[LB481 LB631 LB699]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, February 15, 2007, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB481, LB631, and LB699. Senators present: Joel Johnson, Chairperson; Tim Gay, Vice Chairperson; Philip Erdman; Tom Hansen; Gwen Howard; and Dave Pankonin. Senators absent: Arnie Stuthman.

SENATOR JOHNSON: Ladies and gentlemen, would you please have a seat? Good afternoon everyone. This is the Health and Human Services Committee for the Nebraska Legislature. Let me introduce several people and we've got some empty chairs. And one of the things that you will see this afternoon is that people have to come and go to different committees because this afternoon, for instance, I need to introduce bills at two other committees. So you'll see those of us who have those responsibilities, come and go. It's not for lack of interest in the bill that you might be interested in. Let's start with Senator Pankonin, from Louisville, on the end; pretty soon you will see Senator Phil Erdman, from Bayard; our Vice Chair is Tim Gay, from Papillion, and he will be running the show while I'm off doing my business in other areas; Jeff Santema is our legal counsel. And then to my far left will be Senator Gwen Howard, from Omaha; Senator Tom Hansen, from North Platte; Arnie Stuthman will be in the next chair, and he's from Platte Center; and Erin Mack keeps track of everything up here and she's our committee clerk. With this group from AARP, you guys probably don't even know what cell phones are, so (laughter) I won't have to tell you. Now seriously, please silence your cell phones because when they ring and so on, why these are recorded, our hearings, and so on, it bothers the transcriber considerably when those things go off and then somebody rushes out of the room causing a commotion and so. And it disturbs all of us when we hear the shot down the hall (laughter). Uh, now the way we work things is this: someone will introduce the bill and then we will have first, proponent testimony, then opponent testimony, and then neutral. Now, for the first person that we have talk, we allow them a little leeway, but after that why we would ask that you be clear and concise and if there are several of you testifying about a certain subject, when you come up please add to our base of knowledge, not just keep repeating and repeating and repeating. See, one of the things is if our hearings go too long, it's not fair to the last people, because we lose our attention span as well in this type of thing, so we'd ask your cooperation with that. Other committees actually have a light system where when the red light comes on you're done. We like to be, quote, a little more civil than that but. Now there may be many of you that have a strong interest in the bill, don't necessarily want to come up and express that opinion in the microphone. There will be sheets around where you can sign these or and be either a proponent or if you are against it, that you can record that and it will become part of the official record. For those of you that do testify, why we would ask that you give your name and please spell it for the transcriptionists. Oh, one last thing I guess and that's this: if you have materials, we like to have twelve copies. If you are not aware of the rule, give them to the page and they

will make copies and pass them around. With that, Jeff, did I leave anything out? All right. Let's proceed with the first bill and I will introduce this and it's LB481 and what this is, is, regarding the change of requirements relating to criminal background checks for certain healthcare professionals. Senator Gay, would you take over please?

SENATOR GAY: You bet. Thank you, Senator Johnson. Get yourself situated there. Go ahead.

SENATOR JOHNSON: (Exhibit 1) Senator Gay, members of the committee, I'm Senator Joel Johnson, J-o-e-l, Johnson, J-o-h-n-s-o-n, representing the 37th District. I come before you today with LB481. Basically this is in response to requests from our two medical schools, Creighton and the University of Nebraska. They encounter occasional problems with criminal background checks and so on of their applicants to these residency programs and so on. So this is an attempt to correct that problem. Basically, to do this, what we do with LB481 is to provide a 90-day grace period for the applicants for temporary education permits to comply with these criminal background checks. There are standard provisions in the licensure act. This 90-day grace period will allow sufficient time for medical residents coming from outside the state to comply with background checks. The process for application requires the application and fingerprints to be submitted to the Nebraska State Patrol. This process can delay when that resident might actually assume his residency, the duties associated with that of being a resident. The applicant shall have his or her permit suspended after the 90-day period if the background check is not complete or revoked if the background check shows the applicant not to be qualified. In addition, I offer for the committee's consideration, an amendment to LB481 and this is AM270 and this does the following: under current Nebraska law, a person who wishes to be licensed as a physician must complete all of the required training within a seven-year period. Let me repeat that one because it's kind of important. Under current Nebraska law, a person who wishes to be licensed as a physician, must complete all of the required training within a seven-year period. This seven-year period, however, causes problems for physicians, particularly for those that are in the military or have been deployed for extensive periods of time such as the War on Terror. The new Uniform Credentialing Act, LB463, extends this seven-year period to 10 years. But this act, which, by the way, for those of the people behind me, is some 1,056 pages in length. It doesn't become effective until the first of December, 2008. So we have this gap in time here that we need to take care of. AM270, does, implements the change found in LB463 with the emergency clause. I do not recall that there is any opposition to this change proposed by this amendment at the public hearing of LB463. In our presence today, is Captain Allen Stoye, who will further explain the need for this AM270. With that, I would... [LB481]

SENATOR GAY: Thank you, Senator Johnson. Are there any questions from the committee at this time? I see none. We'll ask for other proponents. [LB481]

SENATOR JOHNSON: Thank you and I probably won't be here to close because I have other commitments. [LB481]

SENATOR GAY: Thank you. Okay. All right, thank you. Other proponents? Could I see a show of hands who would want to speak on this, proponents on this bill? Any opponents? Anybody in the neutral capacity? Okay. Proponents come on up. If you could state your name and spell it out for the clerk, we'd appreciate it. [LB481]

DR. CECILE ZIELINSKI: (Exhibit 2) Okay. My name is Dr. Cecile, C-e-c-i-l-e Marie Zielinski, Z-i-e-l-i-n-s-k-i. I am associate dean of graduate medical education and I'm representing both Dr. Wickton (phonetic), who is the associate dean of graduate medical education at the University of Nebraska, and myself, on behalf of the section of the bill that has to do with the criminal background check as far as it affects our new residents coming into the programs. As many of you may or may not know, it does appear in the news releases that the residents have a match day at which time they all find out where they're going as far as their residency. That usually is the middle of March. Now with the present criminal background check, that gives us barely about 90 days or less depending upon where the resident is, to get that accomplished because they start their work on July 1. So what we're left with is--and I have a handout here, by the way, and if you could pass it out, it gives you just the number of the residents that we have that are from both institutions, the University of Nebraska and Creighton, on an average, the number that come from other states and the number that come from foreign countries. So and I'd like to reiterate that both universities are strongly, we appreciate, and are in favor of, the criminal background check. What we are here for is to ask the leeway to give us a little bit more time to accomplish this because of the distance and the time frame that we have. So what we would like you to also know that both universities, you see we might have a little bit more foreign medical students, but we have, and both at the University of Nebraska, have been able to tap from other foreign countries, the top in their country. For example, at Creighton, in one of the programs, they have six residents and those six residents come from the top school in India which only accept 30 of the top, their most brightest students in all of India per year, and we happen to have six in surgery and probably about three or four in medicine. I know the University of Nebraska doesn't have as many, but they have comparable and they're very speciality. So we're bringing in some of the top students from other countries, and many of them, of course, go on and stay here and contribute. Some of them have gone on to both institutions to become faculty members, so very strongly support the state. What we basically...the problem that we had is primarily with the fingerprinting and what I'm going to do is, I've given you both our institutes' view on this. We strongly support the bill. We are asking for a 90-day extension. In the back of this handout, you will see the contracts from both the University of Nebraska and Creighton University in which it states right there that if the resident is not legally licensed or fails the criminal background check for which they couldn't get temporary educational permit, then the contract is null and void. So all of our residents know ahead

of time that this is a requirement. So I wanted to make that clear and we included a copy of that. And with that, I know you've got a very busy schedule and I appreciate the opportunity to come down and talk to you, and I'm going to turn it over to Angie Alberico, who is my administrator, and also represents Vicky Ham (phonetic), from the University of Nebraska, who is the administrator and some of the problems that they have had. They are the ones that do all the work and send it out and she'll just very briefly give you a brief rundown of this, and thank you very much. [LB481]

SENATOR GAY: Okay, hold on, Doctor, let's see if there are any questions for you. Senator Hansen has a question. [LB481]

SENATOR HANSEN: Thank you, Senator Hansen. Doctor, do these background checks start after the students are on campus or do they have to be done prior to their arrival? [LB481]

DR. CECILE ZIELINSKI: They have to be prior to them coming out. [LB481]

SENATOR HANSEN: Their arrival, so they're not on campus? [LB481]

DR. CECILE ZIELINSKY: They have to have a license before they set foot into the hospital. They cannot practice medicine without a license. In order to get that licence, they must--in this case it's a temporary educational permit--they must first pass the criminal background check. [LB481]

SENATOR HANSEN: Okay, thank you. [LB481]

DR. CECILE ZIELINSKI: You're welcome. I'm sorry. Any other questions? [LB481]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB481]

DR. CECILE ZIELINSKI: Thank you. [LB481]

ANGIE ALBERICO: Hi, I'm Angie Alberico. I work at Creighton University. It's A-n-g-i-e A-l-b-e-r-i-c-o. As Dr. Zielinski said, Vicky Ham and I are the administrators of the GME Programs at both Creighton and UNMC. And just a quick overview of the processing or what we've encountered with trying to get the criminal background checks for our residents so they can start on time. As Dr. Zielinski mentioned, we have a short time frame between mid-March to July and with the initiation of the CBC, the Criminal Background Check, that adds on an additional...about two weeks to four weeks depending on if the Criminal Background Checks come in correctly and they pass them. What we had experienced was there is no Web site system, no way to track if our residents', criminal...their fingerprints have made it to the state patrol or whether they were rejected and sent on to the state. So what we had to develop, or what I did at

Creighton--it wasn't uncommon for me to contact the state patrol two to three times a day from about the end of March until July 1 to check on various peoples' fingerprints, if they'd come in--and then I'd contact the state licensing board to see if they had received the approved or rejected ones. And then the state would turn around and send the rejected fingerprints out to the residents and then we tried to stay on the residents to make sure they get them done. But what Creighton, as you see, we have quite a bit of international graduates that we take on and probably 51 percent of our foreign medical grads were abroad. So we had to then, is to express courier mailing to get these criminal background checks out to them and then they would come back and be rejected, so it was a constant. And that's a delay in time and is cutting our time short and we have even had two residents get a visitor's visa, fly over, pay over $2,000 for airfare, to come into Lincoln to get their criminal because they had been rejected twice. Then they would fly back home and that's a $2,000 airfare just to get a criminal background because we require our residents...we're very strong on, you got the position at Creighton, you are expected to be here on July 1 for your job. And if you can't then they have the possibility of losing their position and it's very hard. It's a competitive market with the residency programs. So they were flying in from countries on visitors' visas just to get this done as well as we had people in the U.S. that were flying in from New York because their fingerprints were rejected and so forth. And there is no real way to process these any quicker; it's not electronic. And even in the packets, they'll indicate it's better if you come to Lincoln to get these done. Well, we don't have that opportunity for a lot of our people because they are not here in Omaha or in Lincoln. We take people from all over the world into our residency programs. And by allowing the 90-day extension from the date that the TEP is issued to get it done, that will allow our people who are foreign, particularly to get their visa because you have to have a license in order to get the visa to get here. That allows time to get them here to get their fingerprints done so we can have our residency capacities starting on time. [LB481]

SENATOR GAY: Thank you. Senator Pankonin. [LB481]

SENATOR PANKONIN: Thank you, Senator Gay. As I understand it then, you work with both programs, UNMC and Creighton then? [LB481]

ANGIE ALBERICO: I work with Creighton and Vicky Ham was not able to be here so I'm kind of representing them. [LB481]

SENATOR PANKONIN: Oh, okay. In your experience, how many times have we had people rejected because of the criminal background check? [LB481]

ANGIE ALBERICO: How many times? [LB481]

SENATOR PANKONIN: Yeah, or, I don't know if you can give that, but I mean, does it

happen? [LB481]

ANGIE ALBERICO: It happened quite a bit. I can tell you on all my foreign's that were abroad, every one of them were rejected because in the other countries--it says you have to go to official, like a legal site--to have these done. They don't have that a lot of times in their countries. [LB481]

SENATOR PANKONIN: I hope not. Okay, what my question is... [LB481]

ANGIE ALBERICO: I'm sorry. [LB481]

SENATOR PANKONIN: ...how many times have you had someone that had a legitimate criminal record, that you had to say you've got to leave, you're not going to be in the program? [LB481]

ANGIE ALBERICO: None, none. [LB481]

SENATOR PANKONIN: Okay that's what I'm getting... [LB481]

ANGIE ALBERICO: I'm sorry. [LB481]

SENATOR PANKONIN: ...at because if there was some of that or quite a bit of that, then I'd be a little more concerned about the 90 day, that's why... [LB481]

ANGIE ALBERICO: No... [LB481]

SENATOR PANKONIN: ...I'm grilling down to that. [LB481]

ANGIE ALBERICO: ...all of our residents have passed their criminal backgrounds... [LB481]

SENATOR PANKONIN: Okay, for several years? [LB481]

ANGIE ALBERICO: This has only been implemented the last two years... [LB481]

SENATOR PANKONIN: Okay. [LB481]

ANGIE ALBERICO: ...for last year. [LB481]

SENATOR PANKONIN: Okay. So but, everybody has passed, once they... [LB481]

ANGIE ALBERICO: Everybody passed. [LB481]

SENATOR PANKONIN: So this would just give them more time... [LB481]

ANGIE ALBERICO: To get it done. [LB481]

SENATOR PANKONIN: Okay. [LB481]

ANGIE ALBERICO: Because we have a short time frame from when they match and when they can come into Creighton... [LB481]

SENATOR PANKONIN: Thank you, that's very helpful because obviously if we are going to allow this, I want to make sure there wasn't a high incidence of it. [LB481]

ANGIE ALBERICO: And I can tell you for the foreign medical graduates, they already go through an extensive criminal background to even get into the United States to get an ECFMG certificate. [LB481]

SENATOR PANKONIN: That's true. Okay. Thanks. [LB481]

SENATOR GAY: Okay, thank you. Any other questions? I don't see any. Thank you. [LB481]

ANGIE ALBERICO: Thank you. [LB481]

SENATOR GAY: Any other proponents? [LB481]

ALLEN STOYE: Vice Chairman Gay, members of the Health and Human Services Committee, and members of the public, my name is Allen Stoye, A-l-l-e-n S-t-o-y-e. I'm a military officer and a physician at Offutt Air Force Base, Nebraska. To make a long story short, I am one of the reasons for AM270 onto LB481, the portion that Senator Johnson was speaking about, increasing with the emergency clause from seven years, the requirement, to ten. This, as I understand, is something already listed in LB463, but it's the large uniform licensing law which will not be implemented until December, 2008. The reason for my concern is this: I grew up in Minnesota and came to Offutt Air Force Base when I got activated. And I speak for myself personally but there are three others at Offutt tho are in the same boat as I. And what happens is when you are activated and called to active duty there are normal time lines that have to be met as far as state rules such as the seven-year rule. This becomes, in many ways, impossible in many to meet...because when you are called to active duty, you are called for a reason, whether it is to be deployed as I was and will be again in May, or because there are other people deployed and you're coming there specifically to take someone else's job. You are there to work essentially, not to prepare for tests that take quite a bit of preparation. Me, personally, I passed the test without any issue but it was seven years six months, it was an extra six months before I got the time to be able to do that. As such, I could not

practice in Nebraska. Moving from Minnesota to Nebraska, we always thought we were going back to Minnesota. We...my wife, I shouldn't say is insistent, because we now both want to stay in Nebraska and practice and make this our home and make this where I'm going to have my career. The concern is I will be most likely out of the military next summer. LB463 does not take effect until December of 2008 which puts me in a quandary. I have a choice of either not practicing medicine or leaving the state of Nebraska, hence the reason for the emergency clause. There are a number of people because of the War on Terror and because of the current situations with the military that have been activated and as such, have not been able to meet these deadlines. And so my request for the committee is to consider the amendment on LB481 the extension from seven years to ten. Again, this is part of the uniform licensing law, LB463. Again, I understand the Nebraska Medical Association's regulatory and licensure division, nobody has a problem with the seven to ten year issue. It is just that that will not take effect for approximately two years which puts a couple of us in limbo in the meantime. Thank you for the opportunity to speak. [LB481]

SENATOR GAY: Thank you, Doctor. Any questions? Senator Pankonin. [LB481]

SENATOR PANKONIN: Thank you, Senator Gay. First of all we thank you for your service to our country and I'm just curious, it's a little bit off, but if you were so...if your wife was especially so bound that you were going to go back to Minnesota, why have you decided you want to stay in Nebraska? [LB481]

ALLEN STOYE: Well, my life has lived about...for 25 of her years, about five miles from where she grew up. And then once we got married, within an hour or so of where she lived up, her family all is right there. She's a farm girl and that was...she was quite traumatized by the fact of hey, we're leaving the state. When she got here she's realized there's lovely people here in Nebraska. I've really enjoyed the area and we just really like it. We have enjoyed it, we've met great friends and we've both come to realize that it's only a day's drive to get back to see, you know, the in-laws, so. [LB481]

SENATOR PANKONIN: Well, we appreciate your testifying today and we'll put you on a tape for economic development as well, right? (Laughter) [LB481]

ALLEN STOYE: All right. Thank you, Senator. [LB481]

SENATOR GAY: Where do you live at? [LB481]

ALLEN STOYE: Bellevue, Sir. [LB481]

SENATOR GAY: Well, there's the reason, in Sarpy County and it's a... Any other questions from the committee? I don't see any, thank you very much. [LB481]

ALLEN STOYE: Thank you for the opportunity. [LB481]

SENATOR GAY: Any other proponents? Any opponents? Anybody in the neutral capacity? I see none and Senator Johnson waived his closing, so I will close...yes? [LB481]

SENATOR HANSEN: Senator Gay, I have a question. Who wrote the amendment, Jeff? It's longer than the bill (laughter). [LB481]

JEFF SANTEMA: I can't respond on the record, Senator Hansen, but I'll talk with you. [LB481]

SENATOR HANSEN: Okay. [LB481]

SENATOR GAY: All right. [LB481]

SENATOR PANKONIN: Then you got that letter, do you want to (inaudible) accept from Dr. Schaefer for the record? [LB481]

SENATOR GAY: (Exhibit 3) Oh yeah, thank you, Senator Pankonin. We did have a letter that doesn't say no formal position from the Department of Health and Human Services that we will enter it into the record. With that then, I would close the public hearing on LB481 and open the public hearing on LB631 to prohibit interchange of antiepileptic drugs. Is Senator Dierks here? We'll wait a minute or so for Senator Dierks to come. Senator Dierks we're moving right along here today, so it's kind of rare here, but... [LB481 LB631]

SENATOR DIERKS: Wonderful. A real progressive outfit here. [LB631]

SENATOR GAY: Yeah. We'll open with Senator Dierks' opening remarks on LB631 whenever you're ready. [LB631]

SENATOR DIERKS: (Exhibit 1) Thank you, gentlemen of the committee and ladies, it's a pleasure to be back here again. My name is Senator Cap Dierks from the 40th Legislative District and I'm here to introduce to you, LB631--spelled Dierks, D-i-e-r-k-s. LB631 was brought to me by the Epilepsy Foundation. I was told sometimes there are problems for epilepsy patients in receiving the medications that they've been prescribed by their medical practitioners. I have a special personal interest in this bill. One of my sisters was afflicted with epilepsy and I remember all to clearly how she suffered with this neurological condition, and I describe it as being in the Dark Ages because they really didn't know much about epilepsy at that time. She was a very little girl and she had these what they call petit mal seizures. As she grew older they became the grand mal seizures which has disabled her completely and she'd be exhausted when it was

over with and they didn't have medication for it. And I saw some graphic descriptions of what epilepsy can do to people and how they really need the treatment and they've come up with some good treatments. She was married and her husband is a medical doctor and they were living in California. She couldn't get a driver's license there because of their laws about epilepsy. When they finally developed the product called Dilantin, why that was good enough to treat her condition and she was then able to get a driver's license. Up until that time, her husband had to go to the grocery store and do all the shopping for her and anyway, I think we've gotten away from the Dark Ages, but I have an interest in this disease. I saw it work first hand in my family and anyway... Finding the correct medicine that works in controlling seizures makes all the difference in the quality of life for these people. Once the bill was introduced, I was approached by a drug company representative who said organ transplant--did you get a handout? [LB631]

SENATOR GAY: Yeah, we have your... [LB631]

SENATOR DIERKS: The organ transplant patients are experiencing some of the same problems as people with epilepsy. These patients need special medications so that their bodies do not reject their new organs. I agreed to that organ transplant basis to the bill and would like to introduce AM0075 to the committee at this time. LB631 is about patient safety and patient rights. If a problem exists for patients who need to receive a specific drug, we need to find out the source of the problem. This bill does not make a preference between brand name drugs and generic drugs. Epilepsy and organ transplant patients have been well-served using both types of drugs. Federal law does, however, allow for minor variances between brand names and their generics which sometimes adversely affect these patients--if the particular brand or generic drug works in controlling seizures, the patients to receive that specific medication. During the testimony today you'll hear from the medical association which supports the bill. The pharmacists are opposed to the bill. They say there's already a state law which mandates that pharmacists fill exact prescriptions when this action is designated on the prescription form. Insurance companies may be involved in the problem of receiving exact prescriptions. They are asked to hold down operating costs and medications can be extremely expensive. I emphasize again that I am not trying to single out one profession and make accusations. My interest is strictly in assisting patients who need specific medications. Thank you for your time and attention to LB631. I will try to answer any questions that the committee has. [LB631]

SENATOR GAY: Thank you, Senator Dierks. Are there any questions from the committee? I don't see any. Will you stay around for closing or? [LB631]

SENATOR DIERKS: I think I will. [LB631]

SENATOR GAY: Okay, thank you. [LB631]

SENATOR DIERKS: Thank you very much. You are very kind. [LB631]

SENATOR GAY: Could we see a show of hands, proponents on this bill? Raise them high. Okay. And then opponents? Okay, so we are about evenly split. And then anybody in neutral? Okay. Thank you. Let's have opponents come forward, or, I'm sorry, proponents come forward? And then if you can work your way, we have a few open seats up here too if you are going to be a proponent on this. Come on forward, we want to speed things up. Go ahead. [LB631]

VICTOR VERNI: (Exhibit 2) Hi, my name is Victor Verni. I have been the executive director of the Epilepsy Foundation of north central Illinois, Iowa, and Nebraska for 35 years. I'm here today to testify in support of LB631. I want to talk to you today about what could have happened to people if this bill is not passed. The issue of medication substitution assumed a critical importance to me when I saw the child of one of my employees nearly lose her life. Megan (phonetic) has had seizures since she was an infant and had her doctor struggled to find medications that would control them. When she was six years old, she had severe complications from three medications she was on that were switched in an attempt to improve her seizure control. She spent months in an intensive care unit fighting for her life. Even today there are only three medications that she can safely take and changing the formulations of those medications are potentially life-threatening to her. It is important to recognize that because two formulations of the same medication are bioequivalent, does not mean that they are therapeutically equivalent. For most conditions, this difference may not be meaningful, but for epilepsy patients, small changes in therapeutic equivalency could result in a breakthrough seizure or in toxic side effects. This is true whether the change is from a brand to a generic or from one generic formulation to another formulation. There are, for example, 12 formulations of the widely-prescribed drug Carbamazapine. This bill does not promote brand names over generics. It promotes people with epilepsy getting the same formulization of the medicine that is working for them. If that medicine is a name brand, then they will avoid the high cost of therapy failures by paying a little more for medication. If they are doing well on a generic, they should continue to receive the same generic formulization from the same manufacturer that has been controlling their seizures. Before any substitution of any kind takes place at the pharmacy, we'd like patients and the prescribing physicians to consent so that these patients can be monitored for adverse incidents. Megan, today, is a happy middle-school child who loves to listen to music and hang out with her friends. Passage of this bill will keep other epilepsy patients from enduring what she has gone through by not placing them at unnecessary risk from medication substitutions. I also have, and would like the page to pass out, the position paper from the American Academy of Neurology, from our national association, The Epilepsy Foundation of America, and also from the National Black Caucus of State Legislators. I was told to bring ten copies of that. [LB631]

SENATOR JOHNSON: That's fine. [LB631]

VICTOR VERNI: You have 12, but maybe you can share for a couple of... [LB631]

SENATOR GAY: We'll make a copy, that's all right. All right, thank you. [LB631]

VICTOR VERNI: I'd be happy to take any questions. [LB631]

SENATOR GAY: All right. Thank you. Are there any questions from the committee? [LB631]

SENATOR HANSEN: Just one. [LB631]

SENATOR GAY: Senator Hansen. [LB631]

SENATOR HANSEN: Thank you for your testimony. I'm not sure I'm qualified to ask the question, but the therapeutic equivalent, you said there's quite a difference in that? And I know the drug and the dosage is important. How do epileptics, once that's diagnosed, what is the routine? How do they find that level of drug and the dosage? Which drug works best at what dosage? How do you find that? [LB631]

VICTOR VERNI: Okay, and I'm going to postpone the answer to that question. We have two doctors that will be testifying after me. Part of the thing here is that the patients get the doctor, so it, let's let...that's a great present for them. [LB631]

SENATOR HANSEN: Okay, great. [LB631]

SENATOR GAY: All right, are there any other questions? I don't see any, thank you. [LB631]

VICTOR VERNI : Thank you. [LB631]

SENATOR GAY: Other proponents? [LB631]

BECKY ANDRICKS: (Exhibit 3) Hi, my name is Becky Andricks, it's B-e-c-k-y, last name is A-n-d-r-i-c-k-s. Senators, thank you for allowing me to speak today. My name is Becky Andricks and I've had epilepsy since I was five years old. My seizures became controlled around the age of 8 which lasted until I was in college. It was at this time my seizures became worse and were uncontrollable by my senior year in college. My main goal was to graduate from college. By December, 1993, I had reoccurring seizures two to three times a day that made it incredibly difficult to participate in the classroom as well as taking an exams. It became frustrating since I lost my independence of being able to drive that made me rely on close friends and family for transportation. I was

completing an internship with American Express, financial advisers, and had to withdraw my participation because of my seizures. In my last semester, in 1993, I finally went back to my doctor to see if I was a candidate for epilepsy surgery. It was determined I was a primary candidate so after my graduation in December of 1993, I went through final testing and had surgery in 1994. From that point moving forward I was seizure free, being able to drive without relying on others, being able to go back to American Express for work, and recently engaged. Then five years later my husband's company just had switched insurance programs and they were substituting my Tegratol with its generic Carbamazapine. I had no concerns and it was filled but the day after I had my first seizure in five years, then they continued and continued until I called my doctor and informed him of my seizures. He determined immediately to change back to Tegratol. But unfortunately one seizure provokes another seizure so it took me time until they subsided. Senators, I come asking you for help in voting for LB631 that can simply inform our doctors of any changes being made to our prescriptions. My life was affected and I briefly felt that my old lifestyle was coming back where I had to rely on others and I was losing my independence and career that I worked so hard for. By having this bill, there will be no questions and changes being made to our prescriptions whether it's name brand to generics or generics to generics, without approval. As I mentioned earlier, I am now living a normal life and want others to be able to do the same. Epilepsy can be very frustrating and I'm simply asking you to consider what the lifestyle effects can be by changing a prescription. So, thank you. [LB631]

SENATOR JOHNSON: Thank you. Any questions? Senator Hansen. [LB631]

BECKY ANDRICKS: Sure. [LB631]

SENATOR HANSEN: One question, thank you, Senator Johnson. What a...explain a little bit about your, how the insurance company handled your case? I mean, you switched jobs or your husband, or your...you switched...? [LB631]

BECKY ANDRICKS: My husband's company switched insurance programs, yeah. [LB631]

SENATOR HANSEN: So what...how, tell us a little bit about that procedure. How were you notified, or were you notified? [LB631]

BECKY ANDRICKS: Actually, in a way, we were notified. It came through once we went to the pharmacy...just assuming everything was going to be the same. But they said your program's changed in that, do you have any problems with going, you know, generic? And basically, we had no idea about it, assuming it was the same, so I did go ahead and start taking the Carbamazapine. And it was basically the day after that things started coming into play where I was having the seizures, and this was five years I was seizure-free, so it was such a surprise--and then what they do is they kind of multiply

after that. And I did, I called my doctor pretty much immediately that time, but basically one can trigger another and trigger another, so it takes time to stop and you know, go back to normal. But it was after that time I went back to the Tegratol and things were just fine and continued pretty much from there. [LB631]

SENATOR HANSEN: Did you have contact from your insurance company and get their permission to get the previous drug that you were on? [LB631]

BECKY ANDRICKS: You know, it was. When we contacted the insurance company, you know, it went...to be okay. You paid a little bit more on your copay but, you know, we definitely...that was fine because pretty much health, if you pay a little bit more, my belief is to just continue to be healthy. [LB631]

SENATOR HANSEN: When you talked to your doctor the second time after you started having the seizures again, did you ask your doctor to contact the pharmacist and say put on a do not change prescription? [LB631]

BECKY ANDRICKS: I sure did. He pretty much, he did, he took care of that. [LB631]

SENATOR HANSEN: And have you had any problems since then with that note at your pharmacy? [LB631]

BECKY ANDRICKS: No, no. I haven't had any problems, so, yeah. [LB631]

SENATOR JOHNSON: Any other questions? I don't see any, thank you very much. [LB631]

BECKY ANDRICKS: Okay. Thank you. [LB631]

SENATOR JOHNSON: I believe we're...Senator Gay, I presume we are still on proponents? [LB631]

SENATOR GAY: Yes. Yes. [LB631]

SENATOR JOHNSON: Okay. Further proponents please? [LB631]

SANJAY SINGH: (Exhibit 4) My name is Sanjay Singh. I'm here on behalf of the Epilepsy Foundation. I am a physician, a neurologist and I'm the director of the Nebraska Epilepsy Center and associate professor of neurology at the University of Nebraska Medical Center. My name is spelled, the last name Singh, is spelled S-i-n-g-h and the first name is Sanjay, S-a-n-j-a-y. Thank you for allowing me to testify here. I came to Nebraska about four and a half years ago from Yale University to establish the first epilepsy center in the state and today I have more than 2,000 patients under my

care here at the University of Nebraska Medical Center. I am here today because this bill is critical to helping patients with epilepsy. And whatever can help and make the life of patients with epilepsy better and keep them safe, it is worth our time and effort to do that for these patients. The American Academy of Neurology which was alluded to a little while ago, is a professional organization of neurologists, the primary physicians that actually treat this condition. And this is a professional organization of over 19,000 of these neurologists here. And it is their considered opinion in the position statement that a physician and the patient need to be informed if a drug formulation is being changed from brand name to generic or generic to brand name. And the reason for that is in epilepsy, is a different kind of medical condition. In this the antiepileptic drugs have a very narrow therapeutic index and I will try and explain that to the best of my ability. In epilepsy, drugs are effective in a very narrow spectrum. If the level in the blood of that drug goes high, the patient becomes toxic and that toxicity can lead to cardiac toxicity, him not being able to walk properly, him seeing double. If the level of the drug goes below the therapeutic index, then the patient can have seizures and seizures can have important and bad consequences here because if he's driving, he may kill himself or kill someone else. If he's doing some work and he's not aware that he is at risk for seizures, he can actually fall down and hurt himself. Also, in our state of Nebraska, the state laws says that if you had a seizure, you cannot drive for three months. It's three months in our state of Nebraska; it's six months in Iowa; it's 12 months in South Dakota. Those are the primary areas where my patients come from. If someone in our state of Nebraska cannot drive for three months, in a number of circumstances that means that that person cannot work anymore and cannot be financially independent. In the over 2,000 patients of epilepsy that I treat, I hear these stories unfortunately one too many times. And if we can keep these patients safe by informing the physician who's treating the patient that a formulation may be changed, then that is worth doing. Let me explain a little bit about the therapeutic index that we have talked about earlier. The FDA actually considers a drug bioequivalent if the rate of absorption of that drug is between -20 and +25 percent, so a variance of 45 percent is allowed for a drug to be considered bioequivalent. In an epilepsy medication, that in a number of patients, can be devastating to that patient's stability and treatment. So in a number of other classes of drugs, it is perfectly fine, but in these patients, that can be dangerous. Is it dangerous in every one of them? No. But is it dangerous in some of them? Yes. And if so, if we can keep these patients safe and even in that small number, then that is worth doing at least in my opinion. That's why I'm here in front of you today. In our state of Nebraska, there are about 15,000-20,000 patients with epilepsy and as I say it's not just the patient who's affected by this condition, it's the family too. So you can multiply that by four or five and you'd have about 80,000-100,000 people who are looking for safety in this particular condition. I'll stop and be happy to take any questions that anyone has. [LB631]

SENATOR JOHNSON: Senator Pankonin. [LB631]

SENATOR PANKONIN: Thank you, Senator Johnson. I would like to thank you for coming to Nebraska and setting up that program and going the fine work that you are doing. I think your testimony is very valid. I have one major question here. Would you agree if the doctor puts on the prescription--script, no substitutions, then--I understand the lady's situation with insurance companies, I'm an employer, we all know how the next bill that comes up, we've got a room full of people. We are going to trying to talk about keeping drug costs low and I wholeheartedly agree that...I understand what you're talking about, these drugs are important. But would you agree if that's put on the prescription, no substitutions, that's what should happen? That's what the law is? [LB631]

SANJAY SINGH: That is true, Sir. Let me just state for a fact that in the state of Nebraska there are only very few specialists who specialize in treating epilepsy. The vast majority of our patients of epilepsy are treated by primary medical physicians or family physicians, who, if they were educated epilepsy or went to medical school more than 15 years ago, the treatment of epilepsy has almost completely changed. And so in a number of those prescriptions, they do not write dispense as written because that has not reached them. And one of the primary purposes of our center is to also educated our fellow physicians. But it is going to take a long time before we educate every physician in the state that you have to write dispense as written for these patients to be safe. And if that's the idea here, then if we can keep these patients safe by passing this bill, LB631, then I am all for that. Because until we educate every physician that you need to write dispense as written, and the years that it is going to take us, we are going to put patients at risk until that period of time. [LB631]

SENATOR JOHNSON: Other questions? [LB631]

SANJAY SINGH: Yes, Sir. [LB631]

SENATOR PANKONIN: Sir, that's my concern though, is passing a law that might open up many other groups to come and say, we need this particular drug or whatever. I think the issue here for me, as a public policy, hopefully maker, helping make laws, is that, you know, to me, it's about following the rules we already have and educating the doctors and consumers to a lesser degree. I would think that we have some way to communicate with all the doctors to say this has been an issue, it's important. A letter under your name going to every doctor in the state, or whatever, versus putting another law on the books that may open up a whole another set of people saying, well, we want our particular drug. And that defeats the idea that, and I agree with you, those people need those drugs and that's important; but to me, we've already got it. So you are telling me that--I sell tractors and combines for a living. We get what we call service bulletins on how to fix them and they come in real big letters--fix this. Can't do that; doctors can't get that done, huh? [LB631]

SANJAY SINGH: Let me just state, Senator, that the issue here is that these family physicians and primary care doctors may treat maybe one or two epilepsy patients or three patients in a year. This is not the primary thing that they do. They probably treat blood pressure, heart disease, strokes, much more often. This is not on their radar screen. And by the time we get this on their radar screen, we are putting all of these patients at risk. Or if a nurse or a medical technician forgot to put the dispensed as written, then we are going to put that patient at risk at that point. I take your point completely that if we could educate all the physicians and everyone could write that on every prescription that goes out for epilepsy patients, then that would be fine. But in lieu of that perfect scenario, to keep these patients safe, this is the way to do it as this bill, LB631 states. [LB631]

SENATOR PANKONIN: Thank you. [LB631]

SENATOR JOHNSON: Any other questions? Senator Gay. [LB631]

SENATOR GAY: I've got a question for you. [LB631]

SANJAY SINGH: Yes, Sir. [LB631]

SENATOR GAY: You talk about 2,000 patients you are seeing now. Of those 2,000 patients, how many different drugs are you prescribing? [LB631]

SANJAY SINGH: Okay. Thank you for the question. The issue was that before 1993 there were only four drugs to treat epilepsy. And a lot of epilepsy patients did not have many options of treatment. Right now we have over, in the last ten years, we've had ten new medications of epilepsy that are available. So that provides a wider range of therapeutic options that are available to patients. Most of these newer drugs are actually not available in generic formats, they are just in the brand name only because they are still under patent. But the options for treatment of epilepsy have completely changed in the last ten to fifteen years. Now we have surgeries of the brain that we can do if patients fail medications. If that fails them, you can do brain stimulation, nerve stimulation, that can treat this. We are coming up with new treatments where we would predict through a computer chip when the person's going to have a seizure and stimulate the area of the brain and stop the seizure even before it comes on. So the options have increased and fortunately for our patients and also fortunately there are more new drug options that are available now. [LB631]

SENATOR GAY: Okay, then I have a follow-up question to that. You had mentioned that some...primary physicians don't see near as many cases as you do. Are they, in your opinion, and I know you can only give your opinion, in your opinion, are they just prescribing, oh, the four drugs instead? They don't know about the other ten or do they just stick with a couple and here's what we use? Is that what your... [LB631]

SANJAY SINGH: And that's true for a significant number of our primary care physicians because it differs from physician to physician; it depends on how a physician keeps himself educated about a particular topic. But, still the majority of physicians would use those four primary medications more than they would ever use the new medications. [LB631]

SENATOR GAY: Thank you. [LB631]

SENATOR JOHNSON: Any other questions? I see none, doctor, thank you very much. That was very helpful. [LB631]

SANJAY SINGH: Thank you. I have my testimony for the page. [LB631]

SENATOR JOHNSON: Thanks. Great. [LB631]

RICHARD BALTARO: Thank you for this opportunity. My name is Richard, R-i-c-h-a-r-d Baltaro, B-a-l-t-a-r-o. I am representing the Nebraska Medical Association and the 2,000 plus physicians that are practicing in this state that are its members. We believe that individuals and physicians should be notified and given their consent before switching a medication, whether it involves a generic substitution for a brand name or a generic to generic substitution. To answer Senator Pankonin's question, one of the reasons why the Nebraska Medical Association is in favor of supporting this and is that we discussed this bill in our legislative council, and we have a number of physicians who had written do not substitute and although it may not be perfectly legal, it may not be perfectly done, their substitution was changed. And some of the physicians believed that some of their patients had epilepsy because changes were made to their do not substitute or give us dispense as written. And one of the things that epilepsy medication, and I may also say about transplant by medications are different than other kinds of medications, is that they have a narrow therapeutic index. And patients have to take them for years and years and years, so the benefit to ratio to harm is quite different than say, an antibiotic that may only be for ten days. So that's why these drugs are in a special category and if it's felt that a patient is controlled under one generic name, they should be kept under that, and it is not just a financial advantage. Sometimes it's just generic versus generic substitution and certain pharmacies only carry one brand or the other, normally, and they would prefer not to change. Thank you. [LB631]

SENATOR JOHNSON: Thank...Senator Hansen. [LB631]

SENATOR HANSEN: Thank you, Senator. Are you an M.D.? A doctor of... [LB631]

RICHARD BALTARO: Yes, M.D. Ph.D., I'm an associate professor at Creighton and I would like to thank Dr. Singh, who is a colleague, from the other medical school.

[LB631]

SENATOR HANSEN: The other one. (Laughter) [LB631]

RICHARD BALTARO: A good colleague and friend of mine. [LB631]

SENATOR HANSEN: Doctor, would it ever happen that a patient, and we see it on television a lot, it says ask your pharmacist if we can get generic and it might save you money. So we have people and you have patients with epilepsy, they're paying copays or they're paying completely out of their pocket. If they went to a pharmacist and said, you know, I've got my epilepsy under control, do you have a generic that would work? Does that ever happen? Does that cause a problem? [LB631]

RICHARD BALTARO: Oh yes, and actually, in many cases now especially when we have so many medications, we can control--in fact in most cases, you can control epilepsy with medication--and in many cases it does not really necessarily make that big of a difference. But there are a number of patients where it does make a difference. There are individual variations, not only the way these drugs are absorbed, but by the way these drugs are metabolized. So a number of patients, physicians have to use a laboratory to determine the level of the drug. Dilantin, for example, is a notorious drug that has zero order kinetics and many, many different individuals will metabolize it quite different, so it's kind of unpredictable how it's going to work out. So that patient might have a risk or but many patients will be just fine with the change. [LB631]

SENATOR HANSEN: So probably part of the problem is then, the education of the patient? Do you need to say to your patients don't go off this medication, don't change it. I mean that's harder to educate probably even than doctors. [LB631]

RICHARD BALTARO: Actually, most patients, they are the first ones to know that the medication is working and actually they are the first ones to know that their new pill of a new shape and color, whatever, didn't do as well as the other type. So they are the ones that first go to the physician and tell them, this is what happened. I got a new set of pills and now I have trouble. And they may have been the ones that might have started the experiment, but they are quite knowledgeable because they take these things every day. [LB631]

SENATOR HANSEN: Will this legislation that we have before us today take care of any of that problem with the patients asking their pharmacist to change their drug? [LB631]

RICHARD BALTARO: Well, I mean there is obviously an economic advantage to have from a brand name to a generic name especially depending on what kind of insurances and most of the time that would work, but for some patients, that will not work. And also the other issue is generic versus generic substitution. There's not a question of money,

one works better than the other because of the issues that Dr. Singh mentioned about if it's bioavailable, there is a very large range and you have to have that minimum dose every time, every day, every hour, to keep people from having seizures. [LB631]

SENATOR HANSEN: I know you are not an expert on the bill, but this is the bill before us. In Section 4, they underline so it's a new language, "A pharmacist may not interchange an antiepileptic drug without prior notification and the signed, informed consent of the prescribing practitioner and the patient or the patient's parent, legal guardian, or spouse." [LB631]

RICHARD BALTARO: In that case, they would have to ask the physician if it's okay to substitute, you know, one generic, or one brand name for whatever the physician has written. [LB631]

SENATOR HANSEN: So a patient couldn't go and ask the pharmacist, do you have a generic to save me some money? [LB631]

RICHARD BALTARO: Yes they could if their physician is also informed, yes. [LB631]

SENATOR HANSEN: But they couldn't do it that day that they ask for the prescription. [LB631]

RICHARD BALTARO: Correct, but you know, they will call the physician and they will say, yes, it's okay, let's try this. [LB631]

SENATOR HANSEN: Thank you. [LB631]

RICHARD BALTARO: Thank you. [LB631]

SENATOR JOHNSON: Any other... [LB631]

SENATOR GAY: I have a question. [LB631]

SENATOR JOHNSON: Senator Gay. [LB631]

SENATOR GAY: I have a question. I understand the differences of the drugs, but you made a statement, in many cases it does not make a difference. What percent are you talking in, you made the statement, in many cases it does not make a difference of the switch. But on those cases where it does, is there any studies or anything? [LB631]

RICHARD BALTARO: Well, with ten drugs what is the percentage that it probably will not make a big difference, the numbers substitution, is the only full-time practice of epileptologists in the state, is much better knowledgeable in this. [LB631]

SENATOR GAY: Okay. A percent I guess... [LB631]

SANJAY SINGH: Am I allowed to speak in this? Senator, the exact percentage has not been... [LB631]

SENATOR JOHNSON: This is Doctor Singh, who is substituted now in the chair. [LB631]

SANJAY SINGH: Thank you, Sir. The exact number has never been studied. There is no scientific study that has shown the number of substitutions that does not make a difference. There are published studies and scientific literature where they have documented the problem of substitution resulting in seizures in patients. [LB631]

SENATOR GAY: Thank you. [LB631]

SENATOR JOHNSON: We have got another question. Senator Pankonin. [LB631]

SENATOR PANKONIN: Thank you, Senator Johnson. Just one additional question while you're up here. Doctor, how many states have enacted legislation like this do you know of? [LB631]

SANJAY SINGH: You know I'm not aware of that, but there are a number of such bills pending in many, many of these states, especially since the American Academy of Neurology and the Epilepsy Foundation have become seeds to this issue and are putting this issue before legislators like yourself now. [LB631]

SENATOR PANKONIN: Okay, thank you. [LB631]

SENATOR JOHNSON: Any other questions from the committee? I've got one for you guys. With one being from UNMC and the other one from that other medical school (laughter). Did you ride down here together? (Laughter) [LB631]

SANJAY SINGH: That's correct. That's right. [LB631]

SENATOR JOHNSON: Thank you very much. [LB631]

SANJAY SINGH: Thank you. [LB631]

SENATOR JOHNSON: (Exhibits 7, 8, 9) Any other proponents? I see none. Do we have any opponents? There we go, and why...I think, opponents? And for those others of you that want to testify as opponents and also neutral, please make your way to the front. While they're doing that we have a letter in support from the National Kidney

Foundation, there is a letter in opposition from a Jeffrey Baldwin, and a letter in opposition from the National Association of Chain Drug Stores. [LB631]

ROBERT J. HALLSTROM: (Exhibit 5) Chairman Johnson, members of the committee, my name is Robert J. Hallstrom, I appear before you today as a registered lobbyist for the Nebraska Pharmacists Association in opposition to LB631. There's been some discussion today about what the state of the law is presently with regard to the alleged need for this law under LB631. We currently have a Drug Products Selection Act which in reference to Senator Pankonin's question, is exactly what the law is today that if a prescribing practitioner wants to limit the drug that's going to ultimately be dispensed to the one that's written on the prescription, he or she can take care of that easily and readily by putting something to the effect of dispense as written, brand name medically necessary and so forth, to make it clear that the pharmacist should make no substitution. I do want to address--there could be some anecdotal stories, perhaps there are some in reality, but the representative from the Nebraska Medical Association suggested that there had been some cases where a pharmacist may have disregarded that restrictive notation on the prescription. If that was done, that pharmacist should be sanctioned for violating the law, there's no question to that. We would rather imagine that it does not happen on any type of basis whatsoever. We did, in advance of this committee hearing, contact the department to determine if they had had any complaints either from the provider community or individuals. They indicated that they had had two complaints, I believe, in the last two years, neither of them having to do with somebody overriding the restriction on the prescription but rather a consumer concern that they had wanted a brand name and a generic was provided. But again, there was no restrictive notation on the prescription in that case. This committee more than any others, I think, is fully aware of the issues of rising healthcare costs, rising costs of providing and administering the Medicaid program in this state, and I think this bill will go a long ways towards contributing to both of those problems, both from a consumer's perspective. We have issues involved with LB631 that while it does provide for no interchange or substitution between generics, that it also prevents the substitution from brand names to generics. As a result, from the consumer perspective, there will be cases where the drug will be more costly--the copay, the deductible, the actual cost of the drug out of pocket to the consumer, will be increased in some of those particular situations. There will be financial consequences to the pharmacist. Many of our third-party insurance contracts do not allow for the dispensing of the brand name if there is a bioequivalent generic drug. For example, if that is the case, the pharmacist may not be reimbursed for the brand name cost of the drug. So we have some concerns personally with the regard to the pharmacist. I think more importantly, from a public policy perspective, we have the issue of Medicaid. Again if we have more situations in which brand names are dispensed rather than the lesser costly generic, we will have increased costs in administering the Medicaid program at the state level. One issue that's not been addressed is the issue of the increased costs to those consumers who are not taking a particular drug that is otherwise prescribed for the treatment of epilepsy

but is not for a patient suffering from that particular disease, so-called off label utilization of that particular drug. What we are looking at here is particularly if it's a brand name that cannot be substituted in those cases, those individuals who are not being treated for epilepsy, are going to have higher out-of-pocket costs because of the provisions of LB631. We also think it's going to be an inconvenience to the prescribing practitioners if the medical profession doesn't currently have the time in these significant types of situations to put brand name medically necessary on the prescription at the outset. How enthusiastic are they going to receive the many calls that they are going to get from the pharmacists when the patient is in front asking for the lower-cost generic in getting that call to override what this law would provide and impose upon the pharmacist who is making the dispensing? Additionally I think there's going to be significant inconvenience for the patient in terms of the time with which the medication will be dispensed. I would rather imagine that no one here today is sitting here thinking that the doctors are not so busy that they are going to be sitting idly by the phone waiting for that call to come to see if they can make a change from a brand name to a generic drug. Rather to the contrary, these physicians are very, very busy. They are going to be treating other patients. They're not going to be able to get back to the pharmacist in an expeditious manner and the patient will be inconvenienced as a result. I think from Doctor...I think it was Baltaro's comments, and I would question the need to make a significant change as proposed under LB631 in the law. In two separate items in his testimony, at one point, I believe he said in many cases, this does not make a difference, and he said in some cases, it doesn't work. I would rather imagine in the significant number of cases involved that the generic for brand or the substitution that occurs as a natural course in this particular arena, is not going to have any adverse consequences on the patient. We certainly do not want to discount the significant issues that can occur when someone does have an adverse reaction, but I think again, to make a change of this magnitude, when in our opinion the law already adequately addresses the issue. In my legal profession, when I get particular notifications from the court or if the bankers get notifications from the department of banking, they can readily imagine and figure out what they have to do in any particular subject matter whether they regularly are involved in that particular transaction or not. I would rather imagine that a well-placed letter from those that can educate the physicians to tell them that in this highly specialized and important treatment of a disease, that they should do no substitution notations on their prescriptions--that the message can be conveyed rather quickly and effectively and treat this issue without having to make the changes proposed under LB631. With that, I'd be happy to address any questions. [LB631]

SENATOR JOHNSON: Senator Pankonin. [LB631]

SENATOR PANKONIN: Thanks Senator Johnson. Mr. Hallstrom, thanks for your testimony and your handout which starts out by saying current law allows for no substitution of medications by a pharmacist if the prescriber indicates on the prescription or verbally, in the case of oral, that no drug product substitution is allowed.

Under that scenario, do you believe that pharmacists have liability if they did substitute and it said no substitution on there, they did substitute and that person had a reaction or even an accident because of it? [LB631]

ROBERT J. HALLSTROM: Senator, I have not seen the specific opinions on those types of issues, but we periodically get from the insurance carriers for pharmacists, those types of scenarios where pharmacists have been exposed to pharmacy liability cases. And I would rather imagine that that scenario would be set up perfectly for someone to come in and say, overriding the specific and expressed directive of the physician in that particular instance, led to the consequences or the damages sustained by the patient. And I would certainly think there would be grounds for a liability action against a pharmacist under those conditions. [LB631]

SENATOR PANKONIN: Second question. Because of this issue coming up, Mr. Hallstrom, do you think the Nebraska Pharmacists Association would be willing to send a letter to all, I mean, I would assume most of the pharmacies, if not all, are members in Nebraska pretty much? [LB631]

ROBERT J. HALLSTROM: We don't have all of them, but I think Senator, if I can anticipate your question, I don't think there would be any hesitation on our part to join with the medical association and the groups that are supporting legislation, to try and get the message out of the significance to put the prescriptions in proper form to avoid those individuals who will have adverse reactions from the differences that may result from drug A versus drug B being ultimately dispensed. [LB631]

SENATOR PANKONIN: Thank you, because that was the...you did anticipate. I think if we had a joint effort between pharmacies and doctors that would better inform...and also as Senator Hansen mentioned, patients need to be more aware of this as well. But I just hate to put a law on the books that when we have, I think, current laws that very much can take care of this with some proper communication and education. [LB631]

ROBERT J. HALLSTROM: Yeah, I think that's our position exactly if I didn't convey it to that extent, Senator. I think one other thing here too, while I'm up here with the mike, Senator Dierks referred to an amendment with regard to organ transplants. And while the committee may or may not have any information, there's certainly been nothing publicly displayed today to suggest that even the problems encountered by the epileptic patients, are similar to those in the organ transplant. And I think clearly our position would be the same for the reasons we've expressed. There's no need to go in that direction and particularly without any public information before the committee regarding problem areas. We certainly do not believe organ transplants should be included either in this proposal. [LB631]

SENATOR JOHNSON: Any other questions of Mr. Hallstrom? Seeing none, thank you.

[LB631]

ROBERT J. HALLSTROM: Thank you, Senator. [LB631]

MICHAELA VALENTIN: Good afternoon, Senators. My name is Michaela Valentin, that's M-i-c-h-a-e-l-a V-a-l-e-n-t-i-n and I'm the registered lobbyist on behalf of Blue Cross Blue Shield Nebraska. For those of you who know me, you might think, wow, her voice sounds kind of bad, she must have a cold and I do. Actually I just came from the doctor's office right before this hearing and I got a prescription the doctor handed to me. And I noticed on the bottom of it just with this bill coming up today, it says do not substitute. I didn't recognize the name and I thought oh, this is a brand name. Boy, this is going to really cost me some money. So I said, do you have a generic for this because I'd really like to take amoxicillin if that's cheaper? This particular doctor said, well it is cheaper, but I wouldn't recommend it because with all of the high level of illnesses that are going around now, colds and such, you want a broad- spectrum antibiotic and this one's broad spectrum so you need to go with that. And I thought, wow, she must have just gone to a class or she must prescribe this all the time and that's how she knew this. And it got me thinking a little bit about today, about what Senator Pankonin said about offering like a continued medical education for doctors to let them know when something comes out, you really need to pay attention to this. They do that for lawyers. As a matter of fact, in Nebraska now, we have mandatory legal education and they also let you know for things that are not mandatory. Just to give you an example--I'm not a practicing attorney--I never have been. I've never seen a courtroom in my life. But just recently, in the last week, I received three e-mails from the Lancaster County District Court and two from the Supreme Court letting me know that we now have electronic filing in Lancaster County. And although that doesn't apply to me in any way, shape, or form because I probably will never file any papers there, I was still notified. So to go with Senator Pankonin's idea, I'm not saying that's the answer to this bill, but it is an idea that can supplement it to make sure that the people that need to be aware of this situation, are made aware of it. I'm sure with technology we have now, we could definitely be able to let the doctors know who treat anyone who's epileptic, about the studies that have been done about bioequivalency, and all of that medical terms. I don't really know too much about it, because I'm just a simple ole' attorney. But the other thing I would ask you to remember is that, and the doctors have testified, that there are cases where generics work fine for people with epilepsy, and we'd ask you to just consider again, those people, so that they are still able to get the generics. Just to give you an example from our, let's see, vice president of pharmacy wellness said that Neurontin, a epileptic drug, is $143.10 a month versus its generic which is $33.30 a month. So just trying to keep costs down for the consumers, please keep that in mind as you consider this bill. Thank you. Any questions? [LB631]

SENATOR JOHNSON: Senator Howard. [LB631]

SENATOR HOWARD: Thank you, Senator Johnson. Just to use your example, if you hadn't noticed that written on the prescription and hadn't asked your doctor, had gone to the pharmacist and said, gosh, this is pretty expensive, do you have something that's equivalent that's generic? And he said, yes, here, this is $10 cheaper but you wouldn't have known that extra, the reason the doctor had prescribed the original prescription, because the pharmacist might not be aware of that fact. With him just recommending this based on cost, is there any liability or any part of this that the pharmacist is involved in? It seems kind of questionable that there wouldn't be some in regard to the potency or the effect of the drug? [LB631]

MICHAELA VALENTIN: Um, you know, and as far as that goes, as far as from the pharmacist's liability, I don't have an answer to that question, but I can tell you personally that I've been in a situation through the years where I've gone to the pharmacist and he or she has either said, I would not recommend that you change this, I would stick with what the doctor said, or yeah, this will have no effect on you. But you have to remember as the doctors testified earlier, that there is a bioequivalent, I think it's an index that they were talking about that there is some kind of range, I think the number was 45 percent, that the rate of absorption is different. And so I mean, I'm not an epileptic, it's going to be different for them than it is going to be for like, a common cold. So I would definitely maybe have the doctor speak to that again. [LB631]

SENATOR HOWARD: I would agree with you. It sounds like it would be kind of individual to rely on the pharmacist to provide all the information, especially if you just asked which would be cheaper? So, thank you. [LB631]

MICHAELA VALENTIN: Sure, any other questions? [LB631]

SENATOR JOHNSON: Any other questions? Senator Gay? No. I see none, thank you very much. Next please? Welcome. [LB631]

GARY CHELOHA: (Exhibit 6) Good afternoon, Senator Johnson, members of the Health and Human Services Committee, my name is Gary Cheloha, C-h-e-l-o-h-a. I'm a pharmacist and administrator with the Health and Human Services System, and I'm here today to testify in opposition to LB631. We oppose the bill because we believe that the current Medicaid regulation and the current Nebraska Drug Product Selection Laws are adequate for all classes of drugs including those for epilepsy. We also believe that this bill will result in unnecessary increased expenditures for antiepileptic drugs by Medicaid. You have a copy of the testimony and attached to the back of that as a little form I'll be referring to in the next paragraph. Nebraska Medicaid has, for many years, has had a mechanism in place to prevent drug product selection when the prescriber believes it is medically necessary, on a patient-by-patient basis, to do so. In order to assure that the Medicaid patient receives the prescribed drug and that the pharmacist also gets reimbursed for the drug dispensed, the prescriber signs this form. The rest of

it gets completed and then it gets faxed or mailed to our claims processor, and when that pharmacist's claim is submitted to the claims processor, the pharmacist gets paid for generally, it's the brand name drug. This form is good for the life of the prescription which generally, in Nebraska, is one year. I'm going to skip over largely the talk about the bioequivalents and the drug product selection. I think that's been more than adequately covered so far. Nebraska does have a patient counseling law that requires a verbal offer to counsel to patients or the patient's caregiver every time a prescription is dispensed. Back on page 4, based on claims paid by Nebraska Medicaid for 13 antiepileptic drugs in calendar year 2006, and this is after Medicare Part D came into place, 3,316 prescriptions for brand name antiepileptic drugs were covered at an average cost of $88.45. During that same year we paid for over 50,000 generic epileptic drugs at an average cost of about $30 per prescription. And this is a major assumption here and it is probably not fair in terms of how this bill reads, but it says, if all generics would have been dispensed as the brand name version, the incremental cost to Medicaid would have been about $2.9 million additional dollars. HHS also has concerns about the bill's broad definition of antiepileptic drugs as the description does not rely on FDA-approved medications or other recognized uses in other official compendia as spelled out by OBRA'90 and that's the federal rebate law that we have to live by, and the updates to it. And in terms of approved indications and whether we cover drugs, do come from this other approved compendia. We feel that the definition in the bill language is much broader in that it would require coverage of any drug prescribed for treatment of epilepsy or seizures. The second concern is the definition of interchange which includes drug product selection as it's known in Nebraska and also seems to include therapeutic substitution which is not allowed under current Nebraska law. Final concern about the passage of the bill is HHSS expects that there may be other amendments as manufacturers seek to shelter their products from Nebraska's substitution law. Before I came over, and this is not in your testimony, I thought you might ask how many times this was used for the anticonvulsive drugs. For Nebraska Medicaid, for last year, in the top four classes, and the number are: for narcotics, was used 110 times; for anticonvulsant drugs such as the ones that you've heard this afternoon, Tegratol, 47 times; for a thyroid preparation, 45 times; and then 32 times for drugs like Zoloft, Paxil, and Prozak. Just to give you an idea to put in perspective that the narcotics were the first class of drugs to use this, and the anticonvulsants were the second where the physician signed the form and we paid for the brand name at the physician's request. I'd be happy to try to answer any questions. [LB631]

SENATOR JOHNSON: Are there any questions? Gary, I see none today. How about that? [LB631]

GARY CHELOHA: Okay. How about that? Thank you. [LB631]

SENATOR JOHNSON: Thank you very much. [LB631]

COLEEN NIELSEN: Good afternoon Chairman Johnson, and members of the Health and Human Services Committee, my name is Coleen Neilsen, C-o-l-e-e-n N-i-e-l-s-e-n. I'm the registered lobbyist for MEDCO. MEDCO is a pharmacy benefit manager doing business here in Nebraska and we are in opposition to LB631. We generally concur with the statements that were made by Mr. Hallstrom on behalf of the pharmacists association and I have nothing further to add to his comments, so I'd be happy to try to answer any questions that you might have. [LB631]

SENATOR JOHNSON: Any questions? Other than to call attention to people on future bills, that's the way to do it (laughter). Thank you very much. Any other opponents? Any neutral? I see none. Senator Dierks? [LB631]

SENATOR DIERKS: Well, I want to thank you first of all, for your kind attention to the issue and the great questions that the committee has asked. I came here mostly just to offer myself for more questions if you have them. I do want to tell you that I'm serious about the legislation. It isn't that we think that it shouldn't..I think it should be here. I think we need to address the issue and I have no qualms at all about the professionals--the medical doctors and the pharmacists--I think they're great people. I'm not calling them to task for anything, I'm just saying that someplace along the line, there is some cracks that people have fallen into and we need to fill the cracks. With that, why I'll take any more questions that you might have. [LB631]

SENATOR JOHNSON: Cap, I think we're in good shape. Thank you very much. [LB631]

SENATOR DIERKS: Thank you very much, you betcha. [LB631]

SENATOR JOHNSON: And that concludes LB631. Is Senator Lathrop back there anywhere? [LB699]

SENATOR LATHROP: He is. [LB699]

SENATOR JOHNSON: Oh there he is. Senator, do you want to wait just a second while I clear the room here? [LB699]

SENATOR LATHROP: I'd be happy to. [LB699]

SENATOR JOHNSON: Welcome, Senator Lathrop. [LB699]

SENATOR LATHROP: I think we'll see you in Judiciary soon? [LB699]

SENATOR JOHNSON: I'll be real nice to you. (Laughter) [LB699]

SENATOR LATHROP: (Exhibit 1) Very good. I always like being in your committee

before you have to come to mine. (Laughter) My name is Steve Lathrop, that's L-a-t-h-r-o-p. I represent District 12 in the Omaha, Ralston area, and I'm here today to introduce LB699. I am introducing LB699 at the request of the AARP who first brought this idea to me when I was a candidate. They suggested that they had an idea for me that was going to save the state of Nebraska money and might benefit seniors and some uninsured folks and so that's how LB699 came to you today. I have amended the original version of LB699. It was, to give you a little bit of history, it was the bill that Senator Nancy Thompson proposed last year. I went through it and tried to simplify it and clean it up and so the amendment that you see today is what we'll be talking about. [LB699]

SENATOR JOHNSON: So the amendment will be the bill, is that... [LB699]

SENATOR LATHROP: (Exhibit 1) The amendment will be the bill, yes, Senator. LB699 consists of two separate acts. The first act is a Prescription Drug Savings Act. This act will likely save the state $2 million annually in prescription expenditures for Medicaid participants. The savings is realized with two directives to Health and Human Services--the directives to do what insurance companies are doing. They are: First to establish a preferred drug list. The preferred drug list is established by determining the most effective drug or class of drugs for the treatment of a condition. Once that class of drugs is established, those drugs essentially bid to become the least expensive choice. The cheapest drug and the most effective drug then becomes the most preferred drug on the list. The free market forces bring about the savings as the preferred drugs, or the most effective drugs or classes of drugs, compete to become the drug to be prescribed by physicians to Medicaid recipients. The preferred drug list, and I think that this an important element or feature of LB699, the preferred drug list allows for prescriptions outside of the list particularly important in the treatment of some emotional disorders. The prescribing physician need only okay the prescription of a medication outside or off of the preferred drug list with Health and Human Services in a system that's already in place. This has saved every state that has employed a preferred drug list, money. There isn't a question about whether it will save money, it will. The second directive which is part of the Prescription Drug Savings Act, is a directive to Health and Human Services to negotiate the price of all drugs with manufacturers. They can do that in any one of a number of ways, they can do it directly by negotiating with drug manufacturers, but it's typically done either through pharmacy benefit managers who negotiate the price of medications that Medicaid will pay for, or they can do it through a joint multistate purchasing pool, and the act provides for Health and Human Services to join such a pool. These have historically been effective in states that have employed this technique. Regardless of the means employed, this will, and in other states has, resulted in savings. Presently, Medicaid, I'm told, is spending $60 million a year on prescription medication. That's the state's share from the General Funds, their share of expenses for Medicaid for prescriptions. Every time we save 1 percent on what Medicaid is spending, we save the state $600,000. We expect, from the use of the preferred drug list in

negotiating the prices of medications, to save the state approximately $2 million a year. I told you that LB699 had two acts. The second act is called the Nebraska Rx ACCESS Card. The ACCESS card is issued to uninsured Nebraskans in low or moderate income, that is uninsured Nebraskans in low and moderate income. The card holders are allowed to buy drugs from pharmacies at the same rate that Medicaid is purchasing the drugs for. In other words, we negotiate a rate for Medicaid recipients and for the holders of the ACCESS card. Currently, the moderate and low income uninsured pay the highest price for prescription medication. If you think about it, that's because no one negotiates a lower rate. I'm covered by Blue Cross Blue Shield through my office. Blue Cross Blue Shield goes out and negotiates a lower rate, same as all insurance companies do. But for the uninsured, no one does that. An ACCESS card essentially allows the poor and the moderate income, who are uninsured, to take advantage of the state's negotiating power to secure drugs at the most favorable price the state can negotiate with the drug manufacturers. It will not cost dollars to run this program. It does, however, require some front-end money with a cash flow. Much of the prices that are negotiated for drugs come in the form of rebates back to the state. The ACCESS card will probably need about $400,000 at the front end to get it going--that's a onetime expenditure, and after that it becomes self-funding. We have deliberately timed the ACCESS card to begin one year after the Prescription Drug Savings Act so that the state will realize more than enough savings in the first year of the Prescription Drug Savings Act, to front-load the cost of the ACCESS card for the money needed to cash flow the ACCESS card. This will provide an opportunity for Nebraskans who are uninsured, and poor or moderate means, to secure medication without breaking the bank--that is LB699. I would ask that you advance the bill to General File where we can take it up on the floor. And I'll answer any questions you have. [LB699]

SENATOR JOHNSON: Do we have any questions? Senator Howard. [LB699]

SENATOR HOWARD: Thank you, Mr. Chairman. Can you just give the parameters who would be eligible for the Rx card? [LB699]

SENATOR LATHROP: The ACCESS card. The ACCESS card, the standard is 300 percent of poverty. [LB699]

SENATOR HOWARD: So there's no age limit? There isn't any other criteria? [LB699]

SENATOR LATHROP: Well, they can't be insured. [LB699]

SENATOR HOWARD: By another insurance company? [LB699]

SENATOR LATHROP: They're the uninsured, non-Medicaid recipients who fall within the 300 percent of poverty. [LB699]

SENATOR HOWARD: Okay. And do you have any idea how many people, this might be a very broad question, but do you have any idea of how many people would be eligible? [LB699]

SENATOR LATHROP: I do not know the answer to that. Mark Intermill, who is coming after me, may be able to answer that question for you. [LB699]

SENATOR HOWARD: Thank you. [LB699]

SENATOR JOHNSON: Senator Pankonin. [LB699]

SENATOR PANKONIN: Thanks, Senator Johnson. Senator Lathrop, have you looked at the fiscal note since it was, came up here February 13? Have you? [LB699]

SENATOR LATHROP: I did. [LB699]

SENATOR PANKONIN: Okay. [LB699]

SENATOR LATHROP: I'm learning about fiscal notes. (Laughter) The first thing, in the very first draft of this bill, the bill had listed as one of its sections, one of its provisions in appropriations for $1 million. We've taken that out because first of all, we don't think it's necessary and it shouldn't cost that much to get the ACCESS card off the ground. The second thing is it's not really an expenditure. It is in the sense that we are putting some money into the ACCESS card account to front-load what is a cash flow problem because the money will come back to the state in the form of rebates, when we use part of that $400,000, and that's my estimate. Let's say Mrs. Jones buys the medication and to secure the discount, the pharmacy would accept the Medicaid rate from her. They would be reimbursed from the ACCESS account for let's say, $5, and then the state would be reimbursed from the pharmaceutical company that $5. So it's not so much the true expenses as it is a cash flow problem. [LB699]

SENATOR PANKONIN: I think the key paragraph here, if I could read it, the Department of Health and Human Services Finance and Support has a contract to study the cost benefit of a preferred drug list and joining a purchasing pool. A contract has been awarded for this study. We will complete it by the end of the year. The fiscal impact will be clear once the study information is available. From looking at this, I think this is a good idea that needs to be pursued. I just wonder if we should because we already have this already in place, wait a year to see what they come up with, to actually get--since the contract's already been let...they're going to be studying it. [LB699]

SENATOR LATHROP: Yeah, I appreciate your concern. I reviewed the Medicaid, or at least that provision of the Medicaid reform plan which suggested that we should investigate this. I think that was a recommendation made nearly two years ago. And I

don't know where we are at with respect to any study on the preferred drug list. But I know this: that every state that's done it has saved money. And I don't know what we need to study about it, the concept is simple enough. You have drugs and you make the drugs that are equally capable of addressing someone's medical condition, compete to become the drug that the state prescribes and in that competition, you'll find savings. [LB699]

SENATOR JOHNSON: Senator Gay. [LB699]

SENATOR GAY: Thank you. Senator Lathrop, as Senator Pankonin mentioned, we have...they're studying the issue--study, study, study. And I don't, I say that, some are good and some are bad, because some have been very rewarding. But this multistate purchasing pool would be formed. What's going on now with those? Who's doing it and why aren't we? Are we in it now, or? [LB699]

SENATOR LATHROP: I don't know why we are not in it and that's what I'm trying to do with LB699. There are multistate pools and Mark Intermill, who follows me, could tell you exactly who's doing them, but I'll give you an example. If Iowa and the state of Michigan get together and they agree to have one person negotiate the rate that both states are going to pay, that would be an interstate compact, whatever the term is, and that's the kinds of things. There are several different ones across the country. You join in, you join up, you increase their ability to negotiate with various pharmaceutical companies. And therefore, as you increase your purchasing power, the savings are realized. [LB699]

SENATOR GAY: Thank you. [LB699]

SENATOR JOHNSON: Excuse me, Senator Howard. [LB699]

SENATOR HOWARD: Thank you, Senator Johnson. Well, I certainly appreciate that you brought this in. Any way we can save costs for the state and for individuals, I think is well worth pursuing. And I know it's a complicated--has a lot of parts, the bill does. But I think it's certainly worth our considering, so thank you. [LB699]

SENATOR LATHROP: Thank you. [LB699]

SENATOR JOHNSON: Yes, Senator Hansen. [LB699]

SENATOR HANSEN: Thank you, Senator. Senator Lathrop, if we make, and I know you are going to tell me to wait until Mark Intermill gets up here (laughter), but if we have states that are going to go into a pool, and I really agree with volume buying, do they have to be states of similar size, similar population? Do we combine with Texas? Can we combine with North Dakota? Does it really matter? [LB699]

SENATOR LATHROP: Ask Mark Intermill. (Laughter) No, I'm giving you a hard time. The answer to that is I don't think it matters because what matters is that the more numbers, the more population that you represent in one of these pools, the greater the purchasing power. So if we combine with the state of Wyoming, we probably wouldn't have as much muscle as if we combined with the state of Iowa...certainly with the state of California, or New York. So I think it would, I deliberately didn't say...join this particular pool. There are a number of the--because I think it would be incumbent upon the director to determine which pool is most advantageous to Nebraska and which best meets our needs. Okay? Does that answer it? [LB699]

SENATOR HANSEN: Okay, thank you. [LB699]

SENATOR LATHROP: Does that answer it? Good. [LB699]

SENATOR HANSEN: Yes. I'll wait for Mark (laughter). [LB699]

SENATOR JOHNSON: Any other questions of Senator Lathrop? We do have one tradition here and that is for visiting senators, we do give them cookies (laughter). [LB699]

SENATOR LATHROP: That looks like the ones I left behind in Urban Affairs (laughter). [LB699]

SENATOR JOHNSON: Thank you very much. Senator Lathrop, will you be able to return for closing? [LB699]

SENATOR LATHROP: I'll stay and listen to the testimony, thank you. [LB699]

SENATOR JOHNSON: Okay, fine. Thank you. Mark? Proponents...how many proponents do we have? Very good. Opponents? Three or four each way, so. Mark? Welcome. [LB699]

MARK INTERMILL: (Exhibit 2) Thank you, Senator Johnson. I do have a statement that describes the Maine Rx program which has been under way for several years now and is really a program that we are seeking to replicate here in Nebraska. Before I talk about the Main Rx program though, I did want to address the preferred drug list and let you know that there are 44 states that currently use preferred drug lists, so it's not a new concept--and that's in the Medicaid program. I'd also say, with regard to the multistate purchasing pools, there are three major multistate purchasing pools in operation currently for Medicaid. But it probably doesn't make much sense to join a multistate purchasing pool without a preferred drug list, so that's kind of something that would need to be in place before it would really be effective to address that. Also, in my

statement, I do discuss the number of people who we think could be affected by this particular program. What we know from the Nebraska Center for Rural Health Research, is that there are 150,000 under the age of 65 who don't have any health insurance. So whatever portion of those would be under 300 percent of poverty would be the number of people under 65. We currently have probably about 25,000 over 65 who are not covered by prescription drug coverage of some sort. We've made a lot of progress in that area in Nebraska with the Medicare Part D plans. We now have about 90 percent prescription drug coverage among people over the age of 65. That's up from about 40 percent as recent as five years ago, so there's been a significant amount of improvement in that area. There is a provision in the amendment that does allow coverage of individuals who find themselves in the donut hole in the Part D plan, that point from about $200 a month to $500 a month where there is no coverage under the standard benefit. So the concept of the Maine Rx program is in Maine, they use 350 percent of poverty; we have selected 300 percent of poverty. But Maine Rx has been in existence since 2003. Maine had tried a program that was slightly different than what they have currently, that they adapted because of a need to do that to comply with federal law. They offer 15-60 percent discounts on prescription drugs. Fifteen percent generally, on name brand drugs and up to sixty percent on generics, so there's a substantial savings in the Maine Rx program for individuals who are uninsured. In Maine, pharmacies can voluntarily participate in the program. They are, about half of the pharmacies, have decided to sign up in the program and as indicated in the testimony, what we've heard from people in Maine, is it's because the pharmacies are, the people who encounter the individuals who are uninsured and are trying to deal with the high cost of prescription drugs. So that's one of the reasons why they have had about half of the pharmacies sign up. The preferred drug list is also an integral part of the program in Maine for the Medicaid program. Essentially, the program allows people to purchase drugs at the Medicaid net price; an original price less the rebates the state receives from the pharmaceutical companies. So it does provide them with an opportunity, individuals who are eligible for the program, with the opportunity to receive a discounted price that they might not otherwise be able to get. It's also allowed Maine to negotiate deeper discounts with pharmaceutical companies. We're looking at a situation similar to what a private business might try to do in terms of getting...being able to have enough of a market to be able to negotiate deeper discounts. So this has allowed the state to go in and they're negotiating for a larger pool of individuals and are able to negotiate better prices for those prescription drugs. What we've seen, in Maine, with Maine Rx Plus, is that about 78 percent of Maine's citizens who didn't have prescription drugs, are now eligible for some assistance with those costs. This has been a boon to those people because we wouldn't be here if prescription drugs weren't important. But they do contribute to the health and well-being of Nebraskans. We just are trying to find a way to help make those prescription drugs more affordable so people can be able to find those, that assistance, from them. We have just completed a poll of our members and what we have found is that 27 percent of our members say they are having some difficulty in affording prescription drugs. That's actually an improvement over where we were five

years ago for the reasons I stated earlier. But we also asked them about several different options that the state could pursue to try to make drugs more affordable. And we asked about a Maine Rx type of program, a program that would allow low and moderate income individuals to purchase drugs at the Medicaid price, and we found 85 percent of the respondents felt that was something that would be good for the state to pursue. So we do believe that there is support in the state for taking this type of an approach. It is something that has been done in several states and as we've seen in Maine, with some success. So, Mr. Chairman, I'd be happy to answer questions. [LB699]

SENATOR JOHNSON: Senator Erdman, thank you. [LB699]

SENATOR ERDMAN: Mark, thank you for coming. I was scrambling...I had a bill in another committee, I didn't have my notes here in front of me so I apologize. I wasn't here earlier, but it was my understanding or at least some information that I've received, states that either the waiver that Maine had applied for, or some other provision of their program, is not in place. It was not approved or not accepted and so I'm like, I said I apologize that I didn't have it, and I know that by the time I run to my office and come back, there may not be time to respond. But I was wondering if you had any knowledge of that since this bill is modeled after the Maine program? That you could kind of help jog my memory as to what I'm supposed to remember about this bill? [LB699]

MARK INTERMILL: The Maine Rx program was the original program in Maine that was litigated to the Supreme Court. The Supreme Court's decision was...it's not fair to say it was bifurcated because it split about four different way. But one of the points in the decision was that the state needed to get an approval from the Department of Health and Human Services for this type of a program. There had to be a Medicaid interest for this type of a program to be able to operate. Maine is operating the program. They were able to show that by limiting the participation in the program to an income level; the original program didn't have an income level, now they've established the 350 percent of poverty standard which does meet the criteria that they needed to have some sort of a Medicaid interest in order to offer the Medicaid price to those individuals. [LB699]

SENATOR ERDMAN: So that would be Maine Rx and this is Maine Rx Plus so this is not that original proposal? [LB699]

MARK INTERMILL: Okay. Plus, exactly. That's correct. [LB699]

SENATOR ERDMAN: I guess the one last question. We were here, I think, last week, and we had quite a bit of discussion about the responsibility of the states now have under Medicare Part D. The provision that we call the Clawback Provision as a state and how we're helping as a state to pay for federal programs that were largely supported by a number of organizations--yours included. LB699 would essentially fix a

problem that's known in the Part D for Nebraska residents by allowing Nebraska residents have coverage under what generally would have been the donut hole, I think that's what Senator Lathrop said. So in addition to the benefit of having this plan, the preferred drug list and those, this policy would actually correct what you believe is a deficiency in the federal law and require, or allow coverage, for Nebraskans under what was an error in federal policy? Is that accurate? Or, I guess, an oversight? I mean they intentionally what they did, but... [LB699]

MARK INTERMILL: Yeah, and we're not big fans of the donut hole or the Clawback so but with regard to the donut hole and what this bill would do, there may be some people who have a Part D plan who I would not advise to get a Rx ACCESS card because they may have sufficient drug costs to go through the donut hole to the 95 percent coverage on the other side. If with the card, they wouldn't be able to claim those expenses against the plan expenses. So I don't think that every person who would have experienced the donut hole, that this would be a good idea to use this program. But for those who may be just...get into the donut hole, it may be beneficial to have some sort of program to help them reduce their drug costs. [LB699]

SENATOR ERDMAN: Thanks for the clarification. [LB699]

SENATOR GAY: Thank you. Are there any other questions from the committee? Senator Hansen. [LB699]

SENATOR HANSEN: Thank you, Senator Gay. Mark, would we join Maine? Can we join any other group that's already formed? Do we have to start off and invent the wheel again or can we join someone else? [LB699]

MARK INTERMILL: For a multistate purchasing pool, the option of joining an existing one, and I believe there are three currently that are operating, we could do that. And that would be probably the most advantageous to do because they've already started to accumulate the purchasing power and that it would be to our advantage to join one that already exists. [LB699]

SENATOR HANSEN: I assume we'd have to be accepted into their pool but can we, in Nebraska, accept their preferred drug list? I mean it depends, I'm sure, depends on what there is, but... [LB699]

MARK INTERMILL: That's an excellent question because there are some of the purchasing pools that allow states to maintain their own preferred drug lists. And the preferred drug list is something that we don't enter into lightly because we would not support any preferred drug list if it didn't allow a physician override. And we've heard in the previous hearing the importance of having that. That's essential to have and the ability of the state to identify the prescriptions, to have our experts look at what drugs

make the most sense for the population, I think is important too. On the other hand, there are some states that are going with multistate purchasing pools that have pretty much of a common preferred drug list. So that's something that the state, HHS, would need to take a look at and decide which makes the most sense for us. [LB699]

SENATOR HANSEN: Thank you. [LB699]

SENATOR GAY: Thank you. Are there any other questions? I have one for you, Mark. In Section 12 it says the department shall establish simple procedures for enrolling participants in the program and undertake outreach efforts to build public awareness and a maximized enrollment. I know you can't speak for the department, but what's going on in other states to get people into the program? [LB699]

MARK INTERMILL: Well, I can say that if this is adopted and we establish this program, that AARP would be in the forefront of helping with that outreach. And AARP in other states, out where state pharmacy assistance program have been established, have done that and I will, I think I can commit to you today that we would do that as well. The application procedure, I think, we need to keep it as simple as possible. There are two basic eligibility criteria: no insurance coverage and 300 percent of poverty so I think if we...it may be a two-question application form. [LB699]

SENATOR GAY: So I guess to follow up, so AARP would help but the department ultimately has to be doing this so this is what you're saying, just jointly and team up with them... [LB699]

MARK INTERMILL: Yeah, absolutely. [LB699]

SENATOR GAY: ...assuming they want to pursue this. Thank you. All right, thank you, any other questions? I don't see any, thank you, Mark. [LB699]

MARK INTERMILL: Thanks. [LB699]

SENATOR GAY: Other proponents? [LB699]

TERESA STITCHER FRITZ: (Exhibit 3) Good afternoon, I'm Teresa, T-e-r-e-s-a Stitcher, S-t-i-t-c-h-e-r, Fritz, F-r-i-t-z. I'm program director of the Alzheimer's Association of the Great Plains. I'm here today on behalf of the Great Plains chapter and the Midlands chapter which essentially, both chapters cover Nebraska. We are supporting LB699 for the Healthy Nebraska Rx Card. From newly analyzed data that was analyzed from our national Alzheimer's Association, from the health and retirement survey, indicates that there are maybe a half a million or more individuals, Americans, under the age of 65 who have dementia or cognitive impairment at a level of severity consistent with dementia. And we are having more and more Nebraskans coming to us

looking for assistance who are younger than the age where they would be eligible for Medicare. We have three gentlemen here in Lincoln right now, two in their 50's and one in his early 60's, 61 who have lost their jobs due to the cognitive impairment that they are facing, due to the diagnosis of early onset Alzheimer's disease. And so they are operating currently without health insurance and this would be very helpful to them. There are no drugs to cure or prevent Alzheimer's but we do have four drugs that do help with slowing down the process that are currently available. And we know that these drugs are helpful to these individuals but they are also expensive prescription drugs. And we also are hoping that within the next five to ten years, our research division and the federal research that is being supported, tells us that we might have disease-modifying drugs that will be available. And as the baby boomers age, we are going to have more persons with Alzheimer's disease, both early onset and those who start after the age of 65. So we are very much in favor of this prescription card that would offer coverage for these uninsured individuals with incomes below 300 percent of the poverty income line, to purchase these prescription drugs at the Medicaid price. And that is why we come to you today and we ask that you advance this bill for discussion on the floor. [LB699]

SENATOR GAY: Thank you, Teresa. Are there any questions from the committee? I don't see any, thank you. [LB699]

TERESA STITCHER FRITZ: Okay, thank you. [LB699]

SENATOR GAY: You bet. Other proponents? Any other proponents who would like to speak on this? Come on forward. [LB699]

JOHN O'NEAL: (Exhibit 4) Thank you, Senator Gay and committee. I appreciate the opportunity to testify in front of you today. My name is John O'Neal. I'm chair of government affairs for the National Multiple Sclerosis Society's chapter here in Nebraska and I'm testifying on their behalf today, and also on my own behalf, in support of LB699. I want to thank Senator Lathrop for continuing this bill on this year. He happens to be my Senator--I don't know if he knows that, but he is and we haven't met yet, but we will. I'm going to limit my testimony to the impact of this bill on people with multiple sclerosis for the most part. I want you to know that individuals with MS are usually prescribed one of four primary drugs. And the only reason I go into this a little bit is I want you to get a taste for how expensive these drugs are for people who are uninsured, for instance. I testified in front of this committee in the fall of 2002 on a similar issue. And at that time each of these drugs cost between $10,000 and $13,000 per year to purchase. Well, now, less than five years later, they cost between $15,000 and $17,000 a year. And that's over a 50 percent increase in less than five years, so the costs are going up and you know what cost increases are like for drugs and have been for years and we need some help here. There are two other therapies that are used and they are even more expensive than those, so this is just outrageous, we think. One

thing we want to bring up is that while we completely support this bill, we have a little bit of concern about a preferred drug list, although I have to tell you most of those fears have been allayed by Senator Lathrop's office. What happens with people with MS is this: there are basically six choices of drugs that you can take right now. However, one drug may work for person A; doesn't work for person B. The second drug works for person B; doesn't work for person A. What we are trying to make sure of is with this drug list, that all of these drugs get on the preferred drugs list, because if they don't, some people are going to not be able to get the drug that's going to help them out. And I've done some work with Medicare Part D and since MS is such a rare disease, about one in a thousand people gets it, when they put together their preferred drug list. In most cases that I've looked at under the program, all of the MS drugs are on all of the preferred drug list that are put together. So they have been able to work it out and I'm hopeful the state of Nebraska will be able to do the same thing. That's our one concern about the whole thing. As far as a multistate drug compact for negotiating purposes, I suggested to the department that they do that five years ago on their Medicaid program and was told, well, we looked at that; it can't be done. Well, I think it can if 44 other states are doing it, so I think it can save us a lot of money. I have added to my testimony here just so you'll get a flavor for the costs of MS. I mentioned the major drugs cost between $15,000 and $17,000 a year and I'm probably lowballing the number there. There are also some drugs that are used for various symptoms and there are dozens of symptoms that come with MS to different people. Some people get certain symptoms, others get others, it's a very strange disease. But I wanted you to have this list of all the drugs that are used to treat these symptoms to give you a flavor for the disease and the costliness of it. And I want you to know this too...with the preferred drug list, we understand that while we'd like to have all the major MS drugs on this, we understand that for a preferred drug list to really work, the negotiator has to be able to go into the drug companies and say, look, we're going to this drug company and this company. You need to give us a better price because if you don't, we are going to go another way. So we understand that some of these symptom drugs might not make the cut; we hope they all do? But we understand maybe some of them won't. We think, in the long run, we'll be better off with this bill, so I'd be happy to take any questions one might have. [LB699]

SENATOR GAY: Okay, thank you, John. Any questions from the committee? Senator Erdman. [LB699]

SENATOR ERDMAN: John, let me ask you...you don't know your senator? [LB699]

JOHN O'NEAL: I don't know him personally, I recognize him now though. [LB699]

SENATOR ERDMAN: Can I introduce you to him? (Laughter) [LB699]

JOHN O'NEAL: You certainly can, Senator. [LB699]

SENATOR ERDMAN: Senator Lathrop, this is one of your fine constituents. [LB699]

SENATOR LATHROP: I'm sure I was at his doorstep, he just wasn't home (laughter). [LB699]

JOHN O'NEAL: Well, I just moved there a few month ago, so maybe not. [LB699]

SENATOR ERDMAN: Well, I would, you know, invite you two to shake hands whatever, but others may have questions, but I thought I'd just offer that. [LB699]

JOHN O'NEAL: Well, we're doing a day at the Capitol next week and his office is one that we will be stopping in. I have a meeting set up. [LB699]

SENATOR ERDMAN: There you go. Well, then I really didn't help you at all. You've already taken care of it yourself. Thank you, Sir. (Laughter) [LB699]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB699]

JOHN O'NEAL: Thank you. [LB699]

SENATOR GAY: Any other proponents? Last call for proponents? Okay, how many opponents do we have? All right. Start working your way up, we got a few seats up in front. We'll start off with opponents then. [LB699]

CHUCK STEPANEK: (Exhibit 5) Good afternoon Vice Chairman Gay, and members of the committee, my name is Chuck Stepanek, S-t-e-p-a-n-e-k, and I am the executive director of NAMI, the National Alliance on Mental Illness, Nebraska. I appear today on behalf of the organization in opposition to LB699. Doctor Linda Jensen of Kearney, has been on the board of directors and active in mental health issues for as long as I have been wandering around these halls as a lobbyist on and off throughout the years, about 20 years now. And I think I'm the senior one in the room outside of Mr. Santema, the distinguished Mr. Santema--how many years for you now, Jeff? [LB699]

JEFF SANTEMA: Thirteen. [LB699]

CHUCK STEPANEK: Okay, okay. Doctor Linda Jensen provided a letter from Kearney and that has been distributed to the members of the committee about the concerns that the NAMI governmental affairs committee has been able to identify with the issue. Rather than read the entire letter into the record, I'd be happy to allow you to...I'd ask your indulgence to read it at your leisure. I'd be happy to respond to any issues, any questions independently. I am a person who has severe mental illness and boy, throughout the years, there have been dozens of medications--everything starting from

Paxil, Prozak, Buspirone, Mellaril, Ativan, Effexor, you know, Neurontin, all of those--but I guess there is always that chance that that Godsend drug, that drug that saves somebody's life. For me, there is one. I finally found it after going through dozens and dozens and different cocktails and combinations. Man, there is that drug--I'm not going to mention the brand name or anything like that, but boy, if that would be excluded, that would be a big problem in my life, you know...if I, if the circumstances were such that I would not be able to afford it. So with that, I'll let you take a look at the letter. I'd be happy to respond to any questions, thank you. [LB699]

SENATOR GAY: Okay, thanks Chuck. We will do. Are there any questions right now from the committee? I don't see any. We will definitely look over the information, thank you. [LB699]

CHUCK STEPANEK: Thank you. [LB699]

SENATOR GAY: Other opponents? [LB699]

MARJORIE POWELL: (Exhibit 6) Members of the committee, thank you. My name is Marjorie Powell, M-a-r-j-o-r-i-e P-o-w-e-l-l. I'm the senior assistant general counsel for the Pharmaceutical Research and Manufacturers of America, or PhRMA for short, which is the trade association of those companies that are researching and developing the new medicines, the breakthrough medicines that will help somebody like the last witness, the medicines that will help those 60 percent of epilepsy patients who do not have full control over their seizures--the variety of medicines that we are still waiting for, for a number of diseases and conditions. I want to say first that PhRMA thinks that addressing the healthcare needs of the uninsured is a very important issue. It's one that we and a variety of people around the country are working on and we continue to believe that that's a central thing that needs to happen, probably at the state level first, because states have the ability to move much more nimbly than the federal government does. However, we do not believe that LB699 is the right approach for that. And I'm going to focus largely on the Nebraska Rx ACCESS card issue because we think that you need to understand a variety of things about how this is structured. The description of the bill sounded really quite interesting and simple but the description was not completely accurate. The bill is based on the original Maine Rx program which was a mandatory program for drug manufacturers. And what Maine Rx said was that you, manufacturer will only be able to have your drugs prescribed in the Medicaid program. Now remember that Medicaid is the program for the sickest, poorest people in state. You will only be able to have your drugs prescribed for those patients if you also give a rebate equal to or even greater than the Medicaid rebate for people up to 300 percent of the federal poverty level. That program has, in fact, never been implemented in Maine. What has been implemented is an expansion of a state pharmacy assistance program that Maine has had in effect for about 30 years. Under that program, the state paid a portion of the cost of the purchase of a prescription drug for seniors who had one of

originally, I think, seven or eight chronic conditions. And they asked manufacturers to voluntarily provide a rebate to the state for all of those drugs. So that a patient who was a low income senior, eligible for that program, would pay a portion of the cost at the pharmacy, the state would pay a portion of the cost, and the pharmaceutical company would provide the state with the equivalent of Medicaid rebate. Now let me take one minute and digress and talk about what Medicaid rebate is and then come back and talk about the main program. Under the federal Medicaid program, in order to have your drug covered at all in Medicaid, you must sign a federal Medicaid rebate agreement which says that you, I, pharmaceutical company agree that I will give every state, for each of my drugs dispensed to a Medicaid patient, a discount equal to the very best commercial price I give to any commercial purchaser. So if Kaiser Permanente in California, which represents a huge number of people, or if the Blue Cross Blue Shield programs can negotiate a low price, Medicaid gets the benefit of that price negotiation already under federal law. Fiscal 2006, pharmaceutical companies paid $72 million to the state of Nebraska in Medicaid rebates. That comes regardless of a preferred drug list or any negotiation on the state's part. It was the federal government's way of saying to the state Medicaid programs, you don't need to spend the money to negotiate with the 427 drug companies that participate in Medicaid for the 10,000 or so drugs that are covered under Medicaid. We will require the manufacturers to essentially give you the benefit of the best commercial negotiator out there in the country. So coming back to the Maine Rx program, Maine Rx had already talked with drug companies and had voluntarily gotten companies to agree to provide a rebate equal to the Medicaid rebate for the drugs for these seven chronic conditions. And then over the last 30 years, they've expanded that to cover, I think it was at last count, 16 different chronic conditions and they expanded the program to cover not just seniors but low income people. And then after they passed the Maine Rx program, and there was a series of court hearings, the legislature went back and said, well, we actually think that we don't want to have a mandatory rebate program for low income, uninsured people, what we'd like to do is continue our voluntary program. So they expanded their state pharmacy assistance program to include some generic drugs and a number of other health conditions, not chronic conditions. So a large part of what is now called Maine Rx Plus was actually, and continues to be, the state-funded pharmacy assistance program. That's really quite different from this bill. This bill has a number of other problems that actually make it not workable in reality once if the bill were to pass. For one thing, it covers people up to 300 percent of the federal poverty level. Now that's just a figure and I don't have in my head, a good sense of what that is so I actually checked with a couple of people in my office, and what that means is, a single person earning $30,000 a year, or a family of four with an income of $62,000, I think it's $61,950 a year, would be covered by this. It would also cover people who have a Medicare prescription drug benefit. So it's not limited to uninsured people, it covers insured people as well. Because it is based on having an even more restrictive program for prescription drugs in Medicaid, it would require the state of Nebraska to get an approval from the federal government agency that runs the Medicaid program. Now that agency has never

approved a program that has covered people at more than 200 percent of the federal poverty level. And they require the state asking for approval to put a burden on Medicaid patients saying you are going to have more difficulty getting the drug you want. In order to benefit non-Medicaid patients, they require the state to demonstrate that those non-Medicaid patients would, in the absence of this program, become Medicaid patients and put a greater burden on Medicaid because there would be more Medicaid patients to share the state's Medicaid money and the federal government's match to the Medicaid money. Now the only way you can do that is to demonstrate that these people are almost eligible for Medicaid and if they got some assistance with their drug costs, they wouldn't become eligible for Medicaid. But I'm...don't think that the Nebraska Medicaid program covers people who are already enrolled in a Medicare drug benefit. So those people would automatically not be eligible which means that the federal agency wouldn't be able to approve this and essentially, the program would not be workable in that instance. Even if the Medicaid agency were to approve this, it means that because of several of the federal enforcement issues, there would be potential difficulties with the pharmaceutical company patient assistant programs. Now I passed out copies of a brochure. All of the pharmaceutical companies provide what we call patient assistance programs. These are programs of free or very, very low costs drugs that are provided to people typically who are uninsured and are relatively low income. And I say relatively because the income figure varies by company and it varies by programs. So that a company that manufactures a very expensive genetic drug, for example, to treat a genetic condition, might have a higher income threshold because they know their product costs more and even middle income people might have difficulty paying for it. So the income level varies by product. But companies have had these programs for oh, probably 25 years, but people didn't know a great deal about them so we finally figured out how to put them into a clearinghouse... [LB699]

SENATOR GAY: Marjorie, can...we got about one minute. [LB699]

MARJORIE POWELL: Okay, let me, and I'm just about at the end. We put them into a clearinghouse so that there is a single 800 number people can use. And in the last year and a half, in Nebraska, we've provided help through that program to, I think the number is, 22,000 Nebraskans. This is a program for people who are uninsured. It's a program that the companies...depending on how their program is structured, would not be able to offer that if it was contingent on getting on a preferred drug list which would be part of this program. So passing this program potentially puts the company free patient assistance program at risk. Let me stop and say that I think the concept is a really good one of trying to help the uninsured with prescription drug coverage. They also, frankly, need access to physicians to get the prescription. They would need access to all of the testing laboratories and x-rays and so on. This doesn't address that part of the problem. We just think this is the wrong structure to go about addressing the problems of the uninsured. [LB699]

SENATOR GAY: All right. Thank you... [LB699]

MARJORIE POWELL: And thank you for your indulgence... [LB699]

SENATOR GAY: Oh, you are very knowledgeable... [LB699]

MARJORIE POWELL: ...in letting me stretch out that minute. [LB699]

SENATOR GAY: That's okay. Thank you. Are there any questions from the committee? I don't see any. Thank you. [LB699]

MARJORIE POWELL: Thank you. [LB699]

SENATOR GAY: Are there any other opponents? [LB699]

ALAN GREEN : (Exhibit 7) Good afternoon, Senator Gay, and other committee members, my name is Alan Green, A-l-a-n G-r-e-e-n. I'm executive director of the Mental Health Association of Nebraska. When I first learned about LB699 and was studying it and then prepared the letter that is being handed out, it was based on the original writing of the proposal. I've learned through sitting here that there are some changes to it but it doesn't really affect our concerns regarding this bill. It primarily deals with, again, access to the medication that the individual needs and that need is determined by the individual, by the consumer and their doctor, not an accountant, not a program or division administrator. It's nice to hear that there will be a provision that there will be prescription overrides available. That kind of raises issues then or questions in that how does that jive with the preferred drug list if a doctor can ask for anything they want anyway? What's the point of a preferred drug list? But the biggest thing, again, is the fact that people have access to the medications that they need. One of the things that when I first read the original proposal, that stuck out, is that not only is it necessary that we have some kind of program that insures those that aren't insured and those that don't have the income, to get the medications that they need. But why not look at it also from the point of view, or some of the work that was done through the Medicare Part D drug benefit plan? That is a program that is not perfect; none of them are. There are still issues, but they have the latitude to address some of the issues that concern us as far as the accessibility of certain medications. For a case in point, the Part D program allows for exemption and if the exemption is denied, it allows for both an administrative review and eventually a legal review to find out if this actually is important. My reading provides no recourse for the individual when their drugs may not be available for them to try to make them available. Again, the benefits that would come about with physicians being able to ask for whatever drug they feel is necessary, is a great one. But again, like I said, it kind of then raises issues about the preferred drug list. Also, some of the concerns that came about out from the speaker that was just before me, it seems quite apparent that there is a lot of confusion over to exactly what

this bill would...it's based on, how effective it would be, what it would address. And is it going after a bill that was, in my understanding, actually challenged in court and then led to the new bill that's in Maine now that has been passed. I think that we need...it's in extremely important again, that something is in place to help people get the medications they need, but we need to do it right. We need to do it so that it doesn't have to be revisited in a year or two, or that it is shelved because we just did it and will revisit it in ten years. Again, I will just say that something needs to be done; it needs to be based on the needs of the consumer, not on costs and with that I will entertain any questions. [LB699]

SENATOR GAY: Thank you, Alan. Are there any questions? I don't see any. Thank you. [LB699]

ALAN GREEN : Thank you. [LB699]

SENATOR GAY: Other opponents? Are you just going to follow your written? Are you going to summarize that for us? [LB699]

GARY CHELOHA: (Exhibit 8) I'll just summarize my written. [LB699]

SENATOR GAY: Thank you. Okay. (inaudible) [LB699]

GARY CHELOHA: Good afternoon, Senator Gay, and members of the HHS Committee, I'm Gary Cheloha, C-h-e-l-o-h-a. I'm a pharmacist and administrator with Nebraska Health and Human Services. I'll talk first about the fiscal note that was on the original LB699. There were two versions, one of $1 million and one that I believe was referred to earlier that was somewhat larger than that? That's one of our concerns. Expanding the role and commitment of state government for this project, while at the same time trying to control state rate of growth for state spending overall, seems poorly timed. This may be an investment for the future that will save money, we're not sure. As part of Medicaid reform, and I'll simply refer to the Medicaid reform plan, I know that a number of you are very familiar with this, Jeff, you've seen this before, really is some of the background for the PDL and prior to that even. So now I'm going to become the historian. Prior to that, HHS was very...passed a set of regulations that were very rigorous regarding prior authorization of a number of classes of drugs. And those were written at that time to address those classes of drugs that were growing very rapidly and generally which we felt had other therapeutic classes that could either be used prior to those. And Dr. Raymond, who was here at the time, and the NMA were very supportive, and we got the regulations passed. So we directly went to the classes of drugs without creating a preferred drug list to try to control the drug costs. To give you an idea of the success of that, and this is not in the testimony, I would just refer to three classes of drugs that we dealt with first: Cox-2 inhibitors were the first ones that were put in, in July of 2002 that went very well. You may recall that there were three of those drugs on the market at

that time. We felt that we were doing it partly for cost and partly because we were not convinced that there were the therapeutic advantages of fewer side effects perhaps, and we know that they were no more effective than the other drugs. What has since happened is two of those drugs were removed from the market because of safety concerns. The second class of drugs were the lower sedating antihistamines. They, at that time, were growing like this bar graph and you don't have this in front of you, but it just this kind of an example. The lower sedating antihistamines were growing 10 to 15 percent a year. Several of our top ten drugs were low sedating antihistamines. They are now down here and they not only have not grown at that rate, they have actually gone down in expenditure. So we felt very strongly in the second class that we had done well. The third was the proton pump inhibitors. They are over here. We're not quite as good with them because there are other patients that we slowed the rate of growth but not everybody can get by with Zantac or Pepsid, to control their symptoms, so a number of our patients do have to have the higher-cost proton pump inhibitors, like Nexium, Prilosek, Protonix, and others. I guess the next statement after that is if you've seen one Medicaid pharmacy program, you've seen one Medicaid pharmacy program. Forty-four states have a PDL and as you know, we do not. As part of the Medicaid reform, it was mandated to the department that we write a request for proposal to find a contractor to analyze the pharmacy program as it operates in the Nebraska Medicaid program now, to determine if a preferred drug list and purchasing pool would save additional money, and if so, how much, and to make a recommendation about whether one be implemented. And in deference to what Senator Lathrop and our policy cabinet was very interested and made sure that we got this done. We did not hire a committee or a contractor to write the RFP, I was the primary writer and therefore I'm probably the biggest reason that it took as long as it did. It was published, we received six bids. On January 3, 2007, the winning bidder was posted on the DAS web site, that's Mercer, this is all public information. Since that time there has been some legal dealing with Mercer's requested changes in some of the boilerplate language, but nothing to do with the intent of the contract. Signing of the final contract is imminent and I can't tell you what day, but the contract to do that evaluation and report back to us is very, very nearly done. I know it's longer than anybody wanted it to take, but that's where it is, and that's like the third paragraph in this. We questioned the economies of scale--88 or 90 percent of Nebraskans have some sort of coverage now through Medicare or TRICARE. You probably, I'm sure that you are aware some pharmacies and chains are advertising selling months supplies of certain prescription drugs for $4. I think you just heard from the person before me, to inform you about the PPA-RX program which is from the companies. I'm going to do just a little bit more editorializing. Some states that had state pharmaceutical assistance prior to Part D, were making deep cutbacks in those programs. They were funded by state lottery dollars or tax dollars. They made deep cutbacks in eligibility and drug coverage and even since Part D has begun, one state has discontinued the state pharmaceutical assistance program, I believe that was Minnesota, and as a caveat to that, we must cognizant of change and not enter into commitments that would be difficult, if not impossible, to sustain. And finally, the state of

Alaska announced about two and one-half years ago, they had a $120 million Medicaid pharmacy program. They were going to enter into a PDL and pool purchasing and save $20 million. Last year about this time, Director Nelson asked that I call, with another pharmacist in our department, call Alaska and find out how they did with this. The pharmacy consultant, by phone call, this is not documented in writing, but we have the notes on it, documented that they saved about $2 million rather than $20 million and about half of that was paid to the PBM that was managing this process for them. At this point I guess I'd ask if there are any questions? [LB699]

SENATOR GAY: (Exhibits 10, 11, 12) Thanks, Gary. Any questions from the committee? I don't see any. Thank you. Any other opponents? Last call for opponents? Anybody who would like to speak in the neutral capacity? Come on up. While he's coming up I would read for the record, we have a letter of support on this from the Center for People in Need, and we have a letter opposing from the Bio Nebraska Life Sciences Association, and the State Chamber of Commerce. Go ahead and state your name. [LB699]

TIMOTHY LOEWENSTEIN: (Exhibit 9) Good afternoon, Senator Gay and fellow senators. Senator Stuthman, good to see you again. My name is Timothy Loewenstein, spelled L-o-e-w-e-n-s-t-e-i-n. I am a member of the Buffalo County Board of Supervisors, but I also come to you today speaking to you on behalf of the Nebraska Association of Counties, NACO which I am a member of the board. And as you will see as we move along, also is a member of the board of directors of the National Association of Counties. We're testifying neutral today because we believe it is extremely important to be concerned about the cost of medication to everyone in our state and specifically to those who are underinsured or uninsured. What our position today is to bring you some education of a program that counties are doing and it's functioning in our state, and give you some idea of its success. NACO, two years ago this May, and I, had the honor and the privilege to make the motion that brought this from a trial program to a standing program of the national association. They initiated a program called the Prescription Drug Discount Card. In your packets, you have a copy of the card and you have quite a bit of documentation that I'll refer to. When the task force was put together to find this card, several criteria were demanded. Of those criteria was that: number one there would be absolutely zero cost in the administration and delivery of this card to the constituents of the member counties of the national association. So when you look at the statistics and when you listen to me, remember that each of the counties you are looking at the statistics for, have not had to pay for, subscribe, or have any other expenditure for the card. In fact, the cards are even printed and shipped and delivered to them at the cost of Caremark who was chosen after a RFP process, to manage this program. The cards do not, this is not a discussion of Medicaid, I want to kind of set that aside, okay? This is not a discussion of Medicaid, this is a discussion of those residents of Nebraska who are uninsured or underinsured. The card has no registration requirement so there is no human capital involved for

counties in putting this card out. The card can be used by anyone who picks one up, and in fact, you have two in your folders. And I'll simply begin by saying you have two because one is for your record and I hope you'll give the other one to someone who could need a break, that's why I've done that. But the purpose of the card is to help people. The card carries a 10 to 50 percent discount. Our records we've seen over the last couple of years have actually indicated discounts in excess of 50 percent. Currently, if you open the item that's on the left side of your packet that shows National Association of Counties on the front, the very first page you will see a review of the history of the use of this card as it's on the street in the state of Nebraska. Thirty-seven of your Nebraska counties now have these cards on the street and are distributing them. You say, well what's the cost of distribution? I did a poll of those counties to try to determine how much money has been spent in distributing the cards, added it all up, from Douglas County out to the very western part of the state, and the total was less than $2,500 total in distribution costs. In most cases it's done through press releases, through having them available at public buildings. Again, there's no registration process so there's no human capital required. Of the 37 counties participating, there's been 109,707 prescriptions presented with the card being used to request a discount, and 94,817 of those have been processed by the card. And you ask why? The contract that Caremark has with the 465 pharmacies of Nebraska, that contract requires that the drug be sold to the person standing at the counter, at the lowest price. Meaning that if the pharmacy on that day has a price for that drug that's lower than the discount offered by the card, then the person at the counter wins: They get the lowest price. Statistically we're seeing that that lowest price occurs 11 percent of the time, 11 percent of the time the pharmacy will have a price lower than the discount would have afforded with the card. Now, here's the thing that I think is really, really important because this is real money. The cards have been on the street in Nebraska for approximately right at two years with the first four to five months being just two counties in a trial. And then after that, other counties signing on. I think we actually have one county in the report here that just has their first month report of having these cards on the street. One million twenty-thousand three hundred and twenty-seven dollars, has been the savings enjoyed by Nebraska residents of the 37 counties that have the cards on the street. Now I know that when we are in Washington, D.C., they say a million here and a million there, and after awhile it's real money. Well I guess I'd like to suggest to you that that's real money. That's a lot of money left in the pockets of our Nebraska residents who are uninsured or underinsured. The average savings over this two-year period of time for the Nebraska residents has been 19.11 percent; that's the average, that's the average. I want you to turn the pages and take a bigger look at this program. This program is a national program. It's currently on the street in 550 counties of the United States. There's 3,066 counties total. There's over 500 counties still in line to sign up for the program and you'll see there, $23-1/2 million savings. I've given you a list of the participating pharmacies in Nebraska, there's 465. The Caremark is also the managing PPM for one of the largest insurers in Nebraska and their drug prescription card program for the insureds, so the impact is large. Caremark has 60,210 pharmacies nationwide. They are among the two

very largest networks of this type. I've also given you, for each of the 37 counties, the statistics of each month from the time they began on the program through today and you can take a look and see the success of this program. As I've said to you, we're here to give you an education of what's being done by the counties to help these people. I have one last personal note. Last Saturday night I happened to have been at a banquet and was sitting around a table. We had two chairs empty and a young couple came and joined us. The wife was expecting and we didn't know them and they didn't know us, but we welcomed them to our table and conversation pursued as it does. And somebody at our table happened to make a remark to me that they thought I was doing a good job championing this project. And unsolicited, the husband of this couple said, are you the one that sent us that card? Now I want you to know what Buffalo County did is when the tax statements were sent out last December. We put a card in every one of the tax statements because we weighed the envelopes and found out we could do that and not increase the postage and so I figured, hey, you get a little more bang for our buck of spending that postage money. Anyway, I said, yes, I was. And he said, well, I want to thank you. I got sick just within a couple of weeks after getting that card. He said, we don't have insurance and he said, I went to the pharmacy to get my medicine and I gave them the card. And I said, wow, that's neat. And he said, my story is not over. He said, that card saved me $80. I don't know what kind of medicine that was and I didn't ask him because it was none of my business. But I want to tell you, to that young couple expecting, $80 was real money. And that's what we're talking about. We're talking about money not spent at a time when they're off work and they can't generate income, we're talking about putting a little bit of that back in their pocket. And this is the program that the Nebraska Counties, 37 of them have. There are 60 counties currently members of the national association in Nebraska and I'm working with the other members of them to get them signed up, get the cards to delivered to them and get them on the street. I'd be more than glad to answer any questions for you about this program. [LB699]

SENATOR GAY: Thanks, Tim. Senator Stuthman. [LB699]

SENATOR STUTHMAN: Thank you, Senator Gay. Welcome, nice to see you again. [LB699]

TIMOTHY LOEWENSTEIN: You bet it is, Senator. [LB699]

SENATOR STUTHMAN: This card would take care of the bill that we are discussing now? That would be a part of it? [LB699]

TIMOTHY LOEWENSTEIN: It would be the Nebraska Rx side, the side of the drug card side. We feel that our card does have an equality to what the bill would represent except that our card brings no fiscal impact with it, no cost to the state and no cost to the counties. [LB699]

SENATOR STUTHMAN: Okay, but it could work in conjunction with the bill that we are considering? [LB699]

TIMOTHY LOEWENSTEIN: Yes. [LB699]

SENATOR STUTHMAN: Okay, thank you. [LB699]

SENATOR GAY: Thanks, Tim. I've got a question, or a statement I guess. I was looking at this and I see Douglas County, I see a county commissioner out there...saved $520,000, very impressive... [LB699]

TIMOTHY LOEWENSTEIN: Um-hum. [LB699]

SENATOR GAY: but I also notice, Senator Stuthman, you and I being former county commissioners, our counties aren't on this. We'd better get on that. [LB699]

TIMOTHY LOEWENSTEIN: Well, would you help me out with that? Would you be willing to? [LB699]

SENATOR PANKONIN: But as Cass County's on it, they have, you know, savings... [LB699]

TIMOTHY LOEWENSTEIN: That's right. [LB699]

SENATOR GAY: But I guess, Tim, the point you're making is there is an alternative out there... [LB699]

TIMOTHY LOEWENSTEIN: Yes. [LB699]

SENATOR GAY: ...and we appreciate that and it's a good program and appreciate you bringing that forward today. [LB699]

TIMOTHY LOEWENSTEIN: Good. [LB699]

SENATOR GAY: Senator Erdman, you have a question? [LB699]

SENATOR ERDMAN: This public service announcement was brought to you by Senator Stuthman, Senator Gay, and other former county commissioners in the Legislature (laughter). [LB699]

SENATOR GAY: It's a good program. We'll get on that, Tim. [LB699]

TIMOTHY LOEWENSTEIN: And for those in the gallery who have come today and are

concerned, we have extra cards available for them in the hallway. [LB699]

SENATOR GAY: Are there other people who would like to speak in neutral capacity on this issue? [LB699]

MARY ANN BORGESON: Good afternoon, Mary Ann Borgeson, B-o-r-g-e-s-o-n, 12503 Anne Street. I represent Region 6. I'm the chair of that and also the chair of the Douglas County Board and I'm here today--I actually wasn't planning on speaking at all, but wanted to let Senator Lathrop know that we are in full support of what he's trying to do here and offer whatever help that we possible can to get some type of coverage for the individuals that he spoke of today. Tim Loewenstein really is the champion of this prescription drug card that we have in our counties and it has been a Godsend to many of our residents--almost 20,000 in Douglas County, and we just started it June of 2005. So basically I'm here to offer, Senator Lathrop, as one our senators in our area, that we're here, I'm here to offer any help that we can give to get the bill in order so that it is passed by the Legislature and to help those that truly do need the help. [LB699]

SENATOR GAY: Hold on, are there any questions from the committee? I have one for you, Mary Ann. I talked earlier to Mark Intermill about distribution and Tim had a pretty interesting thing, they threw it in with the tax statements. What are you doing? I mean it looks like you're successful in Douglas County--what are you doing to promote this program? [LB699]

MARY ANN BORGESON: We had a meeting with community providers and the pharmacies and we basically just handed them the packets of information of what it was...packets of the cards themselves. And I carry a box of them around in my trunk and give them to people, so we basically just did it that way through the community providers that we already have in the community. [LB699]

SENATOR GAY: Okay. All right, thank you. Any other questions? I see none, thank you. Any other neutral? Anyone else in neutral on this? I see none. Senator Lathrop, would you like to close? [LB699]

SENATOR LATHROP: I would indeed. (Laughter) [LB699]

SENATOR PANKONIN: He's fired up. [LB699]

SENATOR LATHROP: And gosh, you don't give somebody that used to be a trial lawyer, an opportunity to address six people. I do want to talk about some of the testimony that we've heard today. Of course you've heard some people in support and that's...I appreciate that. But I want to talk about the neutral testimony that we just heard from Mr. Loewenstein. I think, first of all, what he's offering is not a substitute for what we are suggesting. By law, Medicaid has to be given the lowest price so the best this

program can do, which is a terrific program and you don't have to pick one or the other, this is a terrific program. But the best it can do right now is provide for a Medicaid rate that doesn't take advantage of the preferred drug list and it doesn't take advantage of negotiating the rate even further. These cards...I applaud this effort, anything that will bring relief to the uninsured, to the poor, and to anybody that has to buy prescription drugs, I think that's terrific. But it's not a substitute because it cannot have a better rate than we could get with the bill that I've proposed. There were two people who came up suggesting that they were representing groups, mental health associations and that sort of thing, and the fellow from my district, Mr. O'Neal, who represented the MS folks as well. I would tell you that the rules of Medicaid will not allow a doctor...Medicaid, you cannot tell a doctor what to prescribe, so a preferred drug list becomes a suggested drug list which effectively becomes the drug that is prescribed. But it doesn't stop the doctor, cannot stop...nothing we could do here, would stop in the Medicaid program, the doctor from prescribing any drug that he cares to or thinks is appropriate. So I appreciate, and in fact I mentioned in my opening remarks, that when it comes to the treatment of mental health conditions, apparently in the treatment of MS, I think it's also true in the treatment of AIDS, doctors go through a series of medications to find the right one for that patient. Nothing about this bill or the preferred drug list, would impair that or inhibit the doctor's ability to make that selection or go through that process. And then the last remark I have is the suggestion that we will have a study to determine whether or not this is a good idea and how much it will save, and in the meantime we are spending money. I am honestly, I've been down here a month and a half and I'm learning a little bit about state government as I go, but I am dismayed to have someone from Health and Human Services come in here on a bill designed to provide care and relief to poor people and the middle income people, and testify against it. And not to come to my office and give me a suggestion on what's a good idea to make this better or what's a good idea to take care of a problem with your bill that would make it go through Health and Human Services. But to come in and testify against it, that isn't the way we should be running this railroad. If Health and Human Services has a problem with any policy that I suggest, they should come talk to me about it and tell me what the concern is so that I can address it before I come in here instead of coming in and trying to essentially torpedo a bill that's intended to provide relief to poor people, to middle income folks, and to people on Medicaid, and to save the state of Nebraska, $2 million. So those would be my remarks. I appreciate your consideration. [LB699]

SENATOR GAY: All right. Any final questions for Senator Lathrop? I don't see any. Thank you very much. And with that, we'll close the public hearing on LB699. [LB699]

Disposition of Bills:

LB481 - Advanced to General File, as amended.
LB631 - Indefinitely postponed.
LB699 - Indefinitely postponed.

Chairperson

Committee Clerk