TAB M

STATE OF VERMONT

Senate Committee of Finance

Re: Senate Bill 115

Date: March 27, 2007

Type of Committee Meeting: Prescription Drug Bill - As Passed Senate Health and Welfare Committee

Committee Members: Sen. Ann Cummings, Sen. Claire Ayer, Sen. Bill Carris, Sen. James Condos, Sen. Mark MacDonald, Sen. Hull Maynard, Jr., Sen. Richard McCormack

CD No: 07-90/T1,T2

PROCEEDINGS

CD 90/TRACK 1

SENATOR CUMMINGS: The first item on the agenda is S.115 Prescription Drugs. We have figured out how it came back here. It got sent by the Secretary of the Senate, who didn't remember it had started here and the normal course is, if they start in Health and Welfare it comes to Finance afterwards. So it came to Finance a second time. I'm going to try and deal with this as we would as if it were just a proposal for amendments from the Health and Welfare Committee.

We have, on Friday, heard arguments for and against accepting their proposal and there's basically -- there's actually three. One is the new level in fiduciary, going to the level of an insurance company, as that's been defined in law or at least in one court case, which is how we view law. The other one is the data mining section, which -- and the third is the unconscionable pricing. We -- and we can approve or unapprove. We have a compromised middle ground on unconscionable pricing. The

chair of Health and Welfare has managed to talk to a couple of his members; Senator Flanagan is not in today, and he thinks that that would be a reasonable compromise for this committee.

So I'd love to hear what this committee would like to do and get this one moving because we have some really big bills to deal with this week and this one we did spend a considerable amount of time on.

ATTENDEE 1: I would like to get -- to see that language on the financial.

SENATOR CUMMINGS: We've got it --

ATTENDEE 1: Maybe we can -- let's move them along.

SENATOR CUMMINGS: We have extra copies. We had it on Friday downstairs. Where is the copy?

ATTENDEE 1: Is that --

SENATOR CUMMINGS: I think that we have the compromise.

(Inaudible.)

SENATOR CUMMINGS: That we will deal with in the next bill and there will be a next bill starting very soon.

I've got Julie's.

MS. BRILL: (Inaudible.)

SENATOR CUMMINGS: Okay. Now I have it in legal language.

And, Robin, can you remind the committee -- oh, this one is in living color. She did come back with these in color.

MS. LUNGE: Where did we get this? Did we get that?

SENATOR CUMMINGS: Yes.

ATTENDEE 1: It's in blue.

SENATOR CUMMINGS: It was in my folder.

MS. LUNGE: Yes.

SENATOR CUMMINGS: It's from -- Julie passed it out on Friday.

ATTENDEE 1: (Inaudible.)

MS. LUNGE: And the other thing that Rachel is doing, is you will recall from my section by section there are a couple of errors that I needed to correct, so we handed out a replacement section by section that corrected --

SENATOR CUMMINGS: That's right.

MS. LUNGE: -- minor things that I had left out.

SENATOR CUMMINGS: That's why I have two

in here?

MS. LUNGE: Yes. That would be why.

The other thing that I did, because I thought it would be easier to follow, is under the Senate Health and Welfare Amend column I noted which instance of amendment each change was in, so you can easily see, okay, first instance is of amendment --

SENATOR CUMMINGS: They were all in there. Thank you. Okay.

MS. LUNGE: So but back to the proposed amendment on unconscionable pricing, I believe the testimony that you heard from Julie Brill at the Attorney General's Office was that she was offering this amendment in order to address some of the legal issues under the commerce clause, so you will note that, in several places, that the words in blue "in Vermont" have been added to clarify that it was meant to address --

ATTENDEE 1: I'm sorry, which topic are you on?

SENATOR CUMMINGS: Oh, this is from last week.

MS. LUNGE: It looks like this.

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ATTENDEE 1: Yeah.
SENATOR CUMMINGS: And it has a -- okay. I have it.
ATTENDEE 2: A blue "in Vermont" on it.
MS. LUNGE: It has a blue "in Vermont" --
SENATOR CUMMINGS: Uh-huh.
MS. LUNGE: -- midway through the page.
SENATOR CUMMINGS: But is this the same one she gave us last week?
MS. LUNGE: Yes.
SENATOR CUMMINGS: Okay. We had asked to have it, because it was unclear where -- what she was adding to the original or crossing out from our original.
MS. LUNGE: So what you can see is that the blue is new language. On the second page there's some red strike-throughs. That is also meant to address that same issue. And then at the bottom of the second page, the other suggestion that the Attorney General's Office was making is that Senate Health and Welfare had narrowed the definition of the public -- oh, I shouldn't say the public, but the factors that the health department would look at when coming up with --

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SENATOR CUMMINGS: Right.
MS. LUNGE: -- a public health threat. And so the language in blue and the strike-through in that section, which is 46.54, reverts back to your language, as it passed out of this committee.
SENATOR CUMMINGS: Which means it could be an unconscionably high price for a cancer drug like Tamoxifen used by a large number of Vermonters that has unconscionably gone up. If we felt it was a flaw, it is at the federal 30 percent --
MS. LUNGE: 30 percent or greater than.
SENATOR CUMMINGS: -- the federal rate. So it's not like we can just say, Well, we think it ought to be $2 a prescription. There is a flaw with that one.
ATTENDEE 1: That brings chronic illnesses back in.
SENATOR CUMMINGS: It does bring chronic illnesses or the potential --
MS. LUNGE: The potential.
SENATOR CUMMINGS: -- for something other than a pandemic. The way it came to us, this bill, was this really had to be a pandemic and

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somebody had to be holding back flu vaccines and we were really trying to tie it to our line of care initiative.
So, Committee --
ATTENDEE 1: So how does this -- how does the amendment that we have before us change what we -- excuse me --
SENATOR CUMMINGS: That's okay.
ATTENDEE 1: -- originally passed out of committee?
MS. LUNGE: What it would do is add in language, periodically throughout the bill, referencing transactions in Vermont to clarify that your intent was not to reach outside of Vermont transactions which were interstate.
ATTENDEE 1: Okay. If we have an ABC Wholesale that is in Plattsburgh, New York, but sells in Vermont?
MS. LUNGE: The way the bill is structured, it affects manufacturers. So it doesn't give the AG authority to sue wholesalers. It gives the authority to sue manufacturers or its licensee. So the question, I think, for a court would be if a manufacturer is selling to -- let's use a PBM,

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for example, because I think this is the question that I'm not entirely clear on, on what the commerce clause would do.
But so let's say the manufacturer is negotiating a contract with a PBM who is negotiating on behalf of the state employees' health benefit plan. Is that a transaction in Vermont because, even though the PBM is, let's say out of state, all those drugs are coming into the state or is that transaction out of state? So, I think, that, in my mind, is a gray area.
SENATOR CUMMINGS: And this -- Julie, since she did the original drafting, had the ability to talk to the attorneys on both sides of the Washington D.C. case where this was litigated and we've all worked on the idea that it had to have an overriding state purpose and that's why theirs got knocked down. And she said no, that they told her the reason theirs got put down was because it was too broad; it didn't specify that in the event of a health crisis, it would be within the state. It would be selling the drug within the state to people within the state and, you know, limited to this

health crisis declared by the Department of Health that met the criteria.
ATTENDEE 1: Well, let me get more specific.
SENATOR CUMMINGS: Yes.
ATTENDEE 1: How did this -- how does this deal with Burlington Drug?
MS. LUNGE: Well, it would affect manufactured sales to Burlington Drug, although it would not affect Burlington Drug itself, because Burlington Drug is not a manufacturer and I don't believe it's a licensee, because I think a licensee is someone who is manufacturing the drug on behalf of the manufacturer. So it could affect the price between the manufacturer to the wholesalers, but it doesn't affect the wholesaler, because they don't meet this language in 46.52.
ATTENDEE 1: Does this put Burlington Drug at a disadvantage because a wholesaler from outside the state would not be subject to this?
SENATOR CUMMINGS: No.
MS. LUNGE: It would mean that Burlington Drug could sell it for cheaper, I think, because then the out of state -- the reason I'm

saying that. Let me walk you through the whole process.
What would have to happen first is the Health Department would have to declare that breast cancer is a public health threat in Vermont and that the prices are -- you know, that we should look at those prices. There would have to be a court case, then, to decide is that a public health threat and is the price that it is being sold for in Vermont unconscionable in meeting the test in 46.55.
So then the court would after that -- if the court said yes, we think the Health Department looked at the factors correctly. Yes, we think it is an unconscionable price, then the court would say, We think this price should be the federal supply scheduled price or the Medicaid price or 30 percent greater than the Medicaid price. And then --
ATTENDEE 2: I'm struggling to understand how that's going to work and I don't think --
SENATOR CUMMINGS: We hope it never has to.
ATTENDEE 2: Well, no. I guess I'm just struggling because we can't deal with

interstate commerce, at least that's my understanding. Maybe you can explain it better, but we can't deal with interstate commerce. So if you have a company outside the state, a wholesaler outside the state who could cut whatever deal they want with the manufacturer and they can turn around and charge whatever price they want to their customers within the state, how can we control that piece of it versus a company that is located, that resides in the state that, from my standpoint, is clearly --
SENATOR CUMMINGS: Selling lower.
MS. LUNGE: Right.
ATTENDEE 2: It's not necessarily selling lower. I don't know. How can you say that?
MS. LUNGE: Because if the court is stepping in to set the price at a lower price, it goes from the manufacturer to the wholesaler in Vermont, then presumably the wholesaler could mark it up the same amount that they would have otherwise and the total price would be less.
ATTENDEE 2: Is this only if it goes to court?

MS. LUNGE: It's only if it goes to court.
SENATOR CUMMINGS: Yes.
ATTENDEE 2: I guess I'm losing sight of it -- I'm sorry, I was away for a week, so --
SENATOR CUMMINGS: Robin, if there's an outside wholesaler -- this says sold within the state, so if there is a health crisis, that other wholesaler can't sell at a higher price within the state?
MS. LUNGE: I think part of -- part -- it's a little hard to go through the specifics --
SENATOR CUMMINGS: Yes.
MS. LUNGE: But part of it is going to depend on the court looking at the facts of the situation.
SENATOR CUMMINGS: Right.
MS. LUNGE: So if the statute on its face looks like it is trying to stay within legal bounds, the court would then wait until it actually has a situation and then look at the facts and make a decision, is this transaction occurring in the state or out of the state? And I can't -- you know, that's a factual determination that I can't make a call on,

really.
ATTENDEE 1: What I'm struggling to understand, we have -- we have a company that has roughly 200 workers --
SENATOR CUMMINGS: Uh-huh.
ATTENDEE 2: -- people from the state of Vermont that work there. I'm trying to understand what is the impact of this bill on their operation.
SENATOR CUMMINGS: Unless there is a public health crisis in which people seem to be taking advantage of it and marking prices up to an unconscionable level, nothing.
I mean, there is a long drawn-out process. You know, the example we had, when there was a flu shot shortage, that prices seemed to start going up, and supply and demand -- and if you have a public health crisis, there is some documentation about the prices keep going up in the most commonly used medicines for heart and blood pressure and --
ATTENDEE 2: Funny you bring up the flu.
SENATOR CUMMINGS: Yes. Did you get your flu shot when it was here?
ATTENDEE 2: Actually, you know what, I

did get a flu shot, but I guess I got the wrong strain.
SENATOR CUMMINGS: Okay. So stay down there away from the rest of us.
Senator McCormack.
SENATOR MCCORMACK: There must be law on this. When a transaction takes place across state lines where, let's say, you know, a Vermont company buying something from a company in New York. At the time when the transaction is initiated the person -- the thing they purchased is in New York. The company doing the selling, because they have not sold it yet, is in New York so far. By the time a Vermont purchaser has it in his hands, we're in Vermont. Where -- where does the transaction cross the state line?
MS. LUNGE: And I don't know. I can't really answer that question because the case law is very factually specific, so -- and I'm not a commerce clause expert, so I don't feel like I can tell you exactly where that line is in its context, because -- you know, I could research all the different case law in the commerce clause and say, Well, there was this

case involving beer and there was this case involving something else and they came out in completely opposite ways and that's because this person had this much sales in the state, but I don't -- you know, I don't know how helpful that would be because I --
SENATOR MCCORMACK: Well, the thing that distinguishes one case from the other is how it is --
MS. LUNGE: Yes, but this is a complicated fact specific area. So I think -- I mean, I could do that, but I'm not going to be able to do that today. So that would be something that would take me, given that I'm not a commerce clause expert, at least a week to research. So you can see if there's other people in the room who feel like they can tell you the distinguishing features of that, but I'm not going to be able to give that legal --
SENATOR MCCORMACK: I think a lot hangs on that.
SENATOR CUMMINGS: If you remember, we did originally pass out a stronger version of this a whole few weeks ago and we did have the testimony from a gentleman from New York or

Washington. We did have phone testimony from an attorney who is a commerce expert and who felt that this was a valid -- looking back to the agenda, Shawn Robert.
SENATOR MCCORMACK: Well, does anyone remember the principles under which he was operating?
SENATOR CUMMINGS: Julie might. We can have her come up after. Well, actually, Robin, maybe just have Julie come up. Let her go up.
MS. BRILL: I thank you.
SENATOR CUMMINGS: Thank you for staying with us.
MS. BRILL: Sure.
SENATOR CUMMINGS: Out of lovely Chicago -- or is it Buffalo?
MS. BRILL: It's Buffalo.
SENATOR CUMMINGS: Oh, Buffalo.
MS. BRILL: Probably it's snowing there.
ATTENDEE 1: The easier choice.
MS. BRILL: I gave up the trip to Buffalo.
SENATOR CUMMINGS: Is the snow gone yet?
MS. BRILL: Probably still there for all I know.
ATTENDEE 2: It always snows there.

MS. BRILL: Right. The most important thing about this amendment in front of you is that what it will do is avoid a facial challenge to the provision that you all originally passed. The language that you all passed, which would have lent itself to a facial challenge, and I will explain what that is in a minute. It's the language that is on the second page, this business about applying for sale or impose minimum resale requirements for 46.53 and also the language that would have said that results in that prescription drug being sold in Vermont.

And let me take a step back and tell you what a facial challenge is, and the reason we want to avoid that. The facial challenge is a challenge where the court says, I don't care how any prosecutor may apply this law in any particular case. We are going to look at the four corners of the law and we are going to see whether it could be applied in an unconstitutional way, and it was that language that really upset the District of Columbia court, when it was looking at the District of Columbia's law.

So what we are trying to do is to change this so that it will not be subject to a facial challenge. So that would mean that the four corners of the law could be applied constitutionally and it would not affect commerce outside of the State of Vermont.

Now, and that is very important because what that means is when the court is considering any challenge to this law, it will have a whole set of facts in front of it. In other words, we will be in the midst of a prosecution. We'll have a contract or relationship in front of the court and we can examine that in detail, to decide whether or not that is or is not commerce in Vermont. So that's the most important task of this provision.

Now, to get to your questions, you know, if there is someone in New York that has a relationship with someone in Vermont, was that a transaction in Vermont or in New York, legally speaking, it is probably a transaction in Vermont, but it would depend on what the contract said. The contract can actually define where the transaction is taking place.

But, you know, I have heard -- a lot of people in the industry have been calling me over the last few days, saying, Well, you know, there are no manufacturers that sell to anyone in Vermont except for Burlington Drugs. They don't sell to hospitals. They don't sell to the federal health care centers, et cetera, et cetera.

What we are really looking for is testimony under oath. We're not looking for people who were talking about, you know, what they think is happening and what they are hearing is happening, by talking to their clients and maybe it's this and maybe it's that.

You really get a very different picture of relationships when you have people in depositions and they are under oath and they have to tell you the truth. And that is where we can really figure out what all these different relationships are. So you might hear -- people have said to you over lunchtime or whenever, Gee, you know, there are no such sales in Vermont. You know, the only people that are going to be affected is Burlington

Drug. But my response to that is, we don't -- we're not sure if that is the case, we think there are other sales going on.

Certainly, as Robin I think told you earlier, the Congressional Budget Office thinks there are other sales that are going on directly to hospitals and whatnot and we'd like to find that out. If it's true that there are no such sales that would be considered commerce in Vermont, then we would not be able to prosecute. We'd not be able to use the law, but if there are such sales then we want to be able to bring them in under this law.

SENATOR CUMMINGS: And at first there would have to be a public health crisis.

MS. BRILL: Absolutely. You're absolutely right.

SENATOR CUMMINGS: You're not going out there tomorrow and --

MS. BRILL: Absolutely. We have to have this process, assuming you are going to keep that position in, we have to have a process first where the Health Commissioner declares that there is a serious public health threat because a drug is not readily available to

enough Vermonters who suffer from this condition that requires treatment.
SENATOR CUMMINGS: Senator Carris.
SENATOR CARRIS: Could you define licensee for me?
MS. BRILL: Yes. It's going to be someone who has, for instance, a license to market, a co-marketer, for instance. Often drugs are manufactured by one entity, but are co-marketed and co-sold by that entity and another entity in order to, for instance, leverage one manufacturer's sales force. So it relates to licensing agreements to sell or co-marketing agreements, that kind of thing.
SENATOR CARRIS: Now, this, as I read this --
(Inaudible.)
MS. BRILL: Correct.
SENATOR CARRIS: So if a wholesaler from out of the state saw an opportunity --
MS. BRILL: That's right. Then that would not -- this law currently does not affect a wholesaler who receives product from a manufacturer who is not a licensee and then sells it further on in Vermont. That's right.

You're right.
SENATOR CARRIS: But if they jacked up the prices, we'd get no --
MS. BRILL: Well, we have other potential courses of action or causes of action, but we would not need this course of action.
ATTENDEE 3: Essentially it's a pretty big loophole. If I want to sell -- I'm a manufacturer in New York and I want to sell it at an unconscionable price in Vermont --
MS. BRILL: Right.
ATTENDEE 3: -- I just have to sell it in New York to someone who then sells to a Vermont wholesaler and we're home free.
MS. BRILL: Possibly. Possibly. I mean, we need to -- you know, it's very difficult to hypothesize about the exact relationships between manufacturers and all the different entities that they provide drugs to.
Frankly, manufacturers would like to sell drugs directly to consumers, we believe, with a prescription assisted program and maybe those will be affected. They sell directly to Vermonters. They provide directly to Vermonters. We have to look at all those

different relationships. I'm not saying they are wrong. That's a possibility, but, you know, to the extent that they are providing directly into Vermont, we would be able to, again, as Senator Cummings says, once we go through this other process and the condition is declared a serious public health threat, then we would be able to proceed.
We're looking for facts. That's really the most important thing I can emphasize here, rather than hypothesize about all the different relationships. And we think by narrowing it to commerce in Vermont, we are going to alleviate the court of the need to look at a facial challenge of the law. That is what happened in D.C. when there were no facts in front of the judge, facts we think will help us rather than hurt us here.
SENATOR CUMMINGS: Okay. Any other questions? Okay.
MS. BRILL: I would be happy -- I mean, there were some things that were said last week that I could respond to. I'm also happy if you guys have questions about some of the testimony you've heard. We can move on however you want

to proceed.
SENATOR CUMMINGS: I'm trying to figure out what the Committee's pleasure is because we are --
ATTENDEE 1: Well, this one seems to have solved the dilemma that we were in when it came back from Health and Welfare. If Health and Welfare is going to agree with it, which is fair to me, I think we ought to move ahead with it.
SENATOR CUMMINGS: All right. So what this would take is a motion to further amend and we take that under a --
SENATOR CARRIS: We further amend the bill to include the language presented to us by Julie Brill and then, I think, at your discretion, we would have to get that typed up today and get that brought back to us.
SENATOR CUMMINGS: Well, this is the language.
SENATOR CARRIS: You've got the --
SENATOR CUMMINGS: You have got the language. Yeah. You have the language. Right there in front of you you have the language.
SENATOR CARRIS: Okay.

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SENATOR CUMMINGS: Okay. We'll figure out how this goes in the calendar because they are amending our recommendation. We are amending --
MS. LUNGE: I talked to --
SENATOR CUMMINGS: -- what --
MS. LUNGE: -- already and he suggested that the appropriate, best way to do it would be to amend the Senate Health and Welfare's amendment, so that's how I can draft it.
SENATOR CUMMINGS: Okay.
ATTENDEE 1: As opposed to Health and Welfare choosing to withdraw it?
SENATOR CUMMINGS: Yeah, we'll amend it and then, unless they surprise us, agree.
All right. The motion is to amend Senate Health and Welfare's proposal to us with this language. Further discussion on that?
FEMALE ATTENDANT 1: Well, there is another amendment, right? We are just doing one at a time?
SENATOR CUMMINGS: We're going to -- I want to try to get through one at a time so we're focussed when we vote here and not -- I don't want to get confused with the facts.

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ATTENDEE 2: Robin and Julie, did we hear other testimony on this stuff?
SENATOR CUMMINGS: Oh, yes, all last Friday.
ATTENDEE 2: All right. Then I'll abstain from voting, because I actually -- I don't know --
SENATOR CUMMINGS: Okay.
ATTENDEE 2: -- what I'm voting on at this point.
SENATOR CUMMINGS: Okay.
ATTENDEE 2: I haven't heard all that other testimony.
SENATOR CUMMINGS: Further discussion? If not, all those in favor say aye.
FEMALE ATTENDANT 1: Aye.
ATTENDEE 2: Aye.
SENATOR MCCORMACK: Aye.
SENATOR CUMMINGS: Opposed say no.
I'm hearing one, two, three, four, five, one, one; is that correct? There is no second? Okay.
Okay. And the next one is from -- Julie, both of you come up. I think this is the fiduciary language. They had gone to a

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language that Robin had found for a health --
MS. BRILL: I just need a draft in front -- I don't have that in front of me. I apologize.
(Inaudible.)
ATTENDEE 2: Which draft?
SENATOR CUMMINGS: It's a Health and Welfare committee --
ATTENDEE 2: Whose draft -- I mean, what are we looking for?
SENATOR CUMMINGS: There's a Health and Welfare Committee --
ATTENDEE 2: Amendment?
SENATOR CUMMINGS: Amendment --
MS. BRILL: Robin, why don't you come back over since it's your language, if that's all right with you, Senator Cummings.
SENATOR CUMMINGS: Yeah.
It's in the PBM section, which is on your side by side, section seven.
MS. LUNGE: It's in Senate Health and Welfare's amendment.
SENATOR CUMMINGS: We have that. We have this. It says, To the Honorable Senate.
MS. LUNGE: And it's -- hold on. It is in

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their ninth instance of amendment, which is on page three.
SENATOR CUMMINGS: Which I've got at the top.
MS. LUNGE: Oh, okay.
(Inaudible.)
MS. LUNGE: I have too many versions I have to look at.
Okay. So -- thank you, Rachel. You're a lifesaver. Too much paper.
Okay. On page three, ninth instance of amendment. So in the -- the changes in A-1, this language now sets the duty at -- which starts its duty with reasonable care and diligence and would be fair and -- under the circumstances then prevailing. The PBM actually (inaudible) to use and then conduct and enterprise of the (inaudible) case.
Now, as I mentioned on Friday, that is language that I found in a case between an insurance agent and its insured. And your language was based on more of a fiduciary duty, although we didn't use that term.
SENATOR CUMMINGS: And the industry had been asking for pure contract. This is a

medium, medium ground?
MS. LUNGE: This is the closest I could find to the contract's duty in case law, in the amount of time that I had.
SENATOR CUMMINGS: So this takes it down to the contract standards?
MS. LUNGE: And I think that what -- well, the testimony that Senate Health and Welfare heard is that in Vermont the contract standard is higher than other states. So we have a fairly strong contract.
SENATOR CUMMINGS: This is a significant -- we have held for fiduciary standard now for five years?
FEMALE ATTENDANT 1: I thought this was --
ATTENDEE 1: I thought that we already had a fiduciary --
SENATOR CUMMINGS: Huh?
FEMALE ATTENDANT 1: I thought this was in between now or did I just hear that it's really another way to say contract law?
MS. LUNGE: Well, I could not find a duty that was between two --
FEMALE ATTENDANT 1: Contracting parties?
MS. LUNGE: -- contracting parties that

had language like this. So what I looked for was the closest situation that I could find in, you know, 24 hours. So, granted, I didn't have a lot of time to research it.
But so, what I was able to find was a case that interpreted the duty that an insurance agent has to its customer that it's selling insurance to on behalf of an insured.
So, you know, I don't really feel comfortable characterizing it as the same as, or in between, because I wasn't able to find a contract language to compare. But this was the closest situation to what I thought was analogous, that I could find in case law in Vermont.
SENATOR CUMMINGS: Julie, do you have any --
MS. BRILL: I think that -- this is Julie Brill. I agree with Robin that this is the closest we could find on short notice. It does apply to an agent or purchaser of insurance. I think that's a -- that is a medium level of responsibility. It is not quite as high as fiduciary, but it is clearly more than plain contract would be interpreted, broadly

speaking, around the nation. Vermont does have a slightly higher standard of cure for contracting. I think this raises it up a little bit higher, but not quite as high as fiduciary.
SENATOR CUMMINGS: More like agency?
MS. BRILL: It is. It's exactly similar to agency's duty, exactly, or a licensee. And, you know, that seems to be an appropriate level of care the PBM would exercise with respect to its requirement.
SENATOR CUMMINGS: Okay. Okay. So, Committee, are we willing to accept that amendment, something between what the industry asked? The fiduciary standard has been an issue.
ATTENDEE 1: So if we were to accept the amendment here, there would be a motion forthcoming?
SENATOR CUMMINGS: No. I'm taking this as just normally, we will go up there and say, We have discussed it as the committee and we didn't object.
ATTENDEE 2: Right. There is no action required.

SENATOR CUMMINGS: No action required. We just go up and say -- when I'm presenting this on the floor, when I stand up I want to be able to say we discussed it and didn't have a problem.
Okay. Which gets us to the final one, which is the data mining. And they have --
MS. LUNGE: On page five of the Senate Health and Welfare amendment, section three. What the committee did was remove the data mining section and replaced and instead a report from (inaudible) council on the status of New Hampshire's law because, as you recall, there is currently litigation.
ATTENDEE 3: Where are we now?
MS. LUNGE: We're on page five, 15 of the Senate Health and Welfare amendment.
ATTENDEE 3: Okay.
MS. LUNGE: 15th section. 15 consists of amendment --
ATTENDEE 3: Yes.
MS. LUNGE: -- section 13, report on New Hampshire confidentiality. This is the language that they substituted instead. So they wanted a summary of the court's decision

and status of litigation and any other related information provided by the state.
SENATOR CUMMINGS: Basically they said the status quo can continue until we saw what happened in the New Hampshire court case and then we could decide what we wanted to do. There was a compromise presented to us that would have had -- if you remember, the AMA has an out standard. There was a compromise brought to us by the Medical Society and Julie --
ATTENDEE 2: Opt-in?
SENATOR CUMMINGS: -- which had an opt-in standard, and I just saw my copy of that, but it's here.
ATTENDEE 1: Frequently used in the Vermont law.
SENATOR CUMMINGS: I know I have it. I just saw it.
One of the issues -- ah, there it is -- raised, was just like in this body, there is a tremendous amount of paper being shuffled around here. Already, I guess there's already problems with -- with the -- disclosing of what the price of similar drugs is, that we did last

year. There's been complaints and I know that OBA is -- OBA, I think, is working on it.
Oh, you are? Okay. The Attorney General is working on it. That there's just, that they are just coming in with so many reams of paper that it's useless and that this one had a whole lot more reams of paper.
MS. BRILL: Do you think they did that on purpose?
SENATOR CUMMINGS: Gee, I don't know. Do you think maybe --
MS. BRILL: I don't know.
SENATOR CUMMINGS: I've always heard there was more than one way to skin a cat.
But, anyway, this one had some questions about the amount of data that had to go, but that was it, I think.
This is it and then we can get on to TIFs. We are going to have an exciting afternoon.
ATTENDEE 1: Any of this stuff we get --
SENATOR CUMMINGS: I'm the only one that really likes TIFs.
Okay. The pleasure of the committee?
ATTENDEE 2: The middle ground here was to opt in?

SENATOR CUMMINGS: That was a proposed compromise. I don't think that the data mining or processing people consider that a middle ground.
ATTENDEE 2: So if we were to accept the -- this proposal, we would not be -- we'd be endorsing the opt-out or will we just be silent to that?
FEMALE ATTENDANT 1: Oh, we don't get to choose one?
MS. LUNGE: I think you would need to choose one.
FEMALE ATTENDANT 1: Oh, yeah.
MS. LUNGE: Because the language you have includes both the opt-in and opt-out --
SENATOR CUMMINGS: Right.
MS. LUNGE: -- option.
SENATOR CUMMINGS: And there is already an opt-out from the AMA, right?
MS. LUNGE: Correct.
SENATOR CUMMINGS: You can call them up or go to their web site and opt out.
ATTENDEE 1: But in Vermont we --
SENATOR CUMMINGS: Probably call them up.
ATTENDEE 1: -- tend to have had some

precedent in the past for having gone with the opt-in because opt-outs tend to be...
FEMALE ATTENDANT 1: That's how we end up with so many credit cards.
SENATOR CUMMINGS: Am I opting in for this?
FEMALE ATTENDANT 1: Well, if they send it to you.
SENATOR CUMMINGS: Yeah. Do I --
FEMALE ATTENDANT 1: That's --
SENATOR CUMMINGS: Yeah.
FEMALE ATTENDANT 1: Yeah.
SENATOR CUMMINGS: Do I have to sign it? Yeah.
ATTENDEE 2: Madame Chair, for lack of not knowing exactly what discussions were held on this issue, but having had just a quick chance to read this document with this packet and understanding that this type of stuff is already under challenge elsewhere, I think I'm in favor of going along with what the Health Committee has proposed, the language.
SENATOR CUMMINGS: I wouldn't object to that at this point.
FEMALE ATTENDANT 1: I can live with that

amendment if we -- because I'm not sure that we're going to -- I don't know what gives us the idea that the court is going to be making a decision by November 1st. I don't think that is a very good option.

ATTENDEE 1: So if we were to follow this course would we be endorsing opt-out or endorsing opt-in or would we be silent to it?

SENATOR CUMMINGS: We would be silent.

ATTENDEE 1: Let's get back to the --

ATTENDEE 3: Opt-out already exists. I mean, whether we do anything --

SENATOR CUMMINGS: Yes.

ATTENDEE 3: -- or not, that already exists.

FEMALE ATTENDANT 1: Why would we be silent? Why would we be silent? Don't we pick one now and save it until the court ruling?

SENATOR CUMMINGS: What -- the proposal that has come from Health and Welfare -- we said we can't do it.

FEMALE ATTENDANT 1: Uh-huh.

SENATOR CUMMINGS: The proposal from Health and Welfare says, Oh, this is already in court so we're going to let them keep doing it

until the court decision --

FEMALE ATTENDANT 1: Okay.

SENATOR CUMMINGS: -- comes in and then we'll decide what to do.

The opt-in/opt-out is a proposal that is a page and a half long that says the marketer will have to come in and they'll have to provide the prescriber with either an opt-in or an opt-out. They will have to provide them with all the information they have on their pricing, but it will be an individual transaction between each provider and each marketer or retailer.

ATTENDEE 2: But if we take no action on this bill at all, the opt-out provision already exists?

SENATOR CUMMINGS: The opt-out provision --

FEMALE ATTENDANT 1: It's not set up like this, then.

ATTENDEE 2: No. No -- that's correct, but there is an opt-out provision that already exists that if a physician called or could get on the web with the AMA and say, I want off of this.

FEMALE ATTENDANT 1: It assumes that they know that they are in.

ATTENDEE 1: Yeah. As opposed to the physician getting in touch with them and saying, I would like to participate in this.

ATTENDEE 2: They have to be smart.

SENATOR CUMMINGS: They are supposed to be smart.

ATTENDANT 4: I'm -- I'm bothered by it and I know there is a lot of legal precedent for opt-out. I'm just bothered by the main idea that a person can find themselves in an arrangement to which they did not consent simply because they didn't speak up against it. I mean, there is sort of a fundamental principle of that that really doesn't bother anybody. Sorry, you can't be obligated to a contract you didn't consent to. I mean, and I think that the exception is when a company decides, Oh, you're in our deal now unless you say otherwise. I mean, especially if it's a misuse, you know, of people. Why would we give anyone that power over somebody else?

ATTENDEE 1: That's what we do all the time as a legislature.

ATTENDANT 4: How so?

ATTENDEE 1: We make decisions for the rest of the state.

SENATOR CUMMINGS: Our --

ATTENDANT 4: We have --

SENATOR CUMMINGS: Okay. Our decision was no. Their decision was wait and see. The question is do we want to accept theirs. We haven't had a real strong discussion with the chair of Health and Welfare, so I think we are going along with this, since we didn't push back really hard on Friday.

ATTENDEE 3: Well, I'm very much in favor of opt-in and I think we might have some reluctance because the people we are regulating here have asked us, you know, please don't regulate us like that. But on the other hand, they are regulating the public. They are making decisions -- or at least the doctors. They're making -- they're deciding what other people's situation is without asking them and I don't -- you know, I think if anyone is being -- you know, it's the gatherers of the data. It's not us. We are just saying, you know, Leave them alone.

SENATOR CUMMINGS: Do you want to read this document, The Compromise, because there was a lot of concern about what is required in there? Do you want to take a look and see what is there? I mean, you have got it.
ATTENDEE 3: Yeah.
SENATOR CUMMINGS: And give that -- that is a long amendment.
ATTENDEE 2: Could you perhaps do a straw poll on whether we want to opt-in or opt-out?
SENATOR CUMMINGS: Okay. Well, the first question is do we want to stick to our guns or do we want to see to the Health and Welfare Committee -- remember, we tried to kick this one off to them.
ATTENDEE 2: Why don't we ask first for the Health Care Committee amendment first, because that's where it was.
SENATOR CUMMINGS: That's what I'm thinking, right. Do we want to accept the Health Care Committee's amendment, which would basically say until we see the outcome in the New Hampshire court case we will take no action? That leaves the AMA opt-out in place. Two. Anybody else? I'm willing to do that

one, three. Okay. There's seven of us. Okay. So we don't have that.
Okay. Next option, stick to our guns and say, You can't do it. No data mining. That is what we said, right?
MS. LUNGE: For commercial purposes.
SENATOR CUMMINGS: For commercial purposes. Okay. I've got three on that.
ATTENDEE 2: Could we -- excuse me. Could we say we are going to wait until we find out what goes in New Hampshire and meanwhile doctors should be able to opt-in? Is that an in between ground or am I just missing it?
FEMALE ATTENDANT 1: Well, by the time we get the decision we will have another session and we can do it then.
SENATOR CUMMINGS: Julie, do you have something to say?
MS. BRILL: (Inaudible) to understand the constitutional issues that are arising in each of these. One of the things about the opt-in option, which you have not yet voted on, is in our view that will avoid some, if not all, of the constitutional issues in the New Hampshire case. The New Hampshire case is about first

amendment issue whether or not prohibiting certain kind of speak -- of data going forward is essentially prohibiting speech. Requiring disclosures is very, very hard to make out a first amendment claim, that requiring a disclosure to a doctor amounts to an abridgement of the first amendment. The Supreme Court says very clear, that requiring more information is usually not a violation of the first amendment.
So I just wanted to -- to the extent you are trying to figure out, Well, would we go forward with the compromise with the medical society and our office has proposed, would we be back in the same position with respect to the New Hampshire law? Easily the answer is no. It doesn't raise the same constitutional question.
SENATOR CUMMINGS: Okay.
ATTENDEE 1: So if we accept the compromise, then we don't have to wait for the New Hampshire thing?
SENATOR CUMMINGS: Right.
MS. BRILL: Exactly.
SENATOR CUMMINGS: And that would be with

the -- all right. The compromised position would be opt-in.
MS. BRILL: Opt-in.
SENATOR CUMMINGS: Not opt-out.
MS. BRILL: We would strongly urge you to opt-in. I didn't have a chance yet to talk about this opt-out in the AMA thing and what happened on that.
SENATOR CUMMINGS: Has the Health and Welfare Committee seen this?
MS. BRILL: I do not know the answer to that question.
SENATOR CUMMINGS: I strongly suggest, because I have a feeling we may be headed there, that you guys talk to them.
MS. BRILL: I will happily do so.
FEMALE ATTENDANT 1: Oh, I understood that was the case and that they had agreed to this.
SENATOR CUMMINGS: No, they had agreed or they had kind of, semi agreed to the other one. This one, I don't think, they know is coming.
So how many, straw poll, would find this as an acceptable middle ground, the opt-in?
FEMALE ATTENDANT 1: I find it acceptable if the health committee finds it acceptable,

otherwise I would rather stick to the original bill.
SENATOR CUMMINGS: Well, we are going to have to -- we are going to take this upstairs today. Okay. I'm going to call for a vote. I would like to have a motion, so I can call for a vote.
SENATOR MACDONALD: Well, I'd like to make a motion that achieves the language of the straw poll, which is --
SENATOR CUMMINGS: Okay. That is the substitute amendment proposed by the Attorney General and the Medical Society with the opt-in.
SENATOR MACDONALD: (Inaudible.)
SENATOR CUMMINGS: Okay. That has been ruled by Senator McDonald that this committee --
SENATOR MACDONALD: Further amends.
SENATOR CUMMINGS: -- further amends --
SENATOR MACDONALD: -- the Health and Welfare proposal amendment as set forth in the --
SENATOR CUMMINGS: As amended by the compromised document.

Any further discussion? If not, all in favor say aye.
ATTENDEE 1: Aye.
ATTENDEE 2: Aye.
ATTENDANT 4: Aye.
SENATOR CUMMINGS: Opposed say no.
ATTENDEE 2: No.
SENATOR CUMMINGS: One no. So I've got six, one, zero.
And if we get any real strong push back, I'll let you know and we may -- we can always choose not to offer this amendment.
MS. LUNGE: So would you like me to do them as two separate amendments --
SENATOR CUMMINGS: Yes.
MS. LUNGE: -- so that you can hand in one or the other or both?
SENATOR CUMMINGS: No. I think it would be either this or nothing.
MS. LUNGE: Okay.
SENATOR CUMMINGS: Or acceding to them if they push back.
MS. LUNGE: Right. But in terms of the unconscionable pricing, I can do that as one document.

SENATOR CUMMINGS: Yes.
MS. LUNGE: And then do this as a second document and --
SENATOR CUMMINGS: Yes, two separate amendments. And you will see on there a third and as soon as that's typed up, I will take it upstairs.
MS. LUNGE: I should -- I should have the unconscionable pricing ready.
SENATOR CUMMINGS: Okay.
MS. LUNGE: I just need to get this one ready.
SENATOR CUMMINGS: Okay.
ATTENDEE 1: Yes. We need to put just the title of the document on the record when we do the voting.
SENATOR CUMMINGS: Okay. Okay. That --

CD 90/TRACK 2
ATTENDEE 1: (Inaudible) this came out favorably, this amendment.
SENATOR CUMMINGS: The second time.
Further discussion? Julie, you had --
MS. BRILL: Just a point of clarification. In the proposal you just voted on, there was

some discussion in the debate last week that the manufacturers may not have some pieces of the information that is in there.
SENATOR CUMMINGS: Like the patient's name.
MS. BRILL: The patient's name, for instance, is a great example. And I thought it was understood, although I don't believe it's listed in the document you just voted on, that that would be modified to say, is available, so that the manufacturer doesn't have to provide the information it doesn't have.
SENATOR CUMMINGS: Send the amendment here and I'll revise it.
MS. BRILL: Okay.
SENATOR CUMMINGS: Without objection. Okay. Now we are on the bill as amended. Any further discussion? If not, all those in favor say aye.
ATTENDEE 1: Aye.
ATTENDEE 2: Aye.
SENATOR CUMMINGS: Opposed, no.
ATTENDEE 3: No.
SENATOR CUMMINGS: One no.
ATTENDANT 4: I'm not sure yet, so I'm

going to abstain.
SENATOR CUMMINGS: Okay. So we have got five, one, one. All right. Okay. We are now getting back on schedule. I think we --
- - -

CERTIFICATE

STATE OF FLORIDA)
COUNTY OF DUVAL)

I, Holli V. Callahan, Court Reporter and Notary Public, do hereby certify that I was authorized to and did listen to CD 90/T1, T2, the Senate Committee on Finance, Tuesday, March 27, 2007 proceedings (stenographically transcribed) from said CD the foregoing proceedings and that the transcript is a true and complete record to the best of my ability.

DATED this 21st day of August 2007.

Holli V. Callahan,
Notary Public, State of Florida
My Commission No. DD 253307
Expires: November 15, 2007.

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

RE: SENATE BILL 115

DATE: TUESDAY, MARCH 27, 2007

TYPE OF COMMITTEE MEETING: STANDARD

COMMITTEE MEMBERS:

REP. STEVEN MAIER, CHAIR
REP. HARRY CHEN, VICE-CHAIR
REP. FRANCIS McFAUN
REP. SARAH COPELAND-HANZAS
REP. WILLIAM KEOGH
REP. LUCY LERICHE
REP. VIRGINIA McCORMACK
REP. VIRGINIA MILKEY
REP. PAT O'DONNELL
REP. HILDE OJIBWAY
REP. SCOTT WHEELER

ALSO IN ATTENDANCE:

Robin Lunge

Steve Kappel

CD No. 06-117 (Track 3)

Transcribed by:

Eleanor Evensen, RPR

Esquire Deposition Services

West Palm Beach, FL

#887608

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MR. KAPPEL: The topic of drugs for the next few hours. What we are going to do today and probably rolling into tomorrow a little bit kind of depends on when you all hit the key is talk about big picture stuff first: National statistics, theoretical things, what drives the prescription drug market, why are costs going up the way they are, what can be done.

And then we'll come down to Vermont, talk about the specific financial stuff in Vermont and then spend a lot of time on legislative issues related to pharmaceuticals in Vermont.

So, as usual, this will be the Steve and Robin show. We'll step on each others cues all the time, and please interrupt with questions.

Okay. And away we go. So, why is -- why are -- why am drugs, you know, we'll get to that one --

MS. LUNGE: Absolutely.

MR. KAPPEL: We choreographed the whole hand thing.

ATTENDEE: Having to do with AAWB.

MS. LUNGE: AAWB.

MR. KAPPEL: Can we start over? (Inaudible)

ATTENDEE: Make sure we don't get into this

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thing: Prescription drugs, take IV.

MR. KAPPEL: Professionalism above all. So why drugs? Probably three big reasons. Drugs, even compared to other kinds of health care spending are growing very, very quickly. They are much more reliant on out-of-pocket spending so when people pay for pharmaceuticals they tend much more to pay a larger share out of their own pocket rather than have some form of coverage, although that is starting to change.

The pharmaceutical market is different from almost every other major sector in that it's all for profit, very competitive. So, a lot of the things that people are much more accustomed to seeing in other kind of competitive marketplaces, (inaudible) health care. So competition, advertising, all things like that are much more common in pharmaceuticals.

Flip side of that though, pharmaceuticals are a very, very powerful tool. The right prescription drugs keeps people out of hospitals, can extend lives, can keep people much more functional. So, pharmaceuticals are really complex for a lot of those reasons.

The numbers we'll be looking at a couple of

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sources. The national stuff comes from either the centers of Medicare/Medicaid services office of the actuary, who does what's called a national health expenditure analysis. And in the end there is something called medical expenditure capital survey, trying to avoid too many acronyms, done by the Agency for Health Care Research of Quality.

And this is a national survey where folks get asked very detailed questions about their health care utilization, reporting in a log book every drug they take, every visit to a health care provider. So it's probably the best source of what people really do for their health care.

Vermont specific numbers come from Michigan, so this is the expenditure analysis and we can get into that in a little more detail.

Big picture, 1965, the good old days. Total US health care spending was $37 billion. Prescription drugs about 3.7 billion. So ten percent of all spending.

One of the most interesting things when we look at history is from that point to about the early '80s pharmaceuticals, as a percent of total health care spending, declined. What you had

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there was a lot more advances, a lot more growth in the other sectors, so pharmaceuticals in contrast grew more slowly, tended to just lag as a percent of total spending. Starting in the early 80's though the pharmaceutical industries really made up for lost time with a lot more detail. And spending growth in pharmaceuticals way outpaced the rest of the health care system. So, you can see that in the graph, bottom of page three.

The blue line is health care spending as a whole, red line is pharmaceuticals. So, much higher growth up until 1980 or '82. Then interesting big decline in the early 90's in both.

General health care spending really hasn't come back much. Pharmaceuticals came back big time. Growth probably peaked in the late 90's, early 2000 at about 18 percent a year, which is very dramatic growth rate.

ATTENDEE: Do you know why? Do you know why?

MR. KAPPEL: Which part?

ATTENDEE: The people in the pharmaceuticals?

MR. KAPPEL: I think, I'm not sure about the people. What is more interesting is the dip.

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There are a couple of different theories for the [illegible]ip. One of which is every time health care becomes a hot political issue, spending seems to slow down.

I'm not sure if there's a causal effect, but that's been the pattern for the last several cycles.

ATTENDEE: Do you think any of this has to do with the advertising (inaudible)?

MR. KAPPEL: I think that's a piece of it, but do you remember when direct to consumer was legalized?

ATTENDEE: I don't recall when that was.

MS. LUNGE: We can try to find that out.

ATTENDEE: I was just curious.

MR. KAPPEL: But what's interesting is after that peak in the 90's drug growth came down almost to the same rate as under, like, health care. So, whatever it was, it was very much a one time effect.

ATTENDEE: Can I say something? The statement disturbed me. You said most competition in the sector. And I'm going to make a case there certainly is competition in the marketshare. Not based on -- normally you say

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competition makes more effect. People don't say you buy, you know, my Viagra is cheaper than your whatever, whatever the other drugs are. It's we want you to buy Viagra, so there's a disconnect between marketshare and price cut.

MR. KAPPEL: Yeah, that's a real good point. The terms of the competition are less price-driven than in cars or PCs or other kind of competitive markets, but the competition, nonetheless, is ferocious.

ATTENDEE: Right.

MS. LUNGE: And I think the other piece of that is that brand name pharmaceuticals are under patents. So, what that means is for that particular chemical formula no one else can use that particular chemical formula.

ATTENDEE: For how long?

MS. LUNGE: The patents?

ATTENDEE: 17?

MS. LUNGE: I think it is 17 years. I can double-check, I don't recall the exact number of years.

ATTENDEE: And the other case is a person who [illegible]has the control, theoretically, in the choice that's made is not the person who really is

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paying the price.

MS. LUNGE: Right, because it is the physician who is usually making the recommendation to the patient, and then the cost --

ATTENDEE: It's not a normal (inaudible.)

MR. KAPPEL: There is a lot of interesting work though on who actually makes the choice. And I think prior to direct to consumer advertising it was much more clearly the physician.

I think one of the consequences of direct to consumer is the patient wants to be more involved in the decision. I've always been fascinated by advertisements on TV that don't tell me what the drug does, but tell me to ask my physician if it is right for me. Okay. I don't know what it is, but those people on TV are having a great time, so I want it too.

MS. LUNGE: The running in the meadows.

MR. KAPPEL: The flowers, or the two people in the bathtub holding hands. I don't get that one.

ATTENDEE: (Inaudible) A new form of safe sex.

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MR. KAPPEL: Okay. Top of page four. This is one of those patented scary Steve graphs. This is spending, total health care spending, and spending on prescription drugs. Basically what this graph does is it says 1965 is 1.

ATTENDEE: Excellent. (Inaudible)

MS. LUNGE: That's good.

MR. KAPPEL: Okay. All other legislatures are jealous.

ATTENDEE: The hat though oddly is almost invisible.

MR. KAPPEL: I told you.

ATTENDEE: It doesn't do the hat justice.

ATTENDEE: Stand outside the door.

MR. KAPPEL: I think I'll just take it with me. (Inaudible) There is actually a related one on the refrigerator at JF Hubb. Okay, desperately trying to stay serious.

MS. LUNGE: Give it up.

MR. KAPPEL: Yeah, a long time ago.

So, 1965 we set both of these numbers to 1. So what this does is this shows relative growth for 1965.

And what we talked about a little earlier is up until --

ATTENDEE: Where are you now?
MR. KAPPEL: Top of page four.
ATTENDEE: How did you get over there?
MR. KAPPEL: I'm sneaking ahead when nobody is looking.
So, growth for 1965 total spending was higher up until about 2000, then you can see where prescription drugs took off and have been going faster than total ever since. But it's kind of a sobering number that prescription drug spending in 2015 is projected to be about 120 times what it was in 1965. That's an impressive number.
ATTENDEE: This is not total spending, this is growth?
MR. KAPPEL: Right. This sets both numbers to 1 in 1965. So, it's spending growth relative to that base.
ATTENDEE: Right. Are you going to --
MR. KAPPEL: And we'll get into actual dollar amounts.
ATTENDEE: Yeah, okay.
MR. KAPPEL: Bottom of page four, this is what we talked about a little earlier -
ATTENDEE: We have been doing some laughing, so you missed some --

ATTENDEE: Jocularity.
ATTENDEE: Well, I cruised through the MBM things and had one piece of sausage. They have Buffalo -- yogurt with granola. They have apple pies with ice cream. Pizza, quiches.
ATTENDEE: Maybe we'll try to break at 4:30. See how far we can get by 4:30 if we pay attention.
MR. KAPPEL: We'll stop at 4:30 regardless. So, again, same theme, prescription drugs in 1965, 10 percent of total spending declined pretty much crossed out until the early '90s and then right back up again.
I think one of the big factors there is a lot of blockbuster drugs. And we'll talk about some of them in a little while. But the statins, the antihypertensives, the things basically you can't get through your life without getting prescribed at one point or another, that's really what is driving a lot of drug spending.
ATTENDEE: I didn't quite understand that. You have the blockbuster drugs so, the blockbuster drugs were there before or --
MR. KAPPEL: They really weren't --
ATTENDEE: So that's a huge marketing

(inaudible.)
MR. KAPPEL: It's drugs that are expensive and very widely prescribed. And we'll talk about Lipitor as the classic example of this.
ATTENDEE: (Inaudible) I think some of them weren't there before. The most used ones weren't there before.
MR. KAPPEL: Yeah, I think the very expensive and very frequently prescribed drugs is a fairly recent phenomenon. There used to be very expensive drugs, but they were used rarely.
And some of that also ties to the expanding third party coverage of pharmaceuticals. What you will see a lot is when most spending is out of pocket, you don't see this sort of spending growth. As someone else starts paying bills, it becomes financially viable to have this kind of spending.
Okay. Top of page five: Who is paying the bills. Again, this is national.
ATTENDEE: I want to ask you a question. What exists for me, since 1965 up until it is less than one percent increase pharmaceutical, so I mean, that's almost insignificant.
MR. KAPPEL: It's a one percent increase in

terms of share.
ATTENDEE: Of the total health care?
MR. KAPPEL: Yeah. But that's the point I'm trying to make here. That it was a big share in the old days. Everything else moved very fast while pharmaceuticals didn't for many years. And then pharmaceuticals have pretty much caught up and past the growth rate of everything else in the last five or six years. Okay, make sense?
ATTENDEE: All right.
MS. LUNGE: Can I just add a clarification? So, the share does not necessarily mean that there is one percent difference in spending. Right?
MR. KAPPEL: Yeah.
ATTENDEE: One of you guys had a head (inaudible.)
MR. KAPPEL: Top of page five: Who is paying the bill?
Private insurance pays about 90 million dollars for pharmaceuticals. Out of pocket, this is one of the things that is striking about pharmaceuticals, about 45 billion. So, out of pocket spending is actually more than Medicaid on pharmaceuticals. And Medicaid is broken down by

state and federal. Small other federal, other state, and this tiny little sliver called Medicare.

Important point here, this is the year before Medicare Part D. When the Feds come out with their actuals for '05 or '06 and Part D has kicked-in, this graph will look real different. What you will see is a lot less out of pocket, a lot more Medicare spending.

ATTENDEE: Less Medicaid?

MR. KAPPEL: Some less Medicaid, probably some less commercial insurance.

So, about two-thirds of us in 2003 have a prescription drug expense. The mean spending per person $611, median 62.

Everybody knows what the difference is between those or should I talk about it a little bit? A little bit. Median is the point at which half the people have more, half the people have less. So, median is kind of independent of the really big spenders.

Mean or average is driven by the big spenders. So, a small number of people with really big expenses will push the mean up, but not affect the median at all. So whenever you

see that effect, the mean being much bigger than the median, that means there's a lot of very high-end spending pushing it.

Ten percent of the folks account for about two-thirds of all pharmaceuticals spending. So once more, very concentrated in a small number of people.

94 percent of all drug spending is 30 percent of people. And half of us have almost no drug spending at all.

ATTENDEE: Well, in specific it says if you have a drug expense that first half, that could be one, one prescription during the whole year, right, just one?

MR. KAPPEL: Yes.

ATTENDEE: And 611 is per year?

MR. KAPPEL: Yes.

Okay, blockbuster time. In 2004 the top ten drugs accounted for 19 percent of all drug spending in the US. So, think of how many prescription drugs there are. So, if ten drugs account for almost 20 percent of all spending, those drugs are enormous.

Lipitor is the big guy, the top seller since the year 2000. And, interestingly, spending on

Lipitor has tripled from 2000 to 2004. Lipitor has kind of become one of those drugs where if you're not on Lipitor there is just something wrong with you.

ATTENDEE: What does it treat? Depression?

MR. KAPPEL: Hyperlipidemia, cholesterol.

ATTENDEE: Which can be treated by many people by diet.

MR. KAPPEL: Yeah. But this is one of those places where you can watch the market behaving like a market. Demand being created in the interest of profit. Profit in itself is neither good nor bad, but it's clear that Lipitor produces tremendous profits for Pfizer. I think it's Pfizer. Bottom --

ATTENDEE: Starting again with a 17 year patent, so more or less what is going to happen when a lot of these (inaudible.)

MR. KAPPEL: Yeah. One of the fears in that sector, particularly among the Wall Street guys, is the new patents are slowing down. So nobody's seen this kind of blockbuster drug coming down the pike the same way they used to.

Another way of looking at drug spending is by condition. So that somewhat complicated table at

the bottom of page six, these are major diagnostic categories.

First column is total spending in millions of dollars. Second column is spending on prescribed drugs. Third column is what percent of total spending, spending is on that category. Fourth one, what percent of prescribed drug spending. And then the last column is what percent are the meds of total spending.

So let me go through that for hypertension. So about $38 billion on hypertension, of all kinds of services. Of that 38 billion, about 22 billion is prescribed medication. So, even though hypertension as a diagnosis accounts for just under four percent of all drug spending, it accounts for 11 and a half percent of prescribed medication spending.

ATTENDEE: (Inaudible)

MR. KAPPEL: This is national.

ATTENDEE: Wait a minute. Run that by, 3.9 percent total.

MR. KAPPEL: So the 37.8 billion is 3.9 percent of total health care spending. The 22 billion is 11.5 percent of prescription drug spending. So, what you can see is hypertension

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is a category that's very dependent on drugs as a treatment modality.
58 percent of all health care spending for the diagnosis of hypertension goes toward drugs.
ATTENDEE: Where is heart conditions (inaudible)?
MR. KAPPEL: Yeah, the perfect example is the contrast. Heart conditions, almost 10 percent of all health care spending, four percent of drug spending. So, of these it is far and away the lease reliant on prescription drugs, because a lot of treatment for heart conditions is hospitalizations and surgeries, pacemakers, things like that.
So, the importance of prescription drugs varies tremendously in different diagnostic categories. Make sense?
Brand and generic. A lot of discussion revolves around brand and generic drugs. Let's make sure we are all clear on definitions.
Brand and generic drugs contain exactly the same active ingredient. So the particular chemical that produces a lowering of blood pressure is the same in brands X, Y, Z and generic X, Y, Z.

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The other chemicals that makeup the pill don't have to be the same, but the active chemical is exactly the same.
The folks who develop the drug have the patent for 17 years. So they have exclusive rights to manufacture until the patent runs out. And when the patent runs out, the generic guys can start making pharmacologically equivalent generic drugs.
One of the main reasons generic drugs --
ATTENDEE: 17-year patent on the active ingredient?
MR. KAPPEL: Yep. Although some of the games that have been played are extending the patent by changing the delivery mechanism, for instance. Going from plain old something to time release something can get you a new patent.
ATTENDEE: But does it keep your patent on the original one?
MR. KAPPEL: I think it's a new patent.
ATTENDEE: So after 17 years your patent on the original ingredient runs out, but nobody wants it anymore because you now have a time release.
MR. KAPPEL: I think so, but let me check

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with Robin on that. I think that's how it works.
ATTENDEE: Again, that meets some clock for seventeen years --
ATTENDEE: People are praying for those -- what are they called?
ATTENDEE: Look-a-likes.
MR. KAPPEL: Well, there are "me too" drugs.
ATTENDEE: Me too.
MR. KAPPEL: Which are not generic. "Me too" drugs, are a different chemical compound that has exactly the same effect.
ATTENDEE: Well, I thought you were just -- well, different but only slightly different ways, the ends have a chemical change.
MR. KAPPEL: Potentially, yes. That everyone's favorite drug category, the dysfunction category, I believe the first blank alone. Those are "me too" drugs.
How many different drugs to treat that particular different condition do you need? Viagra. Cialis. I mean there are three or four of them on the market. All of which do the same thing. Those are "me too" drugs.
ATTENDEE: When you say "me too" you are saying me also?

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MR. KAPPEL: Yep. Erectile dysfunction (inaudible.)
ATTENDEE: You are using those drugs too? You too?
MR. KAPPEL: Who too?
ATTENDEE: That's a website. (Inaudible)
MR. KAPPEL: Everyone I think has really hoped for a policy point of view to increase the use of generic drugs, since they tend to be much, much less expensive than brand drugs. But, what we've seen over time between 1999 and 2003 spending on brand name drugs rose 88 percent. Spending on generics rose 95 percent. So, generics picked up a slightly larger share, about 25 to about 26 percent, but not the big bang everyone hoped to see from generic drugs.
Another great example of how this industry operates are what are called Cox II inhibitors. Cox II inhibitors are a type of nonsteroidal antiinflammatories. So this is a painkiller.
The advantage that was announced for Cox II inhibitors is most painkillers produce stomach upset, the possibility of damage to the stomach lining. When Cox II inhibitors came on the market the initial evidence indicated much lower

instances of stomach damage. So, a lot of people went rushing to Cox II inhibitors, even though as an analgesic the effect was not strikingly different from the other over-the-counter stuff and much lower cost prescription drugs. So 1997 before the advent of Cox II, total spending on these NSAIDS nonsteroidal antiinflammatory drugs, 3.2 billion.

In 2003 spending on those guys only dropped slightly from 3.2 to 3 billion in constant dollars. So there is no inflation going on there. But Cox II spending was 5.5 billion. So you had this explosive growth in this market, that was not just a substitution. You had people consuming the other stuff at almost the same rate, with this laid on top of it. So a spectacular growth in the use of this.

And it's not entirely clear why. But then what happened was the evidence starting coming out that while they may have had some protective value for stomach upset, they increased the risk of heart disease slightly, heart attacks. So, all of a sudden they're either sharply reduced or taken off the market completely.

So Cox II's, huge marketshare, tremendous

spending growth, and then almost gone. Very much a cautionary tale on both sides of that.

ATTENDEE: So, just so, what was that?

MR. KAPPEL: Celebrex, Vioxx.

ATTENDEE: Vioxx, Vioxx was the big controversy a few years ago causing heart attacks and lawsuits and a relook at the FDA and how a patent affects the aftermarket process is that fairly good for premarket (inaudible) but once they get to market they don't do nearly as good a job as they should have (inaudible.)

ATTENDEE: So then people start suing.

MR. KAPPEL: I think one of the limitations is the biggest clinical trial is a couple of thousand people. So, if something produces a very, very small increase in a risk, like heart attacks, you don't see that in a clinical trial, where you may see inklings of it in a clinical trial.

But when the drug hits the market and a million or five million people start taking it, that's when you start seeing five and ten and fifteen excess heart attacks. So, I think that after market monitoring is essential because you won't see some of these rare side effects during

clinical tests.

So far so good? Okay. Different topic entirely.

What is driving the growth in any kind of spending? So, this is health care. This is my groceries. This is drugs. This is everything. Three basic factors will drive any spending growth: Prices, utilization and intensity. Prices is the easiest one to understand. If you buy the same product this week and next week, did you pay the same amount for it or did you pay more or less? So, the exact same product that changes in price, that's one driver.

Second driver, utilization. Are you buying more or less of the same products? So, let's say your shopping list has been the same for the last year. You go to the supermarket, you buy the exact same things. The only thing that effects how much you spend is whether the supermarket raises prices or not.

But this week you're having a big dinner party, so you buy more of the same thing you used to buy. You buy twice as much meat. You buy twice as much potatoes. That's a utilization increase. So that's buying more of the same

basket of goods.

Those two are usually pretty clear. The one that is a little more subtle is the one called intensity. This is the mix of things that I'm buying. If I go to the grocery sore and I usually buy generics, but I decided for some reason to buy all brand stuff this week. My grocery bill goes up even though I'm buying the same quantity of the same things. I'm buying the same number of cans of tomato juice. I'm buying the same number of bags of Oreo cookies. But by shifting the particular mix of things I'm buying I'm changing intensity.

Best example of changing intensity is going from Aleve to Celebrex. Same number of pills. Neither of those products increased in price, but I jumped from the low cost one to the high cost one, so that makes spending go up. All three of those guys contribute to that big ramp-up in pharmaceutical spending. And all three of them can be controlled with very different tools. And we'll go into a lot more detail about that a little later on.

The interesting question is of those three which has the biggest affect on spending on

pharmaceuticals. A couple of different studies, they typically come out about the same, so the one I'm going to talk about something the Express Script does called the Drug Trend Report. Express Script is one of the big PBM's, pharmacy benefit managers, and they do a report basically on their book of business. But I think they're big enough, it's a good model for all sorts of spending.

ATTENDEE: Are you going to come back to PBM's?

MR. KAPPEL: Yeah, yeah.

ATTENDEE: They're very important and very confusing.

MR. KAPPEL: Yes.

ATTENDEE: So you said they're the one --

ATTENDEE: We'll come back to that.

ATTENDEE: That do the (inaudible.)

MR. KAPPEL: Yeah, they do the report on their business. So to the extent their business is representative of national drug consumption it's good they're probably not that far off because they're so big.

ATTENDEE: In short, we'll give you a one minute on PBM's so you have some reference in

your brain. They're essentially middle -- middle men and women, middle companies between people, employers, health plans, insurers who want to setup essentially, and their members would purchase the drugs and the drug manufacturers. And Robin is here, give us a one minute on what a PBM is. You'll probably do it better. Then we'll come back to it in its due time, but refer to it when we are about to go on, I just want to give a little bit of context.

MS. LUNGE: Yes. A pharmacy benefit manager is a company that provide services to either an employer or a health insurer to manage their pharmacy benefits.

Now there's a few different ways that PBM could do that. And what they, they have individualized contracts with the customer, the customer being either the health insurer, so Blue Cross Blue Shield, for example, or the state employees, or Medicaid, or it could be IBM. So they could have a number of different contracts with the customer. Sometimes all they do is administer the program, so they may -- they may take the benefit as designed by the state employees, or whoever, and then they're the

entity that will make sure that the payments and -- they sort of go in between the customer and the manufacturer for purchasing the drugs and negotiating the deals.

So you can have what is called an administrative services only contract where primarily what PBM is doing is providing this service of administering the deal between the insurer --

ATTENDEE: Middleman.

MS. LUNGE: Yeah, right. But they can also like a TPA. Or they could have a contract where they may do more services and they may also guarantee a set price. For example, they may say we'll give you "x" percent discount as opposed to whatever discount we can manage to negotiate.

So there's different ways that the contracts are structured and probably the PBM's could give you a better, more detailed idea of the specifics if you are interested in that level of detail than I can, because I'm not that familiar with the different specifics of the contracts. But that's kind of what they do.

ATTENDEE: So one of the main reasons, if I were on the other side, the employer, Medicare

insurer is that they can negotiate a better price for me? One of the main drivers?

MS. LUNGE: Right. Say, for example, state employees use a particular PBM and they see it as that PBM is taking all their customers together so they have all the state employees plus whatever other employers and they're negotiating with all those lives with the manufacturer. So, that would be one way of looking at why you use a PBM.

ATTENDEE: Can I ask a question? I never understood, but the mail orders I can understand.

MS. LUNGE: Yeah.

ATTENDEE: But when I go to Kenny Drugs using the state PBM, Kenny Drugs has a certain price for that drug, right? Do I get a rebate from the manufacturer as the PBM; is that how it works?

MR. KAPPEL: Kenny Drugs agrees -- they enter into a contract with the PBM. And the terms of that contract are how much the PBM will pay Kenny Drugs.

MS. LUNGE: So the PBM in that instance has a contract with the state employees, a contract with manufacturers, and a contract with Kenny

Drugs for that transaction, because they're saying that the state employees, the state employees is saying please administer our pharmacy benefit manager, and here is what we want in our PDL or whatever they said. And then the PBM negotiates and comes up with a price vis a vis the manufacturer. And then the PBM also gets the pharmacies in a different contract saying okay, we'll accept that price.

So, that's partially why it's so complicated because there's all these different players.

MR. KAPPEL: And we will talk a little later on about the ways you can control pharmaceuticals spending. PBM has probably used almost all those tools in one way or another. So, they -- it's negotiating, it's administrative stuff, it's preferred drugs lists, they do it all.

ATTENDEE: And PBM's have gotten into trouble, some of them, or we have gotten, policymakers have gotten concerned about some of the -- some of these deals, let's put it that way. It's hard, it's often not transparent and it's hard to know what's happening and whether it's involved.

MR. KAPPEL: There's lot of secret deals and

kickbacks and rebates, not kickbacks.

ATTENDEE: And it is all for profit, there's not non-for-profit PBM's?

MS. LUNGE: There are one or two nonprofit PBM's that I'm aware of. There may be more than that. There is one actually that Medicaid has contact with out of Massachusetts.

MR. KAPPEL: I think the nonprofit model is much more recent in the last couple of years. Okay.

ATTENDEE: We are not ready -- so when I go into the drug store and you go in back of me and I go in and it says "x" drug store my price is. And then it says your price. That's the difference of the PBM being able to influence that price, right?

MR. KAPPEL: What you will see on your label is what you would pay if you didn't have coverage.

ATTENDEE: So you come in, you don't have the same coverage that I do, you're going to pay a different price.

MR. KAPPEL: You betcha. Just like airlines, just like --

ATTENDEE: Somebody called me about that the

other day and said why are you letting that happen.

ATTENDEE: (Inaudible)

ATTENDEE: Why are you letting the hat (inaudible)?

ATTENDEE: What was your answer?

ATTENDEE: I told them I would get back to them.

MR. KAPPEL: So let's look at prices, because I think prices tend to be the area that gets the most discussion, in part because there's huge variability in prices.

Between the U.S. and other countries first brand prices are almost always higher in the U.S., in part because the market is unregulated in the U.S., and it's regulated, to some extent, in just about every other country.

Oddly, generic prices tend to be lower in the U.S., not quite as clear of a difference, but it is an interesting offset to the brand issue. So when you are buying brand drugs from Canada, you are getting a much better deal. Chances are if you're buying generic drugs from Canada you may be able to get a better deal in the US. But brand is a tremendous difference.

And then I think as we talked about earlier there is a lot of difference among payers in the U.S. So, imagine a chart, imagine a range. This chart is courtesy of a guy named Bill Van Osen (phonetic.) And he is the NCSL or (inaudible) contract with NCSL guru of drug pricing.

ATTENDEE: He is an (inaudible.)

MS. LUNGE: His hat is even nicer.

ATTENDEE: Hat is inspired (inaudible.)

MR. KAPPEL: He actually has a propeller that turn itself.

ATTENDEE: Solar powered one?

MR. KAPPEL: Yes, and it's probably silk. Anyway --

ATTENDEE: Powered by (inaudible) rebates.

MR. KAPPEL: This chart does two things. Vertically it compares the prices that different buyers pay for drugs. So, if you set what the cash guy spends at a hundred percent -- so, this is me, no coverage, walking into the drug store. I spend a hundred bucks for my prescription.

PBM's and other private insurers, 80 percent. Medicaid about 60 percent. And then down to everybody's idol, which is the VA, at 45 percent of list price.

The width of those bars is Bill's rough estimate of how big the marketshare is in each of those categories. So, one of the striking things is you can see the VA getting this spectacular deal with only one percent of marketshare. VA is really interesting because they have two different ways of getting there. The first way is the government sets its own best prices. So if you look at --

MS. LUNGE: Federal government.

MR. KAPPEL: The Federal government. FSS, Federal Supply Schedule, that's the most a government agency ever pays for pharmaceuticals. The VA then turns around and says, that's nice, we want a better deal. Because, I've been talking about it a couple of times in here, the VA is, in terms of a system, the most highly structured health care system in the country. So, when the VA says to its doctors, you will not prescribe Lipitor, you will prescribe that other one, the doctors all respond: Yes, ma'am.

So the VA has perfect ability to move marketshare. And the VA can go to suppliers, go to manufacturers and say here's the price we want or we go to your competitor. And they are

phenomenally successful at this. So the VA is the best example at using market forces to get the deal you want.

ATTENDEE: How about Wal-Mart?

ATTENDEE: Committee's titillation, you might have heard a little about this, but you can draw a few pieces together. 340B, the second load is something that Hunt Blair that you have heard about in context of federally qualified health centers and rural clinics, that's the price that they pay for drugs. And B14 proposal to extend that more statewide and is even looking at the idea of making that price available in broader context. So, you want to know the answer as to why that's that low?

MR. KAPPEL: I think that one is more statutory. 340B, the Feds carved 340B plans out because by and large they're safety net providers. So, if you want to think about it this way, they're providers of last resort. And the Feds pretty much say because of that role manufacturers you will give 340B's a really, really good price.

ATTENDEE: So that's basically price fixing.

MR. KAPPEL: Yes.

ATTENDEE: As opposed to negotiating.

MR. KAPPEL: Yes. So, the VA takes that fixed price and negotiates a better deal. But it is interesting to watch this use of both tools.

ATTENDEE: So who gets the 340B deal, because safety net providers, federally qualified and who else (inaudible)?

MR. KAPPEL: Planned Parenthood gets it. The rural health clinics.

MS. LUNGE: I have, you may have it from Hunt already, I have a list of those programs in Vermont. I made copies.

ATTENDEE: We might have it here.

MR. KAPPEL: You want to do this? I'm starting to run out of voice.

MS. LUNGE: Sure.

ATTENDEE: Let me ask you, you might have answered this already. Has this -- how has this shifted, this little -- if they were like an accordion file and I could pull and play this, over this few years has more gone into this section?

MR. KAPPEL: I would bet what's happened is the blue bar has shrunk. The PBM and other type of insurance bar has grown. And the Medicaid bar

has probably grown a little bit. But, again, this is pre-Part D. Part D is going to make everything look a little different. Part D is going to be a huge -- Part D in the aggregate is far and away the biggest drug purchaser in the country. So that is why there is a big debate and ongoing debate as to why the federal government should negotiate Part D prices in one big block or leave each individual administrator of a Part D plan to negotiate separately.

MS. LUNGE: And there's federal legislation that is working its way through right now on that issue on Part D. We'll see how that turns out.

So, the next slide is to give you a sense of how the supply chain works and who the various players are. So, you can see at the top are the pharmaceutical manufacturers. And then there are wholesalers who also buy directly from the manufacturers, but you can also see the manufacturers sell directly to retail pharmacies and some other nonretail providers, like hospitals, HMOs, and nursing homes.

And then the consumers -- the wholesalers also sell to those two groups. And the consumers at the bottom are usually getting it from the

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retail or nonretail. There are some instances where consumers might get drugs directly from the manufacturers in the case of the manufacturer's lower income or reduced price program. Many manufacturers have programs for -- with eligibility requirements, stuff like that. So there is one more arrow that's not represented, but I think a fairly small marketshare.

ATTENDEE: Is this little diagram, is this all within the U.S.? Because I'm not clear on how much, for example, committee manufacturers and other countries, or does this all have to happen within the U.S.?

MS. LUNGE: This is based on a CDO paper, which Lauren has a couple of copies of. So, if you're interested in a lot more detail about this private sector drug pricing and how the supply chain in that works, this would be a good resource.

I think that this is meant to represent kind of the US private sector. So, and one thing that's important to know is that the FDA regulates pharmaceutical manufacturers. So they would regulate the manufacturers who are US based companies. And if the manufacturer actually

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produces the drugs out of the country, which sometimes does happen, the FDA would physically go to that other plant to inspect it and do other safety checks and stuff like that.

ATTENDEE: More routine than you might think that production is done somewhere outside of the country.

MS. LUNGE: And I don't know off the top of my head what percentage of all pharmaceutical manufacturers are US companies versus companies in other countries.

ATTENDEE: (Inaudible)

ATTENDEE: One of the big ones like that, almost all is produced in Ireland.

MR. KAPPEL: A lot of drugs are produced in Ireland. Puerto Rico because of some tax law stuff.

ATTENDEE: And as we learned a couple of years ago when we did the importation bill, the same facility in Ireland that produces Lipitor in the United States can probably also produce it for Canada and others places, that they have to go through a different -- the end of the process, the packaging and labeling, as well as the inspection (inaudible) sometimes it is --

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MS. LUNGE: That's a good point. The FDA also has a lot of rules on the labels and what has to be on the labels and what the packaging looks like.

ATTENDEE: I imagine that's part of the dissertation or charge the U.S. customers is way more than the Irish customers getting the same drug.

ATTENDEE: I don't think -- that would be logical, but I don't think that's actually a big part of it. (Inaudible)

ATTENDEE: When I wrote for a newspaper in my years I did a piece where the pharmaceutical companies are -- unbiased pharmaceutical companies, what they explained, similar to her theory, was that they had to look at each country differently. And like they had to almost -- like to Africa where the AIDS drugs they used, for example, they virtually gave Africa all of their -- all the AIDS drugs because they couldn't, they couldn't get the money from them. So they gave it to them, but then they had to recoup by looking at -- the United States had one scale, Canada had another scale, etc. That's the way they -- it was, I can't remember which one of the

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pharmaceutical companies I spoke to. But I explained that's how part of their system operated.

ATTENDEE: Yeah, it costs you.

MS. LUNGE: So just to give you a sense of kind of percentages in the supply chain chart, from the manufacturers to the wholesalers, that's about 64 percent of the dollar sales.

And the manufacturers to the retail directly to the retail pharmacies is about 30 percent of dollar sales. Directly to mail order is about another two percent. And to nonretail providers it's about three percent.

ATTENDEE: How much?

MS. LUNGE: Three. And these are all national figures. (Inaudible)

ATTENDEE: The chains?

MS. LUNGE: I'm sorry? The chain is about -- I don't have the independent pharmacies separate from the chain, I just have 30 percent, so...

ATTENDEE: Okay.

MR. KAPPEL: Usually I think the manufacturers wouldn't sell directly to independents.

MS. LUNGE: So those are usually from

wholesalers.
MR. KAPPEL: Yes.
MS. LUNGE: So the 30 percent is the chain.
MR. KAPPEL: Rite-Aid and those guys are big enough to buy directly from manufacturers. Harry's Pharmacy buys from the wholesaler.
MS. LUNGE: So we're going to talk a little bit about the different price measures because one of the great confusion in this series of things is pricing. So, do you want me to start, and you can jump in?
MR. KAPPEL: Sure.
MS. LUNGE: So, there are three key price measures, and those are the average manufacturer price, the wholesale acquisition cost, and the average wholesale price.
So, the average manufacturer price is generally the average price paid by wholesalers or from those retailers that purchase directly from the manufacturers. So that you can see from your little diagram above, that would be the line going from the manufacturers to the wholesalers.
Actually, maybe I'll just hand this out now. I was going to do it after we talked about prices. But this is another little chart from

the CDO report that actually kind of represents where the different prices apply. So you can, you will see that the lines going from directly to the manufacturer are the AMP or the average manufacturer price. If you want to talk about what the price actually is?
MR. KAPPEL: Yeah. Well, this is the price the manufacturer charges the average price to actually sell the drug to an actual purchaser. Albeit the one that is the most reality driven.
ATTENDEE: Which one are you talking about now?
MR. KAPPEL: AMP, average manufacturer price. Because this one is reported to the Feds and it's used to calculate Medicaid rebates, which we'll talk about in a minute.
So, this is the one that's actually, in my favorite term, green dollars. The other two are much more like list prices, nobody really pays them, but this one is real.
This one is very important because it is the basis of the rebates the manufacturers pay to Medicaid.
Anybody know how that works or should we go into that for a second? Okay. Over 90 --

MS. LUNGE: I think so.
MR. KAPPEL: Under federal law there was some discussion in the late '80s and early 90's about Medicaid programs having preferred drug lists that could exclude manufacturers completely. And for some odd reason the manufacturers found that a trifle unnerving.
So, in a compromise the manufacturers agreed to assist them under which they guarantee state Medicaid programs a price as good as any private purchaser gets. So, not necessarily the absolute best price, not as good as the VA for instance, but at least in theory as good as Walgreen's or Rite-Aid or Wal-Mart or anybody else gets from the manufacturer.
In order to implement that deal each state reports to the Feds exactly how much of each individual drug it paid for in its Medicaid program and how much it pays. The Feds, in a secret bunker, that only Vice-President Cheney knows the location of, calculates the difference between what the state actually spent to buy that quantity of that drug and what they would have paid at this best price.
And then the manufacturer sends the state a

check for the difference. So that's the Medicaid rebate system. Just a way of guaranteeing the state as good a deal as any private purchaser gets.
ATTENDEE: We were a little sarcastic about it, but truly how do you verify the amount?
MR. KAPPEL: You don't.
MS. LUNGE: Well, the manufacturers have to report the information to the federal government. So the Feds, in theory, are able to at least get that information, but that's not something that we get at the state level.
MR. KAPPEL: The system was set up specifically to insure no one outside the federal government knew what that best price was. And the way they do that is they consolidate -- Pfizer consolidates all the payments for each individual drug into one big check, so nobody can figure out what the best price is, which is to Pfizer's advantage, because they don't want anybody to know what the best price is.
ATTENDEE: Sort of like that survey (inaudible.)
ATTENDEE: If they don't actually send the price, how do they know what to send to Vermont?

MR. KAPPEL: They tell the Feds what that best price is, and the Feds tell no one.
ATTENDEE: And so the Feds know --
MR. KAPPEL: Yeah, the Feds know exactly.
ATTENDEE: And we trust them, so it's fine.
MR. KAPPEL: We trust them, sure.
ATTENDEE: We don't have an option.
MS. LUNGE: Well, we do have an option actually, and you will see it when the Senate Finance Bill comes over because there are other states that have passed laws to require the manufacturers to report that information to the state Medicaid program under, still, confidentiality restrictions. So we can talk about that later.
ATTENDEE: Okay, we'll talk about it later. Just curious why they do that and (inaudible.)
MS. LUNGE: I can try and get that information for when we talk about that part of the bill, that way you can see the language at the same time, if that makes sense.
MR. KAPPEL: The short answer is if you are going car shopping, wouldn't it be fun to know the best deal that the car dealer gave anyone who bought that car? And the car dealer, that's the

last thing the car dealer wants you to know.
Wholesale acquisition costs. Your turn? My turn? Who's got the hat on?
MS. LUNGE: You do, unless you want me to, but I think you know this better.
MR. KAPPEL: Okay. This is one of the deceptively named prices. Wholesale acquisition costs, it's a list price. It is what the manufacturer publishes as I don't even know who you are so I'm going to charge you a really high price then it will sell to wholesalers. No one actually pays WAC. So WAC, a lot of people believe the pretty good classification of what the wholesalers actually charge the retailers, which is thoroughly confusing.
But, you are into this whole idea of list prices, which can be set for reasons other than making the market function. And the best example of that is the infamous average wholesale price. Everybody remember what AWP really stands for: Ain't what's paid.
So, this is the basis of what Medicaid reimburses pharmacists at. The Vermont system, when it's a brand drug is AWP minus a certain percentage, 11 point --

MS. LUNGE: Nine, I believe.
MR. KAPPEL: Plus a dispensing fee. So, look at that: AWP minus 11.9, plus a dispensing fee. Darn, I just read ahead.
So what Medicaid is trying to do is to, to the best it can, reimburse the pharmacists for what the drug cost the pharmacist, AWP minus 11.9. Then pay the pharmacist an additional amount for the labor of actually preparing and packaging the prescription, the dispensing fee, $4.25.
ATTENDEE: Did we just raise that recently? No?
MS. LUNGE: We might have. I have some recollection that we might have raised that last figure. But I can check.
ATTENDEE: You just whipped out that number, so the dispensing fee is a fixed number?
MR. KAPPEL: Yes.
ATTENDEE: No what matter what the price?
MR. KAPPEL: Right. And no matter how many the pharmacist has to count up to, that's intended to be kind of the average reimbursement. So, a three pill prescription, it's a lot of money.

For a 90 pill prescription that the pharmacist has to rummage around for, it's probably not a lot of money, but it is intended to be the average. And what that's based on is whatever it's based on.
ATTENDEE: Is it state by state?
MR. KAPPEL: Sure.
ATTENDEE: And Vermont right now that averages dispensing is 4.95?
MR. KAPPEL: 4.25.
ATTENDEE: Is it indexed (inaudible)?
MS. LUNGE: That's for Medicaid.
ATTENDEE: Is it indexed (inaudible)?
MR. KAPPEL: No, it goes up when the pharmacists come in and make a compelling case that it's not enough.
ATTENDEE: That's (inaudible.)
ATTENDEE: And where is that --
MR. KAPPEL: I'm trying.
ATTENDEE: 9, what is that exactly?
MR. KAPPEL: Some of this stuff is lost in the midst of history, but the intent of the AWP minus 11.9 is to be a reasonable -- to try to match to what the pharmacist had to pay to buy the drug from either the manufacturer or the

wholesaler, because kind of the underlying goal of this Medicaid reimbursement system is to pay the cost that the pharmacist laid out to buy the drug, fully reimburse for that, and then reimburse for the labor in preparing the prescription.

ATTENDEE: But again, 11.9 is (inaudible)?

MR. KAPPEL: Yes, AWP minus varies from state to state and the dispensing fee varies from state to state. And some states even have a different mechanism entirely. But AWP has been the most common, although the Feds are about to change all that.

ATTENDEE: Who sets those rates?

MR. KAPPEL: You do.

ATTENDEE: The legislature?

MS. LUNGE: I'm not sure that's true, I don't think that's a statutory set amount. It might be something that is figured out in the appropriations process, but I don't think that there is something that says AWP minus 11.9 percent.

I think that's something that's OVA probably developed to be the cost.

MR. KAPPEL: We'll check on that one.

MS. LUNGE: I mean you certainly could set it.

ATTENDEE: If we had the power (inaudible.)

ATTENDEE: The royal "we", what we do more broadly.

MS. LUNGE: But, there are, there are, there is some federal law on parameters. So, for instance, I don't think you could set it lower than the best price as that's defined in federal law because you are restricted like that.

MR. KAPPEL: And there have been some discussions of federal efforts to save Medicaid money by changing this whole mechanism and standardizing it nationally. So that's something to keep an eye on.

Oh, one last thing. From what we've heard, so this is definitely anecdote, unlike physician and hospital reimbursements, Medicaid is actually a fairly good payer if you're a pharmacist, compared to the commercial guys.

ATTENDEE: (Inaudible)

MR. KAPPEL: Not all of this has reason.

So let's talk about rebates. Rebates are an idea that have kind of marbled all through pharmacy world and probably marbled all through

all sorts of things.

Rebates are a nice gimmick where you can lower prices without actually lowering prices, which is why car dealers love them. You still have your same list price with the car. You don't have to mess with that, but you have rebates. And maybe people will forget to send in the rebate form.

But a rebate is you pay and then you get something back. So, as we just talked about Medicaid has this federally mandated rebate system, but what Vermont, as well as several other states have done, is to go one step further and develop supplemental rebates.

So, under supplemental rebates a state that has, again, we'll talk about this more later, developed a way to move volume among competitors, can go to the competitor and say I can buy yours, I can buy the other guy's, will you give me a better deal? And states have said, yeah. I mean manufacturers have said yes.

So Vermont has been fairly successful in negotiating rebates beyond what it gets under federal law.

MS. LUNGE: Maybe we should just explain --

ATTENDEE: We haven't done PDL yet, but you have used it in the slide.

MR. KAPPEL: Go for it.

MS. LUNGE: So the way that Medicaid does this movement of marketshare is through what is called a preferred drug list. You will also hear the term drug formulary used. And the general difference conceptually between those two terms is -- and this isn't always the case, but a formulary often is what's called a closed formulary, which means that you, the consumer, can get what's on the list, nothing else.

If it's not on the list you pay for it out of pocket, your insurer or whoever is developing the preferred drug list or formulary doesn't cover it. More often when something --

ATTENDEE: Let me interject.

MS. LUNGE: Go ahead.

ATTENDEE: Which is an important consideration for your senior citizens constituents in the whole Part D program because one of the things they need to make -- they have 40 some-odd choices of different plans and prices. And one of the things that they need to make sure of is that the particular plan that

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it's not just the price, that the plan they choose, their formulary has the drugs on it that they are used to taking or need to take. So they don't all have all the same drugs. So that's what -- one of the many complications associated with getting people signed-up for that system in the right way for them.

MS. LUNGE: And then the preferred drug list is generally the same concept. There's a list, but there's more options. So, there's more of an open -- sometimes it is also called an open formulary.

But in Vermont the way our Medicaid preferred drug list is setup, there is a list of drugs that are preferred and OVA will use that preferred status as negotiating leverage with manufacturers to get a higher supplemental rebate, so a lower cost. By basically saying if you don't give us, you know, AWP minus 30 for this particular drug, we're not going to put you on the list.

Now, in Vermont the way our Medicaid preferred drug list is setup, you the consumer can get drugs that are not on the preferred drug list by going through an exception process and having your doctor request that.

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There is sort of another approach that private insurers often use, which is they will have a list and, actually, some of the Part D plans use this too, they will have a list which is the preferred drug list, and you have a certain copayment for drugs on that list.

There is another list which you would have a higher co-pay if you use, and then there is also an exception process. So there are sort of a couple different models, but the general concept is the insurer or Medicaid will use the list as a way to leverage a lower price out of the manufacturers by insuring that most people are going to use what's on the list because it will either be a cheaper co-pay for them or the doctor would have to go through an extra process to get it on the list.

MR. KAPPEL: One of the big challenges is how do you construct a preferred drug list. Who decides what goes on the list? And almost universally those are decisions made by clinicians, typically by prescribers, and by pharmacists. And the evaluation is always of a safety, comparative safety of the drugs.

There is an economic component to some extent

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and there is a desire to have an efficacy component. The efficacy component is tricky though because there are not a lot of studies that compare Vioxx and Celebrex in terms of (inaudible.) One of the things --

MS. LUNGE: Do you want me to add something to that?

MR. KAPPEL: Are you going to add something about what I'm going to say? Go for it.

MS. LUNGE: No, you go for it.

MR. KAPPEL: No, you go.

MS. LUNGE: The FDA, and part of why that's -- why the Vioxx/Celebrex is complicated or difficult to do because when a drug is approved by the FDA they look at whether or not that drug does better than the placebo. So they don't compare Vioxx and Celebrex. They compare Vioxx and placebo and Celebrex and placebo.

MR. KAPPEL: Which is why you will sometimes have the odd scenario of a very expensive new drug coming onto the market with FDA approval that doesn't work as well as an old drug.

One of the interesting things that people have started doing is trying to figure out ways to do head-to-head comparisons to actually test

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the efficacy of drugs against each other. And one of the pieces in the bill that is coming up in the Senate is that Vermont is -- will be directed to participate in a program that Oregon State Health University runs, that is setup specifically for this purpose to compare efficacy among therapeutic alternatives.

So, to the extent you can incorporate safety, efficacy and a price in your preferred drug list, then you're doing the best job you can, because the clinicians will be able to decide, okay, this drug is a tiny bit more expensive than this drug, but it works this much better, so we want this drug. Whereas, if all you're doing is price, you might go with their drug.

MS. LUNGE: And this is in general a movement sort of nationally to look at evidence-based prescribing or evidence-based education in developing preferred drug lists, as well as for doctors in prescribing habits.

The other thing I would mention about that Steve was saying who comes up with these lists, and just so you have a sense, some of you may remember from last year we did some changes to the DUR board, the Drug Utilization Review Board.

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And that is the name of the committee that develops the Medicaid preferred drug list.
So there is a committee in Medicaid that does that process that Steve was describing. And similar --
ATTENDEE: Primarily doctors and pharmacists.
MS. LUNGE: Pharmacists, yes. And similarly, for instance, the state employees plans will have, they will have -- the insurer will have -- they often call it P and T committees. What does that stand for?
MR. KAPPEL: Something and therapeutics. Pencils and therapeutics.
ATTENDEE: That's the who and how, but when -- I seem to remember that was one of the complaints about the physicians is that these lists get changed weekly, monthly.
MS. LUNGE: OVA does theirs annually, with the exception if a drug is pulled from the market they take it off the list. And as new drugs come on the market they may add drugs to the list, other than that annual period if there are new drugs on the market.
ATTENDEE: But insurance (inaudible) everybody can change in terms of how often and --

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MR. KAPPEL: Yes, and it's definitely one of those areas where there is a tradeoff between always getting the best possible deal and making people jump from brand to brand to brand to get to it. And how you balance those two is definitely a challenge.
ATTENDEE: Do you have your little thing? He has a little PDA sort of thing, that if you plug in every week or so and it updates it.
ATTENDEE: Years ago used to be it was that big old fat book and nobody carries it anymore, they carry that around.
ATTENDEE: And you can go through each list if you wanted to. You can put on like all the different Medicaid/Medicare drug lists, except I don't have enough memory because I have so many.
ATTENDEE: Like Blue Cross, and you would have the various plans.
ATTENDEE: Or it would say Blue Cross (inaudible.)
ATTENDEE: You have to do that every single time you prescribe?
ATTENDEE: Well, I don't do it much, I do it (inaudible.) You know, but they'll be drugs that will say Blue Cross Blue Shield of Vermont, three

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tier, high co-pay. So I know that drug is an expensive drug that Blue Cross doesn't want me to prescribe because there's a high co-pay.
MR. KAPPEL: So this is a way to kind of wrap all the topics together. Catamount Health is a three tier drug plan. So, co-pay for generics, co-pay for preferred drugs, and co-pay for brand drugs, nonpreferred drugs.
So what we thought we do is just do one more slide to talk to you more about rebates and then leave at 4:30. It's a good segue because the next thing we're going to go into is a lot more detail on all of the tools in the tool box to address savings. We can start tomorrow morning.
So PBM's, benefit managers use rebates a lot. A lot of the deals -- a lot of the money they make comes from rebates.
One of the concerns that has been raised for years is that they will negotiate a deal with insurance companies with large employers, then turn around and negotiate a much better deal with the manufacturers. And because the rebates are contractual and not available for inspection by anybody else, that they're not passing on the savings to their clients. So, you want to talk

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about (inaudible)?
MS. LUNGE: No, we're going to talk about the Senate bill after we know what it says.
ATTENDEE: (Inaudible) concerns that PDM's do not always pass on -- when would they ever if no one (inaudible.)
MR. KAPPEL: It depends on the contract.
MS. LUNGE: It depends on the contract. For instance, the administrative services only in theory they're supposed to pass on everything, every rebate they get for that drug.
Now sometimes -- because they're just administrating, sometimes they might get a negotiating fee from the manufacturer. That's not a rebate, so that wouldn't necessarily be passed on.
So that's part of why -- it is a very complicated area. And one of the things I would suggest, if you want more details about that, is there have been some lawsuits by Attorneys General, including Vermont, which have been settled. So there are definitely, if you want more information on kind of the PBM practices, Julie Gurelick (phonetic) at the AG's office can give you information about.

And there is also... (End of track.)

CERTIFICATE

I, Eleanor M. Evensen, Notary Public and Registered Professional Reporter, do hereby certify that I was authorized to and did listen to and stenographically transcribed CD-06-117 (track 3) proceedings and that the transcript is a true record to the best of my ability.

Dated this 20th day of August, 2007.

ELEANOR M. EVENSEN, RPR
#887608

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: Wednesday, March 28, 2007

Type of Committee Meeting: Standard

Committee Members:

Rep. Steven Maier, Chair	Rep. Harry Chen, Vice-Chair
Rep. Francis McFaun	Rep. Sarah Copeland-Hanzas
Rep. William Keogh	Rep. Lucy Leriche
Rep. Virginia McCormack	Rep. Virginia Milkey
Rep. Pat O'Donnell	Rep. Hilde Ojibway
Rep. Scott Wheeler	

Transcript prepared from Audio on CD

CD No: 07-118/T1-2
07-119/T1-2

PROCEEDINGS

CD 07-118/TRACK 1

MS. LUNGE: -- looking at different ways to achieve savings in prescription drug programs -- in area prescription drugs, I should say. And then start to talk more specifically about Vermont information because, as you will remember from yesterday, we really were focusing on more national data figures. How is that for a summary?

UNIDENTIFIED SPEAKER: What page are we on? Sorry.

MS. LUNGE: 13.

MR. KAPPEL: So before we lunge onward, any questions from yesterday? No? Wow, we were either (inaudible) or confused everyone completely.

Okay. So now we sort of sketched out just how big and significant all this is, let's start talking about how we can get the beast under control. So how can we achieve savings in any program that spends money on pharmaceuticals?

Yesterday, we talked about the three drivers: Prices, utilization, and intensity. So anything you do has to affect at least one of those. You can't have a program that doesn't affect any of those that

will actually reduce spending. Ideally, you want to start figuring out ways to affect more than one at a time, because like the rest of healthcare, there is the infamous Pillsbury dough boy effect, which is you squeeze one of the drivers and the other two pop right out.

UNIDENTIFIED SPEAKER: If I go like this to you (inaudible).

MR. KAPPEL: I'm not the Pillsbury dough boy but give me a few pieces of cheesecake and we'll see what happens.

UNIDENTIFIED SPEAKER: I like to think of it as the whack-a-mole.

MR. KAPPEL: That too.

So what you'll see sometimes is when prices get squeezed, utilization goes up. So the ideal cost containment system wraps all the way around all three.

To achieve your savings on the pricing part of the equation, there's a couple of different things you can do. You can directly reduce reimbursement, and this can either happen through a negotiation process or through a statutory process. When the State sets -- and statutory in the broader sense -- when the State says, we're going to pay this much

for Medicaid pharmaceuticals, that's a statutory price reduction.

You can go outside domestic markets. When you can buy a drug in another county for less than you're buying the same drug for the in the U.S., you're reducing the price you pay.

A really important thing to keep in mind throughout this whole conversation, if you're going to negotiate price reductions, the tradeoff is almost always for increased volume. If you can't show the person you're negotiating with you're going to buy more of the product, they really have no particular motivation to give you a better price.

Flip side, if you go in and say, I'm going to double your market share in my state, they'll have a really good motivation to give you a better price. So that connection between volume and price is essential to keep in mind.

How do you actually move volume? We talked yesterday about preferred drug lists which is probably one of the strongest ways of doing it. When a payer says, this drug is on my preferred list and you, the beneficiary, have less out-of-pocket expenditure or don't have to go for prior approval, that will just move volume immediately all by

itself. In that case, you're moving volume potentially from one supplier to another.

The other way you can move volume is to start consolidating purchases. So when Medicaid buys, it buys quite a bit. Medicaid plus Medicaid programs in other states, plus state employees, plus, plus, plus. When you start creating that mass of buying, you've got a lot more influence in the negotiation process.

REPRESENTATIVE MAIER: This is something that I've never understood. Tell me that when you go -- explain to me, when you go to the pharmacy and they have this tub of a thousand pills, when you talk about Medicaid buying or other people PDL buying, explain that to me. Is that just kind of virtual or did they actually, you know, buy the drug?

MR. KAPPEL: The pharmacist will buy the tub either from the wholesaler or the manufacturer and set price. It's just like cost shifting anywhere else. The pharmacist will set the price recognizing some people will pay that price, some people will pay a little less, some people will pay a lot less.

So everybody who buys from that pharmacy is probably reimbursing that pharmacist a different amount. And the challenge is to make sure you've

collected enough funds to pay for that tub of pills plus your other costs you render your employees and things like that.

REPRESENTATIVE MAIER: So when you say Medicaid buying, you're really talking about Medicaid buying at the level of the retail level?

MR. KAPPEL: Yes.

MS. LUNGE: But also remember Medicaid gets rebates. So that paid pharmacist as we talked about 11.9 percent below AWP plus a dispensing fee but then they get a rebate directly from the manufacturer so that their total cost is lower than what they're actually paying the pharmacy.

And then we also talked about supplemental rebates which are the negotiated rebates that Medicaid gets. So in addition to that direct purchase from the pharmacy, that's how Medicaid gets a better price is through those rebates.

MR. KAPPEL: That's a real good point. So Medicaid writes a check to the pharmacist. So the pharmacist thinks he or she got $100. And then after the Medicaid rebates, Medicaid may have actually paid $80 for the drug that the pharmacist list priced at $150.

There's been a lot of conversation lately

about the way Part D programs buy drugs. So the conversation of whether each individual PBM should negotiate with manufacturers or the federal government should negotiate as a whole.

Again, we're back to volume conversation. If the federal government negotiates all of it but there's a completely open formulary, so there's no movement of volume, I'm not sure what the incentive is for the manufacturers to negotiate in that case because there's no tool to advantage or disadvantage different manufacturers. So that will be an interesting debate to watch.

I think different people have very different takes on the effect on one big buyer, one humongous buyer, who doesn't move volume but is far and away potentially the biggest buyer of pharmaceuticals in the country.

REPRESENTATIVE MAIER: Why aren't they moving volume? I'm not sure I'm following that.

MR. KAPPEL: Most of what I've heard ties to an open formulary.

MS. LUNGE: Right. The bill that passed -- sorry.

REPRESENTATIVE MAIER: But you still have, you know, preferred, nonpreferred, you might have

different --

MS. LUNGE: The bill that passed --

REPRESENTATIVE MAIER: -- co-pay prices or whatever, right?

MS. LUNGE: -- the U.S. house didn't have -- specifically prohibited the government -- the federal government when they negotiate in using a preferred drug list. So I don't actually understand how you can negotiate for prices if you don't have a list of the drugs that you're negotiating for.

REPRESENTATIVE MAIER: I see.

MS. LUNGE: But I think that has been the debate nationally because a preferred drug list is such a powerful tool that on one hand, the industry folks are saying, you know, that really wrecks competition because you're the major buyer of drugs.

So if you set a preferred drug list for Medicare Part D, you know, that really -- it's a powerful tool for reducing prices but also impacts from the industry's perspective negatively on the competition and --

UNIDENTIFIED SPEAKER: The market.

MS. LUNGE: -- and the market, because it's a such a huge volume that you're moving.

MR. KAPPEL: Yeah. The competitor who loses

in that case, if you did go to a preferred drug list, it could be devastating. And you can lose half of your sales or more of your different drugs. So it's a really interesting debate to keep an eye on.

UNIDENTIFIED SPEAKER: That's going on now?

MS. LUNGE: I can check on what the status of the bill is. I know that it passed the House. I'm not sure --

UNIDENTIFIED SPEAKER: What's going on in the Senate?

MS. LUNGE: I haven't heard that it's passed the Senate. But I haven't checked. So I'll look and see.

SPEAKER 1: Robin, is there is a website that you look at to keep up to date on this or does NCSL keep you up to date? How do you --

MS. LUNGE: Sometimes -- I haven't seen anything from NCSL on this recently but I usually just go to the congressional -- there's a website, Thomas.gov, that has all the bills in Congress just like our state has a website. It's not all that user friendly but you can search for bills there either by keyword or sponsor's name.

SPEAKER 1: All right. Thank you.

MR. KAPPEL: Another really good source for general health care news, the Kaiser Foundation distributes a daily e-mail which is kind of a journal of all the interesting things going on in health care. And it's free, you can sign up for it at www.kaisernetwork -- all one word -- dot org. By signing up for that, you get to wear the hat once in a while.

Really, it's a great -- they read all the newspapers, they read all the journals, and they summarize stuff in a paragraph or two and then they link back to the source documents.

SPEAKER 1: Oh, good. Thank you.

MR. KAPPEL: So it's very helpful. There's so much going on, it's hard to keep up.

SPEAKER 1: I know, right.

MS. LUNGE: Assuming you have time to read it.

REPRESENTATIVE MAIER: I'd have to disenroll from --

MS. LUNGE: From all your others.

REPRESENTATIVE MAIER: -- at least one other one that I'm currently getting, which I don't read anymore anyway.

MR. KAPPEL: Okay. So that now we've controlled prices, how are we going to control

utilization? Two basic tools here, one of which is benefit limits. A lot of states, in order to try to control spending in their Medicaid programs, have said things like, we will only pay for four brand drugs a month. We don't really care what your medical problems are, four a month is our maximum. And they control the utilization. Who knows what the consequences are, but that's a way of doing it.

SPEAKER 2: Can I ask a quick question about that?

MR. KAPPEL: Sure.

SPEAKER 2: So if you're a person that one of those medications is $200 a month and then it goes down, can you pick the most expensive ones to get covered, if you require six let's say, in those types of situations?

MR. KAPPEL: I would think so. It's probably whatever you ask the pharmacist to submit to Medicaid for reimbursement.

MS. LUNGE: I think the way I've seen other state laws do it, it just has the script four, you can only have four brands. But we really need to look at the rules for those particular states to see if they have more control than just the number. So I'm not sure how they do it exactly.

MR. KAPPEL: The other major utilization control is what's called prior approval. And this is often used in conjunction with preferred drug lists. Prior approval at its broadest is involving a third party in the decision to write and fill a prescription.

So my doc writes the script for me, it's on the prior approval list, the pharmacist or the doc has to contact some other group and say, here's why I wrote the script for Steve. Here's why I think it's appropriate. The third party group will say, okay, that's fine; or no, we don't think that's a good idea. And that can control utilization.

What you'll see a lot is the pairing of prior approval with a preferred drug list. So a drug on the preferred drug listed doesn't need prior approval; you need prior approval to go off the list.

SPEAKER 3: I'm going to throw this out. I mean, I know we don't have a lot of options here. But although prior approval sounds like a good thing, my concern with it is, insurance companies change their preferred drug list every year. And what happens is these patients go into the drugstore in January and find that three of the drugs that

they were using are no longer on their preferred drug list.

So then somebody has to argue with the insurance companies or the doctor has to find a way to find another medication for that patient that's going to do just as good that's on that preferred drug list. And I think while we look at what we're saving in pharmaceutical costs, we're not really paying attention to what it's costing us on the other end.

Because when every doctor's office now has -- and I know my doctor's office does -- has a nurse in there just to deal with prior approvals. There is that cost shift there, and I don't think anybody's gotten a handle on that.

I think a lot of what we're doing, we're looking at, you know, one silo at a time and we're not seeing what's happened in the other silos, because of the decision we made in this silo. And that's a concern of mine. I see a huge escalation in the doctor's offices just dealing with prescription drugs.

MR. KAPPEL: I think it's an issue in a lot of health care, where you are swapping cost savings on the clinical side for potentially more complexity in

administrative costs. One of the raps against the old managed care models. Because all they did was swap a $1.00 of clinical for a $1.00 of administrative.

So it is something to be aware of in a lot of these policy conversations. You need to be sure in the biggest picture what you're saving more than offsets what you're costing.

SPEAKER 3: And I have a huge concern about the health and welfare of the patients who are waiting for their prior approval before they can get the medication that they've been on for a year that is stabilizing their condition.

SPEAKER 1: Do you have any idea how many preferred drug lists are using them, Robin?

MS. LUNGE: Well, we know Medicaid has one, state employees has one.

SPEAKER 2: Medicare Part D has 114 or something like that.

MS. LUNGE: Yeah. Medicare Part D has a gazillion.

MR. KAPPEL: At a minimum, there's four because Medicaid, Blue Cross, MVP, and Cigna all have different ones.

SPEAKER 1: Plus Medicare D is another.

SPEAKER 2: Do they have just one, though or does every TTA have a different sort of --

MS. LUNGE: No. They each have their own.

SPEAKER 1: And are they available on a website or not?

MS. LUNGE: I think that you can get the Medicaid one on the website.

SPEAKER 2: Medicaid Part D you can get on the website.

MR. KAPPEL: And Express Scripts which is state employees is on their website.

REPRESENTATIVE MAIER: You may need to have a member number. You may need to be -- I forget whether this one for prescription drugs or other benefits. But I think, you know, for example, if you're an MVP person and you have a member number, you can go on the website and put your number in and then get access to certain information about benefits and things; but if you're not a member, it's not open public information.

SPEAKER 3: I know on Medicare Part D, because I had clinics in both the towns that I represent when all this fiasco happened with Medicare Part D, so I was helping people sign up for their program; and we were able to pull the formularies right off

the website.

So when I signed people up, I would pull the formulary off and say, this is your formulary. When you go to the doctor, bring this with you. If he needs to put you another medication, he can look at this formality. But then, of course, those change yearly too, but I assume you can just pull them down.

REPRESENTATIVE MAIER: Well, under Part D, I think under Medicare, they can change more often, like monthly or they change ridiculously often.

MR. KAPPEL: Well, Part D also had that really nice feature where you can put in the drugs you're taking and it would tell you which plans covered all them.

SPEAKER 2: All of those drugs, right.

MR. KAPPEL: So for all of its chaos, that wasn't a bad feature.

SPEAKER 4: This question is actually for Harry. Harry, when you pulled out that little, whatever you call it --

REPRESENTATIVE CHEN: PDA.

SPEAKER 4: PDA. A palm PDA? Do most -- you kind of buy a subscription so they automatically update it for you. And how many physicians do you

think use those, roughly? Do you think more than half or it's unusual to have it?

REPRESENTATIVE CHEN: I really don't know. I mean, I think it depends. It's always accessible. You always have that stuff accessible, and a lot of times the pharmacies will help you with those things too.

SPEAKER 4: I just wondered because I thought if it was very prevalent, then the consumers, the patients, don't really have to stay up with it because they can rely that their doctor has access to it.

REPRESENTATIVE CHEN: I think it's more prevalent in the younger physicians that basically carry them around and do everything with them.

SPEAKER 4: So you're young at heart, is what you're saying?

REPRESENTATIVE CHEN: I'm in the middle.

UNIDENTIFIED SPEAKER: He's on the cusp. (Inaudible.)

MR. KAPPEL: Technologically adapted.

SPEAKER 4: Thanks.

MR. KAPPEL: Okay. Two down one to go. How to achieve savings and intensity. Actually, this is the one where most of the action is in policy-land

right now.
Mandatory generic substitution, really easy way to change intensity. When you've got a brand drug and a generic drug that clinically have the same effect, are based on the same active ingredient, swapping someone from one to the other reduces the spending directly by reducing the (inaudible) with all the cautions about how you can't always swap brand for generic. There are, for some people, medically indicated reasons why the swap doesn't work. But for most people, it's a really great way to save money.
You can change physician behavior. Counter detailing, this is the idea of the pharmacy reps going into the office and say, prescribe my drug because it works so much better. And some less partisans can go in the office and say, here's the clinic evidence on your choices here. So it's a way of trying to work against the marketing folks. Lots of states are starting counter detailing programs.
Other kind of feedback sometimes can be effective. Just the idea of docs who compare their patterns to other docs and see differences and start getting curious about why those differences exist.
SPEAKER 5: Can I ask a question?

MR. KAPPEL: Yes.
SPEAKER 5: Who pays for counter detailing? I mean, if the pharmaceutical companies are sending a rep, who pays for the anti-rep?
MS. LUNGE: It depends on the state. Pennsylvania has a program right now that they're operating in conjunction with their Medicaid program. AHEC has a grant to do some -- AHEC is starting a counter detailing program in Vermont, and they have a grant through the AG's office. Many states are funding it from the settlements from lawsuits in prescription drug area, so the AG's office has a fund that they have to do this kind of thing.
REPRESENTATIVE MAIER: And there's a lot of stuff going on in medical schools, too. So, for instance, in medical schools, they pretty much -- most medical schools have kind of banned a lot of pharmaceutical marketers in just because of the profit associated with it. There's classes on how to use cost effective medicines and things of that sort. I think we're starting to figure out that we need to do something, other than just let the market rule.
SPEAKER 4: On the counter detailing, though,

don't you think most doctors in Vermont now, with all the conversations we've had about prescription drugs, are more educated and aware of what's happening with marketing and not as quick to grab that drug because that's what the pharmaceutical reps are saying that's the best thing?
I know my doctors are saying no. Plus a lot of the insurances are demanding step therapy. So you have to start off with the cheapest drug first and work your way up to that brand name drug.
MR. KAPPEL: But there's still -- this is one of those areas where more evidence would always be better. But there are so many stories from pharmacists about being able to tell exactly when the marketing rep went through town because the script mix changes.
If there is clearly an effect -- I mean, one of the things it's hard to argue with is the pharmaceutical manufacturers are smart guys. They would not invest all the money in this if they didn't believe they got an effect out of it.
SPEAKER 4: That's true.
MS. LUNGE: And I think what a lot of doctors -- and I'm getting this information from the medical society so that's my source from hearing their

testimony and other areas -- would say is that because of their schedule, they don't have time to necessarily read all of the journal articles and that kind of thicker heavier information that they would really need to digest and read in order to kind of understand for themselves the range of the evidence. So it's helpful to have an independent source that they can rely on.
And for instance, in Pennsylvania one of the things they did was they do these little cards that they hand out to doctor's offices that say, for hypertension, here are your choices. And kind of compares the side effects and stuff so that the doctor has a easy-to-use handy thing. And they would update that with new evidence as it's available, so that the doctor doesn't have to process that themselves.
So it's really, in other states at least, the way they've designed the programs, it's meant to kind of digest the evidence-based information for the doc and put it into easy-to-use form, so the doctor doesn't have to spend a lot of times doing that themselves.
SPEAKER 4: Thank you.
MS. LUNGE: Of course.

SPEAKER 6: There was an article in the Times Artist just in the last week about the weakness in some of these kind of detailing laws and I'll track that down.

SPEAKER 7: Can I just add, the sample thing is a big thing. So now what happens is you get this guy he comes in and buys you lunch, drops you off this fancy literature that obviously says this is a great drug, and then he gives you starter packs for your patients. And now you see a patient or the next patient you see, oh, I have a starter pack I'm going to give it to you.

REPRESENTATIVE MAIER: Especially if they don't have any drug coverage.

SPEAKER 7: Right. Here's a starter pack and now they're on the newest most expensive drug but they happened to get the first month free.

SPEAKER 4: And it's harder to swap them from that new more expensive drug.

SPEAKER 7: It's a lot easier to do that then to take the time look at one of these evidence-based sources, which there's a ton of them out there, you know, looking for generic drugs to do that. It's a time thing as much as anything.

REPRESENTATIVE WHEELER: My wife works in the

hospital pharmacy, so if you come to my house, you can find coffee cups with every kind of drug name on it, you can find pens with every kind of drug name on it. So --

UNIDENTIFIED SPEAKER: I thought you were going to tell us we'll find drugs all over your house.

REPRESENTATIVE WHEELER: The sample packs have been left at work.

UNIDENTIFIED SPEAKER: I thought he was going to say that too. I'm like, Oh, Scott, this is on tape.

(Inaudible.)

MR. KAPPEL: Okay. Parallel to changing doc's knowledge and behavior is changing patient knowledge and behavior. I think we talked a little bit yesterday about how the role of the patient has definitely increased over time in the medical decision-making process.

So things which affect what the patient wants are a way to influence prescribing patterns. It's a place where there's definitely opportunities for change. There's been discussion of the virtues and the vices direct-to-consumer advertising.

Again, I think these are smart guys. They

wouldn't invest all the money they do in TV ads if they didn't work. I keep seeing that NASCAR race car that says Viagra across the hood. It's just the strangest thing.

UNIDENTIFIED SPEAKER: I don't know if I would drive that if I was a guy.

(Inaudible).

UNIDENTIFIED SPEAKER: Well, if I did, I'd do it quietly. Sorry.

UNIDENTIFIED SPEAKER: I forgot what year that -- it's been a long time, 15 -- how long -- when that law was changed.

UNIDENTIFIED SPEAKER: It was in the '80s.

UNIDENTIFIED SPEAKER: And so when you say ban that direct to consumer, you're saying that there's a movement to reverse that law?

MR. KAPPEL: I think it's another one of the trade offs. I think there is something to the argument that the advertising helps inform consumers. And there's clearly something to the argument that the advertising helps change what consumers want which isn't always in the consumer's best interest. So it's a little bit of both, I think.

UNIDENTIFIED SPEAKER: There's a lot of

hypochondriacs out there who can -- they listen to everything, and they go to the doctors and they'll -- they already have themselves diagnosed and just tell the doctors what they want.

(Inaudible.)

MR. KAPPEL: Okay. The last ways to change intensity. We've talked about already preferred drug list and prior approval. And I think those are the ones that get the most attention because they are the tools that affect multiple things.

They affect price, they affect utilization, and they affect intensity. So that's in some ways the ideal model for doing cost containment because it doesn't let things leak out to some other avenue.

UNIDENTIFIED SPEAKER: I'm sorry. You said it would affect price, utilization, and --

MR. KAPPEL: Intensity.

Okay. So far so good? You guys are doing really well.

On to Vermont. When you look at health care spending in Vermont, there's a couple of interesting things that happened. Vermont has always been less expensive per person than the U.S. average in health care spending. But over the last 20 years or so, we've been catching up. So our rate of growth in

spending is actually a little faster than the national rate of growth.

UNIDENTIFIED SPEAKER: Steve, can I ask you a question? When you look at that in Vermont's lower, is there a characteristic about the states that have a lower per capita spending? For example, are they generally rural states or -- do you know?

MR. KAPPEL: It's -- that's one of those great questions which I can go on for, you know, days. But I think the clearest evidence is that, of course, there's states with lower utilization rates. They are states where people are simply hospitalized less often. One of the interesting pieces of evidence that Jack Weinberg over at Dartmouth has come across what drives that is how many resources spent on the health care system.

Florida is sort of the other poll. Florida's got really expensive. Florida has lots and lots of hospital, lots and lots of docs. So Weinberg found this really strong association between things like beds per capita and spending. Because there's a tendency to use resources if the resources are around. Vermont and a lot of the low use states tend to have fewer resources available to be used.

I think there's also cultural differences. I

think a lot of people have argued -- and I can't point at specific evidence -- that there's a culture in Vermont to not use health care more than necessary, as -- in opposition to do everything you can for the patient, which tends to be a more prevalent culture in Florida which may also have a subtext of do everything you can to produce revenue for the clinic.

UNIDENTIFIED SPEAKER: Is some of this the fact that Florida has an elderly population and maybe our growth is that Vermont's population is aging? It has nothing to do with that?

MR. KAPPEL: No. What statisticians do is what's called age adjusting. And without going into the details, they will look at the utilization of 65 year olds in Vermont and the utilization of 65 year olds in Florida which takes out the effect of the different age distribution and it is still much higher in Florida.

UNIDENTIFIED SPEAKER: Do they also affect income?

MR. KAPPEL: No.

UNIDENTIFIED SPEAKER: Because there's a lot of 65 year olds in Florida.

MR. KAPPEL: This is not one of those where

you can point at the one factor and say it's because of. But clearly culture and certificate of need and social demographics are tremendously important. You can't really just say, it's this.

UNIDENTIFIED SPEAKER: We've heard so many years here in this building that some of the increase in our health care cost is the fact that we have such an aging population.

MR. KAPPEL: In that case the "we" is everybody. That's the entire United States has that same issue. Vermont has it a little more because we tend to be -- we're like the second or third oldest state right now. But the demographic contribution arise in health cost is not insignificant, but it's not the big one. It doesn't drive the differences for sure.

UNIDENTIFIED SPEAKER: What is the big one then?

MR. KAPPEL: That drives health care spending?

UNIDENTIFIED SPEAKER: You said demographics is not that. My understanding is as you get older you use the health care system more.

MR. KAPPEL: Yes. That's absolutely true but you're taking a population that's aging is -- also, everybody in that population is spending more and

more over time. And the big one, in my opinion, is technology. The capabilities of the health care system.

That's probably the single biggest contributor of health care cost growing much faster than inflation is because we can do stuff this year we couldn't do last year. And we learned how to do stuff last year, we couldn't do the year before. That's the big push for good and for bad.

Okay. So Vermont was just named the healthiest state in the country. We're typically among the top three or four. There's a firm called Morgan Quitno that does a lot of state ranking. And it's usually Vermont or Minnesota or New Hampshire. We swap around. But Vermont's been number one for a while now.

UNIDENTIFIED SPEAKER: Well, they obviously have not been in this committee room.

UNIDENTIFIED SPEAKER: That's right.

REPRESENTATIVE MAIER: Or this House, the State House.

UNIDENTIFIED SPEAKER: Where do we rate internationally? Because we're higher than the U.S. average I know internationally.

MR. KAPPEL: In spending or in health status?

UNIDENTIFIED SPEAKER: In health status.
MR. KAPPEL: I don't know if anybody's ever taken Morgan Quitno's specific methodology and tried to apply it internationally.
UNIDENTIFIED SPEAKER: We saw stuff last session, or we were told, that in terms of outcomes, that we were higher up the scale in -- Vermont was higher up than the U.S. on average when compared with other countries.
MR. KAPPEL: If you look at some of the real specific indicators like infant death rate, Vermont tends to be among the best in the U.S. which puts us probably somewhere in middle internationally.
UNIDENTIFIED SPEAKER: I think it's our proximity to Canada.
MR. KAPPEL: That could be. But some of the international comparisons are really interesting because it's been real clear, there is no perfect healthcare system. All of the countries they looked at we're really good at something and really bad at something else. The one thing that emerges every time is that we're the most expensive.
UNIDENTIFIED SPEAKER: And not the best outcome.
MR. KAPPEL: Definitely not the best.

Spending on pharmaceuticals is a little tricky because of the way Fisca (phonetic) categorizes spending in Vermont doesn't match up directly the way the Feds categorize in this category. But our rate of growth in what Fisca (phonetic) calls drugs and supplies, the big chunk of which is pharmaceuticals, is definitely faster than the U.S. growth rate.
Who pays the bill -- not who pays the bill, yet. Where does the money go? So this takes all of the roughly $4 billion of health care spending in Vermont and divides it up among the categories.
Hospitals is the big one. It's been that way for a long time. Drugs and supplies is actually just about caught up to physicians. Probably the next couple of years, the state as a whole will spend more on drugs and supplies than we do on physician care.
Where does the money come from? Next graph. Again, this is the interesting point that for pharmaceuticals, over a third of all spending is out of pocket. For health care as a whole, less than 15 percent.
So drugs, even with the growth and coverage, drugs are much more reliant in out-of-pocket

spending than all of other categories, with that caution of wait 'til Medicare Part D is fully into the Bushca (phonetic) estimates because everything will change.
UNIDENTIFIED SPEAKER: I have a question. We heard so much from primary care physicians, particularly about the rate of reimbursement and basically losing money. So the pharmaceuticals aren't losing money. They're not saying, gosh, we're only -- it costs us $1.00 to provide the drug and we only get reimbursed at (inaudible) insurance.
I mean, to me, I'm not being clear on this, but if one part of the service spectrum, the human being, is losing money but the drug portion of the service is making money, you know they're not going to be losing money, then it seems to make sense that you have more investment in that part of the service plan to a person in the area where they're not losing money versus where they are losing money.
Do you know what I'm saying?
MR. KAPPEL: Not exactly.
UNIDENTIFIED SPEAKER: Never mind.
UNIDENTIFIED SPEAKER: Can I take a hit at that?
I think some of it is because we can't control

the costs that are coming from out of state which is the drug costs. But we can control in Medicaid and Medicare. We can control the cost with the State which is the doctors -- what we will reimburse to the doctors.
So there's some of that there. If we actually reimbursed at a higher rate, at a fairer rate to the doctors, you'd see that line go up and it wouldn't be quite so even. The difference is is we can't say to drug suppliers, we're not going to pay you this because they just won't do business in our state. And that makes a difference.
Did that help?
UNIDENTIFIED SPEAKER: Yeah. And I'm guessing it similar. This is Vermont but I'm guessing it's not that dissimilar from the rest of the U.S. where the costs of drugs and supplies is getting close to the cost for physician services.
SPEAKER 7: I think another difference is we negotiate with drug companies, we don't negotiate with physicians. So it's a different kind of relationship.
UNIDENTIFIED SPEAKER: Can I ask another question too? In all fairness to some of the -- I mean, there are a lot of doctors that are being told

that they don't need the higher cost drugs, but there are also drugs there that are getting people healthier longer.

Has there been any analysis done of what our health care costs, hospitalizations, and doctor's visits would be if we didn't have some of these medications? Because, I mean, there's that side of it, too.

MR. KAPPEL: There's actually been -- that question tends to get brought up in a lot of conversations about whether we're spending not enough, the right amount, or too much on drugs. But it's really hard to -- and I've never seen a really good reputable study that says, this much spending on drugs, even in this particular diagnosis, produces this big an offset of hospital care, for instance.

So drugs to control chronic heart failure, clearly they reduce hospitalizations. But I've never seen a nice clean dollar-for-dollar comparison. It would be really nice to have one.

UNIDENTIFIED SPEAKER: It would be interesting. I know, (inaudible) I just got my mother out of the hospital yesterday. She's a real bad asthmatic. And she used to be in the hospital

four and five times a year for three and four days.

Now she's in once a year. She takes a new medication. I don't know what the medication costs but I'm sure that it's a whole lot less than being in the hospital for five and six days, three and four times a year. So, I mean, you know, there's that part of it too. I think it would be interesting (inaudible).

MR. KAPPEL: One of the things that always amazes me about health care is that we spend almost a 5th of the gross domestic product on something we really know so little about how things work in it.

There was a study, I think it was in The Times yesterday, that drug-eluting stents -- I think that was the term -- which were the great advance for heart disease, may not work a whole lot better than just taking drugs for some people. And it takes years for people to figure this stuff out.

It's that conversation we had yesterday about the clinical trials and what happens in clinical trials versus moving this stuff out into real life and seeing how it actually behaves, which is very different from the way it behaves in a clinical trial.

UNIDENTIFIED SPEAKER: Not to be too cynical,

but there's the years it takes to figure it out and then there's the years that the drug companies are successful in suppressing the data about that, right? And then finally something happens.

MR. KAPPEL: I would not dream of having an opinion on that.

UNIDENTIFIED SPEAKER: There's been a few occasions where I've had the opportunity to listen to people from the drug industry. And they always say that drugs are cheaper. It's that -- there's a big savings in money but I've never seen the documentation. That's one of their battle cries about, you know --

MR. KAPPEL: I think one of the places that study would be so interesting is for the group of people for whom the diagnosis is clear and serious, sure, there's definitely a savings. For the people for whom the diagnosis or the need is not as clear, then that offsets the savings.

UNIDENTIFIED SPEAKER: And I've also heard the argument made that in some cases in speaking purely about money, not about human life or the quality of it, that drugs because we pay for them for a long time and people ultimately end up with the same consequences but later on that we actually end up

spending more on some conditions which is interesting.

MR. KAPPEL: Well, that's the wonderful prevention paradox that sometimes when you delay a disease, there's a huge life. It's a wonderful thing. If you just focus right down on the economics, it's not always a wonderful thing. Especially when you swap a somewhat earlier low cost (inaudible) for high cost (inaudible). But that's one of the things we need to think about.

Okay. Spending on drugs and supplies, Vermont. So this is just total dollars spent starting in 1996 about $180 million, 2004 not quite 500 million. So it's one of those numbers to keep in your mind. Vermont residents, 500 million bucks a year on drugs and supplies. So not quite $1,000 per person.

UNIDENTIFIED SPEAKER: Wow, I didn't get my share.

UNIDENTIFIED SPEAKER: Not yet.

UNIDENTIFIED SPEAKER: Somebody took my share.

UNIDENTIFIED SPEAKER: Don't worry, your time will come.

UNIDENTIFIED SPEAKER: I went to the doctor --

UNIDENTIFIED SPEAKER: You took my share?

UNIDENTIFIED SPEAKER: Yeah, I got part of your share, too, I think a couple of weeks ago.

MR. KAPPEL: Bottom chart on page 18, this is relevant growth rates. The blue one is drugs and supplies. So this is just growth and spending over the previous year. Red bar is all other health care, excluding drugs and supplies. The yellow bar is the consumer price index.

Some of those years are really scary. Look at 2000, for instance, drugs and supplies growing about 23 percent from the previous year; health care about 9 percent; consumer price index about 2 percent. So that's where you've got the effect of health care spending above and beyond underlying CPI. And on top of that, drug care spending above and beyond the rest of health care.

I think the introduction yesterday was the focus on drugs tends to be because fast growing heavy out of pocket and that's pretty clear from that.

UNIDENTIFIED SPEAKER: But there still is the factor that the health care hasn't grown as fast because of the fact that we decide the reimbursements. I mean, if we had reimbursed the $19 million that we shortchanged the different

hospitals, you'd see these graphs grow --

MR. KAPPEL: No. All you're doing is swapping pockets. If you, as Medicaid, reimburse $19 million more than -- assuming their regulatory model works fairly well, which is a big assumption -- the commercial insurers will reimburse $19 million less.

UNIDENTIFIED SPEAKER: That's true.

MR. KAPPEL: So your aggregate spend stays exactly the same.

UNIDENTIFIED SPEAKER: It would affect the cost shift but not the overall spending.

MR. KAPPEL: A really important concept to understand, the difference between cost containment and cost shifting. When you control costs for one payer and that expense gets shifted to another payer, you've done nothing to aggregate spending. You simply said, I'm paying it out of my left pocket instead of my right pocket.

UNIDENTIFIED SPEAKER: Did you have a question?

SPEAKER 8: I have a question on the chart. And if I'm off on a tangent, let me know right away, okay?

Over the last three years, we have viewed evidence, people have talked to us about the health

care, the cost of health care rising somewhere between 25 and 35 percent every year.

MR. KAPPEL: I have not heard anything like that number.

UNIDENTIFIED SPEAKER: Cost of which?

UNIDENTIFIED SPEAKER: Health care or insurance?

SPEAKER 8: Let me phrase it this way. Last year we spent how much money on health care total, approximately, total?

MR. KAPPEL: A number which I should have in my head, but I don't.

SPEAKER 8: Three point something billion.

MR. KAPPEL: Yeah.

SPEAKER 8: 3.2, I think it was.

SPEAKER 7: I think that was the year before.

SPEAKER 8: All right. The year before. So now this year, what did we spend on it so far?

SPEAKER 7: The estimate for your current year that we're in is just about 4 billion.

SPEAKER 8: What I'm trying to do in my head is if this is all health care and this chart is saying that the growth and spending is down somewhere around seven percent, is that -- how does that equate? That to me is like a 4th, that's 25

percent.

MR. KAPPEL: This is the year-to-year numbers.

SPEAKER 8: Yeah, I know.

MR. KAPPEL: So the red line is the 3. -- not quite the 3.2 to the 3.7 to the 4. And, historically, that averages out between 7 and 10 percent a year, every year. It will go down for a couple of years. It will go up for a couple of years.

But if you look at the long-term average, it's about 7, 8, 9 percent a year. And it's about 4 points above inflation, and it's been doing that forever. Although, it does have that up-and-down cycle and no one is quite sure why. But you can just about bet over the long run, you're going to spend about 8 percent more on health care this year than last year.

UNIDENTIFIED SPEAKER: It appears that that curve goes down sometime around or shortly after this major move towards health care reform.

MR. KAPPEL: I think that's one of the factors. Another one is what's called the underwriting cycle. And this is something insurance companies live through. And, again, it's about a three- or four-year cycle. No one can say this is

what's going on. But they will get into a competitive mode where they lower their premiums to try to get market share. And from the point of view of consumers, that lowers the growth in health care spending.

They all get into solvency trouble, and they all have raise their premiums, so you get the big growth those couple of years. And it just goes up and down and up and down. And that's one of the factors. Political attention, and random noise is the third factor. So it's not just dead flat 7.5 percent a year. It goes up and down; but over time, it's been frightenly consistent.

UNIDENTIFIED SPEAKER: So when we have a good year, watch out.

MR. KAPPEL: No good years go unpunished.

MS. LUNGE: So the next part of the presentation, we're going to shift gears a little bit and talk about current initiatives that Vermont already has in place so you have a sense of the landscape.

And one question I wanted to ask before we jump into that is: Do you want to take a little break before we shift, because this would be a good sort of a logical place to take a break if you need

a break, or do you want to just keep going and stop when we stop?

UNIDENTIFIED SPEAKER: You're talking about going for like another hour, right?

MS. LUNGE: It may take a little more than another hour, depending on how much detail we get into.

UNIDENTIFIED SPEAKER: Five-minute break.

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UNIDENTIFIED SPEAKER: My neighbor, my closest neighbor is a doctor, mid-60s about to retire. And every time we get chatting across the fence about chronic care or this sort of stuff, he goes, you keep them alive longer, they just cost more. And we laugh. He understands. And you keep saying that 50 year old that would have died of a heart attack, it's not costing the health care system very much.

UNIDENTIFIED SPEAKER: Except for Sarah.

UNIDENTIFIED SPEAKER: If you go by 100 years ago, average life, none of us would be here.

UNIDENTIFIED SPEAKER: Hey, I'm 42. I would be alive.

(Inaudible.)

UNIDENTIFIED SPEAKER: Lucy must come close, wouldn't she? She's 42.

UNIDENTIFIED SPEAKER: Although, it sounds like she almost just died. Still sick, feels like hell, unbelievable. Those were her messages this morning.

(Inaudible.)

UNIDENTIFIED SPEAKER: It's not just a cough. She's got --

UNIDENTIFIED SPEAKER: Fever, chills, aches, pains.

UNIDENTIFIED SPEAKER: She apparently had the real flu.

UNIDENTIFIED SPEAKER: She's got what my wife had.

UNIDENTIFIED SPEAKER: That's why you get a flu shot.

UNIDENTIFIED SPEAKER: She couldn't even get out of bed, my wife.

UNIDENTIFIED SPEAKER: I didn't do that.

UNIDENTIFIED SPEAKER: I hope whatever strain she has is what I had a flu shot for.

UNIDENTIFIED SPEAKER: That would be good.

MS. LUNGE: He'll be right back. We don't need him to start.

(Inaudible.)

MS. LUNGE: So to get started, page 19. What

we're going to just -- what I wanted to start with was just to go through some of the different ways that the State is involved in purchasing prescription drugs directly.

So obviously, one of the biggest players is the Medicaid program with approximately 147,000 Vermonters. And you're fairly familiar with that program, so I won't go a lot of details; but, of course, Medicaid, V-hab, Dr. Dinosaur all purchase drugs for folks who are enrolled in those programs. We had the V-farm program which is the state program that wraps around the Medicare Part D coverage and assists Vermonters in paying for the premiums in the doughnut hole and all that.

We also have Vermont-RX, which is a pharmacy program for non-Medicare eligible elderly and individuals with disabilities that provides coverage primarily for maintenance drugs. It varies by income. The lower income folks gets the same coverage as Medicaid.

The details of this is on that yellow sheet that Lauren handed out to you. So if you want more details about what's covered and what are the income guidelines, that has that information.

We also have what's called Healthy Vermonters,

which a prescription drug discount card for individuals who do not have prescription coverage or who exhaust their prescription drug coverage. And what that discount card does -- there's no cost to the state -- what is does is it enables the individual to go the pharmacy and pay the Medicaid price.

So instead of paying the out-of-pocket cost, the individual is able to access the Medicaid price. And they would pay for that themselves, so there's no state contribution.

UNIDENTIFIED SPEAKER: And who receives that card?

MS. LUNGE: People who to not have prescription drug coverage or who have caps or limitations on their drug coverage which they've exhausted.

REPRESENTATIVE MAIER: And they meet some eligibility criteria?

MS. LUNGE: Yes. Currently --

REPRESENTATIVE MAIER: It's not just anybody?

MS. LUNGE: If I could steal your card. It's on the back side of this yellow sheet and for the -- for anyone in Vermont, who is uninsured, it's up to 300 percent of the federal poverty level, which is

for one person $2,553 a month; and it's up to 400 percent of the federal poverty guideline for the elderly or disabled who have exhausted their coverage, and that's $3,404 for one month.

UNIDENTIFIED SPEAKER: Thank you, Lauren.

REPRESENTATIVE MAIER: You up-dated that?

UNIDENTIFIED SPEAKER: Not since last spring.

REPRESENTATIVE MAIER: That's 2006. Okay. It's not too --

MS. LUNGE: I haven't seen them come out yet.

UNIDENTIFIED SPEAKER: I haven't either.

MS. LUNGE: Usually somebody emails them around.

UNIDENTIFIED SPEAKER: And those are not -- I know this sounds stupid because it's federal poverty levels, they don't adjust it all (inaudible) that's incredible, usually New York is the same standard as Michigan or something.

MS. LUNGE: So --

REPRESENTATIVE MAIER: What about in other states? I mean, the levels of all these things are very dramatically by state. I mean, quickly, the other day there was mentioned -- I don't know if you picked up on it in the Chicago meeting -- there are some states that have, you know, 30 percent of not

even 100 percent. They're down before you get other benefits.

UNIDENTIFIED SPEAKER: It was Kansas that was 37 percent.

MS. LUNGE: So if you remember from your colorful chart yesterday to get a sense of how healthy Vermonters helps individuals, you can see that the blue is what the uninsured individual or a person who exhausted their coverage would pay. And then the Medicaid is the yellow. So it does offer Vermonters about a 40 percent savings to have that card.

Of course, the card only helps you if your drug is one of the Medicaid formulary drugs, so it doesn't help everyone. Also, of course, through Catamount Health by subsidizing the health product with Catamount Health assistance, we are somewhat less directly but still involved with drug purchasing through that program, the Vermont state employees, the teachers and municipal employees, and also -- it's not listed -- but workers' comp is other area where the state is somewhat involved with drug purchasing.

What have we done to control cost in our public programs? In Medicaid, we've implemented

several cost containment strategies including the preferred drug list, which we talked about in some detail yesterday. Which I think I mentioned yesterday, we do have an authorization process for drugs that aren't on the preferred drug list. So we have implemented that pieces of cost containment.

Also, we do negotiate supplemental rebates from drug manufacturers in the Medicaid program. We're part of the multi-state purchasing pool with Maine and Iowa. It's called the sovereign states drug consortium. What that means is Vermont, Maine, and Iowa, the Medicaid programs bargain with and negotiate with manufacturers together. So they pool all the lives across those three states in order to leverage more negotiating power.

SPEAKER 1: Do you know if those drugs come from the manufacturer or through the wholesaler?

MS. LUNGE: What the purchasing pool does is they negotiate the supplemental rebates. So the drugs -- so your question depends on where the purchaser, the Medicaid person, buys their drugs.

So if they buy it from an independent pharmacy, it probably comes through a wholesaler. If they buy it from a chain pharmacy, it could either go through the wholesaler or directly from

the manufacturer.
SPEAKER 1: Got you. Thank you.
REPRESENTATIVE MAIER: So when that first started, we were with South Carolina and --
MS. LUNGE: I don't recall who but we were in a different pool.
REPRESENTATIVE MAIER: So when did we change and why did we change?
MS. LUNGE: We changed to this purchasing pool last year at the same time that we switched to Medmetric's which is the nonprofit PDM. I think normally there's some connection between what PDM you use and the purchasing pool. So that may be why we switched, although I'm not 100 percent sure of that. We can ask OVHA to explain more thoroughly about that.
MR. KAPPEL: I think CMS requires multi-state purchasing agreements to all be running through the same PBM.
REPRESENTATIVE MAIER: Right. I remember that, now that you're saying that. Because that was -- as we were approving it at the time they were using First Health and you had to work only with First Health states.
MS. LUNGE: Right.

REPRESENTATIVE MAIER: And there was some cause for concern related to that.
UNIDENTIFIED SPEAKER: And there were other states with First Health besides what states were working --
MR. KAPPEL: I think part of the issues with First Health drove Vermont to go.
REPRESENTATIVE MAIER: Do we have -- is it possible to get any information about performance? I mean, do you have any idea whether this particular one is doing about the same, better, worse, in terms of price discount?
MS. LUNGE: Yeah. OVHA should have that information. Some of the cost information is confidential, so they may not be able to give you specific numbers but they might be able to give you aggregate figures or general -- at least a general sense I would think so, but OVHA should have that information on the performance.
REPRESENTATIVE MAIER: We can try to remember -- we're going to try to do, Joshua, this afternoon, they're aware that we have a couple of things on the floor; and at least one of them I need to be there for, the education thing, but -- so we're going to try to fit them in a little bit later

in the afternoon.
MS. LUNGE: In addition, through our Medicaid program, we have instituted coverage of some over-the-counter and generic drugs as a cost containment measure. And as part of that, OVHA has what's called the maximum allowable cost program which sets a maximum reimbursement for generic drugs. And that is something which many Medicaid programs around the country use as a cost savings.
I think I probably don't need to remind you that Medicaid is a federal/state partnership. You know all that stuff, so I'm just going to skip that. And I had included some information about Medicare Part D because I wasn't sure if we had talked about that in a lot of detail. But I think you all are fairly familiar with that program.
It is a federally funded program. There are federal law and regulations which govern it. And it's private insures (inaudible) the program through CMS oversight. And as we have discussed earlier, the federal government is looking at their role in negotiating drug prices.
So the point of explaining that is really that for Medicare Part D in terms of the state role, most of what -- we're very limited in terms of what we

can do in shifting cost containment for Medicare Part D. We have more authority over the Medicaid program, although there are some perimeters, prefer drug lists, and things like that of federal law.
I just wanted to give you a general sense of that so that you can start thinking about, you know, in terms of what can you do, where you have the ability and authority to.
MR. KAPPEL: Part D moved about 30 or 35 percent of all Medicaid drug spending from the state to Part D.
UNIDENTIFIED SPEAKER: Because I'm assuming though -- again, most of the people who are using -- have that shall we say whatever it is, 30 percent of the people are consuming 70 percent of the prescription drugs. And I'm assuming among those, most of them are Medicare that they tend to be older folks.
So what I wonder then is when you talk about shifting costs, you know, if you could be (inaudible) very much with the Medicare that's state publicly funding portion but what can you get out of the (inaudible).
MS. LUNGE: Well, we used to -- this -- many states had started all of these initiatives prior to

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Part D, so they had much more ability to affect that because the Medicare program had all of those or many of those elderly folks or many states had started prescription drug programs to cover elderly folks.

And now we still have some ability to affect folks who are on Medicare because there's a significant population of people who are both Medicare and Medicaid eligible. And for those folks, we do provide, and through our wrap around program, we provide additional coverage for certain drugs that Medicare does not cover.

There are several categories of drugs that Part D does not cover at all. And so that is an area that is still open for management. But I think, that's a -- you make a really good point, which is, we used to have -- we used to be able to make a bigger effect because most of it was in Medicaid. And at a state level, in terms of our public programs, we are a little more limited because of that shift from Medicaid to Medicare.

UNIDENTIFIED SPEAKER: I was actually going to mention (inaudible) we have -- and I'm not a big fan of Medicare Part D. I think it's a absolutely horrible program because we in Vermont were doing an

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awful lot for our elderly people. And I refused to get my AARP card because they're the biggest lobbyists of Medicare Part D.

And when you go online and you try to find prescription drug companies for these elderly people, there's a great deal of many of them that are supplied through AARP under different names. So, you know, you talk about the prescription drug companies, but you forget that the lobbying effort is strong in all different ways. And part of the reason why we have Medicare Part D is because of profit. So that's my little (inaudible).

UNIDENTIFIED SPEAKER: So are you saying that AARP is a drug dealer?

UNIDENTIFIED SPEAKER: Well, they own a lot of companies that provide pharmaceutical benefits for people. I'm not saying that they are drug dealers. I'm saying they are certainly making a profit off of Medicare Part D, right Steve?

MR. KAPPEL: They make a profit off a lot of things.

REPRESENTATIVE MAIER: Do we know -- I'll play the conservative for a moment. Do we know --

UNIDENTIFIED SPEAKER: That's my job.

REPRESENTATIVE MAIER: I'm taking your job for

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a moment.

MR. KAPPEL: Do you want the hat?

UNIDENTIFIED SPEAKER: I just took his and I don't do hats.

REPRESENTATIVE MAIER: I mean, we now have a second entry into -- or we're in the first quarter of the second year of Medicare Part D, can we -- is anybody trying to say anything yet about prices? You know, the prices -- things were rebid and came around a second time, do we -- I think most of us skeptics sort of presumed the prices would come in low, and then once people were used to it, then, you know, then they would jump the prices up.

Didn't seem to me that that happened for the second year. But is it still way to early to draw any conclusions about the competitive environment and prices regarding Medicare Part D?

MR. KAPPEL: I think you won't see the big price jump until the market starts consolidating. You know, you've still got 25 guys selling the product. Nobody is going to use their size to start leveraging. If a lot of (inaudible) are dropping out, that's when you'll start seeing the prices go up.

MS. LUNGE: And I think we actually have a

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greater number of plans this year than we did last year. Do you recall? I don't recall the numbers off the top of my head.

MR. KAPPEL: A couple more plans the prices are not going up even as fast as they were predicted.

MS. LUNGE: They did go up a little bit but not a ton.

MR. KAPPEL: Apparently, once everyone figured out how it works, consumer satisfaction is pretty high.

REPRESENTATIVE MAIER: Well, for those people that don't live in the doughnut hole.

MR. KAPPEL: Right.

REPRESENTATIVE MAIER: Those people, there is data there.

MS. LUNGE: And in Vermont --

REPRESENTATIVE MAIER: I've heard in NCSL or other places, pretty much if you're in the doughnut hole, you hate it. And if you're anywhere else and you've got coverage, why wouldn't you like it?

UNIDENTIFIED SPEAKER: It's either very low or very high.

MS. LUNGE: And in Vermont, we do offer the wrap coverage. I don't know if the consumer

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satisfaction is just state specific information or national; but at least in the states that are providing wrap coverage, those folks are insulated from that doughnut hole.

REPRESENTATIVE MAIER: Well, the people -- I mean, you've got -- there are plenty of Medicare --

UNIDENTIFIED SPEAKER: Duel eligibles.

MS. LUNGE: Not just duel eligibles, but in Vermont is up to 100 and -- 225 is poverty.

REPRESENTATIVE MAIER: But just so nobody goes away, it's not, I mean, not for my mother-in-law. I mean, you know.

MS. LUNGE: Absolutely.

REPRESENTATIVE MAIER: There are plenty of people that have to live or go through the doughnut hole that don't get wrapped because their income level is such that they didn't get these wrap around coverages.

UNIDENTIFIED SPEAKER: The hard thing in the beginning of this program is Vermont had done such a good job of taking care of its elderly that we weren't really penalized by this program financially.

And for the people who didn't have any program at all, even if they used a lot of drugs, it was a

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great program. So you're not going to hear a lot of complaining from those folks. You know, like you said, we insulated a lot of Vermonters from what's going on but it still doesn't make it right.

SPEAKER 8: Can people on the Healthy Vermonters program, if they're in the doughnut hole program, can they use that program?

MS. LUNGE: They can use the Healthy Vermonters discount card, but it won't help them move through the doughnut hole because it's not an allowable prescription drug program under the federal law.

So what you, the consumer, would have to figure out is, is it cheaper for me to use Healthy Vermonters because I'm never going to get through the doughnut hole based on what my drug usage is, or is it cheaper for me to pay out of pocket because my PDP has a better -- they shouldn't have a better price than Medicaid but, you know -- so you can use it but there's sort of a semi-complicated analysis that they expect you to figure out which is in your best interest.

UNIDENTIFIED SPEAKER: The most sick elderly people are not going to be able to navigate through that system.

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(Inaudible).

MS. LUNGE: So on page 21, we've talked a lot about PDL so I'm not going to go into that in a lot of detail, except to say that what we have tried to do in our preferred drug list in Medicaid is to really balance both cost and quality considerations.

So our statutory language is really focused on those dual considerations, to the extent that we have information on both of those things that can be considered.

REPRESENTATIVE MAIER: And I should also say, I mean, the information that I can bring forward from the old health and welfare committee that before my time put this into place. Now, Vincent, for example, I served with was -- had the seat before Sue Minter did from Waterbury. Her husband is a pharmacist.

And she gushed about this, partly because there was so much concern as it was brought forward from the pharmacist and the doctors and, you know, lots of people were concerned about how this would play out. And so I think another thing just to say, quickly, is that most people think this has worked very well in Vermont, the way that we have done it, and the board works and that it is the way that it

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was rolled out and played together that's an important -- how much money, you know, it has saved money but how much --

SPEAKER 1: The first year said 16 million?

REPRESENTATIVE MAIER: I don't remember.

UNIDENTIFIED SPEAKER: Somewhere around that. I can't remember exactly.

MS. LUNGE: For this state?

SPEAKER 1: Yeah.

MS. LUNGE: There's a report from 2003 we can try and dig up, if you're interested in it.

So next we're going to shift gears a little bit and look at the cost containment initiatives that Vermont's done related to pharmacies and providers. So this is broader than just Medicaid in our public programs, this applies for everyone in Vermont.

And the first initiative is our generic substitution law, which has the pharmacist generally select the lowest price chemically and therapeutically equivalent drug, if there is a generic available. There is an opt-out provision for the proscriber and the purchaser; so that you, the consumer, can say, no, I really -- you know, there's a reason why I want the brand drug instead

of the generic drug. But the general concept behind this is to move -- to shift people from brands to generics because they are, generally speaking, lower cost alternatives.

We also have a program that requires that at the pharmacy level that certain prices are disclosed to the consumer. The way that was structured was that you would get the comparison between the usual and customary price and the price of your particular drug plus your cost sharing.

So, for instance, I think Topper brought this up yesterday, when I go to the pharmacy, I see retail cost X and then I see the cost to my plan. And Topper's cost might be different than Jenny's cost and might be different from my cost. But the point of that initiative was to give consumers more information about what the actual cost of the drug was, even if they were just themselves paying a copayment.

So I think the general philosophy was giving consumers most education would assist them in choosing lower cost alternatives. I don't know that we really studied that to see if it's had an effect on what drugs people are asking for or choosing. But that was the driving force behind that one.

UNIDENTIFIED SPEAKER: I have a question.

MS. LUNGE: Sure.

UNIDENTIFIED SPEAKER: You said that a person can opt out of that provision; but when that individual opts out, then they have to pay the higher cost out of pocket?

MS. LUNGE: It depends on their insurance or if they're paying out of pocket. So, again, you have to remember that this is in connection with drug formularies, too. And so it would depend on your insurance, what your insurance copays were, and if they have, you know, a tiered system where you pay a higher copayment for brand. But, generally speaking, usually if there is a formulary though the system, you do pay a higher copay for brand than generic for the same reason.

Okay. Also, we did initiate a counter detailing program, which we call an evidence-based research education program in statute. It's meant to look at what drugs are most cost effective and to also, as we talked about earlier, counter some of the marketing strategies.

And that program was established in OVHA and it's something that OVHA has not yet implemented. They did issue a report in January 1, 2005. And

this was a program that actually I'll give you more information about in this because the Senate changed how this was happening because OVHA hasn't implemented it. I think in part because they have many other things that they've been working on.

In part, I don't believe there is ever specific funding tied to this program. And the Senate wanted to know: Is that because they asked for it and we didn't give it to them, or they didn't ask for it? And I wasn't able to dig up that much budget history, although you might actually just remember.

So that is something that we did try but haven't really gotten off the ground in the way that it was written in statute. AHEC has been working on a counter detailing program that's not written in statute anywhere. That's just an initiative that they've kind of taken on.

In addition, we have looked at promoting 340B drug pricing. Again, you'll recall from yesterday, 340B drug pricing is the price that is paid for -- through a FQHC, so health care facility certified by the federal government such as FQHC is planned parenthood.

And from that colorful chart that you received

yesterday, you can again see the price comparison. The 340B, the price is in red, so it is one of the lower prices. Generally, you know about the FQHC so I'm not going to go into a lot of detail about that.

And Lauren was going to make me copies of the list of Vermont entities, so I'm sure we'll have that for you at some point today.

UNIDENTIFIED SPEAKER: Which list?

MS. LANGE: It was the list that I gave you at the end of the day yesterday, the one-page chart, and it has a list of the FQHCs, all planned parenthood, and all the people in that network.

In addition, one issue that this committee worked on quite a bit in 2005 was importation. And Vermont has worked on importation -- issues around importation. So a little bit of background on that. The federal law regulates that sale of drugs including importation that's done through the FDA.

And the FDA approves drugs for certain uses by specific manufacturers. And they also -- also governing that area is a whole body of patent law and the ability to keep the formulation of a particular chemical used in -- or chemical combination used to produce the drug private for a period of time. There is --

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MR. LANGE: Also, the FDA does have the authority to approve importation programs. Vermont did seek FDA approval for an importation program, which was denied. The Attorney General sued to overturn the FDA's decision and we were unsuccessful in court. So to date, I don't believe that the FDA has approved any request for states to establish importation programs.
However, several states and cities has started them anyway. And as you know, Vermont joined the I-Save RX program, which was started in Illinois and was a program for individuals, so individual Vermont residents, to go a website and use forms and other things available on the website to purchase drugs through that program which imported the drugs either from Canada, Ireland, and they may have expanded it to Australia and New Zealand at this point.
Generally, it was expected to save individuals between 20 to 50 percent, depending on what drugs they were using. And also in that same act in 2005, there was insurance coverage requirement for I-Save RX purchases. And there have been efforts federally to change the law on importation. There are bills pending. At this point, it's too early to know this

year exactly what's --
UNIDENTIFIED SPEAKER: I think, Mr. Chair, that this committee needs to go to Ireland and New Zealand and check out the I-Save program and see where they are coming from so we know exactly where they are coming from.
REPRESENTATIVE MAIER: Would you write up a proposal for me?
MS. LUNGE: I think you need to bring your staff.
UNIDENTIFIED SPEAKER: We can't go and on without you guys.
MS. LUNGE: And Steve and I will clear our calendars.
UNIDENTIFIED SPEAKER: Supposedly in that program the state of Illinois, they sent people to the places. We did check them out.
REPRESENTATIVE MAIER: They did. That's right. They sent their own inspectors or something.
UNIDENTIFIED SPEAKER: Who did?
SPEAKER 1: Illinois.
UNIDENTIFIED SPEAKER: State of Illinois did.
SPEAKER 1: I don't think they were legislators, though.
UNIDENTIFIED SPEAKER: I've been around here

long enough to not believe what another state says. We need to check it out for ourselves.
UNIDENTIFIED SPEAKER: Especially Illinois.
UNIDENTIFIED SPEAKER: We might want to take that trip.
REPRESENTATIVE MAIER: So do we have any information about how many Vermonters have access to the program?
MS. LUNGE: We do. I think I brought that with me.
REPRESENTATIVE MAIER: And is this in the category of I shouldn't ask unless I already know the answer?
MS. LUNGE: Yes. Not many is the answer.
REPRESENTATIVE MAIER: I was afraid of that.
MS. LUNGE: I didn't bring my whole file but I can bring you -- I got an e-mail from Illinois. I did check for the Senate to see what our participation was.
UNIDENTIFIED SPEAKER: I'd like to know that.
MS. LUNGE: And I think it was under 1,000 scripts for a year. So it was quite -- it was lower than I think most people expected. But I'll get you the exact figures on that.
REPRESENTATIVE MAIER: Was it initially lower

and it's grown to that or was it initially higher and now it's gone down with Medicare Part D? I wonder if it's --
MS. LUNGE: I'll see what I can dig up in terms of trend. They didn't give me the data for every single month. They gave me a few months and the cumulative data, I think. But we can also ask them for other data.
UNIDENTIFIED SPEAKER: How would people know about it?
UNIDENTIFIED SPEAKER: That was what I was wondering whether we did a good job publicizing it -- good enough job publicizing it.
REPRESENTATIVE MAIER: We didn't do a great job.
UNIDENTIFIED SPEAKER: It was up to the state to market it, essentially.
REPRESENTATIVE MAIER: It was one of those things that happened and the administration wasn't particularly enthusiastic about it. They did not support it, although Governor did sign it was passed. So they weren't enthusiastic about marketing it. They sort of -- most of it was just putting something up on websites.
MS. LUNGE: So in addition --

UNIDENTIFIED SPEAKER: I think Medicare Part D had a lot to do with that too, though. Because when it first started happening, it was a lot of elderly people they were putting on buses and bringing them to Canada. And I think that was a lot of it.

And I think that is one of the reason why we need to go over there and check it out and make sure it's safe. That way we can come back and we can market it ourselves and tell our constituents, we saw these manufacturers and we know that they're safe so you can buy the drugs there. I don't want to go to Canada. I want to go to Ireland and Australia.

UNIDENTIFIED SPEAKER: You start off with Ireland and then New Zealand and Australia. Ireland and then Australia because then you'll be following the path.

MS. LUNGE: We can just get a round-the-world ticket. I mean that's really the way to go.

UNIDENTIFIED SPEAKER: Gee, three weeks together with the Health Care Committee.

REPRESENTATIVE MAIER: If they say no, Pfizer might pay for it.

(Inaudible.)

UNIDENTIFIED SPEAKER: I'll ask them.

UNIDENTIFIED SPEAKER: Maybe I can get AARP to pay for it for me. I'll tell them I'll finally join AARP.

UNIDENTIFIED SPEAKER: I never joined either, so there's double incentive for them.

UNIDENTIFIED SPEAKER: I'll bet they're waiting on your membership fee.

MS. LUNGE: So, lastly, there's a couple of cost containment initiatives that we've passed relating specifically to drug companies as opposed to mostly -- we've talked so far about the public programs and pharmacies and providers. Most of them have to do with marketers and disclosure of information.

So we have a pharmaceutical marketing disclosure law and a pharmaceutical marketer price disclosure law. The first one is an annual disclosure by drug companies of their marketing activities and that goes to the Attorney General. And they do have reports available on the website about marketing activities in Vermont, how much each company has spent on marketing, etc. So if that's something you're more interested in getting details about, certainly Julie Brill can talk to you about that and we can also get you stuff from the website.

MR. KAPPEL: There was also just an article last week in the New England Journal of Medicine looking at the two states with these disclosure laws. And I think, generally, they were supportive of the concept and said there was serious information difficulties in both states.

SPEAKER 1: It was Gamma (phonetic)?

MR. KAPPEL: Was it Gamma (phonetic)?

SPEAKER 1: Actually, I emailed the guy, the guy who wrote it and he'd be happy to -- if you get back and want to go into it, he'd be happy to talk on the phone with us.

MS. LUNGE: I forwarded it to Julie Brill because I thought she would be interested because she is the one who gets all the data. She was -- she, I think, has some other information that kind of undercuts -- she believes undercuts some of his information. Because she, for instance, said some of the information is posted on their website that he was saying wasn't available so --

UNIDENTIFIED SPEAKER: That article that I copied from the Times Artist is about that report.

MS. LUNGE: Maybe it's a good time to hand it out.

UNIDENTIFIED SPEAKER: So if that report says

how much and does it say what type of activity? For example, I heard them saying, you know, the going to lunch, free samples, versus advertising on television.

MS. LUNGE: They might have breakdowns like that. I haven't looked at it in a lot of detail recently enough to remember how they break down the data. But I'm sure that the AG's office, because they have the data, could break it down in different ways possibly, if you'd like them to do that.

MR. KAPPEL: Although, I don't think it includes things like advertising on TV.

MS. LUNGE: Right. This is direct to doctor.

UNIDENTIFIED SPEAKER: You know, tickets to the ball game and stuff like that.

(Inaudible.)

UNIDENTIFIED SPEAKER: Education and sending someone to Hawaii for, quote, education purposes.

UNIDENTIFIED SPEAKER: Tickets to the ball games and stuff like that, I think, especially if you know the guy or the woman and they want to, you know, take you out to dinner and stuff like that.

UNIDENTIFIED SPEAKER: Are you going to Atlanta this weekend? Delta is coming out of bankruptcy and so why not go. Delta is coming out

of bankruptcy and they want to fly me down there.
REPRESENTATIVE MAIER: You're done with this presentation, right?
MS. LUNGE: One more thing and then I'm done.
So the other initiative is the pharmaceutical marketer price disclosure. That requires the marketer to -- who is directly marketing to a prescriber, so the folks who visit you in your office, to disclosure the average wholesale price and the price relationship to other drugs in the same therapeutic class to the doctor. So the doctor would have some pricing information available in making decisions.
SPEAKER 1: A side note to that, when I did my thing with Fletcher Allen and I went to a health care provider, and the stock person said this whole thing is ridiculous. Every month I get a stack of data like this. So all the way, it's just a waste of time. And some of the detailers have said, I spent my morning or a couple of hours at Kinkos duplicating this stuff and distributing it.
I've tried to talk to Julie to say if there are any changes, then the detailer will provide the changes but I don't know if that's happening or not. And I got this from a health care provider not a

detailer. So this is kind of -- what this practice is is kind of ridiculous and a waste of time and paper.
UNIDENTIFIED SPEAKER: So they don't really enforce it, then. They're just doing all the paperwork and nothing is happening. Is that what you're saying?
SPEAKER 1: I'm saying a lot of this information is needless because the price that they charged last month is the same price they charge previous month and the health care provider knows that. So he just takes it, thank you very much, throw it away. And that's a -- I don't know if she has a -- I think she has the prerogative of changing that under the statute.
MS. LUNGE: What exactly the provider gets?
REPRESENTATIVE MAIER: What the detail is supposed to provide.
MS. LUNGE: Well, the statute says: When a pharmaceutical marketer engages in any form of prescription drug marketing directly to a physician or other proscriber, the marketer shall disclose to the physician the average wholesale price of the drugs being marketed.
So she might be able to, under rule,

determine --
SPEAKER 1: The frequency?
MS. LUNGE: -- the form and manner but not the content.
SPEAKER 1: Okay. It's not a big deal. I just thought of that. Thank you.
REPRESENTATIVE MAIER: In all fairness, I mean, I think there are ways that it can be done in a user friendly way and there are probably ways that are not user friendly way. I'm not sure this -- where you had to look at two sides to it too.
SPEAKER 1: Definitely. That's why I emphasized that I got this from a provider not a detailer.
REPRESENTATIVE MAIER: Right. So tomorrow morning, we're going to hear from Sharon Treat first at 8:30. So, Committee, get it in your brain that it's earlier than normal. She is former State Senator term limited, was out of the legislature for two or four years, and now back in the legislature as a representative.
I just learned recently you can do that. Someone definitely in Maine, you can go back and forth and take time off or whatever. In California, you can't to that. You have a maximum number of

times you can serve -- years you can serve in the House and the Senate and then you're done forever.
UNIDENTIFIED SPEAKER: A lifetime limit.
REPRESENTATIVE MAIER: Yeah. Anyway. And she's also the executive director or some similar title of the National Legislative Association on Prescription Drug Prices. And I think Robin and others term that NLARX, so of their --
So she's on tab for tomorrow morning to talk with us about -- I think maybe Robin and I had hoped that we would have had time by now to go through what the Senate has actually proposed, because we were teeing up Sharon to talk about what some of the other ideas are, other than the ones that the Senate has proposed.
So it may be a little bit out of sequence. She may be still talking about some different ideas than the ones -- I presume, then, after she's done tomorrow, you'll then be presenting to us about what the Senate has done?
MS. LUNGE: I can. What I would -- and you can tell me what you want. The bill is on notice today and there are several amendments. So I'm not going to know exactly what passed. But I can give you broad -- there are certain things that there are

no amendments for. So it might make sense for me to do those in a little more detail. Or I can give you kind of the broad categories and general ideas without a lot of detail so that I don't give you detail that ends up not passing.

So that's really -- you know, you can decide what you think would be the most useful. I can do it whatever way. But I also have to figure out when the Senate is going to be on the floor, because I probably have to be there, which might be 11:00 or 11:30.

REPRESENTATIVE MAIER: Tomorrow?

MS. LUNGE: Yeah.

SPEAKER 7: I just have to say that we're really not limited to what's passed, theoretically.

REPRESENTATIVE MAIER: Right. So I want to understand what the landscape is.

Just for the committee, I may ask to juggle the committee's schedule tomorrow as well. There's a leadership meeting going on in the Speaker's office today, some other conversations that I expect to have by this time tomorrow that relate to the bigger question about Catamount health funding and that sort of brouhaha that's flying around the building.

So it may be -- one of the ideas on the table is for us to spend more time looking at that issue. So if that's the direction we choose to go in, we may redirect some of our time tomorrow and/or Friday to that issue, so people are aware that things may change. But we'll do Sharon in any case at 8:30 in the morning. We've got that scheduled. Her time is precious at this point, so --

UNIDENTIFIED SPEAKER: Two questions. One is, this afternoon, I mean, the education bill, I can't imagine that bill will take hours so --

CD 07-119/TRACK 2

SPEAKER 8: I was kidding when I was talking about you should take these junkets and all this stuff. I want you to understand that. That's on record. It's right here. Right here.

UNIDENTIFIED SPEAKER: Now you tell me.

REPRESENTATIVE MAIER: So I don't need to talk to you?

SPEAKER 8: I was kidding. Sometimes I say stuff and I got to watch out because my wife tells me this too. She says, you say something, they believe what you're saying. And I was kidding about that.

REPRESENTATIVE MAIER: Yeah. Yeah. Yeah.

UNIDENTIFIED SPEAKER: Does your wife know the difference between when you're kidding and --

SPEAKER 8: She absolutely knows.

UNIDENTIFIED SPEAKER: I just want to set the record straight, I am not kidding about going to Ireland and --

SPEAKER 8: I have one more thing and I am not kidding on this. It's a little bit of sad tire but I have to do it to make my conscious -- you know, as we set policy around this building, I was amazed or -- I was amused, I guess, amused is a better word, on page 17 of the chart that we saw, I think that first line, if I'm not mistaken, I think it's the blue or purple line or whatever the color is, it's labeled hospitals --

UNIDENTIFIED SPEAKER: And what bill was that?

SPEAKER 8: No. No. Let me lay this thing out a little bit. Biggest expenditure -- and I was -- you know, as we set policy, I was wondering should we take a look at the thing that costs the most money?

REPRESENTATIVE MAIER: That's an interesting --

SPEAKER 8: When we try to reduce that -- bend that curve on spending. Just stimulate that thought

process with that.

REPRESENTATIVE MAIER: Thank you.

SPEAKER 8: You're welcome.

REPRESENTATIVE MAIER: I wanted to do two things with you, quickly. I want to ask Joshua a question because it came up in the context of prescription drugs and even now or maybe if you can come back later.

The general question was raised, they were giving us background about the fact that we've recently -- in the past year or so, we've changed both your PBM and then the interstate grouping and my -- and I had asked: Do we have a general idea of whether -- of sort of performance?

Does that mean that have we saved any more money or have we kept even and why did we change? And there was just a couple of questions around that as it related to prescription drugs. And I don't know, you can either give a short answer now or do that when you come back later.

MR. SLEN: I think it is probably better to do that when I come back later. I don't think I can give a short answer.

UNIDENTIFIED SPEAKER: Josh, I couldn't either that's what I didn't answer.

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REPRESENTATIVE MAIER: And before we break, I passed out -- we did pass this out, right, to the committee? This question from the appropriations about the distribution of the AHEC loan repayment money. They were asking if we would like to have any input on that or whether this looks generally okay to us or whether we would like to suggest a different allocation and so I just want to open it up for a couple of minutes.

This looks -- it's sort of hard to know -- we didn't take any particular testimony on this. We did more of this last year. We talked with them more particularly about what the amounts should be. My general recollection is that these have sort of gone up on some relative pro rata basis from where they were last year.

Just to remind the committee they had -- they were working with a budget for this of about $880,000 last year. So the amount of money they have available to do these things has more than doubled.

SPEAKER 8: I have one question: Is this a shortage of nurses, a big shortage?

UNIDENTIFIED SPEAKER: Because we have a shortage of nurse educators.

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SPEAKER 1: That's a bigger shortage.

UNIDENTIFIED SPEAKER: So I was wondering why we had only 100 nurse educators.

SPEAKER 8: What I meant in relative terms compared to primary care physicians is about the same?

UNIDENTIFIED SPEAKER: At least the same but you get more bang for the buck with nursing.

(Inaudible.)

UNIDENTIFIED SPEAKER: I remember talking to a nurse who wanted to teach and she said she needed $40,000 to make the move, you know, the incentive. Because what I mean by that is, she was going to lose $40,000 a year by being an instructor versus a practitioner. So I look at this $100,000 for a nurse educator's faculty and I think about that conversation and think what does that buy you two or three.

UNIDENTIFIED SPEAKER: What's the loan repayment? Who pays their loans? That's what I think all this stuff is.

UNIDENTIFIED SPEAKER: The nurse educator faculty? If they had to be trained in order to become one.

UNIDENTIFIED SPEAKER: And they do have to get trained in order to become one so we pay back their loan.

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SPEAKER 1: What is a DO?

REPRESENTATIVE MAIER: Osteopathic physician. They are --

SPEAKER 1: Versus on M.D.

REPRESENTATIVE MAIER: There are -- they have the same general category as an M.D. They're trained like a doctor but they have also can have training that moves in some of the more alternative directions: Chiropractic, naturopaths, sort of moves in some of those directions.

So what I'm hearing is we might like them to just ask about whether there's -- might be more in nurse educators or whether there's --

UNIDENTIFIED SPEAKER: I'm not saying that.

REPRESENTATIVE MAIER: You're not saying that?

UNIDENTIFIED SPEAKER: I just wondered. I assume it's not random figures there.

UNIDENTIFIED SPEAKER: There's are a lot of history behind these number and where these numbers come from. Like I just said to Sarah, one nurse educator can teach 25, 50 nurses. So, you know, you're paying for more nurses to go into the system. You don't need as many nurse educators -- I mean,

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there is a shortage but you don't need as many nurse educators to fill the hole as you do nurses to fill the holes in hospitals.

This is a, geez, I got to say four, five-year conversation that's led us to this. So I certainly -- I don't think arbitrarily we can say just say, we'd like to change this when we don't have any history.

UNIDENTIFIED SPEAKER: Especially if we don't know what the figures were previously.

SPEAKER 7: I think if we want, we can have them come in and talk and have a conversation about -- I mean, one of my conversations would be how many of these for the primary care physicians are people who knew people versus people you just giving them money to that are already here.

To me, that would be an important distinction. I mean I happen to know -- I think it's a great program. I would write letters in support of people who for (inaudible) of forgiveness who I knew were going to stay here. And it didn't make any difference. So the question is -- I mean, that's fine too. But in terms of make sure to (inaudible) getting new people.

UNIDENTIFIED SPEAKER: To attract new people

instead of --
REPRESENTATIVE MAIER: How do you draw the line? Obviously, retention is also as important as recruitment. I don't know how you easily draw those lines. There's a lot of history.
SPEAKER 1: Who can make that decision better than we can? Is there some other group that can look at that with a lot more expertise?
REPRESENTATIVE MAIER: We haven't even -- as I said in the beginning of this, I don't think we've ever put these numbers into the statutory language. It's always been -- we sort of ask AHEC and they give us a letter or an e-mail just so we have an idea.
But it's not that we direct -- but AHEC has the authority to have some flexibility here. And as the year goes along, they direct it where they seem to think that it's needed most. And, I mean, so far it's worked pretty well.
UNIDENTIFIED SPEAKER: They have the pulse on what's happening in health care community across the state. I don't think we do as much.
SPEAKER 8: Last year we had -- what was her name?
UNIDENTIFIED SPEAKER: Mimi (phonetic).

REPRESENTATIVE MAIER: She's retired now.
SPEAKER 8: She talked a lot about this and some other people that came with her.
REPRESENTATIVE MAIER: One of her assistants, Liz, is now -- taken her place.
UNIDENTIFIED SPEAKER: I have to say I think the success of this program is because Mimi's (phonetic) always been so damn cute, no one can say no to her. That's really how it started out.
SPEAKER 7: She's very effective in a wonderful way.
UNIDENTIFIED SPEAKER: She educated all of us to what she was saying. It started out with she was so cute so knowledgeable and just, you know, respectful and responsible in the way she handled us. And I think that's what made everybody love her. Okay, you can have another $200,000. I like you.
REPRESENTATIVE MAIER: It's hard to forget her voice, too.
UNIDENTIFIED SPEAKER: She was a sweet lady.
SPEAKER 8: If they do -- unless we take testimony.
UNIDENTIFIED SPEAKER: All right. I don't feel --

(Inaudible).
UNIDENTIFIED SPEAKER: New disciplines is chiropractors and stuff like that, naturopaths?
UNIDENTIFIED SPEAKER: Health care needs slash workforce shortages in Vermont. They're going to base it on data. That's what I hope. That's what we asked them to do. And they had at least named a category to include them. To be determined.
REPRESENTATIVE MAIER: I think it's also conceivable that naturopaths would fit in the first line.
UNIDENTIFIED SPEAKER: That's true.
REPRESENTATIVE MAIER: It says primary care practitioner which includes almost everybody in that list that we would have listed except naturopaths.
UNIDENTIFIED SPEAKER: I do not see them in the same category.
UNIDENTIFIED SPEAKER: Only two places in the U.S. --
REPRESENTATIVE MAIER: Usually out west Oregon and Washington.
UNIDENTIFIED SPEAKER: Topper, stop causing trouble back there, will you?
UNIDENTIFIED SPEAKER: Topper, did you say something?

UNIDENTIFIED SPEAKER: You didn't hear me?
UNIDENTIFIED SPEAKER: No. I heard you say something but I didn't --
UNIDENTIFIED SPEAKER: I asked is naturopaths were UVM.
UNIDENTIFIED SPEAKER: These aren't limited to people with UVMs.
UNIDENTIFIED SPEAKER: Does anybody remember the number of the chicken bill from last week?
UNIDENTIFIED SPEAKER: The chicken bill --

CERTIFICATE

STATE OF FLORIDA)
COUNTY OF HILLSBOROUGH)

I, Kelly A. Roma, Notary Public, do hereby certify that I was authorized to and did listen to CD 07-118/T1-T2 and 07-119/T1-T2, the House Committee on Health Care, Wednesday, March 28, 2007, proceedings and stenographically transcribed the foregoing proceedings and that the transcript is a true and accurate record to the best of my ability.

Dated this 21st day of August, 2007.

_____
Kelly A. Roma
Notary Public
State of Florida at Large
My Commission Number: DD472817
Expires: 05/22/2009

TAB N

STATE OF VERMONT

HOUSE COMMITTEE ON HEALTH CARE

Re: Senate Bill 115

Date: March 29, 2007

Type of Committee Meeting: Standard

Committee Members:

Rep. Steven Maier, Chair	Rep. Harry Chen, Vice-Chair
Rep. Francis McFaun	Rep. Sarah Copeland-Hanzas
Rep. William Keogh	Rep. Lucy Leriche
Rep. Virginia McCormack	Rep. Virginia Milkey
Rep. Pat O'Donnell	Rep. Hilde Ojibway
Rep. Scott Wheeler	

CD No.: 07-122/T1 & T2

Esquire Job No. 887537

PROCEEDINGS

CD 122/TRACK 1

MS. TREAT: -- so what happens is, these ads are on for a period of time, and then the FDA finally says, you know, you really have to take them off because they violate all of the federal standards, and it's usually about the time that those ads were ready to go off anyway.

So this gives authority so that if you had an attorney general or public -- under many consumer protection statutes, there is an ability for the public to challenge this, you know, you would have more of an ability at the state level to go after really misleading ads, and there are a lot of misleading ads.

And it's really a health and safety issue, again, because what's generally misleading is that they don't mention side effects, so -- and this is the thing that they get in a lot of trouble, or there's kind of this -- well, we can go into a lot of detail about that.

There is a great report that was done by a New

Jersey PIRG by a woman named Abagail Kaplowitz Field that I'd be happy to (inaudible) to the committee, and she actually used to be an attorney that at one time worked for the drug -- you know, represented the drug industry, and she's now working for a public interest group, and is really an expert on misleading advertising and the safety implications of off-label prescribing and that kind of thing. So (inaudible) thing on that.

There is also legislation in a number of states to ban GIF and really goes a little farther than your disclosure legislation. I drafted some language for Massachusetts that is now pending there that basically combines language that's already in the law in Minnesota which has a GIF ban, but we believe it hasn't really been enforced and has a lot of loopholes.

So we tightened up that language and added in language that Massachusetts had already been working with. They got it into their budget last year in the senate, but the House didn't pass it. So they're trying again with a major prescription drug bill that includes this language, the confidentiality language, language on purchasing pools, and evidence-based prescribing, and academic

detailing, and that's all pending in that state.

I've listed a whole bunch of things that did not pass in state on advertising and marketing, which you can take a look at. Some of this is very interesting (inaudible) and would be worth, you know, considering.

Going, again, to this issue of detailing, you know, there are other states that have looked at registering detailers, and in some way, you know, giving -- requiring them to be actually qualified to provide information. These bills have not, to date, passed anywhere.

So that's kind of advertising and marketing quick overview. There is a lot more you could do if you really wanted to focus on this conflict of interest and confidentiality issues as well. I don't know if you have questions on that.

Okay. Then I will move on to communicating effectiveness and safety evidence which is described on my handout. I've already talked a bit about counter-detailing program. Where I'm actually working, my colleague, Ann Woloson, who runs an organization called Prescription Policy Choices, which is working to provide more general information on prescription drug options, has

already been talking informally with Vermont, New Hampshire, and Maine medical societies about seeing if there was more that could be done around academic detailing in a regional manner. I have a bill pending in Maine that would require the state to actually get involved in this and maybe get some state money towards it, perhaps coming out of one of the settlements, the drug settlements that we have.

The kind of gold star standard for doing this is currently the Pennsylvania Independent Drug Information Service. I've provided you with their web site. Michelle Spetman, who runs that program is fantastic. She did a presentation to our organization about a year ago about how this program -- it was just getting up and started at that time.

The whole issue with this is it takes some up-front money to, you know, do the materials, to -- but mainly to have the people who are trained to go out around the state and meet with doctors and other providers and talk about the options, and again, this is providing objective information that's not there to sell a particular drug that may have just come on the market, but instead to say,

hey, there is three drugs that treat this condition. You know, one's the generic that has these issues -- these -- you know, people respond this way and it cost this. There's these two other drugs that just came on the market, here is the clinical information about all of them, and by the way, did you know that this clinical study shows that people that, you know, change their diets radically and, you know, exercise every day actually don't need any medication at all.

So it's trying to get that in a much more sophisticated way to try to combat the sophistication of the marketing detailers who, you know, are doing their job, which is to, you know, get doctors to switch over to a particular drug, but it's not necessarily about providing evidence so that they can make the most informed decision.

Now, a lot of information has already been created. There is great stuff being done by consumers even in this also working on this issue. And, you know, what I see right now is this tremendous economy of scale, if states were to get together, because a lot of the materials are already done. And the reason I was interesting in seeing something happening regionally is my parents

live on one side of the Connecticut River in Vermont, and, you know, the closest pharmacy is across the river and I thought, you know, geez, there is some real opportunities here if we could share resources and have -- you know, maybe not be duplicating (inaudible) especially in some of the small states and in northern New England, so that may be something you want to look at.

One of the things that I know -- at one point in the senate bill -- I don't know if it's still there -- was to try to get the state of Vermont to participate in something called the Oregon Drug Effectiveness Review (inaudible) many states have been moving towards that as they design their preferred drug list so that it doesn't focus only on getting the best rebate, but also it's based on the best evidence of what's the best drug that should be (inaudible.)

And the thing about this drug program is that they are independently evaluating all the clinical evidence as public evidence and they, you know, are making it available to states and others that want to pay in to participate in this program. And it would ducktail very nicely with any kind of an academic detailing program that you do, or anything

that you're doing around a preferred drug list.

And you might want to combine that as well if you have legislation or are looking at legislation to expand the state's participation in purchasing pools, whether it's between programs within your home state or participating, because I know you already do with a multi-state pool with Vermont and I believe Iowa. So that's on that.

And some states have -- in addition to looking to get this information in a better way to doctors, have also moved to try to provide more information to consumers, and there is some very interesting things going on with consumers union that I heard about at our latest meeting, and I know that Senator Mullin was the only one from Vermont who was able to come.

But in Minnesota they've got a great project providing information in doctor's offices and potentially in pharmacies and other places that provides consumers union has this Best Buy Drug that is based on the Oregon drug information materials, and to get that out to consumers about, you know, really what the options are and the fact that generics are frequently the best choice as well as the cheapest choice drug.

And the other thing that states are doing is to require posting of clinical trials on results so that that information is public information, because what has been happening is that information -- what happens is a trial may go forward if the results are positive about that drug, and they be stopped and the public will never hear about it, yet the drug may go on to be marketed and then, you know, two years later after people have been taking it for a while, we discover that there is serious problems with it. So this would be an early warning system as well as a full disclosure. It goes along with transparency.

The state of Maine has passed this, they have -- they're almost at the point of issuing regulations that are going to be extremely detailed about what information must be posted and what clinical trials. This is not the same as what's going on right now. You may hear, well, this is already required, clinical trials are already posted; they are not. What is posted is the fact that a clinical trial is ongoing and -- so that people can find out about it, that it's going to be happening. But in terms of the results, there is, in fact, requirement, and so Maine was really the

first in the nation. And in fact, once it goes up, any state can, you know, link to it. So that might be something to consider, you know, looking at. I mean, it wouldn't take a lot of money to link your web site to the new site that's going to be created in May.

ATTENDEE 1: We have a couple of questions.

MS. TREAT: Yep.

REPRESENTATIVE CHEN: Sharon, this is Harry Chen. This clinical trial results, is this just what's happening in Maine, or is it clinical trials period?

MS. TREAT: It's clinical trials period, but it was linked to Maine because we have to do this legally, of course, (inaudible) the Commerce Clause. It was liked to Maine, but in terms of any drug that is sold through any state program, which would include our MaineCare or Medicaid program, our Drugs for the Elderly, you know, Maine Rx which is available to others, you know, or any other kind of thing. So it's probably not every drug in the world, but it's a heck of a lot of drugs, and it's certainly the ones that are effected here in Maine. I suppose, if you were interested in Vermont, and there might be some

other medications that aren't covered by the Maine -- the way the Maine law is.

We also passed -- and this was at the request of the department -- a thousand dollar fee on each drug company. There is, actually, a lot of drug companies which, of course, range from small to large. The fee isn't very much overall, but added together they felt it would be enough to help them do a public education campaign which would help -- which would be for consumers to know more about prescription drugs and also about potential adverse effects and to report those to our health department so that they could start to get more up to speed on -- and this all comes out of, you know, a lot of issues we've had around Vioxx and all these other drugs that -- you know, there's been a lot of concerns about.

So, you know, that's where it went in Maine, and again, it's not yet online, there was a requirement that the department come out with regulations. They came out with regulations and they were fairly weak, and there was a lot of testimony from consumers union, from our organization and others, advising to rewrite them, which they did, and they rewrote them so much that

they reposted them, and that's delayed, you know, them from going into effect. But they should be out very soon in final form, and they were going in the direction of being quite comprehensive. So I think if you were interested in this, those regulations, actually, would be the place to start because they filled some of the gaps in the law which was written by people who, you know, didn't know as much as they now know.

ATTENDEE 1: Another question.

MS. TREAT: Sure.

REPRESENTATIVE MILKEY: Hi, Sharon. It's Ginny Milkey.

MS. TREAT: Hi, Ginny.

REPRESENTATIVE MILKEY: Hi. I want to back up to a few minutes ago when you mentioned something about exercise and diet and things like -- as an alternative to drugs.

MS. TREAT: Yep.

REPRESENTATIVE MILKEY: Could you just elaborate on what I just -- I can't write fast enough to keep up with you and -- so I -- if you can just back up and tell me a little more about that.

MS. TREAT: Sure. I was talking about that in

reference to the academic details discussion. You know, you have people who go to the doctor's offices and provide information about particular drugs who are working for the drug companies.

Now there are some practices, for example, in the hearing on my legislation on confidentiality yesterday, Dan Myers from Family Medicine Institute, which is -- actually, all of their residents come from our participants in the University of Vermont medical program, so we have a connection there.

But they simply banned detailers from coming into their -- the premises of their offices. They think there is nothing good that is provided by this. So they don't even get the information from the drug companies; whether that's good information or bad information, they're not getting it.

So the idea of an academic detailing program is to have independent people -- they could be doctors, they could be pharmacists, they could be nurses. In West Virginia, there is pharmacists. In Pennsylvania, they're nurses and nurse practitioners. I believe that in the Vermont program they're doctors, but I'm not sure on that. I'm not an expert on that program.

But certainly there is an interest in their Maine doctors, and in the program that we've been talking to people in northern New England about. The idea is they go and give -- you know, set up meetings with doctors, themselves, and other medical providers, and develop relationships with them and bring them information about, you know, not just drugs, but about, you know, all clinical practices that relate the best information that they have. Najari Aborn(phonetic) is an expert on this, and again, his testimony relating to my bill on confidentiality goes into some detail about this. He's actually done academic studies to look at the effectiveness of what he called "unadvertisements", which would -- were similarly glossy materials like the drug companies have, but which could be given out to doctors and doctors could give to their patients to say, you know, here is what you need to be doing.

One of the things he found when he did this academic study was that patients like to walk out of an office with, you know, something that tells them that -- like a prescription. And when they walk out without a prescription, they may feel that they haven't been well served by their doctor

because they want that piece of paper that says, "Here is what you do."

So he actually created materials that were like that, they were prescriptions for exercise and, you know, this is the kind of thing to do. I mean, obviously, you know, the drug companies are going to be there to sell their drugs, that's appropriate, but it's not necessarily providing the entire pan of leads on evidence about what could be done. And so this is something that Pennsylvania has gone into in a big way because they think it's going to significantly cut drug costs for their Medicaid program and their senior citizens' drug program which is far beyond part D and it's like the most expansive in the country and extremely expensive. And they also think that it's going to lead to better outcome because, you know, you're providing evidence about everything.

So that's what -- and I personally think and our organizations been very supportive of, you know, states really doing this. The issue is you need up-front money to pay for the salaries of the people that go out and do this. Now one of the things that we're trying to do is see if there is potentially at least some grant money we could get

to initiate the planning part of this.

As I said, Vermont is doing this, but it's very (inaudible) way right now, and I think it's focused on the federally qualified health centers, but I'm not entirely sure on that. And I do have a paper on this that I could e-mail that Ann Woloson did for Prescription Policy Choices, and it goes into a little more detail on the different academic detailing programs.

REPRESENTATIVE MILKEY: That would be great.

MS. TREAT: Yeah. I could -- actually meant to e-mail all of your members with that.

REPRESENTATIVE MILKEY: Thank you. That's very interesting to me. I think that the point about taking -- going away from the doctor's office with something is right on.

MS. TREAT: Right. And the Consumer Union thing is very interesting too. I mean, the thing -- we have this presentation from Peter Wycoff of Minnesota Senior Federation. He's also going to be -- he's working with Community Catalyst in Boston now that's in a major project with the Pew Foundation nationally to work on evidence-based prescribing, and also eliminating conflicts of interest in prescribing.

And this whole project that he outlined was really, really interesting about how to read (inaudible) and -- I mean, we're getting all excited about it, how we should have him in the State House in Maine and, you know -- so anyways.

REPRESENTATIVE MILKEY: Thank you.

MS. TREAT: Okay. Just really quickly on part D, my bill on this is sailing through the legislature, it came from our Bureau of Insurance to protect seniors from being (inaudible) marketed with other insurance products when someone cuts in the door to sell them part D materials, and I think that there was something on that in the senate bill, and we actually strengthened it in the committee from what the bureau wanted. But I think that's a really good thing to do. And it's just a little thing that wouldn't cost any money.

Purchasing pools, you're already doing that. I talked about tying that to evidence promoting generic. Again, I've got a lot of information here. I don't know if there is more that Vermont could do, but I've listed a number of things that are road blocks to generics prescribed that the states have, you know, overcome in terms of how their prescribing paths are and making sure that

the generic can be prescribed, unless the doctor says otherwise.

On Page 8 of my handout, I have a long discussion about PBM transparency and fiduciary duty legislation. This continues to be an issue in states all over the country trying to make sure that the middle man is either cut out entirely from rebate discussions with states. And, you know, some states go through a PBM, other states negotiate directly and get rebates directly from their manufacturers. And I suggest that they get more money back, but it's hard to pin that down, because, you know, their rebate -- the actual rebates they get are confidential, but, you know, it's hard to know for sure.

But Maine has passed, and as has the District of Columbia, South Dakota and North Dakota and a number of other states have provisions that aren't as incomprehensive that require pharmacy benefit managers to be free of conflicts of interest (inaudible) those conflicts when they're negotiating on behalf of a client, whether it's a state or a health plan. And there have been, again, major litigation over kickbacks, and then many of these have been settled with states getting

multi-millions of dollars around the country because PBMs have engaged in practices that really aren't unethical, but just getting kickbacks on actually selling more expensive drugs as opposed to less expensive, which is what they were supposed to be doing, for example. And practices around drug switching, some things that were on a -- that were actually prescribed by a doctor and switching to other things.

Pharmacists have other concerns in terms of prompt payments, and just around that, some of the pharmacy benefit bills around the country really focus on how pharmacists are treated and paid, and what kind of rights of auditing they have or the state has over PBM practices. And again, there was language in the senate bill. I believe it was pretty, severely weakened in the latest version I saw, so I don't know if it really accomplished very much.

And then 340B pricing, again, this is something I think that Vermont has done quite a bit, but I list a number of things, basically, 340B prices under the Federal Public Health Act, and it's a lower price than Medicaid. And therefore, you know, particularly where there is some very

high cost drugs, and I would mention, say, HIV aids drugs or hemophiliac drugs, if there was a way to run the program through a federally qualified health center or one of the many hospitals that are qualified in the same way, you can get the lower cost, and particularly for something where the state has a very high outline laid for it, and it's practical to, say, have clinics -- you know, go through the clinics for the provision of these drugs, the reimbursement of it, there's tremendous savings that are possible.

And this is all very complicated, but states have done it and I have given you a list of a, you know, couple of types of projects out there in country. And again, I think you've done something on this, but perhaps there are additional savings that could be accomplished as, you know, through (inaudible.)

And then I mention, finally, False Claims Act which our legislation -- basically, they're whistle-blower provisions that allow for states to bring cases against companies for fraud. And again, there has been many cases under Medicaid and Medicare that have gone after medical providers, particularly pharmaceutical industry, for

inappropriate pricing, inappropriate marketing, and they have been multi-million dollar settlements for state.

The reason I bring this up specifically is even though many states, such as Vermont and Maine, have participated in these lawsuits without having their own multi-claims act which has special whistle-blower provisions, under the Deficit Reduction Act that was passed last year by Congress, there was a provision in there that said that if states adopted a False Claims Act that was equivalent to what the feds have, they would get a larger recovery in any of these lawsuits if they participated and were part of the settlement.

And so if you're looking to save money in Medicaid, this is one way to do it. And the expert on this is the Taxpayers Against Fraud. I can -- I don't know -- yeah, I have their web site cited in my handout. They also have a model state law that would comply with the federal standards, and they have a lot of information about, basically, how much money would have been saved if states had, you know, participated in the same way. So again that's something that might save you some money.

And then briefly, I mentioned trade issues

just because I know that you already are a leader in this area, but you certainly want to make sure that you guys are educated about what could happen in some of these trade agreements. There's one pending right now with Korea which essentially would prevent Korea from having what is very similar to a preferred drug list just like Vermont has.

And these are bilateral treaties. That means they could be enforced not only against Korea, but also against who Korea is agreeing to this with which would be the United States. And states are kind of left off the table in the whole concession of those, so you just should be aware that there's things pending right now that could drastically affect the -- your Medicaid program. And somebody might want to weigh in on this, and I believe that actually you have that, I know you've got resolutions to address that.

Okay. That's it.

REPRESENTATIVE MILKEY: Sharon? Sharon, on that last issue, if that trade agreement goes through, would it prohibit a state from looking at the various drugs available to treat a particular condition and discovering which one is the least

expensive and basing the reimbursement on that --

MS. TREAT: Well --

REPRESENTATIVE MILKEY: -- and not saying that, you know, you've got -- saying, this is what we reimbursed for this -- for treatments for this particular condition? Or, I mean, are we just at the mercy of these laws to fork over more and more money to the --

MS. TREAT: Right.

REPRESENTATIVE MILKEY: -- pharmaceutical companies?

MS. TREAT: I mean, I think the thing to remember here is it's not automatically preempted, so you could still go about your business and do that. But where someone could bring a challenge to it, it would be vulnerable to challenge based on what you've described.

REPRESENTATIVE MILKEY: And would this need to be a consumer of pharmaceuticals that brought it, or could a pharmaceutical manufacturer bring it?

MS. TREAT: Well --

REPRESENTATIVE MILKEY: Where does the -- where would the disagreement come from?

MS. TREAT: In this case it would be a government-to-government challenge.

REPRESENTATIVE MILKEY: Okay.

MS. TREAT: But there have been some. And the difficulty is that we've -- members of our organization have actually met with U.S. Trade or those, you know, agencies and the representative, the person who does the pharmaceutical (inaudible) stuff and tried to get written, you know, agreements that it won't affect the state, and they just won't do that. So they'll say to you, they won't, but they don't want to do anything that's binding between, you know, as part of the agreement.

So we do have serious concerns about this, and again, you know, it's kind of the big picture, but the difficulty is that the drug industry is very much part of that big picture, states are not. And in fact, all of the advisories are made up almost entirely of manufacturers and industry folks and there's very limited participation from, say -- the Public Health Organization are actually suing the government because they are not part of these advisory groups, and they think they should be.

So it's just something to pay attention to and, you know -- again, I believe there is some resolutions that may be pending. I don't know what

the status of them are in Vermont right now.

REPRESENTATIVE MILKEY: Okay. Thanks.

ATTENDEE 1: Question?

REPRESENTATIVE CHEN: Yeah. Sharon, Harry Chen again. I actually have a couple of questions. What is --

MS. TREAT: Harry, you're a little quiet.

REPRESENTATIVE CHEN: Okay.

MS. TREAT: If there is anyway to get closer to the microphone.

REPRESENTATIVE CHEN: Well, people say that about me anyway. I have about a couple of questions.

One is on this academic kind of detailing. I don't know if you're familiar with a publication and organization called "The Medical Letter." Have you read into that at all?

MS. TREAT: No, I haven't.

REPRESENTATIVE CHEN: I might want to send you that, because in my view it's kind of the consumers union of prescription drugs.

MS. TREAT: Yeah?

REPRESENTATIVE CHEN: And it's a medical resource that -- it's one of the ones that I read every year, that literally analyzes all drug

classes, tells you how much they cost, and tells you what the evidence is for the newer drugs, if there is any. So I might even send you a couple sample copies.

Because my concern is that everybody's reinventing the wheel, you know, every state has a pharmacist that's doing the same thing, that people are doing all over this -- that they're doing on a not-for-profit basis already.

MS. TREAT: Yep.

REPRESENTATIVE CHEN: The other question I had was just a general question if you could react on this, the thought we've had here or discussed some brief mention of a statewide PDL, and how that might change things and whether it's even possible.

MS. TREAT: Yeah. I think it's possible, and it would be a helpful thing to drive down costs, and also, it would make this whole education effort, you know, easier because you'd have consistency.

I do know that it's a very thorny thing to try to do in practice. We've been trying to do that in Maine for a couple of years, and have gotten state employees that are self-insured have their own health plan.

Then there is, you know, Medicaid. Then there is, you know, a different list for actually the Corrections. And it's -- you know, it doesn't really make sense to have all this splintered buying going on where you're losing buying power. But getting them on the same page has been extremely difficult, and in fact, my -- the committee I serve on had a hearing because a legislator came in with a bill to actually put all the health programs together which really didn't go over very well, especially with the state employees, and I understand why, and practically speaking, it didn't make sense. But they agree that they had really sort of fallen down on trying to get the PDL together and kind of sent them back to keep working on it.

It's a interesting thing because I've talked to foundations about this issue, and they really didn't understand it. They said, well, that's so easy, I don't even know why you would need help, you know, doing work trying to explain to people how to do those.

And I'm saying, well, I don't think you understand this. I mean, you know, you really have different programs that have their own

constituencies. There is a lot of fear that even just saying that the PDL is the same for Medicaid or let's say state employees, that would appear that that means you get the Medicaid program.

Now, the fact of the matter is that, of course, the Medicaid PDL is as broad as anything. Generally speaking, it covers more. But people don't know that, and -- you know. So there is a lot of fear, and I think that it just takes a lot of effort. My experience has been there is very few states that there is someone sticking to it to try to make it happen.

REPRESENTATIVE CHEN: Thank you.

ATTENDEE 1: Okay. Well, I think you need to move on to your other life there. I think we had you till about 9:30; is that right?

MS. TREAT: It is, and I have to get over to the State.

ATTENDEE 1: Okay. Well, this has been very helpful. I think we'll -- my guess is that, you know, once we hone in on some things that we might like to speak with you again at some point in the next week or two.

MS. TREAT: Well, that would be great. And then what I can also do is if you have particular

areas where you have an interest, you know, I do have a lot of materials. Some are on the web site, but a lot of them aren't on the web site that -- especially newer stuff that's just come out. And so I'd be happy to forward that to you, and also take a look at, you know, any bill you actually are looking at, and comment on, you know, any of the provisions there in terms of how they're drafted in what they might do or not do.

ATTENDEE 1: All right. Well, thanks very much, Sharon.

MS. TREAT: Okay. You're welcome.

ATTENDEE 1: Okay.

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ATTENDEE 1: -- summary of the senate bill.

MS. LUNGE: Yep. This is Robin --

ATTENDEE 2: And we're gonna get it.

MS. LUNGE: Yep. I'm going to hand it out to you.

ATTENDEE 2: Oh, okay.

(Inaudible.)

MS. LUNGE: Robin Lunge --

ATTENDEE 2: Are we going to get it before the break or after the break?
MS. LUNGE: -- Legislative Counsel. And before I hand out the senate section by section, there are two things that I needed to get back to you on from yesterday. One is the I-Save Rx numbers. And the numbers that I have are October, November, and December of last year, and they're cumulative, so I'm going to do it backwards.
So as of December 31st, there had been 242 enrollees and 752 orders. And that was up from 750 orders and the same number of enrollees in November, and 746 orders and 236 enrollees in October. So if you want more than kind of the cumulative total, if you want to see a trend, we could ask Heidi Tringe at AHS to provide that to us.
ATTENDEE 3: I don't need that now. That's says to me that we didn't do much.
FEMALE ATTENDEE 1: So only 242 people?
ATTENDEE 4: But we helped 200-and-something people.
ATTENDEE 1: Right, we helped 242 people.
ATTENDEE 4: That's right.
(Inaudible.)

FEMALE ATTENDEE 2: They got 700-and-something --
MS. LUNGE: 752, yep.
ATTENDEE 2: What percent would that be of employees? Very small.
ATTENDEE 3: Of employees?
ATTENDEE 2: Yeah.
(Inaudible.)
ATTENDEE 4: State employees?
MS. LUNGE: It's not just state employees; it's all of -- all of --
ATTENDEE 4: It's the whole state.
MS. LUNGE: -- Vermont residents can participate.
FEMALE ATTENDEE 2: The whole state of Vermont. That was the I-Save Rx --
MS. LUNGE: Yeah.
ATTENDEE 2: Yeah.
FEMALE ATTENDEE 2: -- bill that we passed, that first bill last session?
ATTENDEE 2: A very small percentage, I would assume, but --
MS. LUNGE: Yeah.
ATTENDEE 4: I mean, the only piece of information that might be useful is pre- and

post-Medicare part D.
MS. LUNGE: Lauren, would you be able to e-mail Heidi Tringe and ask her for that?
ATTENDEE 4: Right?
ATTENDEE 2: That might be interesting.
ATTENDEE 4: That would be -- I don't need trends. I just need to know --
MS. LUNGE: Yep.
ATTENDEE 4: -- was there a drastic difference between pre and post?
MS. LUNGE: Okay.
Okay. And the other information that I had is that I did check on the U.S. House Bill 4 which talked about Medicare part D negotiations, and that bill did pass the House, it's currently in the senate, and it hasn't moved in the senate yet.
And what that bill did was direct the secretary -- the Federal Secretary of Health and Human Services to negotiate with pharmaceutical manufacturers for prices, including discounts, rebates, and other price concessions, that may be charged to a Prescription Drug Plan sponsor under Medicare part D. However, that is not to be construed to authorize the Secretary to establish or require a particular formulary or preferred drug

list.
And then there is semi-annual reports. So that's the status on that.
ATTENDEE 2: Thank you.
MS. LUNGE: And now, without further ado, here we have -- This is a section-by-section summary and comparison of S.115 as introduced, the Senate Health and Welfare amendment to S.115, the Senate Finance amendment to the Senate Health and Welfare amendment, and also, an individual amendment by Senator Condos.
So what I'm going to do is walk you through really more the concepts that are in the bill than the details, because I think it would just be a waste of time to go through all the different amendments in detail. It probably just makes more sense to do that once we know exactly what they pass.
FEMALE ATTENDEE 1: Good idea.
MS. LUNGE: So the first part of the senate bill looks at the Medicaid program in the Office of Vermont Health Access. As we talked about yesterday, we have what's called the Best Practices and Cost Controlled Program which sets up our preferred drug list.

One of -- One of the key concepts currently in law is this concept of a statewide PDL. Our statute currently directs the state purchasers to ban together in a statewide PDL, but that has not happened.

Similar to Maine, the same -- we have the same three different groups of folks who have different preferred drug lists, and it just hasn't been accomplished that everyone's gotten onto the same list. So what this --

ATTENDEE 3: Is there a reason why?

MS. LUNGE: I would suggest you ask OVHA, the state employees, and the Department of Corrections because I don't think I want to put words in their mouth about the difficulties or challenges of doing that. I think it's better to hear directly from them about why they haven't done that.

So what Senate Finance decided to do was to take a different tact in that issue and -- so they took out the statewide PDL language and put in language relating to a joint pharmaceutical purchasing consortium. The idea being that if there is -- if people are resistant to having one list of drugs for whatever reason, that maybe what we should do is allow people to have different

lists, but still direct them to the extent that there is overlap on their lists, which there probably are, that they should be purchasing together.

So they sort of switched to this slightly different model which still goes for bulk purchasing, but doesn't require people to use one list. It would only require them to negotiate together when there is overlap in the list.

FEMALE ATTENDEE 1: Robin, it requires them to do that or allows them to do that?

MS. LUNGE: It, um -- I believe it encourages them to do it making it mandatory in 2010 for state purchasers.

FEMALE ATTENDEE 1: Uh-huh.

MS. LUNGE: So it allows a voluntary period for folks to figure out how best to do that, and then mandates it happen in 2010, if it hasn't happened by then.

ATTENDEE 2: Now, you said drugs -- if I'm getting in too much detail, tell me. You said that drugs that are overlapping, in other words, if there's two drugs doing the same thing or --

MS. LUNGE: No. If there is two lists that have the same drug, they would -- so let's say

Medicaid has Lipitor on their list, and the state employees have Lipitor on their list.

ATTENDEE 2: Mm-hmm.

MS. LUNGE: -- so they could negotiate together --

ATTENDEE 2: Okay.

MS. LUNGE: -- with the manufacturer of Lipitor.

ATTENDEE 2: Okay.

MS. LUNGE: But if Medicaid has Celebrex -- this is a bad example because Vioxx isn't on the market, but I know these are in the same class --

ATTENDEE 2: Okay.

MS. LUNGE: -- so that's why I use it. But if Medicaid has Celebrex and the state employees have Vioxx, they don't have to negotiate on that because it's a different drug and a different manufacturer.

ATTENDEE 2: Okay.

MS. LUNGE: Did that make sense?

ATTENDEE 2: Yep.

MS. LUNGE: This section also created a plan around FQHCs to encourage the use of FQHCs as a way of increasing the number of people who are getting a 340B pricing. You'll remember from that colored chart we handed out, the 340B pricing is lower than

the Medicaid price and other prices, and there is some differences between the two versions on that language as to whether it's focusing on increasing the usage or just an informational kind of plan.

The other thing the senate did was add requirements that the preferred drug list process be evidence-based. I think this doesn't so much change current practice as clarify in the statute that the Drug Utilization Review Board and Medicaid would use evidence-based information, which I think they are already doing, they testified they were already doing that, but it sort of brings the statute in line with their current practice.

ATTENDEE 2: Would that remove any drugs that are on the PDL?

MS. LUNGE: I don't think it would have that effect because --

ATTENDEE 2: No? Okay.

MS. LUNGE: -- the way the language is written, it's really more consider these different aspects when you're picking a drug. So you consider costs and you consider advocacy, and if there is information about which drugs are more effective against each other, you consider that. So it's more considerations, really, than requiring

any one factor to outweigh any other.
ATTENDEE 2: Thank you.
ATTENDEE 3: Harry, I had another question.
REPRESENTATIVE CHEN: Sure.
ATTENDEE 3: Um, I probably should know this, but I can't remember it. What percentage of the population is involved in these state programs?
MS. LUNGE: In Medicaid --
ATTENDEE 3: Well --
MS. LUNGE: -- or other state purchasers? You know, that's a good question. I don't have the exact percentage. We know it's about 147,000 Vermonters IN Medicaid, and the pharmacy programs you would add on to that the state employees, you would add on to that the Department of Corrections, the people in the state hospitals and some other folks, so let me ask Steve Kappel if he can come up with that figure.
ATTENDEE 3: And my other question related to that is, is this particular bill only geared to people that are eligible and on state programs?
MS. LUNGE: The bill, as a whole, covers a bunch of different topics. This particular topic that -- the specifics that I've been talking about now are in the Medicaid section, so what I've just

spoke about is just the Medicaid and Medicaid waiver programs. So when we get into some of the other things, I'll try and make sure that I say who it would apply to. Would that be helpful?
ATTENDEE 3: Yeah. To me it would be --
MS. LUNGE: Okay.
ATTENDEE 3: -- because I want to see what you're doing for the general population outside of these state programs.
MS. LUNGE: Yeah.
ATTENDEE 3: If any of these can apply.
MS. LUNGE: Right.
So this was really focused on OVHA because OVHA and the other state purchasers are -- I should say that the joint purchasing consortium does add other state purchasers, like the state employees and the Department of Corrections and that kind of thing, but it wouldn't affect private insurers.
ATTENDEE 2: But the bottom it says they're publicly funded purchasers, in the bottom of that box.
ATTENDEE 3: Yeah, that's my concern.
MS. LUNGE: Right. Well, and part of that is because we don't mandate to insurance companies what they do in their preferred drug list, so --

ATTENDEE 3: And I agree.
MS. LUNGE: -- right now, but --
ATTENDEE 3: The problem is --
MS. LUNGE: -- doesn't mean you couldn't, necessarily, but we don't currently do that.
ATTENDEE 3: Right. And even -- even if we did -- it looks to me like even if we tell people they're supposed to do it, they're still not doing it anyway. That's why I asked the question before.
MS. LUNGE: Right.
ATTENDEE 3: I mean -- Okay.
MS. LUNGE: The other thing that happened in this section of statute, which is the Medicaid statute, it was in this section where the evidence-based education program was initially established and directed OVHA to do that. I'll talk about this in more detail later, but the senate moved that program to the Department of Health from OVHA, in part because OVHA hasn't done it. So I'll talk about the details of that when we get to that section.
The other thing about OVHA that's in this section of the bill is that OVHA is directed to seek out independent research from independent sources on clinical effectiveness of prescription

drugs that would include the Oregon Health and Science University Drug Effectiveness Review Project that Steve briefly mentioned yesterday which is the project that's comparing drugs in the same class on effectiveness.
The next big topic in the bill has to do with pharmaceutical marketing disclosures. Yesterday we talked a little bit about this program that's currently in law which has the drug marketers disclosing to the attorney general information about marketing in Vermont to physicians and what amounts are spent in doctor's offices and that kind of thing on marketing.
So what this section does -- would do a couple things. It would allow -- right now, the Attorney General receives that information and it's confidential and no one else in state government receives it. Senate Finance modified the statute to allow the attorney general to share that marketing information with the Department of Health, and then Senate Health and Welfare added OVHA, so that the Department of Health and OVHA in their prescription drug programs would have that information.
The marketing information stays confidential

with Department of Health or OVHA, so there is not disclosure of the confidential information publicly, it's just to other entities in state government who are either big purchasers for prescription drugs or working on education-based programs.

Also, right now there are -- in the Marketing Disclosure Law, there is an exemption from disclosure, meaning it doesn't have to be disclosed for continuing medical education programs, and the Senate Health and Welfare removed the exemption so that that information would be provided to the AG's office.

FEMALE ATTENDEE 3: But not OVHA and the Health Department?

MS. LUNGE: Also OVHA and the Health Department because that applies across the board to that whole section of statutes.

FEMALE ATTENDEE 3: Okay.

MS. LUNGE: And some of that information is publicly shared, but some of it is considered to be trade secret, and so that's the part that has to stay confidential.

FEMALE ATTENDEE 3: Mm-hmm.

MS. LUNGE: Um, the next big topic that the

senate looked at was price disclosure and certification. This section is based on a Maine law with some revisions based on a Texas law, and this would require drug manufacturers to disclose to OVHA certain prices for drugs dispensed under the Medicaid programs, and that would include -- there are three different price standards. It is the -- see if I can -- I don't know if I have the bill right in front of me. It's the average manufacturer price, the best price which is a federally defined price that Medicaid is supposed to be getting, and the price paid to wholesalers in Vermont.

So those three prices would need to be disclosed to OVHA so that OVHA could get a sense of whether or not the prices that they were getting for the -- for Medicaid were indeed the best price.

You may remember from yesterday we talked a little bit about how the prices in Medicaid, information is provided from the manufacturers to the feds but not to the state. This is meant to address that situation so that Medicaid would get pricing information that could help them determine if they were truly getting the best price in the state, which is what the federal requirement is.

FEMALE ATTENDEE 1: I'm just curious, you said Maine was doing this now?

MS. LUNGE: Mm-hmm.

FEMALE ATTENDEE 1: So right now Maine is doing --

MS. LUNGE: I should -- I can't remember if it's a bill or if it passed so -- but I probably have that information in my file. I just can't remember.

FEMALE ATTENDEE 1: I'm sure if it just happened it wouldn't -- I was curious what actual impact that had on cost, but they wouldn't have that yet if they just passed it.

MS. LUNGE: Let me double check and see if it's currently pending or when it passed, if it did pass, because a lot of these provisions are based on other states, and I don't have that all quite clear in my head anymore from when I first drafted it --

FEMALE ATTENDEE 1: Yeah.

MS. LUNGE: -- so I can -- I'll check on that.

ATTENDEE 3: And Robin, just a little background. Currently, right now, (inaudible) make sure that we get the best price.

MS. LUNGE: Well, I would think in theory CMS

does, but I don't know what they actually do. I mean, that would be, I would think, the purpose of them getting the information, but that would be a good question.

ATTENDEE 3: When the FQHC -- when they get their price --

MS. LUNGE: Mm-hmm.

ATTENDEE 3: -- how does that -- do they talk to the Medicaid people, or does --

MS. LUNGE: With the 340B price?

ATTENDEE 3: Mm-hmm.

MS. LUNGE: Well, the 340B price is a little different because the 340B price involves a federal statute which kind of -- that's more based on a price-setting model as opposed to -- like the Medicaid price which has the rebates and the supplemental rebates, so Medicaid basically -- the difficulty for Medicaid is they know what they paid the pharmacy and they know what they're getting in the big lump sum rebate and supplemental rebate checks, but they don't know what they're getting for particular drugs, so that's why they need this additional information.

And the 340B price, I believe -- and I can double check the federal stuff if I need to -- I

don't think that's designed around a rebate system. I think that's more -- the 340B price is set, so it's a little bit easier to tell if you're getting it.

I don't know if that made sense what I just said, but, um, I -- but I don't think that the -- I don't know that OVHA gets the information about the specifics of the information about the 340B price. I'm not sure. And they wouldn't probably get that from the FQHCs, I would think that would be from the feds, so...

The pricing stuff is complicated because of the way it's structured and also because some of the pricing information is not generally available or publicly available, so it seems like it should be easier than it is -- really is, in reality.

This section would also require the president, CEO, or a designated employee to certify that the price that Medicaid was getting was the best price in the state, the best of the private prices in the state, and also ensures that the information stays confidential with OVHA.

Healthy Vermonters Plus, this is the discount.

FEMALE ATTENDEE 1: May I --

MS. LUNGE: Sure.

FEMALE ATTENDEE 1: -- just ask?

MS. LUNGE: Yes.

FEMALE ATTENDEE 1: This stays confidential with OVHA, but I'm thinking although the price information stays confidential, couldn't private -- I wonder if -- never mind. I'll ask this question off -- off line.

MS. LUNGE: Okay. Sure.

Healthy Vermonter's Plus, this is the discount card that we talked a little bit about yesterday that uninsured Vermonters or Vermonters who have exhausted their prescription drug insurance can use to get the Medicaid price instead of the retail, just the off-the-street price. And basically, the way this, I think, will end up is that it will increase the income eligibility from 300 to 350 percent of federal poverty like Maine's program.

There -- there was a provision currently in law that has -- also allows people who have spent a certain amount, either on health care expenses or pharmaceutical expenses, if it's a certain percentage of their income, to be eligible, so it would bring in people who have high drug costs.

But OVHA testified that that was going to be

really hard to implement, and the health care ombudsman also said she could see how that could be really hard to implement because there is something similar in the Medicaid spend-down program. So I think what -- where that will end up is just a straight increase in income eligibility because that's much simpler.

Pharmacy benefit manager regulation, there are two different statutory provisions around PBM regulation in the bill. This is one of the sections that was worked on quite a bit by both committees. Basically, the way I think it's going to end up, it would require that pharmacy benefit managers provide notice to the people they are offering quotes for, and let me just back up a minute.

The way the transactions work in this area is that a health insurer or an employer will set out an RFP for pharmacy benefit management, and the PBMs then respond to RFPs. So what this would require is in the response to the RFP, they have to provide notice that certain contract terms are available. So you can see in the section by section in 7 that there are six different duties that a PBM would need to comply with unless it's

otherwise provided for in the contract.

So the senate version allows PBMs to contract around the duties with their clients if the clients are agreeable to that. So --

FEMALE ATTENDEE 1: Well, let me just make sure I understand that. So they all have to include these six and then additional, or they? These are not a minimum standard.

MS. LUNGE: They have to include these six unless they say in the contract that they're not including these six, so which basically means it's not a requirement. It sets a standard, but it says that --

ATTENDEE 1: It's more transparent though. They have to explicitly --

MS. LUNGE: Right. It's more transparent because there has to be a conversation about these six issues between the PBM and the -- either the health insurer or the employer who's contracting, or at least -- and it may be -- I -- let me just back up.

It may not actually be a oral conversation. It also could be an exchange of written documents.

FEMALE ATTENDEE 1: Mm-hmm.

MS. LUNGE: So I don't want to mislead you to

think that it's -- that there is a written -- there is requirement that there be a conversation, so...

ATTENDEE 1: Has there been any discussion about sort of around that couple of comments we just made? I mean, you could -- seems to me you could require that -- that the PBM actually sort of shine a light on these things in the context of their negotiation rather than just hiding it somewhere in their documents.

MS. LUNGE: The bill currently says that they'll provide notice that the duties are potential contract terms, and it's silent on the form of that notice or the content of the notice or anything like that. So the way the senate version is, and I think it's likely to stay, is to basically say you have to give notice and then leaves it up to the PBMs to determine how to do that, so that's certainly an area --

ATTENDEE 1: But nobody's actually talked about -- and for some reason rejected the idea of having more -- specifying more form to the notice.

MS. LUNGE: It's possible that I could have missed that conversation, but at least I didn't hear it, so if it happened, it was when I wasn't in there for some reason. There wasn't a lot

discussion about that.

FEMALE ATTENDEE 2: Robin, Number 5 --

MS. LUNGE: Mm-hmm.

FEMALE ATTENDEE 2: -- passed -- What are passed payments? Is this supposed to be passed payments? Is that a typo?

MS. LUNGE: It should be passed through payments and benefits to the health plan.

FEMALE ATTENDEE 2: Oh, passed through.

MS. LUNGE: So there's -- one of the things that you may be interested in hearing more about are -- like how the actual transactions between PBMs and health insurers work, and I'm not really the person to give you that level of detail. Either the AG's office or the PBMs, themselves, would probably be the best source, I would think, of that information.

But there are types of contracts between PBMs and insurers that say, "I, the PBM, am going to pass through any rebates I received from the manufacturer to you, the health plan," so that -- in order for the health plan to feel more secure that they're getting any rebates or negotiated discounts from the manufacturer.

FEMALE ATTENDEE 4: Can I ask you --

MS. LUNGE: Please.

FEMALE ATTENDEE 4: The health insurer, that includes a self-insured plans, all plans?

MS. LUNGE: Yes. The way we defined health insurer was more broadly than would at first blush appear. It does include self-insured plans and employers and -- who are using a TPA and --

FEMALE ATTENDEE 4: Who would it not include? Anyone?

MS. LUNGE: Let me double check the actual language. I think it was written pretty broadly, but...

FEMALE ATTENDEE 4: Okay. Thanks. (Inaudible).

ATTENDEE 3: Just -- this is out of curiosity, where it says the PBM must provide notice that the above duties are potential contract terms, so now relating to you what you were just talking about, does that mean if I was one of these organizations, I could say it's a possibility that I might let you know that -- or I might provide past due payments?

MS. LUNGE: You mean orally or just in a --

ATTENDEE 3: Yeah, either orally or in writing. Would I be in compliance if I -- if I said that's a possibility to provide those?

MS. LUNGE: Well, the statute isn't very specific, so I think in part it would depend on if BISHCA decided to do rules and specify what the notice would be. But the statute right now just says notice, so it would be up to a court to decide if what you just said meant the definition of notice.

ATTENDEE 3: And not to --

MS. LUNGE: So it's poss -- so I think yes, it could, but you know, it's one of those areas where it's not so specific in the statute that it's easy for me to say what a court would -- how it would be interpreted.

ATTENDEE 3: Right. And I'm not trying to be the devil's advocate here.

MS. LUNGE: No, no. I know. I know.

ATTENDEE 3: I have another question too. What exactly is BISHCA going to enforce? I mean, they -- if all of this is -- you know, they give notice and that's it. What are they enforcing?

MS. LUNGE: Well, the enforcement would be if someone did not provide notice.

ATTENDEE 3: Not provide what?

MS. LUNGE: If the PBMs didn't provide the notice that certain terms were available, that

would be enforceable as a consumer fraud action by the AG or the -- or BISHCA through their insurance regulation. And -- I mean, I think that -- since that's really what this statute requires, I think that's really the enforceable piece is the notice.

ATTENDEE 3: So they send you an E-mail and say that potentially these things will be there. Doesn't make any difference whether they actually do happen, right?

MS. LUNGE: Right. These six are not now required as long as the contracts -- I think the contracts would have to say, "I, the Health Insurer, agree to not receive past through payments, benefits, etc." So the contract has to specify that these six don't apply. So it's the notice and then whether -- you know, either the contract has these six or they have something saying, "We agree not to do these six." So I guess those are the two enforceable pieces.

ATTENDEE 6: And the PBMs currently, are they already licensed, regulated in some way through BISHCA?

MS. LUNGE: As part of the -- it's just starting. As part of the health -- the multi-paired database, BISHCA is registering PBMs,

and my understanding is that they're doing that as a pilot program, so they're beginning on that process, it hasn't been completed yet.

ATTENDEE 6: So is -- this, though, is envisioned or written in such a way that envisioned them more direct regulation of PBMs?

MS. LUNGE: Yes. In Section 8 of the bill, it would require a registration with BISHCA, so that sort of codifies more clearly or more visibly, I guess, the registration provision, and --

ATTENDEE 6: I see. And they have all the regular authorities that they have? So I would imagine -- I mean, we'll obviously then have them -- BISHCA come in and talk about how they would intend to implement this section, but it seems likely to me that, you know, they would -- or they could, at least, and likely would ask for forms of contracts and things like that that they could approve or --

MS. LUNGE: And that would be a very good question for them, because I don't know if they do that for registration or if they only do that if they license. Because licensurism is a higher standard of review, in a sense. So I think that would be a good question to ask them, if, in their

registration process, they would envision checking contracts.

ATTENDEE 6: Okay.

FEMALE ATTENDEE 4: Well, I know you said you want to talk about the amendment, but I'm trying to just get this all in my head.

MS. LUNGE: Yeah.

FEMALE ATTENDEE 4: I am drawn to that on the right, the 11th, where it says, "Provides BISHCA with exclusive jurisdiction over PBM contracts with Health Insurers."

MS. LUNGE: And health insure -- I'm sorry about the confusion. In 11, "Health Insurer" is meant to be defined narrowly to mean just a health insurer, not an employer or other entity.

FEMALE ATTENDEE 4: Okay. So -- Okay.

MS. LUNGE: So that's confusing. I should clarify that.

So that came about in a discussion between the AGs office and BISHCA because the way the original bill was drafted was to give them concurrent jurisdiction, which was something that they had agreed on the last time PBM regulation went through the senate two years ago, I think, or maybe three.

But BISHCA feels strongly that they have

jurisdiction over health insurance companies, and they should retain all jurisdiction relating to health insurance companies. So there is a new discussion between those two, and their compromised language that they brought in was that BISHCA would have exclusive jurisdiction over the health insurance piece, and that the AGs office, they would have joint jurisdiction over the rest of the players. So that was their compromise.

The other big change in that section between the two -- the Senate and the Health was the standard that a PBM would use -- or the duty that a standard -- that the PBM would have to its customer, and the Senate Finance Committee started out with a standard that's used in the Maine law which is a fiduciary standard, which is a higher standard, and Senate Health and Welfare went to a standard that's lower, but still probably higher than a normal contract term, and the senate -- the welfare standard is the current duty owed by an insurance agent to a customer in Vermont law, so --

ATTENDEE 1: Where is that? Where are you now in your --

MS. LUNGE: This is in 7 and --

ATTENDEE 1: Still in 7, okay.

MS. LUNGE: Yep. One, says, "Prudent Standard", and then 9th on the --
ATTENDEE 1: Yeah.
MS. LUNGE: -- right, says modifies the prudent standard to the standard under current Vermont Law.
ATTENDEE 1: I see, Mm-hmm.
MS. LUNGE: So basically, what that has to do is how careful the state -- PBM would have to be in their dealings with their customers, whether they can assume that their customer is a savvy customer who understands these kinds of things, or whether they have to be more careful about explaining everything and that sort of kind of detail.
So the other thing the PBM section does is require the PBM to notify their customers that an administrative service's only contract is available in the market. It doesn't require them to offer that type of contract under the Senate Health and Welfare amendment. And that type of contract is when the PBM is basically administering the benefit, but isn't necessarily guaranteeing a particular price for the customer. They're saying we'll pass through your rebates, etc. And this also provides for an audit provision for an

administrative services-type contract, but only that type of contract.
The next big topic is there are several different items that are sort of focused more specifically on cost containment. One of the technical changes that I made in this bill was to move some of the provisions that are currently in the Medicaid chapter that don't have to do with Medicaid to a new prescription drug cost containment chapter in Title 18, so there is some moving around of things to a place that makes a little more sense; that's what 10 and 11 are.
Section 12 of the bill creates an evidence-based education program. This is a -- what's also referred to as a counter detailing program. And it takes our language currently directing OVHA to do it and moves the program to the Department of Health who is working with the AG, OVHA, and AHEC, the Area Health Education Centers through UVM medical school, which is the entity that's currently operating our limited counter detailing program right now. It would allow for support of the evidence-based education program by independent research organizations like the Oregon program, and it would also provide that

the Department of Health and the AG can apply for grants, or use damage awards from lawsuits as a funding source for the program.
ATTENDEE 1: Provided the Senate Health and Welfare remove the reference to Oregon?
MS. LUNGE: To Oregon? They just didn't want to reference a specific program, so they just made the language broader, so it wasn't --
ATTENDEE 1: It was a FQHC thing?
MS. LUNGE: Exactly, yeah. So it wasn't meant to be really a substantive change. It just wasn't -- they just didn't want to direct them to use a particular program because what if there were other ones that were doing as good a job or better or whatever.
FEMALE ATTENDEE 4: A question here.
MS. LUNGE: Sure.
FEMALE ATTENDEE 4: As I recall, yesterday, Josh was saying, you know, that, in fact, this wasn't implementing in part because there weren't any resources to go along with it. So when it says that you can use the damage awards from lawsuits against manufacturers, is that a pipe dream? I mean, is there actually money in the state or are there lawsuits pending?

MS. LUNGE: No. There are --
FEMALE ATTENDEE 4: How real is that as a source?
MS. LUNGE: I think Julie Brill would have more specific information about pending lawsuits. I don't know if we have any pending. The money that's funding AHEC did come from one of those lawsuits. And the -- our AG's office has been active with other state AGs in this area, so I don't -- I think Julie could give you a better sense of how realistic is this as a funding source, and is it sustainable, those kind of things. I just don't know.
FEMALE ATTENDEE 4: Because if I understand that response correctly, that to use it now would be to take away money from AHEC because the money's being used for AHEC, so unless there's new money coming in, it might --
MS. LUNGE: I think the idea would -- well, I think you would want what AHEC is doing to be aligned with this because you wouldn't want to have two counter detailing programs in the state. So I think what the senate had in mind is that by including AHEC, that the Department of Health would work with AHEC to figure out the best way to

develop this program in Vermont. And the language also allows them to work with other states, so to take into consideration the sort of regional effort that's going on.

FEMALE ATTENDEE 4: Right, which is what you were saying earlier, Harry, right, about the concern?

MS. LUNGE: So it's not -- I don't think it would necessarily result in the money being taken away from AHEC because I think they have it now, but the question -- it does sort of raise the question of how are we going to proceed and who is going to do it, and what the senate did was include all the relevant players and give the -- put Department of Health in charge but say make sure you include all these other people when you're designing and coming up with the program.

FEMALE ATTENDEE 4: Okay.

MS. LUNGE: And it -- you know, it makes a lot of sense to involve the medical school because they're educators and so they're, you know, I think going to have some ideas about appropriate ways to do this.

FEMALE ATTENDEE 4: Thanks.

MS. LUNGE: Yep.

Section 13 of the Senate Finance bill is introduced, started -- this is one area that's very much in play right now.

ATTENDEE 1: Which section? I'm sorry.

MS. LUNGE: Section 13.

ATTENDEE 1: Okay.

MS. LUNGE: This is the Prescription Drug Information Confidentiality Law, it's based on New Hampshire's law, and this -- the bill is introduced included basically the New Hampshire law with some changes to address some of the issues that were raised in the lawsuit that is pending in New Hampshire relating to that. And basically, what it would do is prohibit the use of prescription information that identifies a prescriber or a patient for commercial uses, which is defined to include things like marketing and advertising, or analyzing your sales force to see how they're doing in terms of selling a drug to a particular doctor, and allowed for AG enforcement of that through the Consumer Fraud Act.

Senate Health and Welfare decided they didn't want to do that, so they removed that provision and included instead a study where Leg. Counsel would basically report back on what's happening with the

New Hampshire lawsuit. And I think in part that was because they were concerned about the fact that there was a pending lawsuit and they kind of wanted to see how that ended up, and in part because some of the members of Senate Health and Welfare weren't convinced that doctors really needed somebody to do this for them, that doctors had the where-with-all to just say, "I don't want to see you, marketer, go way."

So -- but Senate Health and Welfare -- I mean, Senate Finance -- excuse me -- liked this provision, so then they did an amendment to the amendment to suggest an opt-in program which would basically require the pharmaceutical marketers to disclose to physicians when they visit them the prescribe -- the information that they have about the physicians, because some of the testimony they heard from the medical society is that doctors don't necessarily have their own prescribing data, and that would be helpful for the doctor to have as well, but -- so this would require the disclosure of that information to the doctor or the other prescriber, and the marketer would give the physician the option -- it should actually say the "prescriber" because it could be anyone who

prescribes, not just the physicians -- the option of allowing their information to be used through an opt-in mechanism, so it would provide that the physician opt-in to the program, the use of the data. And that --

FEMALE ATTENDEE 4: Can I ask --

MS. LUNGE: Yes.

FEMALE ATTENDEE 4: I'm not sure how this works now.

MS. LUNGE: Okay.

FEMALE ATTENDEE 4: So --

MS. LUNGE: Do you want me to describe how that works?

FEMALE ATTENDEE 4: Yeah. How do they get the information now --

MS. LUNGE: Yep.

FEMALE ATTENDEE 4: -- because you said partly, you know, the doctor would have to say, "go away," basically, but I'm thinking if they're engaged with them now, they must be getting something because, you know, we hear how busy they are. So what's the incentive for them to participate now, so, yeah, if you can explain how it works.

MS. LUNGE: Well, let me explain how the data

collection process works first, because that's probably good background on this.
FEMALE ATTENDEE 4: Although, is this boring? Does everybody else already know this?
ATTENDEE 2: No.
ATTENDEE 1: No. It's good background, I think.
MS. LUNGE: So right now, the American Medical Association has prescriber numbers for all doctors in the United States, regardless of whether or not they're AMA members, so -- and the AMA sells that information to information processing companies. I can't remember exactly what they're called, but IMS, for example, is one of them and I'm sure you'll hear from them in testimony.
ATTENDEE 3: Who? I --
MS. LUNGE: IMS.
ATTENDEE 3: IMS, okay.
MS. LUNGE: Do you remember what it stands for?
FEMALE ATTENDEE 5: It no longer stands for anything.
MS. LUNGE: Oh, okay. It's just IMS, so it's an acronym name.
FEMALE ATTENDEE 4: A lot of us no longer

stand for what we --
MS. LUNGE: Like AARP, it no longer stands for anything; it's an acronym name. So anyway --
FEMALE ATTENDEE 4: Okay.
MS. LUNGE: So there are these companies who will buy that -- the prescriber numbers from the AMA, and there are other, I guess, sources of numbers that are associated with specific doctors, but that's -- this is the process that I most clearly understand, so I'll use this example.
And then this same company would buy the prescription information, which doesn't have the doctor's name but has the identifier, like the doctor number, from pharmacies. And then that company takes the AMA data and the pharmacy data and combines it so that they can see the doctor's prescribing patterns. So the information is --
ATTENDEE 1: So when Harry writes a script --
MS. LUNGE: Yep.
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CERTIFICATE

COUNTY OF BROWARD)
STATE OF FLORIDA)

I, D. Renee Watson, Notary Public, Stenograph Reporter, do hereby certify that I was authorized to and did listen to CD 07-122/T1 & T2, the House Committee on Health Care, Thursday, March 29, 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 23rd day of August, 2007.

D. Renee Watson
Stenograph Reporter