of this committee before sending it out in November.

MS. BRILL: Yeah.

SPEAKER 4: That would be build up.

MS. BRILL: That would be -- we would be more than happy to help you with that.

SPEAKER 4: I am sure.

MR. MacDONALD: I am sure.

MS. BRILL: Anyway, that was all I thought that you might want to hear from me today. I know that you had people come in to talk about different things that states are doing, and I have all the material that they submitted to you. And, you know, if you want me to at sometime in the future, I would be happy to react to that list and tell you some of the things that we think make sense, what we have been hearing out here, but today I just thought I would talk about what we have been working on here.

SPEAKER 4: Okay.

Are you prepared to talk about that at all, because you got probably a half hour?

MS. BRILL: I just don't -- I have the materials. I just haven't gone through them, I am sorry.

SPEAKER 4: Okay. No. No problem.

Because it looks like the pharmacy bill is at least fast-tracked in this committee. We have been -- I think I met with Senate Health and Welfare this morning, and since this committee has done PBM legislation a number of times, we might be able to do that a little more quickly than his committee, and you know, start the bill here. We are starting with a recommendation Sharon Shreet gave us last time, and then we will bring it out to this committee.

MS. BRILL: What would be the areas that you are thinking at this time of focusing on or have you not decided yet?

SPEAKER 4: Well, the pharms again --

MS. BRILL: The PBMs?

SPEAKER 4: The PBMs, the transparency, and the fiduciary.

MS. BRILL: Right.

SPEAKER 4: We have done at least twice, at least that I can remember.

Some of the price gouging, you know, tying prices to -- was one we talked about, and the third was talking perhaps with you about any interest in allowing the Attorney General to enforce the advertising laws.

MS. BRILL: Oh, the federal advertising laws.

SPEAKER 4: Yeah, because we know we cannot ban Platzberg (phonetic) from being here.

MS. BRILL: Right, right, right. Okay. That's interesting. I am going to look through her whole list, and I will look through my list, and I will let you know what else has been done out there. Know, Maine has done a clinical trial registry, for instance.

SPEAKER 4: There is talk -- there is a lot of interest also in -- is it Colorado where they are trying to do an efficacy, you know, this drug may cost 10 percent more --

MS. BRILL: Oh.

SPEAKER 4: -- but it is 40 percent more effective.

MS. BRILL: Absolutely, right. It is only -- Consumer's Union actually has a program that, you

know, they have best buy, and they are doing that now for drugs, you know, what is a best buy drug, you know, what is the best for your dollar, best value for your dollar. I think that makes a lot sense. The clinical trial registry, I only mention it because I am not sure we ought to do that.

SPEAKER 4: Okay.

MS. BRILL: If Maine is doing it, I am not sure two states need to do it. If you have one up there, why do you need two. And if you don't know what a clinical registry is, I can explain it to you.

SPEAKER 4: I remember Sharon mentioning it, but it didn't make it, I don't think, to the paper just yet.

MS. BRILL: Yeah, and I can explain that to you at some other time. It just seems to me it is a lot of work, and it is a great effort. In other words, you are letting consumers know about all the clinical trials that are out there and what the results are, and it is really -- it is actually really meant more for prescribers than it is for consumers.

SPEAKER 4: Yeah.

MS. BRILL: So they can know, well, gee, there was a study done, and oh, this product wasn't as effective as we thought it was, but I am --
SPEAKER 4: Even if it is for a disease I don't have.
MS. BRILL: Right.
SPEAKER 4: I am just thinking of all the --
MS. BRILL: Right.
SPEAKER 4: -- about all the stories about people going with the list of things from the TV they are supposed to --
MS. BRILL: Exactly. It really is for prescribers, but my view is that's the kind of thing if one state does it and does it well, that's sufficient. You don't need to have two Web sites where Vermont is duplicating what Maine has done. We can just send people to Maine's Web site. Why recreate the wheel, if they do it right. But I -- let me take a more --
SPEAKER 4: Take a look at that.
MS. BRILL: -- take a look at the list, and I will get through it. And I certainly was involved in the PBM discussions previously.
SPEAKER 4: Yes.
MS. BRILL: So I would be happy to do it again.

SPEAKER 4: Makes sense to probably do it (inaudible).
MS. BRILL: That's right. That's right.
SPEAKER 4: But I think finding out what has happened, you know, we sense some movement from the industry, and you know, perhaps that movement is enough, but we will look at it.
The other one was --
MS. BRILL: The prescription privacy issue? Is that something you guys --
SPEAKER 4: That came up, and it is slipping my mind, but we want to just take a look at what is out there.
MS. BRILL: Sure, sure.
SPEAKER 4: Probably put it together in a committee bill. If the memorandum is right, we can do one and they can't. You know, and it is just no decision, it is just what -- the new thoughts, what sounded interesting.
MS. BRILL: Great. That sounds perfect, and I apologize for not being ready to do that today.
SPEAKER 4: We didn't ask you to be ready.
MS. BRILL: Right.
SPEAKER 4: We just -- we are still scheduled for a less efficient committee or something. This

committee has been really good about being here.
MS. BRILL: Good.
SPEAKER 4: We are used to last year, between health issues, campaign issues, having many empty seats at this table, so it has been a pleasure this year.
MS. BRILL: Great.
SPEAKER 4: So it's been good.
MS. BRILL: I am nearby, so any questions -- and I will come back when you guys want to talk about that.
SPEAKER 4: Okay.
MS. BRILL: I am ready to do that. So thank you.
SPEAKER 4: That may be sooner rather than later.
MS. BRILL: Perfect. I am around.
SPEAKER 4: Okay.
MS. BRILL: Thank you.
(Thereupon the proceedings concluded.)

CERTIFICATE

STATE OF FLORIDA
COUNTY OF BROWARD

I, Sara Glazer, Notary Public, do hereby certify that I was authorized to and listen to CD 2007-36, the Senate Committee on Finance, Tuesday, February 6, 2007 proceedings and stenographically transcribed from said CD the foregoing proceedings and that the transcript is a true and accurate record to the beat of my ability.

Dated this 7th day of April 2008.

_____
Sara Glazer
Esquire Job #928011