[LB759 LB830 LB866 LB882 LB885 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Wednesday, January 30, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on gubernatorial appointments, and on LB866, LB759, LB830, LB882, and LB885. Senators present: Tim Gay, Vice Chairperson; Tom Hansen; Gwen Howard; Dave Pankonin; and Arnie Stuthman. Senators absent: Joel Johnson, Chairperson; and Philip Erdman. []

SENATOR GAY: All right, we'll get started, 1:30. Welcome to the Health and Human Services Committee. Our hearings today, we have some appointments and some bills. I'm going to introduce the committee: Senator Howard; Senator Tom Hansen; Senator Arnie Stuthman; our clerk, Erin Mack; my name is Tim Gay, I'll be filling in for Joel Johnson today; Jeff Santema, our legal counsel; and Senator Dave Pankonin are here today. Throughout the day, many people have to...will be coming and going, testifying on bills and doing some other things today, so don't take any offense to that but they'll be in and out. And we do have a lot of information here on the appointments we do. We have all your information. If you want to come up and add some other comments and be available to answer any questions, we'd appreciate that. In order to be fair to everybody at the front end and the back of a long day is...what we like to do is the introducer of the bill can have, you know, as much time as they're going to need to fully explain the bill, what the bill does. If you're testifying as a proponent, opponent or neutral, we're trying to ask you to limit it to five minutes. We kind of keep a loose eye on the clock, but if it gets to be too much, I may stop you. But, you know, and that's just fair because the person that's waiting here all day at 5:00 or 6:00 is probably...has just as much to say as the person at 1:30. So you can all understand that and work with us on that. Any questions that are asked, too, of any testifier will not count against that time, of course, and so if we have any questions, we go on as long as you want on that. So with that, we'll get started. We have some appointments here. Kathy Boswell, on the Rural Health Advisory Commission, come on up, Kathy. Come on up and... []

KATHY BOSWELL: Would you like me to sit? [CONFIRMATION]

SENATOR GAY: Yeah, just have a seat. You want to just say a little bit about yourself, state your name for the record. [CONFIRMATION]

KATHY BOSWELL: (Exhibit 1) My name is Kathy Boswell. I'm from northeast Nebraska, Dixon County, Senator Engel's district. My husband and I farm. Occasionally we get a little help, but the two of us do most of the work ourselves. My sons are grown, leaving me time to serve on a variety of different boards and be active in my community. [CONFIRMATION]

SENATOR GAY: Okay. All right. Any questions from the committee for Kathy? Senator

Pankonin. [CONFIRMATION]

SENATOR PANKONIN: Senator Gay, thank you. Kathy, my wife is from Laurel so I'm familiar with your country, and we appreciate you, you know, stepping forward to serve. These are important positions and obviously it's great to have people like yourself willing to serve. Thank you. [CONFIRMATION]

KATHY BOSWELL: You're welcome. [CONFIRMATION]

SENATOR GAY: I'd echo those comments. Thanks for coming down. Appreciate it. And looking through your resume, quite a list of community activities, so add one more to the... [CONFIRMATION]

KATHY BOSWELL: I thank you. [CONFIRMATION]

SENATOR GAY: I'm sure you'll do a great job. Okay. Thank you very much. [CONFIRMATION]

KATHY BOSWELL: Uh-huh. [CONFIRMATION]

SENATOR GAY: All right. Michael Buscher for the Board of Emergency Medical Services. [CONFIRMATION]

MICHAEL BUSCHER: (Exhibit 2) Name is Michael Buscher, B-u-s-c-h-e-r. This is a reappointment for me. I've been on the EMS board for the last ten years, since it was initially established. I'm a retired firefighter from the Omaha Fire Department. I retired in 1999, after 28 years of service, and almost a whole period I was a paramedic EMS provider that whole time; 22 years in the field, and the last 6 in administration. So I'm currently an EMS instructor and still hold my paramedic license. I have a contract with the city of Omaha where I provide all...the fire department with all the continuing ed hours for EMTs and paramedics. [CONFIRMATION]

SENATOR GAY: Okay. Senator Howard. [CONFIRMATION]

SENATOR HOWARD: I'll have to say we miss you in Omaha, but thank you for taking this on and doing this. [CONFIRMATION]

SENATOR GAY: There any other questions? Don't see any. Thank you very much. It's nice to put a face with the name when we see some of these. Thank you. Robert Dunn is on the list; he will be here later. Nebraska Rural Health Advisory Commission, Martin...I don't want to...is it Fattig? Welcome, Martin. [CONFIRMATION]

MARTIN FATTIG: (Exhibit 3) Hi, Senator Gay. My name is Martin Fattig, F-a-t-t-i-g, and

this is a reappointment for me. I've served on the Rural Health Advisory Commission for the last three years and was reappointed last year. I find the Rural Health Advisory Commission to be a very challenging and yet very important commission to keep everyone informed of the problems associated with rural health, and also the opportunities that we feel are out there to help us, in fact, beef up rural healthcare, rural health, the health of all Nebraskans in some way. I've been involved in rural healthcare in this state for over 30 years and it's a passion for me. And I've worked with a lot of you in the past and look forward to working with you in the future. [CONFIRMATION]

SENATOR GAY: Thank you. Senator Hansen. [CONFIRMATION]

SENATOR HANSEN: Thank you, Senator Gay. Thank you for coming here today and I also...I'm from North Platte so I appreciate the Rural Health Commission. [CONFIRMATION]

MARTIN FATTIG: Well, I grew in Wallace, so... [CONFIRMATION]

SENATOR HANSEN: Oh great. And what you do for the state and keeping the rest of the state informed about rural health issues and the volunteer part of rural health that we have. [CONFIRMATION]

MARTIN FATTIG: It's very important. [CONFIRMATION]

SENATOR HANSEN: Very important. [CONFIRMATION]

MARTIN FATTIG: And I'd also like to comment that getting a citizen to volunteer to serve on the committee, on the Rural Health Advisory Commission, that is not, you know, involved in healthcare day to day is very important to us and I thank Kathy for volunteering. I really appreciate that. It's an important aspect that we need to take into account. [CONFIRMATION]

SENATOR GAY: Absolutely. I've got a question. What do you see in the future here, any improvements that need to be made? In short, what are the...next term that you're on here, what are you looking...what's the projects? [CONFIRMATION]

MARTIN FATTIG: One of the things that I'm currently working on with Senator Heidemann and the Appropriations Committee is that the Rural Health Advisory Commission is charged, through statute, to administer the Rural Health Loan Repayment Program for providers. If a provider goes to a medically underserved area and has student loans, we have a program in place where the state pays a portion, the community pays an equal amount, and help them pay off that student loan. The problem with that whole program is that, since it was established in 1991 and then the rural health...the loan repayment part of it was funded in '94, the amount of money that has

been appropriated for this program has never increased. And we've increased a number of people who qualify for it four times and we've doubled the amount that they can qualify for, and still we're trying to operate on the same amount of money. And right now we have 18 on the waiting list, so this is a problem. [CONFIRMATION]

SENATOR GAY: Right. That's good to know. [CONFIRMATION]

MARTIN FATTIG: So we're working through that with Senator Heidemann and Appropriations and see what we can get done there. [CONFIRMATION]

SENATOR GAY: Okay, great. All right. Thank you. I don't see any other questions. Thank you for your service. [CONFIRMATION]

MARTIN FATTIG: Thank you, sir. Appreciate it. [CONFIRMATION]

SENATOR GAY: Appreciate it very much. We have the Board of Emergency Medical Services, Ann Fiala. [CONFIRMATION]

ANN FIALA: (Exhibit 4) Hello. I'm Ann Fiala from Ainsworth. I'm married and have two children, and I manage an assisted living up there and have for eight years, since it opened. I also, in the other part of my spare time, I have been an EMT with the Brown County ambulance for ten years, a firefighter with the Ainsworth Fire Department for eight years, and serve on the critical incident stress management team for Troop B. And I have also been appointed to the...or not appointed, but serve on the board, the state Trauma Board, for Region I for the last three years. And feel honored to be able to serve on this board of EMS and look forward to learning a lot about it. [CONFIRMATION]

SENATOR GAY: All right. Thank you. Any questions? Senator Stuthman. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Gay. Ann, since you served as an EMT before, prior, or you still are an EMT,... [CONFIRMATION]

ANN FIALA: Yes, I am. [CONFIRMATION]

SENATOR STUTHMAN: ...do you see...and you're from out in the rural area. [CONFIRMATION]

ANN FIALA: Uh-huh. [CONFIRMATION]

SENATOR STUTHMAN: Do you see that there's a need to try to get more EMTs in the rural area? We have a problem--I'm from a rural area--of first responders and EMT and

emergency. Have you got any idea how we can try and solve that problem? [CONFIRMATION]

ANN FIALA: Oh, I have ideas: benefits from both local, state and perhaps federal government packages would be helpful to be able to help reimburse the time that the volunteers put in, in some way; just different encouraging ideas to keep them interested, making...you know, we always talk about the number of hours it takes to become an EMT, the amount of training that goes into it and the national registry test, but we get faced with so many different situations that I do believe those hours are necessary. I do believe in the national registry test, so cutting any of that out would be detrimental to the quality of emergency services we provide out there. So I'm a little reluctant to fall in line with that idea. Currently, our association, we do get some compensation through the county, but we are the only part of our county government that actually raises money for the government because we do billing out through Medicare and bill to the patients, and that has really sustained us and kept our association going very well. And it has kept our members interested because we do get paid for the runs that we do take, and I know that most of the associations across the state don't. I think that would be one idea to work towards. [CONFIRMATION]

SENATOR STUTHMAN: Because it is a time involvement and commitment for volunteer work and... [CONFIRMATION]

ANN FIALA: It is. Yes. [CONFIRMATION]

SENATOR STUTHMAN: ...out in the rural areas it's almost impossible... [CONFIRMATION]

ANN FIALA: It is. [CONFIRMATION]

SENATOR STUTHMAN: ...to give that amount of time to become an EMT. [CONFIRMATION]

ANN FIALA: There's several times...I think four times last week we transferred out of our hospital to Grand Island. Sometimes we go to Omaha, Lincoln, Kearney, and that's hours away from work, hours away from home. And so that would be nice to be compensated at some point or somehow. [CONFIRMATION]

SENATOR STUTHMAN: Uh-huh. Okay. Thank you, and thank you for serving. [CONFIRMATION]

ANN FIALA: Thank you. [CONFIRMATION]

SENATOR GAY: Thank you. Any other questions from the committee. And this, I see

this is the first time on this board. [CONFIRMATION]

ANN FIALA: Yes, it is. Very interested in the regulations portion of EMS statewide, as well as what's regulating the rural areas. It's a little bit different scenario than the urban areas, so I'm interested in that and keeping up with that for our area. [CONFIRMATION]

SENATOR GAY: I'm sure you'll be a good asset to the committee. All right. Thank you. I don't see any further questions. Thank you very much for coming today. [CONFIRMATION]

ANN FIALA: Thank you. [CONFIRMATION]

SENATOR GAY: We have Nebraska Rural Health Advisory Commission, Sharon Vandegrift. [CONFIRMATION]

SHARON VANDEGRIFT: Good afternoon. [CONFIRMATION]

SENATOR GAY: Hello. Thank you, Sharon. [CONFIRMATION]

SHARON VANDEGRIFT: (Exhibit 5) It's a pleasure to be appointed to the commission. This is my first time. I am an RN and have been for 30-plus years. Most or half of it has been in rural health; the other half has been in a large trauma center. So I feel I have a very good background in healthcare from large to small. I feel that it's very important that we help support, monetarily, those people who are going into healthcare and I think this commission is designed to do that and certainly is poised to be able to do that. As Mr. Fattig had said earlier, we have 18 people on that list who would desire some monetary help and I noticed, in looking at it, that the costs are quite large compared to when I was in college. I know one of them is for a pharmacist who is asking for $79,000 in help and that's, I think, on the lower end of what it costs now to get a good education in healthcare. [CONFIRMATION]

SENATOR GAY: All right. Thank you. Any questions from the committee? I don't see any. Thank you. Thank you for your service. I appreciate it. With that is just one. Robert Dunn here by any chance? He said he'd be joining us later, but did he make it? Okay, we have one more appointment. I'd just like to say on behalf of the committee, we all appreciate you coming here today and being in front of us. Like I say, it's good to put a face with the name. These do get confirmed by the full Legislature and sometimes we're asked questions and it's nice to know a little bit of the background. We have a lot of your information you sent in. Senator Stuthman alluded to the time involved. We know you're all very busy in other things and the time you put into these committees and commissions is very much appreciated. So on behalf of everyone here, we appreciate that and thank you for coming here. So okay, with that, we have legislative bills. We'll close the public hearing on the appointments, and we have LB866. I see Senator

McDonald is here. Welcome, Senator McDonald. [CONFIRMATION]

SENATOR McDONALD: It's a pleasure to be here. Chairman Gay and members of the Health and Human Services Committee, I'm Senator Vickie McDonald, representing the 41st Legislative District. According to the Center for Disease Control, five chronic diseases--which are cardiovascular disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes--account for more than two-thirds of all the deaths in the United States. Healthcare for people with chronic diseases accounts for 75 percent of the nation's total healthcare cost. Because these diseases are so widespread, we all know someone who has one or more of these diseases or we have them ourselves. While chronic diseases can be terminal, they're often treatable and manageable with the right drug regimen. Unfortunately, the drugs used to treat these diseases are among the most expensive, and in many cases a person may try several different drug regimens before they find the right combination of dosage to treat their disease. Patients with a chronic disease may have several unused prescriptions that haven't been open and haven't expired. Families of patients who die from a chronic disease have to dispose of unused and very expensive drugs. Right now that's their only option. That's why I introduced LB866. LB866 creates the Chronic Disease Drug Repository Program and participant registry. For purposes of this bill, chronic diseases include, but are not limited to, Alzheimer's disease, arthritis, cardiovascular disease, stroke, all cancers, chronic obstructive pulmonary disease, chronic lower respiratory disease, diabetes, mellitus, cirrhosis, hepatitis C, and kidney disease. LB866 is patterned directly on the Cancer Repository Drug Program, which became law in 2003. It requires the Department of Health and Human Services, and the Board of Pharmacy to establish a Chronic Disease Drug Repository Program for the collection and redistribution of prescription drugs used to treat chronic diseases and their side effects, or the side effects of chronic disease drugs. LB866 permits the program to accept chronic disease drugs from any person, drug manufacturer, or healthcare facility if the drugs are donated at a physician's office, pharmacy, hospital, or health clinic that has elected to participate in the program. Participation is voluntary. Drugs donated to the program can't be resold, but a reasonable handling fee will be allowed as determined by HHS. Drugs must be in their original, unopened, sealed and tamper-evident packages. Single unit doses may be accepted if the outside packaging is open but the single unit dose packaging is unopened. Expired drugs cannot be accepted. There is no limit on the number of doses that can be donated as long as the drugs meet the packaging and expiration requirements. LB866 requires HHS to create and maintain an easily accessible participant registry which allows potential donors to easily locate a participating pharmacy, physician...excuse me, participating physician, hospital health clinic. The participant registry for the Cancer Drug Repository Program is updated weekly and available on-line. Five years ago, when I introduced the bill creating the Cancer Drug Repository Program, I promised that I would introduce legislation to expand that program to include more types of drugs before I left the Legislature. LB866 fulfills that promise. I encourage you to support this concept again and advance LB866

to General File. When my husband passed away, and there is no one here that was here at that point in time, and so when my husband passed away and the hospice nurse came in that morning and she said we have to take all these drugs and we have to throw them away, and I said, oh, my goodness, this is worth many, many hundreds of dollars, even thousands of dollars worth or prescriptions that we had received, we had not used, maybe in unopened containers. She said, that's the law. And I said, oh my goodness; well, when I get to the Legislature I want to change that law. And I did. I changed it so now we have a cancer repository law that allows unopened, untampered with medicines that have been used for cancer to be donated to a repository to then be used and taken back by people that cannot afford medications. Maybe they're on Medicaid and have no way of being able to afford those. And when I passed that bill, many people came to me and said, that's a great idea; how about drugs for the chronic diseases, diabetes and those things? And I said, well, at this point in time, I'm only going to do the cancer repository because I know that if we can get through that obstacle, hopefully we can add all chronic diseases. And it was a difficult thing to pass because not everybody feels the same way I do about donating those prescriptions, they're concerned about being tampered with, but we've been able to overcome all those obstacles. The bill passed in 2003. It's been up and running for several years now. We've not had any problems with it whatsoever. So I would like to add chronic diseases to that and for various reasons. I think it's something that we need to be proactive in, not only using medicines for other people, but I think that as we dispose of those medications, we're flushing them down into our water system. That is not a good place to take our medicines that are being disposed of on a daily basis. So by donating to a repository, we are serving actually two issues. We are making sure those medications can be used by others, but we're also managing our water supply because of it. And so I think that because of that, that is two reasons enough to pass this legislation. And I will take any questions. [LB866]

SENATOR GAY: Are there any questions from the committee? Senator, I have a question. [LB866]

SENATOR McDONALD: Sure. [LB866]

SENATOR GAY: Right now, if you don't have this, do they destroy those drugs that are left? They have to be destroyed under the law? [LB866]

SENATOR McDONALD: Yes. [LB866]

SENATOR GAY: Okay. And then another question: I was reading in the fiscal note there's no liability then to the person that donates these drugs. Is there liability...I see on this other one, in the fiscal note, it says you can charge a fee but not resell them; civil and criminal immunity for persons providing the drugs is waived. Right? [LB866]

SENATOR McDONALD: Yes. [LB866]

SENATOR GAY: That would be the same way? [LB866]

SENATOR McDONALD: And that was an issue that we dealt with the cancer repository. This is just mirrors the cancer repository except we just changed it to chronic drugs. And that was an issue. The Board of Pharmacy also opposed it at that point in time, which they're also opposing this one, and the trial attorneys opposed that at that point in time. We were able to work through both of those issues, as I remember right. I think, in order to receive cancer drugs, you have to know that they are repository or they have been from a repository. And so you're saying, okay, I know that these drugs I'm receiving are from a repository, I will take them anyway. That's not a problem. And those that are donating, after several years of the repository, we tweak it every time we see that there might be a concern, and so what we have had them do is they have to sign a form saying what the medicine they had, who they are that are donating it to the pharmacy, so there's a trail there so that they know where those drugs came from. And so we've been able to satisfy all of their concerns when it comes to the cancer repository and hopefully that can be done with the chronic drug repository also. [LB866]

SENATOR GAY: Okay. Thank you. Any other questions? I don't see any right now. Are you going to stick around a little bit? [LB866]

SENATOR McDONALD: I am. I am. [LB866]

SENATOR GAY: Okay. Okay. [LB866]

SENATOR McDONALD: Thank you. [LB866]

SENATOR GAY: Other proponents on LB866? Any proponents on this who'd like to speak? Okay, I don't see any others. Any opponents on LB866? And please state your name and spell it out, too, for the clerk. [LB866]

ROGER KACZMAREK: (Exhibit 1) My name is Roger Kaczmarek, K-a-c-z-m-a-r-e-k. I am the current chairperson for the Nebraska Board of Pharmacy and I would like to thank you for allowing myself, representing the Board of Pharmacy, to speak to you. I'm going to keep my comments relatively short because I feel that potentially there's a lot of questions that you may have. You should have received a letter, I believe yesterday or possibly today, from the board stating our general reason for being a opponent rather than a proponent of this bill. Our biggest concern has to do, and this follows the other two bills that were passed by Senator McDonald, and I want to state something right off the bat. We are not against people getting free medication or getting medication that they need. There is a lot of avenues out there available for people to get medication. Currently, I work at the Fremont hospital and we are setting up, as we speak, a clinic

where we're working with people in the area and physicians and other healthcare members to getting free drugs for those people that kind of fall between the cracks, and we have several of those. And I agree with Senator McDonald, there is a lot of people out there that, for whatever reasons, have difficulty getting medication, taking medication. I wanted to address a couple comments that Senator McDonald talked about. Prior to going out to Fremont, I worked in an oncology practice for four and a half years, and I understand what she went through and several families go through that have loved ones that are treated for cancer. It is a very expensive disease in order to take care of. When the cancer repository was introduced by Senator McDonald, the DEA, which is the Drug Enforcement Agency, came out and they would not allow the redistribution of narcotics. And being in a cancer practice, this is what I saw as the main dollars that people spent on their care because most of these drugs were given in the clinics and the majority of the medication that people had at home were some of the various narcotics that they had to take, you know, for pain control. The comments that she made as far as the CDC and chronic disease--two-thirds death in the country, 75 percent costs--I'm not going to argue with any of those because I'm sure she did her homework on that. We are seeing, and I've been a pharmacist, practicing pharmacist, for 37 years, I see a lot of areas out there where we have been able to help people and we just introduced Medicare Part D which was a huge boom and help to older people, and I'm not looking at any of you implying that you're Medicare eligible, but you know from just your own practices and people that you've talked to in your community that this has been a great asset to a lot of people. Plus, those of you that live in the Omaha-Lincoln area know that there's a big push for...we've introduced $4 generics. A comment that Senator McDonald talked about was about the expense of the drugs and several attempts in order to get their disease under control, I've never seen any statistics on that but we have several drugs out there that we can use in order to, you know, take care of patients like that. I would like to stop there and just answer any questions that I could, you know, for you, because I don't know if any of you were on the cancer repository committee when that was introduced and I'd like to give you as much time as you could and whatever I can help you understand. [LB866]

SENATOR GAY: All right. All right, let's see. Is there any questions from the committee? Senator Hansen. [LB866]

SENATOR HANSEN: Thank you. Thank you for being here today. [LB866]

ROGER KACZMAREK: Thank you. [LB866]

SENATOR HANSEN: Is it your contention then that the drugs that you find at the patient's home after they pass away from cancer are mostly pain medications? And I don't know what other, what other medications there would be. That's part of the question. And then the follow-up question, I'll just ask that now, couldn't those be reused in the same...in the same light? I mean they're going to get...aren't they going to get

those prescriptions again, someone? [LB866]

ROGER KACZMAREK: Let me back up just a little bit. In the practice that I worked at...and the answer is, yes, the majority of medications that I saw when patients would pass away, a lot of times they would ask us to dispose of them and it was a very emotional issue and time for them because that was their husband or their wive's or their loved one's, you know, medication. And what I saw and what I interacted with, the bulk of those were pain control. And the Drug Enforcement Agency has said that we cannot redistribute those. Now let me back up a second. The hospice nurses that I have worked with in the past have really done a great job as far as working with these patients in order to get a reasonable amount of drug for them so that they don't have a lot of extra drug that...especially when they're near the term of the end of their life. They really try to watch that very closely, and if you've ever worked with the hospice community, the hospice nurses, they work very diligently because they know that that's an important factor in these people's lives. It's very emotional at that time and they're doing everything that they can in order to make the patient comfortable but, at the same time, not put a financial burden on these people. I'm sorry, what was your other question that you had? [LB866]

SENATOR HANSEN: Well, I just was wondering if those drugs are going to be prescribed to another patient eventually, the same prescription. But then you said that there's a, what, federal law that says you can't... [LB866]

ROGER KACZMAREK: The DEA will not allow, like, morphine-type products or Duragesic patches or Vicodin or any of the pain control medications that we commonly use, you know, with cancer patients. Now the last few years there's been a lot of oral medications come out that are treated for cancer, and they are extremely expensive. The office that I worked at, we had two and they added a third person that worked with the pharmaceutical companies to work with the people to either get the medication free or to get them at a reasonable amount so that they could afford it. As far as this new bill right now, the biggest thing that sticks out in my mind are...would be, like, diabetic patients or people that have chronic pulmonary disease. Both of these products require drugs that have to be refrigerated. An example would be insulin. Insulin would not be allowed under this because of the refrigerated component on there. It's a very...it's a type of medication where you have to be very careful. It's very temperature dependent. And if that's not kept under a reasonable degree of accuracy and watchfulness, the drug isn't stable, and if the drug isn't stable and you don't know it and you're giving yourselves these shots, you could end up, you know, in the hospital. Did I answer your questions okay? [LB866]

SENATOR HANSEN: Thank you. Yes. Thank you. [LB866]

ROGER KACZMAREK: Thank you. [LB866]

SENATOR GAY: Any other questions? I don't see any. Thank you very much. [LB866]

ROGER KACZMAREK: Thank you very much. [LB866]

JONI COVER: Good afternoon. My name is Joni Cover, it's J-o-n-i C-o-v-e-r, and I'm the executive director of the Nebraska Pharmacists Association, and we'd like to offer our opposition to LB866 as well. I echo a lot of the things that Roger Kaczmarek just stated to you. I'd like to clear up a couple of things, though. The cancer drug repository and this legislation, neither one allow for return of controlled substances, so that's sort of an issue we shouldn't be discussing because it's not allowed by federal law. Senator McDonald did not have it included in the cancer drug repository and it's not part of this legislation as well. So I just wanted to clear that up. We're opposed to the legislation primarily because this is a very, very broad thing for the Legislature to do. In our opinion, it's bad public policy. Pharmacists know probably better than anyone how important it is for patients to take their medicines, to take them properly, to have access to them. And Roger had brought up the idea of Medicare Part D. That has helped take care of a lot of the folks who could not afford their medications. Is it perfect? No. Are there still people out there that cannot get their medicines? Yes. The drug companies all have patient assistance programs which have been a great asset and a great resource for folks, and I would rather see people be able to access those kinds of programs rather than taking medications, putting them back into a repository, and then making them available. We have some concerns, and I think that this may be even something that we need to address with the cancer drug repository as well, and that is Nebraska passed a Wholesale Drug Distributor Act requiring pedigrees outside of the normal chain of command. And I would say that this is outside of the normal chain of custody, and how do we get around that issue? We did that to ensure that medicines were safe and effective, that people weren't dumping Internet drugs from Canada or Pakistan or wherever into the supply. And so I think that that's something that this committee needs to be aware of. I also am concerned about people donating drugs from Internet sources, unreputable pharmacies and out of the country into the repository. So while we'd like to think that doesn't happen, it's a potential. One of the things is part of the practice of pharmacy is making sure the drugs are properly labeled; that they are counseled on their drugs; that DUR occurs, which means I'm going to check to make sure you're not allergic to anything else. It would be very difficult to do that with this broad gamut of medications. And, you know, something that I think is very striking is that a few years ago Nebraska had a Lipitor scare where repackagers put in fake Lipitor. And according to the bill, those kinds of medications, because they can be accepted from wholesalers and manufacturers, could be possibly put into the repository, and I don't know how you would figure out that those were legitimate or not legitimate drugs. So for those reasons, I would ask that this committee indefinitely postpone LB866. In our opinion, it's bad health policy and it's bad public policy. I'd be happy to answer any questions. [LB866]

SENATOR GAY: Senator Hansen. [LB866]

SENATOR HANSEN: Thank you, Senator Gay. Joni, can you explain to us the physical way that they get rid of narcotic drugs? Senator McDonald had the concern about the water safety... [LB866]

JONI COVER: The take-back programs? [LB866]

SENATOR HANSEN: ...and what do they do with that? [LB866]

JONI COVER: Uh-huh. Well, that's a very good question and it's actually something that we're going to be addressing after the session is over with. We would like to convene a task force to talk about this, because it is a hot topic. Of course, we have a concern, whether or not the drugs are being flushed down the toilet or excreted in a normal way, which you can argue...but we don't need to talk about that. (Laughter) But there's two...with narcotic drugs, you have the requirement of a registrant, so a pharmacy, a physician. There are certain requirements under the DEA on how the medicines can be properly disposed of. If you have extra narcotics hanging around in your medicine cabinet and you want to get rid of them, we are encouraging, if you haven't taken them properly and they are expired, to dispose of them, either dump them in kitty litter or coffee or something like that and throw them in the garbage, which maybe not be the best thing but at least it's something, or there are communities across the state that are starting to work on take-back programs. With take-back programs, narcotic drugs have to be in the control of law enforcement, so pharmacists are usually involved in the fact that they look at this and they say, this is a narcotic, this is not, and there's different disposal techniques. But then law enforcement then would have to take control of those narcotic drugs and dispose of them, whether they incinerate them. I'm sure that somebody from the State Patrol or law enforcement has a specific...in their policies how they destroy those meds. But pharmacists are not allowed to take back controlled substances even into their pharmacy on a normal basis, so you couldn't take your drugs back into the pharmacy if it's a narcotic, so...but, like I said, you know, this doesn't talk about narcotics. But it is an issue and it's something that we're going to address after the legislative session ends. [LB866]

SENATOR GAY: Thank you. Senator Stuthman. [LB866]

SENATOR STUTHMAN: Thank you, Senator Gay. Joni, I have a concern about the fact that, you know, the senators or people come up with an idea to hopefully try to utilize drugs and medications and stuff like that,... [LB866]

JONI COVER: Uh-huh. Uh-huh. [LB866]

SENATOR STUTHMAN: ...and it seems like we continually get opposition for this

because it don't work, it don't work. [LB866]

JONI COVER: Uh-huh. [LB866]

SENATOR STUTHMAN: I would like to see somebody come forward and say here's a plan where we can really try to accomplish... [LB866]

JONI COVER: Uh-huh. [LB866]

SENATOR STUTHMAN: ...and look to the future so that we can utilize these drugs. [LB866]

JONI COVER: Uh-huh. Uh-huh. [LB866]

SENATOR STUTHMAN: And there may be something in there, in my opinion, that, you know, monitors where they've been stored and everything like that. [LB866]

JONI COVER: Right. [LB866]

SENATOR STUTHMAN: I know some of them are temperature controlled. [LB866]

JONI COVER: Uh-huh. [LB866]

SENATOR STUTHMAN: That's what I would like to see. [LB866]

JONI COVER: Right. I'm...since I'm not a pharmacist, I don't even know the answer to my own question I'm going to pose, but I'm curious, and I need to ask somebody, how many drugs would actually be qualified to be in this repository where you have an unopened or unsealed medication. I mean, most of the time when we go to the pharmacy to get medicines, they're in the brown vial, so they're not even in the original tamper-proof vial or in the unit dose or the blister pack or whatever, so... [LB866]

SENATOR STUTHMAN: Because I'm sure there's a part of the population that could really utilize those drugs that are low income and... [LB866]

JONI COVER: Uh-huh. And, you know, I would say that if we trusted everyone and everybody didn't, you know, leave them in their back seat when it's 100 degrees and, you know, or in their back seat when it's freezing cold like that, there's a storage issue. [LB866]

SENATOR STUTHMAN: Indoors, yeah. [LB866]

JONI COVER: And so these are our concerns. [LB866]

SENATOR STUTHMAN: Okay. Thank you. [LB866]

JONI COVER: You're welcome. [LB866]

SENATOR GAY: All right. Thank you, Joni. I don't see any other questions. Thank you very much. [LB866]

JONI COVER: You're welcome. [LB866]

SENATOR GAY: Any other opponents, LB866? Any opponents? I don't see any. We do have a letter...Joann, Dr. Schaefer is not going to be here. We do have a letter in the neutral capacity from the Department of Health and Human Services from Dr. Schaefer that we will submit for the record. (See Exhibit 2) Senator McDonald, would you like to close? [LB866]

SENATOR McDONALD: In mirroring the cancer repository, think it was last year or the year before, the University of Nebraska came to me and wanted me to do a repository for immunosuppressor drugs for...antirejections drugs for people that had received organ transplants, and that passed; same concerns from the same people with the pharmacy. They, you know, they're concerned about that. We have taken away their concern in the bills that have passed but, of course, they still have those same concerns. Any pill that's donated to a repository cannot have...cannot be temperature controlled, and they just don't accept those pills. So it's not an issue of whether it was left in the car. Those pills are not acceptable in a repository. There are very, very...statements that say what can be donated and what can't be donated, and we've gone through it with the cancer repository, we've gone with the immunosuppressant one, and so we know which drugs can be and which can't, and also the pain medications cannot be. Those are federally regulated. They are out of the control of anyone except law enforcement, and they have to be regulated by the federal government. So repositories can't take those prescriptions. This is not a novel idea for the state of Nebraska. Many...in fact, we were one of the first states that passed the cancer repository. Many states now have cancer repositories and many of them are open to allowing all drugs for chronic diseases. In fact, I think five or six states last year passed similar laws. So it's not new to Nebraska. Other states are doing this also. Looking at talking about whether a drug is the correct drug and not knowing if it came from the Internet or where it came from, it has to have the original prescription on it where that drug came from, so it will not accept those that you ordered for mail order services. And we don't really know the drugs that we get from our pharmacy came from a reliable source. We assume that they do, but there's a lot of fraud out there when it comes to drugs in our drug stores. We don't know. We assume that they are, we hope that they are, but there are really no guarantee that they are. I think the biggest contributor to a repository might not be you and me, but our nursing homes. Our nursing

homes receive medications in blister packs and they're disposing them regularly. So they would have the drugs that qualify for this, but they don't have an opportunity to give those away. Looking at the $4 medicines that you can get at Hy-Vee or get at Wal-Mart, not all people qualify for those, so it's not necessarily an option for them. I think that, you know, the Board of Pharmacy have their concerns. We have gone through many of those in past bills because it's the right thing to do, and that's what we do as lawmakers--do what we think is the right thing to do. And because other states have passed laws very similar, it's the right thing for them to do in their states too. So I would certainly look at this and consider this to move to the floor. [LB866]

SENATOR GAY: Thank you, Senator McDonald. [LB866]

SENATOR McDONALD: Any questions? [LB866]

SENATOR GAY: Any questions? I don't see any right now. Thank you very much. [LB866]

SENATOR McDONALD: Right. Thank you. [LB866]

SENATOR GAY: Thank you. With that, we'll close the public hearing on LB866, and start with LB759. I see Senator Hudkins is here. It's change provisions relating to relabeling and redispensing prescription drugs. Welcome, Senator Hudkins. [LB866]

SENATOR HUDKINS: Thank you, Senator Gay, and hello to everybody on the Health Committee. I am Senator Carol Hudkins, C-a-r-o-l H-u-d-k-i-n-s, and I represent the 21st Legislative District. I'm here today to introduce for your consideration LB758 (sic). This bill will allow jails and correctional facilities to enter into contracts with pharmacies to allow for the return, relabeling and redispensing of prescription drugs that have been prescribed to an inmate but which were not fully consumed before the inmate was released. It's important to understand that the bill does not require anyone to do anything. It simply allows jails and correctional facility to have a conversation with a pharmacy to see if there is a process by which certain prescriptions could be returned, relabeled, and then redispensed for use by another inmate instead of just throwing the drugs away. Current law allows community health centers to engage in this procedure, and I believe that the safeguards that exist in a community health center also exists in a jail or correctional facility. While this bill is intended for...to allow for the counties and the state to look at the possibility of cost savings when it comes to the expense of prescription drugs, it's not intended to reduce the safety necessary to ensure that the drugs prescribed are the drugs dispensed and consumed. If you look at the fiscal note, it says that the Department of Correctional Services estimates that there would be a significant cost saving. We don't know exactly how much because it's unknown how often the circumstances allowing the relabeling will occur and what drugs they are and, of course, what their cost is. But DCS spent over $2,400,000 on drugs for inmates in

fiscal year '05-06. In '06-07, they spent almost $2,600,000. And so far this year, and this is obviously January so we're not quite halfway through the year, $1,436,000. The agency currently destroys approximately 250 pounds of medications every three months. This bill will allow relabeling of some portion of these drugs. DCS notes that relabeling and redispensing will help in controlling the steadily increasing cost of drugs. Now I am not going to be here for closing, but I want you to know that...well, I'll finish the rest of this first. Some of you may wonder why the inmate to whom the drug is dispensed isn't allowed to take the drugs with them when they leave. The answer is very straightforward. Many of the drugs that are prescribed for certain conditions associated with drug or alcohol withdrawal and many of the psychotropic drugs that are prescribed have a black market value and it is a valid concern that the inmate will leave the facility and, instead of consuming the drug as prescribed, will instead sell the drug for others to consume. That risk is too real for the county and state to assume the liability for those types of drugs leaving the facility. And I would go back to what I started with. I will not be able to stay to close and you are going to...I hope there's someone from DCS here to explain further this bill, but you are going to hear Joni Cover in opposition to this from the Pharmacy (sic) Association, and she has a valid point. We discussed this, this morning. So what I would do is ask you not to kill this bill but to hold it, and I fully intend to have meetings with the Pharmacy (sic) Association, with Corrections and with whomever else is liable to be involved in this. Hopefully we can work out a solution to this problem, so we take care of Joni's concerns, and you'll hear those, and we'll also take care of part of the state and the counties' concerns about throwing all of these meds away when there are most likely other inmates who have the same condition and we can perhaps save the state some money. So I appreciate your time and, like I said, hang on to the bill and we will be working on it. [LB759]

SENATOR GAY: Thank you, Senator. Could you hold on one minute? Any questions for Senator Hudkins? I have one quick one. [LB759]

SENATOR HUDKINS: Sure. [LB759]

SENATOR GAY: Do you envision this mainly on the larger counties and jails using this? You talked about Douglas, Lancaster, Sarpy, some of the bigger ones, or... [LB759]

SENATOR HUDKINS: Well, yeah, Senator Gay, I would think that it could be applicable to all counties, but obviously Lancaster, Douglas and Sarpy, Hall would be the most that...or the counties that would most greatly benefit. [LB759]

SENATOR GAY: And they don't have to. This is just... [LB759]

SENATOR HUDKINS: No. No. [LB759]

SENATOR GAY: ...only if you want to. [LB759]

SENATOR HUDKINS: Yes. [LB759]

SENATOR GAY: And you're in the process of working something out possibly. [LB759]

SENATOR HUDKINS: Yes. [LB759]

SENATOR GAY: Okay. Thank you very much. I don't see any other questions. Thank you, Senator. [LB759]

SENATOR HUDKINS: Thank you. [LB759]

SENATOR GAY: Any other proponents who would like to speak on this? Proponents. State your name and spell it out for us. [LB759]

KENT GRIFFITH: Good afternoon. My name is Kent Griffith, it's G-r-i-f-f-i-t-h. I'm a jail administrator for Lancaster County Corrections, and I come to you today supporting this legislation because I believe and we believe the passage of this bill will result in significant savings for our department and potentially other jails and corrections departments throughout the state. In jails, we deal with a large number of individuals that come through our system. For example, in Lancaster County we book approximately 10,000 a people a year. Now most of those people leave us pretty soon, but we don't, with many of them, we don't have a good idea of how long they're going to stay with us. We have this constant churning of population through our facilities. We can't accurately predict how long they're going to be in our care and this results in a significant amount of prescription medications going unused. As of this morning we had an inmate population of 417 inmates in our system with 157 of them, or 38 percent of them, taking some kind of medication. Most of those are prescriptions. Referring to the fiscal note completed by our department, we destroy more than $30,000 in medications yearly that we can't return to our supplier and can't be reissued to us for future use with detainees. LB759 would help us recoup some of that expense, as well as reduce needless waste of these medications. I would appreciate your consideration on this bill and I'd be glad to answer any questions you may have. [LB759]

SENATOR GAY: Thank you, Kent. Senator Stuthman. [LB759]

SENATOR STUTHMAN: Thank you, Senator Gay. Chuck, your first name is Chuck? [LB759]

KENT GRIFFITH: Kent. [LB759]

SENATOR STUTHMAN: Kent. Griffith? [LB759]

KENT GRIFFITH: Yes. [LB759]

SENATOR STUTHMAN: You're the jail administrator? [LB759]

KENT GRIFFITH: I'm a jail administrator. [LB759]

SENATOR STUTHMAN: Jail administrator. [LB759]

KENT GRIFFITH: Yes. [LB759]

SENATOR STUTHMAN: Can you tell me what is the process of attaining those drugs through your jail? And the cost of them, does your county get discount prices or do they pay the full price or do you get them through health departments? [LB759]

KENT GRIFFITH: We have a contract with a company called PharMerica that supplies our medications to us, and that's a contract that's negotiated, I guess you could say, through our purchasing department, although it's difficult to get people to apply for those contracts because there's a significant amount of immediate work involved. They have to generally be in the vicinity and able to deliver drugs to us when we need them. [LB759]

SENATOR STUTHMAN: You do not acquire any of the drugs through a health department? [LB759]

KENT GRIFFITH: No. No. [LB759]

SENATOR STUTHMAN: Or is that possible to do? [LB759]

KENT GRIFFITH: I don't know if it's possible or not, to be quite honest with you. I don't know if we've looked at that avenue. Through the state Health Department? [LB759]

SENATOR STUTHMAN: Through those federally qualified health departments. [LB759]

KENT GRIFFITH: Ah. [LB759]

SENATOR STUTHMAN: I'm not sure, because...I mean, that's what I was wondering, if you had any idea. [LB759]

KENT GRIFFITH: Yes, I don't believe we get any of our medications that way. [LB759]

SENATOR STUTHMAN: Okay. Thank you. [LB759]

SENATOR GAY: Senator Hansen. [LB759]

SENATOR HANSEN: Thank you, Senator Gay. Kent, who does the actual prescribing of these medications then? You said PharMerica does the...they deliver it, but who does the prescription? [LB759]

KENT GRIFFITH: Right. We have...well, first of all we have inmates that come in through the door, sometimes with medications in hand or they tell us that they're on medications. In those instances, we have to verify who prescribed them the medications and where they were getting them, and then our doctor will review them. We have a physician that is by contract that visits several times a week and assesses inmates and makes prescriptions. [LB759]

SENATOR HANSEN: So it could be a few days before they are allowed to even take the prescription that they came with. [LB759]

KENT GRIFFITH: It may take a few days for us to, yeah, verify the prescription and then order it and get it. [LB759]

SENATOR HANSEN: And will you give them the prescription that they brought in or order a new one? [LB759]

KENT GRIFFITH: In certain cases, we will give them, if it's a critical prescription that they brought in, we can verify that that's the actual drug as best we can, yes, they will get that. [LB759]

SENATOR HANSEN: And then if they get a new prescription then they leave, then you take that prescription and what do you do with that? [LB759]

KENT GRIFFITH: And that is generally destroyed. If it's critical medication, something that they're going to be in big trouble if they don't have it consistently, we will give that to them. Or if they're going to a care center or something like that where we know that it will be administered to them, we can do that. But it's a case-by-case basis. For the most part, they're destroyed. [LB759]

SENATOR HANSEN: And it said somewhere in here you destroyed so much every three months. Do you just...do you wait and destroy them after three months, compile them, have a bucketful of prescriptions? [LB759]

KENT GRIFFITH: I believe that was from the former testimony. That was the Department of Correctional Services... [LB759]

SENATOR HANSEN: Okay. [LB759]

KENT GRIFFITH: ...and I'm from Lancaster County Corrections. I know we do it, I believe, a few times a year and I think we have to have a pharmacist come and witness that with one of our nurses. And I'm not sure what their current method is. I know in the past it was flushed down the toilet, but I don't know if that's what they're doing right now. [LB759]

SENATOR HANSEN: So if we pass this bill, is the doctor that prescribes it going to have to come and search through the remaining prescriptions and then represcribe them, or will PharMerica come in and do that for you, or... [LB759]

KENT GRIFFITH: Well, I think that... [LB759]

SENATOR HANSEN: ...how do you envision that? [LB759]

KENT GRIFFITH: Okay, the procedure...we get our medications in it looks like a bubble-pack card that you push the plastic through and there's foil on the other side. So those that aren't dispensed, they're still sealed, would be sent back to PharMerica, or whoever our contractor may be, for them to readminister when our future needs...when we have someone else that needs that medication. We would just send the packages of unused ones back to them. [LB759]

SENATOR HANSEN: Okay. Do you see that being repackaged or just... [LB759]

KENT GRIFFITH: I would see it as being repackaged, but I don't know what their procedures definitely would be for that. [LB759]

SENATOR HANSEN: Okay. And we assume that none of those are narcotic drugs. [LB759]

KENT GRIFFITH: Some of them may be. They...and evidently those wouldn't apply. But some of them are very expensive psychotropics and we'd like to use them again... [LB759]

SENATOR HANSEN: Okay. [LB759]

KENT GRIFFITH: ...or use them at all. [LB759]

SENATOR HANSEN: Okay. Thank you. [LB759]

KENT GRIFFITH: Certainly. [LB759]

SENATOR GAY: I don't see any other questions. Thank you. [LB759]

KENT GRIFFITH: Thank you. [LB759]

SENATOR GAY: Any other proponents? [LB759]

JON EDWARDS: Good afternoon, Senator Gay, members of the committee. My name is Jon Edwards, J-o-n E-d-w-a-r-d-s, and I'm here with Nebraska Association of County Officials in support of LB759. As I'm sure you all are aware, county jail facilities are significant cost factors and there's a lot of issues dealing with those costs, and one of those certainly is the healthcare of those inmates. And we feel that something like the language in this bill might help to alleviate some of those costs and reduce some of those costs. And we understand there may be some problems with the way it's put together, possibly where it's placed in statute. We believe that it seems reasonable that the underlying idea of this bill to find a way to be able to redistribute these drugs in order to place a little bit of a handle on the prescription drug costs that are associated with inmates. So with that, I can try and answer any questions if there are any. [LB759]

SENATOR GAY: Thanks, Jon. Any questions from the committee? I don't see any. Thank you. [LB759]

JON EDWARDS: Thanks. [LB759]

SENATOR GAY: Any other proponents? Any opponents? [LB759]

SARA WEEDER-KORUS: (Exhibit 1) Good afternoon. My name is Sara Weeder-Korus, that is S-a-r-a W-e-e-d-e-r-hyphen-K-o-r-u-s. I am a fourth year pharmacy student at Creighton University and I'm currently with the Nebraska Pharmacists Association and I am testifying on their behalf. Thank you again for allowing me to be here. Certainly, I guess, I want to start by saying that the Nebraska Pharmacists Association, I'm sure I can speak for all pharmacists when I say that we recognize the rising cost of medications, the rising costs of dispensing them, and we certainly support any effort that can curb those costs. However, we don't want to jump ahead with any efforts that could potentially compromise the safety or the legitimacy of the drug supply. That should be our primary concern. I don't ever want to dispense a drug to a patient because it saved us money, and then later on find out that it could have harmed them. We encourage the dispensation of appropriate quantities at the beginning so that we don't have those leftovers later on, if at all possible. I would like to start by maybe noting the contrast. Of course, the original section that this...that these amendments have been made to deals with the five federally qualified community health centers, and they have some pretty specific guidelines as to how they go about this process of relabeling and redispensing. Unfortunately, to my knowledge, we have polled all of our pharmacist members to get a good feel for how pharmacies across the state of Nebraska are currently dispensing to jails and what their understanding of the chain of command of those drugs is, and what we found is that there really are no standards right now. That

would be standards in terms of how those drugs are delivered to the facility, how they're dispensed, how they're stored particularly, how they're administered. We don't have any standards in place and I think before we do anything like this we need to know exactly what process those drugs are going through to get where they need to be. I know the gentleman who testified before me gave a really nice scenario for how the drugs are handled in his facility, but I cannot stress enough that that is not a standard across the state of Nebraska. This bill specifies that the drug or device must have been in control of the correctional facility or jail at all times, but this doesn't necessarily guarantee that that drug was in the possession of a person who is specifically trained to handle it. In our poll that we did with pharmacists across Nebraska, we found that in many cases it is a nurse or LPN who is administering the medication, but in a lot of cases it may be a correctional officer who is administering those medications. The bottom line is that we don't always know. There isn't a standard. I don't know if a correctional officer has proper training to understand what kind of storage requirements are needed, how medication should be handled. We just don't have those standards in place. In general, relabeling and redispensing is always kind of a concern for pharmacists, particularly if the pharmacy that provided the medication isn't the one that it's being returned to. That certainly is a legal liability. Another point that we would like to make is the process of relabel and dispensing is a significant burden of time and manpower to pharmacies, and I don't think that it's unreasonable for pharmacies to ask to be compensated financially for that process. It certainly, I don't think, should be done free of charge, and this bill doesn't talk at all about a fee for that service. We would like to see that. The bill also doesn't address any length of time for which those drugs can be out of the control of a pharmacy and certainly, for us, the longer that drug is out of the control, the higher the likelihood that it may have been improperly handled, and that's just not a risk that we as pharmacists are willing to take. It also states, the language states, that for relabeling...and the drugs should be for relabeling and redispensing to another inmate of such correctional facility or jail, and so we're wondering if this then would require, you know, my pharmacy to have a separate inventory for the jail or correctional facility patients, and that poses a lot of problems in and of itself. While we believe that, you know, this bill does pose significant threats to patient safety, it is important to recognize that the bill is limited in its current language. It really only applies to a limited number of situations. The bill only allows reuse for products that are in their original, unopened container. That language, to me, doesn't necessarily include those blister packs or what we call unit dose packaging. This, when I read it, it sounds like only that original bottle, and certainly I don't think that there's very many situations, and in our polling of pharmacists it's not very often, that the original bottle is dispensed. So I'm not sure how many drugs this is really going to apply to. And of course, as it's already been pointed out, per federal law, any controlled substances, including some psychotropic medications are controlled substances--Adderall or Ritalin, something like that--those would not be allowed to be returned because they're controlled substances. Finally, though we don't support this legislation, we do think that there are other solutions and I would certainly suggest that we look into other solutions for this problem. We would

encourage jails and correctional facilities to review the prescribing habits of their physicians. You know, are excessive amounts being prescribed initially. Rather than passing this redispensing/redistributing bill, we would ask the committee to maybe consider addressing why those excessive amounts are being prescribed initially. Again, when we talked with pharmacists across the state, there were some facilities that are requesting 30-day supplies at a time without knowing that the inmate is going to be there that long. So maybe if we can pull back and only dispense a week at a time or even less than that, that might save some. And I think that that's worth looking at before we jump ahead with this sort of legislation. So thank you for my opportunity to comment. I would be happy to entertain questions. [LB759]

SENATOR GAY: Thank you. Senator Stuthman. [LB759]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you, Sara, for coming and testifying. [LB759]

SARA WEEDER-KORUS: Yeah. [LB759]

SENATOR STUTHMAN: You did a wonderful job. [LB759]

SARA WEEDER-KORUS: Thank you. [LB759]

SENATOR STUTHMAN: I will tell the board she is one of my constituents. (Laughter) [LB759]

SENATOR GAY: Oh. Be nice to her, huh? [LB759]

SENATOR STUTHMAN: I mean that's where she was in the 4-H program and everything like that. [LB759]

SARA WEEDER-KORUS: Uh-huh. [LB759]

SENATOR STUTHMAN: But I do have...I also do have a concern with jails relabeling drugs like that, and several years ago we were very fortunate to pass a bill for the health departments and community health departments to relabel, but they had to be under lock and key all the time and under the direction of a pharmacist at all times. And they were the only ones that were able to do that. Now I don't think...I don't think the county jails do have a pharmacist that's on duty... [LB759]

SARA WEEDER-KORUS: No, not to my knowledge and not in talking to them. [LB759]

SENATOR STUTHMAN: ...all the time. And they may have, but I don't think they do. And I just...I just feel that the only way that drugs could be relabeled is if they went

through the health department and had never left the health department to go to the detention facility and then the inmate was dismissed. But that drug was still under the supervision of the person in the...the pharmacist that's in control at the health department. But I have a real concern, you know, with those drugs being in a container at a detention center and not knowing really what happened to them, so... [LB759]

SARA WEEDER-KORUS: Yeah, I certainly agree that that chain of command and chain of control is a huge concern for us as well. [LB759]

SENATOR STUTHMAN: Yeah. Thank you, Sara. [LB759]

SARA WEEDER-KORUS: Uh-huh. [LB759]

SENATOR GAY: Any other questions? I've got a...I don't know if it's a question or a comment, but as I heard about this (inaudible) with the jail system, they have very good tracking mechanisms, some of the larger jails, of exactly what the patient can eat and do, where they're going at all times. Wouldn't that be helpful if we...it sounds like they're trying to work our some agreement here, Senator Hudkins said, but wouldn't that be more beneficial? What you're saying is, well, a jailer can't give this prescription. But they know exactly, in a lot of the larger jails, what is going on medically with that inmate. And sometimes the inmates will just come, because they want to come to the pharmacy, and it kind of breaks up their day, so...but wouldn't that be helpful though? If we're looking for some kind of compromise, the...from the minute that's prescribed, they know full well what's in there and it's usually a contract, I think at larger jails. I agree with you, we should look at other ways to control costs. There's probably ways that counties can do that or whatever. But they do have these contracts that the dispensing, this...the relabeling and redispensing. Why couldn't they go to their contracted pharmacy and just say, well, this is part of our deal; here's what we do? And then the question, I guess, is if we had more detailed records, where they had a method to keep good records, would that not be helpful for the pharmacist? Usually it's the same pharmacist, unless I'm wrong. [LB759]

SARA WEEDER-KORUS: Yeah, usually, but it's not a... [LB759]

SENATOR GAY: But would that be helpful, in your opinion, if they had that, if they're working on some compromise, that that's a part of the compromise? [LB759]

SARA WEEDER-KORUS: Yeah, that would be nice, but keep in mind those kind of records cost a lot of money and they take a long time to implement. But certainly if we had better records that would maybe make it a little bit easier. I'm not sure that, you know, when you look at the smaller county jail facilities, I don't know that they would even have the means to do that. But it's definitely a direction to look into, I think. [LB759]

SENATOR GAY: Uh-huh. Well, I think some of these are very sophisticated, quite honestly. We do hear stories, of course, that aren't good, but those are the very, very minority. Most of these on a daily basis are run very, very well, and I know you weren't saying they weren't,... [LB759]

SARA WEEDER-KORUS: Oh yeah, no, not at all. [LB759]

SENATOR GAY: ...but I think that might be a very helpful way that I think it would be beneficial to both parties trying to find some kind of compromise here. So anyway, any other questions? Don't see any. Thank you very much. [LB759]

SARA WEEDER-KORUS: Thank you. [LB759]

SENATOR GAY: Any other opponents? [LB759]

ROGER KACZMAREK: (Exhibit 2) Roger Kaczmarek, R-o-g-e-r K-a-c-z-m-a-r-e-k. Again, I'm here on behalf of the Board of Pharmacy. I just had a couple comments, actually. Again, we did send a letter out to all of you expressing our concern about this, but when I was listening to your interaction with this, I want to pose some things to you that I think might be helpful to you, not only in this arena but possibly some others. We talked about the variation that you have within the state of the different correction facilities. You've got obviously a large facility here and then you've got smaller ones throughout the entire state. I don't know what the common bond is in that. I don't know who's over all that, but it seems to me that if you want to look at saving some money as far as the prescription component of it, that you have the software available to have a common software base for all these potential inmates, patients, however you want to classify them. And if they are going from one facility to another, if you had a common contract, you would have to probably have it with more than one carrier. I don't know how your bids work. I don't know who's in charge of your bidding as far as who, you know, what kind of price you get. I believe, Senator, you made the comment about, you know, what kind of bids do you have; is there any federal or state contracts that you would be allowed to get. I would think that you would be, based on, you know, just the way these programs work and stuff. I think if you had someone really look into this on a global picture, I'll bet you could save a lot of dollars by having a common carrier or a common contract carrier where it would cover all your facilities. And if someone goes from this facility to this facility, and if they're given a week's supply, that medication follows them so that there is no medication lost. You don't have to worry about someone coming in every few months to destroy that. We, as the Board of Pharmacy, we're seeing more and more of these places that we don't know what they're doing with the medications. Who's supervising this? Is it getting into illegal channels? We have no idea. And who's supervising this? We don't know. We don't have the manpower to send inspectors out and stuff. I think this is a bill that you could grow on and save the state money, and the bottom line is that I think these inmates, these individuals, would

possibly be taken care of better because a pharmacist is involved. He's doing a drug utilization review. He's evaluating the medications. He's interacting with the physician who's taking care of him, no matter where he's at. They're looking at drug interactions. I have no idea how many drug...adverse drug events occur within the jail system because of a breakdown here. You've got a lot of potential where you could save money and, at the same time, possibly help these people more than they're being helped now. Just a comment. [LB759]

SENATOR GAY: Good point. Any questions? Just...well, on that, you're right. This, I think I'm kind of...maybe this has some merit and we'll see what happens down the road, but...and no pun intended, but you have a controlled group here and you had some good ideas, and I hope some of these come out. If there's working together with Senator Hudkins or whatever is going on there, I think there's some ideas being here... [LB759]

ROGER KACZMAREK: And I think we will. [LB759]

SENATOR GAY: ...that maybe haven't been addressed. And I know the other representatives that are listening to what you said, but I heard some things. I have some experience, Senator Stuthman and, of course, Senator Hudkins, we all kind of have a little bit of knowledge on these issues, but there's probably a good idea here, a little bit, if you can work together and get something done. So that will be interesting to see if that happens. I'd encourage that, so... [LB759]

ROGER KACZMAREK: You know the other thing is, to piggyback with that, I don't know how your contracts work within the state on all your employees, and no matter what area, and I don't know who controls that. But there are a lot of contracts out there and I think there's a lot of potential... [LB759]

SENATOR GAY: Absolutely. Yeah. [LB759]

ROGER KACZMAREK: ...if you have pharmacists involved to help you review some of the medications. You know, we talked about that with the repository bill that was earlier. You know, if you have a pharmacist that's working with you actively in that, you have the potential for him to review, possibly save you lots of money. [LB759]

SENATOR GAY: All right. Thank you. [LB759]

ROGER KACZMAREK: And it's not going to jeopardize the healthcare of the patient. [LB759]

SENATOR GAY: Right, which is key. [LB759]

ROGER KACZMAREK: Thank you, Senators. [LB759]

SENATOR GAY: Thank you. Any other opponents? Anybody who'd like to speak neutral on this issue? Okay. And Senator Hudkins waived close, so we'll close the public hearing on LB... [LB759]

SENATOR HANSEN: Mr. Chairman. [LB759]

SENATOR GAY: Yes. [LB759]

SENATOR HANSEN: I believe what I heard when Senator Hudkins opened this up, she called this LB758. [LB759]

SENATOR GAY: Oh, (inaudible). [LB759]

SENATOR HANSEN: And just for the record, it's LB759. [LB759]

SENATOR GAY: Oh, it is LB759. Oh, okay. So we've been... [LB759]

SENATOR HANSEN: I think she referred to it as LB758, so... [LB759]

SENATOR GAY: Yeah. All right. Just, Erin, do you want to make note of that? Yeah, on her sheet it is LB759, though, so we'll...okay. That will close the public hearing on LB759 and, real quick, Robert Dunn. [LB759]

ROBERT DUNN: Yes. [CONFIRMATION]

SENATOR GAY: Robert, we're going to fit you in on these appointments, if you want to step forward. We got your information and we kind of reviewed it already, so will give a brief....thanks for coming. We'll go backwards just a minute before we get to LB830, but a brief summary of your experience and... [CONFIRMATION]

ROBERT DUNN: (Exhibit 6) Yes. My name is Bob Dunn, or Robert A. Dunn, R-o-b-e-r-t A. D-u-n-n. I've been appointed by Mike Johanns as Governor to the public position on the EMS credentialing board; 17 members on the board and I'm there as the ears of the Governor to see if anything is out of the ordinary. And I would like to take a moment to compliment the whole board and the system, because they have devised a book, a resource manual, and it is an excellent source of what's expected of us and what we can expect of the board. So if you have any questions about it, why, be glad to continue to serve. [CONFIRMATION]

SENATOR GAY: And this is a reappointment, correct? [CONFIRMATION]

ROBERT DUNN: Yes. [CONFIRMATION]

SENATOR GAY: Senator Stuthman has a question. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for serving, and you did state that you're to be the ears for the Governor to listen. [CONFIRMATION]

ROBERT DUNN: Yes. [CONFIRMATION]

SENATOR STUTHMAN: Will you be carrying your camera also? (Laughter) [CONFIRMATION]

ROBERT DUNN: Yes. I've been there, done that. [CONFIRMATION]

SENATOR STUTHMAN: Because I've known you for a long time... [CONFIRMATION]

ROBERT DUNN: Yes. [CONFIRMATION]

SENATOR STUTHMAN: ...and you've taken a lot of photographs. [CONFIRMATION]

ROBERT DUNN: Yeah. [CONFIRMATION]

SENATOR STUTHMAN: So thank you for serving. [CONFIRMATION]

ROBERT DUNN: They...I again will compliment the board on the way they handle applications and when there are investigations, so forth, they do it very professionally, being politically correct right down the line. So I think anything that comes out of the board will be well respected. [CONFIRMATION]

SENATOR STUTHMAN: Thank you. [CONFIRMATION]

SENATOR GAY: Thank you very much. Any other questions? I don't see any. Thank you very much for coming here today and being with us, appreciate it, and for your service. [CONFIRMATION]

ROBERT DUNN: Thank you. Very good. [CONFIRMATION]

SENATOR GAY: Okay, thank you. Okay, get back to bills. I see Senator Lathrop has joined us, open the public hearing on LB830, is adopt the Prescription Drug Cost Savings Act. Welcome. [LB830]

SENATOR LATHROP: Thank you. [LB830]

SENATOR GAY: Some of us are working in other areas, so. [LB830]

SENATOR LATHROP: It looks like it. Well, I just saw Senator Pankonin over in Judiciary so I left him to come over here. [LB830]

SENATOR GAY: So we will be civil to you if you're civil to him over there. [LB830]

SENATOR LATHROP: Pardon me? [LB830]

SENATOR GAY: I say if you're going to go back and be with him, so we'll treat you nice here, if you treat him... [LB830]

SENATOR LATHROP: I think I'll be here longer than he's going to be over there. He's got something pretty simple, it looks like to me. [LB830]

SENATOR GAY: Okay. All right. Go ahead. [LB830]

SENATOR LATHROP: Are you ready? [LB830]

SENATOR GAY: Yep. [LB830]

SENATOR LATHROP: (Exhibit 1) Thank you, Vice Chairman Gay and members of the Health and Human Services Committee. I'm here today to introduce LB830. And first of all, I'd like to offer AM1687 which strikes and replaces the language of the green copy, so that the amendment becomes the bill. The primary change from the green copy to the amendment is to strike any reference to the Rx Card Program. This is done due to problems with implementation of similar programs in other states, which have been recently brought to our attention. The rest of the changes are simply made to clean up the language and clarify the intent of the bill. I'd ask that the committee address their deliberations to the amendment, and those who testify here today could focus their comments towards the amended language. So now addressing the substance of the amendment, let me begin with some background. On December 1, 2005, the Department of Health and Human Services, Finance and Support, issued a report entitled, "Nebraska Medicaid Reform Plan," in response to a mandate from the Legislature. One of the recommendations made in that report was that HHSS contract with a consultant to advise Health and Human Services on whether the establishment of a preferred drug list would be clinically appropriate and cost-effective, and whether participation in a purchasing pool would result in additional savings to the Nebraska Medicaid Program. On October 31 of last year that report was finally completed by the Mercer Corporation and in light of their financial analysis, I saw fit to again bring this topic before the committee. I should note that the Mercer report was complimentary of HHS in many of the programs...many of the cost-savings programs that were already in place. They thought we were doing a very good job with our generics, and our prior

authorization program was also the subject of compliments in the report. My sense was last year the committee's decision not to advance my similar bill was based upon questions about the Rx Card Program, which by the way, turned out to be well-founded. Questions about whether or not the PDL would indeed save the state, and whether the PDL would save the state money. And to this last question I think we can answer an unequivocal yes, in light of the Mercer report. If we are to adopt and do adopt AM1687, we will join 45 other states with similar programs. First I want to make sure we're clear on what a PDL is. A preferred drug list is a list of all available drugs the FDA has approved, divided into therapeutic categories with asterisks next to the drugs that Medicaid pharmacists have determined are preferred. The reason such a list can help Medicaid save money is that doctors are encouraged to prescribe those preferred drugs when they can see no rational, therapeutic advantage for not doing so, and decisions on preference are made partially on cost. Cost is the last factor that is considered, but the small consideration should save the state as much as $1.6 million per year, according to the Mercer report. I want to repeat that, because it bears repeating. In creating the PDL, cost is only used as the final determinant after all therapeutic considerations have been waived. And the language of this amendment emphasizes that very clearly in Section 3, Paragraphs (1)-(4). Opponents of the bill, particularly those testifying directly or indirectly on behalf of the pharmaceutical industry, may argue that PDLs limit availability of drugs. This may be true in other instances, when such programs are run by private insurance companies. An insurance company is free to limit what drugs it will pay for. Medicaid, however, is a special case because it is bound by federal statute to make all drugs approved by the FDA covered at nominal cost, except in certain specified drug categories such as smoking cessation and things of that order. These federal constraints limit somewhat the potential savings that might be available, if it were possible just to take some drugs off the table, as insurance companies are free to do. This is a side issue, however, because the majority of the savings realized by a PDL come not from the direct effect of its implementation, but rather from further savings negotiated that are made available through joining in a multistate purchasing pool. Implementing a PDL is a prerequisite for joining such a pool, and the Mercer report indicates that the state's share of savings from such a program could be as high as $3.9 million a year on top of the savings from the PDL itself. A multistate purchasing pool means that Nebraska would join up with a group of other states that pool together the aggregate purchasing power of their Medicaid programs. They then use this aggregate power as leverage to negotiate what are called supplemental rebates from pharmaceutical manufacturers. The fiscal note makes is clear there are also some costs to implement; however, it appears by all calculations these costs are greatly exceeded by the savings. I expect HHS to detail their specific financial projections in their testimony today, and I may have something to say on that topic in my close. I will close now by saying this measure saves millions of dollars to our Medicaid program and will help ensure Nebraska continues to provide quality healthcare to those without private means. Just as a final comment, it would appear from the Mercer report that we should be able to save anywhere between $3 million and $4.5 million a year by implementing

the PDL and joining the pooling and negotiating with other states for our prices. There is some expense associated with it, but the savings far exceed the expense, and it's all done in a savings to the Medicaid program without sacrificing patient care at all. Thank you. [LB830]

SENATOR GAY: Thank you. Senator Hansen. [LB830]

SENATOR HANSEN: Thank you, Senator Gay. Senator Lathrop, last year we had a hearing on some drugs that the doctors and pharmacists, I think, came up and they said that they can't substitute them, so that preferred drug list is not going to work with those drugs. You have no psychotropic drugs or now antidepressant drugs. The drugs they were talking about were transplant and epileptic drugs; doesn't matter whether they're generic or top dollar or whatever, just so the patient is used to those drugs, don't change it, don't move them back and forth. Would you be willing to put...to expand that list? [LB830]

SENATOR LATHROP: Sure. I think that the idea behind taking psychotropic and antidepressant medications, the HIV and the MS drugs off is that very same rationale, Senator Hansen, which is, some medications, unlike cholesterol where we can figure out what is the best thing and come up with a preferred drug, prescribing psychotropic and antidepressants is more of an art, and what works for you may not work for Senator Stuthman. So if that same rationale applied in different areas, then certainly we'd consider providing that as an area of exclusion. [LB830]

SENATOR HANSEN: Thank you. [LB830]

SENATOR GAY: I've got a question for you. So the fiscal note here that I'm looking at obviously is no good, because it still has the card. [LB830]

SENATOR LATHROP: Yeah, the Rx card...actually, that was something that I was kind of fond of last year and felt pretty strongly about, but we did come into information since really the start of this session, that the Rx card has run into problems in some other states, and it hasn't provided...it's been more expensive than we thought. So that has been taken out, but the fiscal note reflects the cost of implementing the Rx card. [LB830]

SENATOR GAY: So that will be updated? [LB830]

SENATOR LATHROP: It should be. [LB830]

SENATOR GAY: So...okay. Then looking at this amendment here that will replace the bill and--what section would it be?--page 3, Section 3 there. Chief executive officer then has some leniency on what they could put on this preferred drug list. If they find a more

effective or cost effective...and cost isn't the key. It's the therapeutic. [LB830]

SENATOR LATHROP: Right. Basically what is anticipated with this process is that Health and Human Services would establish essentially a prescription drug review committee, and that's my term and maybe not what is in the bill. That would consist of pharmacists and medical doctors who would review all the medical literature, review what other states have regarded as the most effective drugs for something like cholesterol. Once you know every drug that's among the top tier in effective, then what we'd do, cost becomes a consideration only to the extent that we have them bid against one another to be the preferred drug list, which is where the savings result. [LB830]

SENATOR GAY: Okay. Then you had mentioned that the...is it the Mercer report or whatever,... [LB830]

SENATOR LATHROP: Mercer. [LB830]

SENATOR GAY: ...said good things about what we're already doing. Did you say...was that on the generic end or...repeat. [LB830]

SENATOR LATHROP: Mercer said we were doing two things very well, and one was, is that we had in place a very effective prior authorization program, and that's good to know because that's sort of the outlet, in case the doctor wants to prescribe off of the PDL, which they can under this bill. The other thing was that I think we were 5 percent ahead of other states in our prescription of generic drugs, for which we're already realizing the savings. [LB830]

SENATOR GAY: So that kind of flexibility, then...if we allowed our own department...do you think this allows the flexibility to...I assume these lists are changing. Do they change frequently or not? But...so you think this new amended version has more flexibility and will still allow us to keep up the good things we're doing? This just enhances what we're doing? [LB830]

SENATOR LATHROP: It enhances what we're doing. It's also...the Mercer report had a couple more suggestions that I didn't try to incorporate into this. I think the people over at Medicaid intend to implement a step program or perhaps a pill-splitting program that might result in additional savings. But there is flexibility in this, Senator Gay, in that we set up a preferred drug list, which are the safest, most effective drugs for a particular condition, and if a patient sees the doctor and the doctor has reason to prescribe other than that preferred drug, he calls the prior authorization line, which is already in place, and gets the okay within 24 hours, and usually in the same phone call. [LB830]

SENATOR GAY: Thank you. Any other questions? I don't see any. You're going to stick around, then? [LB830]

SENATOR LATHROP: I will stick around. Thank you. [LB830]

SENATOR GAY: Okay, thank you. Any proponents on LB830? And for those of you proponents...and Senator Lathrop, when you weren't here, we're trying to...we give you as much time to open and close as you want, but we're trying to summarize things in five minutes or so. I know this is a complex subject, but...and then we're...any questions, they aren't counted against the testifier, okay? [LB830]

SENATOR LATHROP: Okay. Thanks. [LB830]

SENATOR GAY: Okay, just so you know the...Vivianne, yeah. Come on up. [LB830]

VIVIANNE CHAUMONT: (Exhibit 2) Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Vivianne Chaumont, V-i-v-i-a-n-n-e C-h-a-u-m-o-n-t, director of the Division of Medicaid and Long-Term Care, Department of Health and Human Services. I'm here to testify in support capacity on one part of LB830. We would like to acknowledge that Senator Lathrop has introduced an amendment that would remove the language that creates the Healthy Nebraska Rx Card Program and therefore I will not be reading the comments that we had prepared on that topic. We do look forward to continuing to work with Senator Lathrop on language that will allow Nebraska to have an efficient and effective preferred drug list that allows the department the flexibility it needs to implement and administer such a list. I'll move past the things that I was going to say. My support testimony is on the issue of the establishment of a preferred drug list for Medicaid. One year ago we were working with a contractor to analyze the positive and negative aspects of the Medicaid pharmacy program and to study the issue of whether a PDL would be right for Nebraska. The contractor, Mercer, issued their final report on October 31. Quoting from the executive summary Mercer states, "the State's Medicaid pharmacy department has employed and follows a progressive and sound operational program. The Pharmacy Department is committed to understanding inefficiencies, identifying opportunities for cost containment, and driving the programs toward a higher quality, more efficient structure. Examples of this include the State's Maximum Allowable Cost program for generic drug reimbursement, its prior authorization program and the significant recovery of Medicaid federal rebate funds." The department wants to fully recognize the hard work and cooperation from the Nebraska Pharmacists Association, the Nebraska Medical Association and their practitioner members, that have helped to build this program. The targeted and focused use of prior authorization on certain drugs and the Behavioral Health Drug Education Project, both of which are important parts of Medicaid reform, are integral to the success of the pharmacy program, measured in terms on continued access to needed medications and helping to change the rate of growth in expenditures for drugs. In the feasibility study Mercer states that Mercer believes the state is well-positioned to implement and benefit from a PDL, as long as it is willing to

invest the money and required resources, including staff hires, to launch a successful program. Mercer's report states that the range of net savings from joining one of the national PDLs is from 4.8 percent to 7 percent of the drug expenditure. In FY '07, the Medicaid program purchased about $140 million of drugs. Mental health drugs account for approximately $40 million of those dollars. However, we would recommend exclusion of mental health drugs from the PDL. This would reduce the overall savings from this program. According to Mercer, the start-up costs we would need to bring up the program and administer it are substantial. They responded that the state would need to invest $1.4 million to $2.4 million in total funds, or about one-half of that amount in state funds, and at least one state FTE would be needed. Up-front money would be necessary the first year without the benefit of cost savings that first year. The current Medicaid budget does not contain the administration funding for the implementation costs for the first year, so the Legislature would need to consider the allocation of these costs with other budgetary requests this session. We're actively working to determine whether the numbers provided by Mercer truly reflect the savings that can be realized by implementing a PDL and a drug pool in Nebraska. I'd be happy to answer any questions. [LB830]

SENATOR GAY: Senator Hansen. [LB830]

SENATOR HANSEN: Thank you, Senator Gay. Vivianne, we've heard from two testifiers already about the Mercer report. Would it be beneficial that this HHS Committee of the Legislature read through the Mercer report on our own, or are you taking just bits and pieces out of it? [LB830]

VIVIANNE CHAUMONT: The Mercer report...two of the issues in the Mercer report are whether it makes sense for Nebraska to do the PDL and the purchase pool, and the Mercer report concludes that it does make sense, that there are cost savings there. That's the part of the report that is at issue in this hearing. Other parts of the report contain other suggestions that the department can do in order to improve the pharmacy program, and we are going to be doing some of those enhancements to our pharmacy program. We are in the middle of a transition between the contractor that does the point-of-sale pharmacy claim payment, so we are transitioning from one provider to another contractor that just recently won an RFP. And that's taking, you know, a lot of time to transition, but as soon as that is done, we're going to start work on some of the other things that were suggested in the Mercer report. I would be happy to provide copies of the Mercer report to all of you. [LB830]

SENATOR GAY: I just...excuse me, Senator Stuthman. Jeff can get you a copy of that, too, or Erin. We do have that, so thank you. [LB830]

SENATOR HANSEN: Thank you. I could...I need more to read it. (Laughter) [LB830]

SENATOR GAY: Tonight? You going to read it all tonight? [LB830]

VIVIANNE CHAUMONT: You will not need Ambien if you read the report. (Laughter) [LB830]

SENATOR HOWARD: That's a cost saver. [LB830]

SENATOR GAY: Yeah. Senator Stuthman. [LB830]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for testifying, Vivianne. [LB830]

VIVIANNE CHAUMONT: Thank you. [LB830]

SENATOR STUTHMAN: And you stated that the state would have to invest $1.5 million to $2.5 million in the program. Are we going to get a cost return on this by having the program, for that investment? [LB830]

VIVIANNE CHAUMONT: The Mercer report indicates that, yeah. We would have to invest, it's about $1.4 million to $2.4 million in total funds, so about half of that would be state funds, but their projections--which our projection is slightly lower than their projection, because...and we would take out the mental health drugs, so that would decrease it--indicate that there would be cost savings. [LB830]

SENATOR STUTHMAN: Okay, thank you. [LB830]

SENATOR GAY: Vivianne, I have a question. You said...so the start-up costs are between $1.4 million and $2.4 million to get going and are not budgeted for, at this point, and this takes effect in '09. So would you budget for it then? This act becomes operative July 1, 2009. Would that be a new...would we have had a new budget by then? [LB830]

VIVIANNE CHAUMONT: Well, that's one of the things that I think we would want to work with Senator Lathrop. I didn't...it's not clear...it wasn't clear to us and we have not had an opportunity to discuss this, whether we would begin work on implementing the program July 1, 2009, or whether the expectation is that we would have a PDL program operational July 1, 2009. So if we had to have it operational July 1, 2009, that means that this fiscal, this next fiscal year, we would need the funds in order to do that. We don't have those funds. If it's later, then you could appropriate the funds so that we would have the funds in order to be able to build the program. [LB830]

SENATOR GAY: So it's something that should be looked into or worked out, implementation and... [LB830]

VIVIANNE CHAUMONT: I think that's...right. [LB830]

SENATOR GAY: Yeah. [LB830]

VIVIANNE CHAUMONT: It's not clear to me. [LB830]

SENATOR GAY: Senator Howard. [LB830]

SENATOR HOWARD: Thank you, Senator Gay. Will this include children, as well? State wards? [LB830]

VIVIANNE CHAUMONT: Yes. [LB830]

SENATOR HOWARD: Because I know we spend quite a lot of money on medications there, psychotropic especially. [LB830]

VIVIANNE CHAUMONT: Well, and that's an issue in, you know, establishing a PDL. A lot of the states delete mental health drugs. They do not include mental health drugs in a PDL. We would recommend that we not include mental health drugs in the PDL because of some of the issues that I think were mentioned about the difficulties of arriving at an appropriate dosage and medication for severe mental illness. But that's something that we're willing to talk to Senator Lathrop about. [LB830]

SENATOR HOWARD: Thank you. [LB830]

SENATOR GAY: Vivianne, I know you've had conversations with Senator Lathrop and been working very well with him, I understand. Have you seen this amendment? [LB830]

VIVIANNE CHAUMONT: Yes. [LB830]

SENATOR GAY: Okay. On what I asked him earlier, on page three, it looks like it has some flexibility for the department to be able to, well, be flexible. But on that you're looking at the most cost-effective sometimes, taking into consideration any rebates, and then the drug that is clinically effective and is the less costly, could put that on the list. Do you think there's enough flexibility for you in this now? [LB830]

VIVIANNE CHAUMONT: There's a couple of areas where I think that we would like to discuss with Senator Lathrop, some places where we could perhaps get more flexibility. But I think that those are...the things that are in the bill are the criteria that states have commonly used to do PDLs, and most states at this point hire a contractor to help them do the PDL, and those are the criteria that I'm familiar with that are used. [LB830]

SENATOR GAY: So when we're talking start-up cost and somebody to help implement this, then the $1.4 million, is that with a contracted service, or are you doing it on your own? You're looking at a contracted service possibly? [LB830]

VIVIANNE CHAUMONT: Yes. We're looking at contracting. In the Mercer report, those are the costs that they're looking at. They're looking at contractor costs, and then they're looking at the state FTE cost would be to have someone that can manage that contract. And it's more labor intensive up front, obviously, than once you're just maintaining the PDL. But with the fact that new drugs come on the market all the time that have to be evaluated about whether they go on the PDL, it's an intensive. [LB830]

SENATOR GAY: So when you say it's more labor intensive up front, which means there's more cost up front, the cost then would be declining as it becomes more efficient? So after the implementation, those costs would go down then, the ongoing costs. And the only reason I ask, the fiscal note is kind of long term. [LB830]

VIVIANNE CHAUMONT: Right. [LB830]

SENATOR GAY: What do you...is it half that? [LB830]

VIVIANNE CHAUMONT: You know, I think we will probably be filing an amended fiscal note, and that will go into that. I would rather not answer that until I know the numbers for sure. [LB830]

SENATOR GAY: Yeah. Don't guess. Okay. Any other questions? I don't see any. Thank you. [LB830]

VIVIANNE CHAUMONT: Thank you. I forgot to do the copies of the testimony. [LB830]

MARK INTERMILL: Good afternoon, Senator Gay. My name is Mark Intermill; that's M-a-r-k I-n-t-e-r-m-i-l-l, and I'm here today on behalf of AARP. We do support LB830. We are supportive of actions that will improve the efficiency and effectiveness of Medicaid, and I believe this bill with a preferred drug list will do that. As was mentioned earlier, a preferred drug list can enhance the effectiveness of prescription drug therapy as well as help to contain the costs. Medicaid needs to be commended for their efforts to control the costs of the Medicaid program. Over the last five years we've seen an annual average rate of increase of 3.8 percent, which is a very sustainable rate. Last year we saw the vendor expenditures increase at less than 1 percent. But we need to continue to act to make sure that healthcare is purchased efficiently and effectively in Medicaid. We think the preferred drug list can be an effective, quality enhancement tool. We have seen the Mercer report. The estimated General Fund savings that we saw in the report ranged from--and this is for the preferred drug list and a purchasing

pool--from $2.7 million to $2.9 million for the lowest savings from the National Medicaid Pooling Initiative, to $3.6 million to $3.9 million for the Sovereign States Drug Consortium. So that does indicate through an objective party that there can be savings as a result of the preferred drug list. As Senator Lathrop also said--we support it--we like the idea of a discount program, but we recognize that this is probably not the time to pursue that. We think that giving the department an opportunity to gain some experience with a preferred drug list is probably the first step that needs to be taken to gain some experience with preferred drug lists. And at some point in the future we may be back to the committee to talk about some other ways that we can help contain the cost of prescription drugs for those people who don't have drug coverage. With that, I would close and ask for questions. [LB830]

SENATOR GAY: Thanks, Mark. Any questions from the committee? Senator Hansen. [LB830]

SENATOR HANSEN: I have one. I was just making a note. Thank you, Senator Gay. Mark, I could wait and ask Senator Lathrop, but he might escape so I better ask you. In Section 18 of the green copy--and you said you were in support of the bill, LB830,... [LB830]

MARK INTERMILL: The amendment. [LB830]

SENATOR HANSEN: ...but you're talking about the amendment, okay. [LB830]

MARK INTERMILL: Yeah, we support the amendment. [LB830]

SENATOR HANSEN: And Section 18 of the green copy is the same as Section 6 of the amendment, and it says the department "may" adopt and promulgate rules and regulations to carry out the Prescription Drug Cost Savings Act. How do you explain that, that they may? [LB830]

MARK INTERMILL: I think the department will probably find it necessary to establish regulations that would enable them...sort of set the rules of the game for how the process...for example, how the preferred drug list may be established, what the...a good preferred drug list will have physicians, pharmacists, having input into its development, so there may be some regulations needed along those lines to make sure that there's a good process in place, to make sure that the PDL has the best possible chance of being successful. [LB830]

SENATOR HANSEN: And the green copy and then again in the amendment, there are several places where it says that the department "shall" do this. And should that be changed? We argue this all the time, "may" and "shall." So should we put "shall," so they have rules and regulations to make the act effective? [LB830]

MARK INTERMILL: I guess I would leave the regulations to the discretion of the department, I think. It may be that they find that what is in the act is sufficient to allow them to operate the program. Rules and regulations are just ways of clarifying how the program will be operated, what the rules will look like. So I guess I think "may" is probably appropriate for that. [LB830]

SENATOR HANSEN: Thank you. [LB830]

SENATOR GAY: I don't see any further questions. Thank you. [LB830]

MARK INTERMILL: Thank you. [LB830]

SENATOR GAY: Any other proponents? [LB830]

JENNIFER CARTER: Good afternoon, Senator Gay, committee members. My name is Jennifer Carter, C-a-r-t-e-r. I am the director of the Health Care Access Program at Nebraska Appleseed, and I'm also their registered lobbyist. And we wanted to come in and testify today from a consumer perspective in support of LB830 and the amendment that Senator Lathrop brought. We are, as you all know, and I think I've talked to all of you about the continuing efforts at Medicaid reform, which we often have some serious concerns about, in terms of the suggested reforms and their effect on consumers in the program. But we think this actually is a really positive way to achieve some savings in the program, and the effect on consumers, I think, is limited in terms of...there may be some times where through prior authorization a consumer might not be able to get the drug that the doctor might think they need, but for the most part it seems that it has worked really well in other states, and the preferred drug list will provide the recipients with the kind of drugs that they need. And I think because our prior authorization system seems to be working well enough, that that allows for the bypass to comply with the Medicaid rules, and otherwise to make drugs available when they need to be. Sorry, I'm getting over a cold. And I would just caution that if we do do any kind of tiered leveled cost sharing, where if you use a drug off the PDL that person might have to pay more for that, that that remains. And I think the rules in Medicaid would make...that cost sharing would remain nominal, I would hope, and so that's the only thing we might be a little bit concerned about. But generally speaking, we think this is a really positive way to save money in the program, and so we are supportive of it and hope you will advance it. And I'm happy to take any questions. [LB830]

SENATOR GAY: Thank you. Any questions from the committee? I don't see any now. Thank you. [LB830]

JENNIFER CARTER: Okay, thanks. [LB830]

SENATOR GAY: Any other proponents? Okay, I don't see any there. I do have a letter from Terry Werner, from the Nebraska Association of Social Workers in support, and we'll add that to the record. (See Exhibit 3) Any opponents who would like to speak on this? Any opponents? Here we go. [LB830]

JONI COVER: My name is Joni Cover, it's J-o-n-i C-o-v-e-r, and I'm the executive director of the Nebraska Pharmacists Association, and the Nebraska Pharmacists Association opposes LB830, as amended, so we're going to discuss AM1687. I'd like to talk about, first of all, to let you know that Nebraska Pharmacists Association contracts with the state of Nebraska to have the DUR program, the Drug Utilization Review program, which is a requirement under federal law, and whether or not a PDL exists or not, there will still have to be a DUR program. So I want you to know that my interest in the DUR program...yes, we have a contract, but that will be in place, no matter what. Our current prior authorization program saves the state about $7.2 million. We have about a 60 percent dispensing rate of generic drugs currently, which I think is outstanding for the state. And I have to tell you that our association works very, very closely with the Medicaid department, with the Medicaid pharmacists, and have to commend them for the outstanding job that they do do. I think Nebraska should be very proud of what is already in place. One of the things that we're required to do with the DUR program is to issue this little report, and if you'd like to add it to your reading pile tonight, I'd be happy to get you one of these (laugh). And it just talks about which drugs are dispensed, the top 10, the top 20, as far as number of prescriptions and then number of drugs and the drugs spent. One of the things that I have a problem with as far as this amended version is, first of all, involving a pharmacy benefit manager to negotiate drugs. That's always a huge red flag for pharmacies, so I'm just going to state that right up front. The second thing is we feel, as healthcare providers, that patients have incredible access to drugs right now, and yes, there are some hoops that physicians have to jump through, but there are less hoops than what would be required under a PDL. And I believe that if you make it too difficult to get the drugs, that you'll have providers that will say, I'm not going to participate in the program. Now I don't know what kind of activity happens in other states, if they have great success or not. I'm also curious if the PDL...you asked about an implementation date. Is that something that is going to start immediately? Everybody is on the PDL and so there's no grandfathering in of patients? Because that could be a complete nightmare for providers in our state. As far as a multistate purchasing pool, I know I've glanced at the Mercer report, and it looks like there's all kinds of varieties. I think Nebraska has the reputation for being rugged individualists, and we like to do things our own way, and I think that some of the recommendations in the Mercer report basically said, here's a program, adopt it. And I'm not sure that we would be very comfortable with doing that. I'm not saying that it wouldn't work; I'm just saying, we need to consider that. The Mercer study did discuss that the state could save money on a PDL, and it also commended the state for the PA program that we have currently in place. I do believe that if the Legislature enacts a PDL that you need to be committed to putting the resources forward to make it an

effective PDL. And I also would say--and I don't know that I would have anybody in this room agree with me, but from the perspective of the Pharmacists Association, if you start exempting drugs, you might as well forget about a PDL. And I know that that's probably not a popular statement, but you know, Nebraska has, in the top ten drugs, five of those top ten drugs dispensed in the state of Nebraska under the Medicaid program are mental health drugs. That's about $8.8 million a year. I'm not saying that that population of individuals would necessarily like having mental health drugs not restricted, but we just need to make sure that all drugs are included to make an effective PDL. Senator Hansen, you talked about the epilepsy drugs. I think that's a whole other issue, but I really would caution you before you start exempting. I think if you're going to make it effective, put in all classes. Another thing that is very concerning to us is, we just implemented a really big PDL formulary type program, and it's called Medicare Part D. And as many great things that came out of Medicare Part D as far as senior citizens getting their drugs, it was a complete nightmare for the pharmacies and for the physicians, and I don't want to see that happen with a PDL. Nebraska's pharmacies are being reimbursed on an average of $4.66 to dispense a prescription drug. We just completed a cost-of-dispensing survey, and the average cost to dispense a drug in the state of Nebraska is $10.18. If the pharmacists are asked to carry the burden of administering or implementing this PDL, I can tell you that $4.66 is not enough to keep us in the program. So I would really hope that if a PDL comes to fruition that you consider paying the providers an adequate amount to incentivize them to stay in the program. I also really am concerned about, with a PDL, not having that generic incentive there anymore, so something else that you might want to be concerned about. You know, one good thing that the state has just done is...has implemented a cough-and-cold covered drug list, and it was implemented in November, 2007. And since then it's saved, I think, approximately a million dollars, and Director Chaumont could probably answer that question a little bit better than I can, but I think it's around a million dollars. And so I really encourage you to consider working with Senator Lathrop or with the department to enact more of those kinds of programs and not just scrap what we've done and start over with a new process, until we really know that it's going to work, it's going to be cost-effective, that patients are going to have access to their medicines, and that you're not going to drive providers out of the program. So with that, I would be happy to answer any questions. [LB830]

SENATOR GAY: Thanks, Joni. Any questions from the committee? [LB830]

JONI COVER: Do you want my copy? [LB830]

SENATOR HANSEN: Well, if you can spare one. [LB830]

JONI COVER: (Laugh) I'll get you one. [LB830]

SENATOR GAY: I don't see any. Thank you. [LB830]

JONI COVER: Thank you. [LB830]

SENATOR GAY: Any other opponents? [LB830]

RUSS SVOBODA: My name is Russ Svoboda. I represent Sanofi-Aventis. We are a drug manufacturer, the second or third largest in the world, depending on what week it is. We are very involved in chronic care, chronic diseases--things like asthma, things like diabetes, things like cancer. It's...I've just celebrated my 25th anniversary as a pharmacist. Part of that career has included being on the Medicaid P&T committee in Wisconsin. I've worked with Medicaid programs in 18 different states, seeing about the best, the baddest, and the ugliest of what works and what doesn't. And as I was sitting here today, I had not planned on testifying but I thought, there are some things that need to be shared. When I built my house a couple of years ago, if I wanted to save money on my nail budget, I could have used half as many nails or cheaper nails, but I'd be paying for it big time today when that cold front came through and maybe a few shingles fell off. And that's really, when I look at, from my training as a pharmacist, at drugs, they are the tools that help treat patients. There's nothing...I read the Mercer report, all 98 wonderful pages, in its entirety. There's nothing in there that addresses the quality of care or that addresses what the impact, fiscal impact, is to the state for total medical costs or the societal costs. And what I mean is, we use medicines to treat people's diseases, and if you're a taxpayer in Nebraska, you care that your neighbors and family and friends are being taken care of, and you care that your money is being stewarded in a proper way. You don't really care if it's for drugs or for hospitals or for ambulances or emergency care. But you care about that whole thing. And that's what I'm asking the state to do. They already do a wonderful job. I have to compliment the Nebraska Pharmacists Association. They have one of the best Medicaid DUR programs in my experience that I've worked with, and Mercer compliments that. But there's nothing in the Mercer report that says, how do we lower the overall medical spent that the state is at risk for? An example, over in Iowa is something that we're talking about right now at their legislature, is their contractor for their PBM restricts diabetes medication. It may save them $60,000 to $100,000 a year in medical costs in just one drug class. The analysis by the University of Iowa and using data from the National Institutes of Health says that the state may be on the hook for $3.1 million to $4.3 million in downstream medical costs. That's just one drug class, and what my proposal is to you is, if you extrapolate that out to what it could mean in general, this is a very, very expensive program. I've been on a P&T committee, and I remember sitting there going, there's some things I'm good at, there's some things I'm not--this is as a pharmacist. And when you go to see P&T committees--and they're the ones who decide which drugs are covered and which ones are not--and Senator Lathrop was right, is that cost should be the last component. Often it's not, because if you have a disease that you're talking about or drug class you're talking about, and you don't have anybody on that committee that's an expert in that area--let's say it's diabetes, and there's not one endocrinologist

in the group, you're making decisions for the personal care of an awful lot of people, with nobody in the room being an expert. And that's where it falls short, because what if five of you here have a drug that works just fine, but there may be two of you where it doesn't work just fine. We're placing an undue burden on those two people in the room, in an at-risk population. And that's where PDLs and restrictive formularies often fall short, and you have to ask, it is necessary? I would ask you, if you have any friends who are physicians or pharmacists outside the state of Nebraska, and ask them, what does it take to get the right medication for your patient in your Medicaid programs where there is a PDL? And they'll say, well, we have to go through this hoop and that hoop, and sometimes we throw up our hands and say, the heck with it. We'll give them just what we find easier, because there's not a family practice or general practitioner out there that's not just crazy busy these days and burdened with all kinds of administrative burden, and you're asking them to do one more burden to get the right drug to the patient which will do the overall better job, and that notwithstanding, when Nebraska already has one of the best programs in the country. That's all I have. Any questions? [LB830]

SENATOR GAY: Thank you, Russ. Any questions? I don't see any. Thanks. Any other opponents? [LB830]

WILLIAM MUELLER: Senator Gay, members of the committee, my name is Bill Mueller, M-u-e-l-l-e-r. I appear here today on behalf of the Pharmaceutical Research and Manufacturers of America. The regional director for PhRMA, Linda Carol Suhr (phonetic), had intended to be here, but she had two airplanes that would not operate leaving Minneapolis this morning, so she's there and she's given me her notes, and I will deliver them to you. LB830, as amended, proposed to implement a preferred drug list for Nebraska Medicaid patients, in addition to legislation, seeks to allow the department to enter into a multistate purchasing pool for the purpose of purchasing drugs as well as imposing supplemental rebates on the pharmaceutical industry. There are several issues of concern in this amendment. Let me first address preferred drug lists. PhRMA acknowledges that many states over the past five years have implemented preferred drug lists. However, what many don't realize is that the new federal Medicare drug benefit, Part D, has substantially decreased the states' possible savings from a new PDL in multistate purchasing initiatives, because dual eligible beneficiaries, those individuals eligible for benefits under both Medicaid and Medicare, are now covered by Medicare since January 1, 2006. As a result, the potential savings from a PDL is greatly diminished. PhRMA supports unrestricted access to medications to all patients, particularly those on Medicaid who are the most vulnerable in our society. Preferred drug lists interfere with the physician's professional judgment and responsibility to deliver quality medical care. Only the physician should determine the appropriate treatment or medicine for the individual patient. Different people respond differently to different drugs. An allergy medicine that works for me may not be as effective for you; thus, when PhRMA sees language that implies that if all things are

equal, pick the most cost-effective or least-costly drug, we have concerns. What if the least-costly drug isn't as effective for that particular patient? As LB830 is presently amended, we acknowledge that the legislation does include language that says that the PDL should be based on the best current evidence and clinical effectiveness when making decisions about the PDL. However, what has happened in some states, and you heard that just a moment ago from Mr. Svoboda, in those states it is the lowest-cost drug that has been chosen for inclusion on the PDL. Due process protections must be included to patients when the department is determining what drugs to place on the PDL list. Over the past few years critics of the pharmaceutical industry have been sounding the alarm over increases in pharmaceutical spending in the use of new drugs. However, these critics oftentimes do not take into consideration the economic benefits associated with newer drugs. Research demonstrates that use of newer drugs increases life expectancy, improves the quality of life, and can mean lower healthcare spending overall. They may be more effective or have fewer side effects. Some may treat conditions for which no treatment was available. The next issue I will address is the multistate purchasing pool. Due process protections again are extremely important for the patient if a state is going to implement a PDL, and even more vital if a state is going to enter into a multistate agreement. When purchasing for multiple populations and for multiple states, it's difficult to meet a state's various population's needs as well as program requirements. As a result, the quality of care of Nebraska patients may not be addressed the same way as if Nebraska actually purchased the drugs itself. Finally, pharmaceutical manufacturers currently do pay Nebraska millions of dollars each year in federally mandated Medicaid rebates. In 2004, pharmaceutical manufacturers paid an estimated $46 million in total prescription drug rebates for Nebraska. We'd like to end by bringing the committee's attention, it's been mentioned already, the Partnership for Prescription Assistance program that does have a toll-free number. It has a Web site. The mission of the PPA is to increase awareness of prescription drug assistance programs. In Nebraska over 29,000 patients have been served by this program by receiving free or highly discounted medicines by the industry. For the above reasons, PhRMA opposes LB830. Thank you for allowing us to testify. I'd be happy to answer any questions the committee may have. [LB830]

SENATOR GAY: Thanks, Bill. Any questions? I don't see any at this time. Thank you very much. [LB830]

WILLIAM MUELLER: Thank you very much. [LB830]

SENATOR GAY: Any other opponents? Anybody neutral? Senator Lathrop, would you like to close? [LB830]

SENATOR LATHROP: Thank you, and just a few thoughts to close. First of all, it's rare that we have a bill--I've only been here a little over a year, as many of you have--but it's rare that we have a bill that somebody introduces that saves millions of dollars a year.

We have a terrific opportunity here, and I tried to introduce this bill last year and we...the committee thought the best approach was to wait for the Mercer report. And the Mercer report was the report done that took into account Nebraska's situation. It was not a book report on what...or a survey of what's happened in other states but actually said, this is the savings that will be realized in Nebraska. And whenever we talk about saving several million dollars each year on prescription drug expenses, you can expect that the vendors will come in or their associations and tell you why it's not a good idea. But I think if you look at the report...I would encourage you to read the Mercer report because the PDL will...first of all, it has safeguards in it. The first consideration and the most important thing to me is the quality of care for the patient. I would not offer this bill if it sacrificed the care of the poor in this state. But the bill has the support of the Appleseed group, which is, I think, your assurance that we're not going to sacrifice care for these folks. But we do have an opportunity to save a good deal of money, and it comes, to some extent, on the backs of the pharmacy manufacturers, and this kind of a thing interferes with their marketing efforts. So I would expect them to be opposed to it. I am...I'd like to tell not only the committee but the folks who are sitting behind me, I'm willing to work with those who have an interest in the bill who think it needs some tweaking in order to accommodate legitimate concerns, and I look forward having this committee move it to the floor. [LB830]

SENATOR GAY: Thank you, Senator Lathrop. Any questions from the committee? I have just one. On that Mercer report, Medicare Part D, the Medicare Part D savings that they said, well, you know, we may not get...the way I understood that is we may not get as much savings as we thought now. Was that in the report, or... [LB830]

SENATOR LATHROP: I don't remember seeing that in the report. I read it from cover to cover also. It is 98 pages, and I don't remember every bit of it. [LB830]

SENATOR GAY: I mean, that's something I suppose we need to probably look into, as well, before we throw these numbers around of the savings. [LB830]

_____: Senator Gay, maybe Chaumont knows about that, but... [LB830]

SENATOR GAY: Do you want to answer that? Would you care, Senator Lathrop? [LB830]

SENATOR LATHROP: No, not at all. [LB830]

SENATOR GAY: Vivianne, why don't you come up here, just to get on the record? I guess the question is, how does that affect this bill and the savings? [LB830]

VIVIANNE CHAUMONT: The report takes that into account, Senator. The report is based on data that takes that into account. [LB830]

SENATOR GAY: New data. [LB830]

VIVIANNE CHAUMONT: Yes, um-hum. [LB830]

SENATOR GAY: Okay. Okay, good. That's good news. [LB830]

VIVIANNE CHAUMONT: So those would be post-Medicare Part D savings. [LB830]

SENATOR GAY: Okay, good. Okay, sorry to interrupt (inaudible). [LB830]

SENATOR LATHROP: No, I...unless you have other questions, I... [LB830]

SENATOR GAY: I don't. Is there any other questions? [LB830]

SENATOR LATHROP: Thank you. [LB830]

SENATOR GAY: Thank you very much. I'm going to have to excuse myself for another appointment. Senator Stuthman, you want to take over? [LB830]

SENATOR STUTHMAN: Okay. Thank you, Senator Gay. At this time we will have the opening on LB882 of Senator Johnson, and Roger Keetle will do the opening. [LB882]

ROGER KEETLE: Good afternoon, Senators. For the record, my name is Roger Keetle, K-e-e-t-l-e. I'm the legislative aide for Senator Joel Johnson. Senator sends his best, really appreciates the card, and he really wishes he was here. Senator Johnson introduced LB882 on behalf of the Department of Health and Human Services. It's Senator Johnson's understanding/intent that this is really not a significant change in a program that's existed since 1981. This particular legislation did pass in 1981 as LB95. What it deals with is providing pharmaceuticals to persons who have been discharged after mental health board treatment. What this bill does is it provides the needed medications so that people can go back to the community after their mental health board ordered treatment. Specifically, this bill clarifies that it covers both outpatient and inpatient care. It prescribes responsibilities for determining eligibility for drugs. It allows the Department of Health and Human Services to contract with local pharmacies to provide this medication. And it allows the department to issue regulations relating to the definition of an indigent person, standards for ability to pay, and the types of medication to be dispensed under the program. Finally, LB882 adds a provision to current law that requires the patient to supply sufficient information to enable the department to determine the patient's ability to pay. People who can afford to pay for their prescription drugs should pay. However, since some of the persons served by this program are homeless and may not possess written records, it may be helpful for the department to provide an explanation to the committee on how they intend to implement this new

requirement that's now statutory. Scot Adams, director of the department...or director of the Division of Health and Human Services Behavioral Health, will follow me and will provide more details on this bill. Thank you, and if you have any additional questions, I'd take them now. [LB882]

SENATOR STUTHMAN: Thank you, Mr. Keetle. Does the board have any questions for Roger? Seeing none, thank you. [LB882]

ROGER KEETLE: Thank you. [LB882]

SENATOR STUTHMAN: We will now have the proponents for this bill. I would also like to mention that if you plan to testify on this bill, if you would make the process to come forward and sit in these seats right behind the testifying desk, things will move along very swiftly, so...welcome. [LB882]

SCOT ADAMS: (Exhibit 1) Thank you very much, and good afternoon, Senator Stuthman and members of the Health and Human Services Committee. My name is Scot Adams, S-c-o-t A-d-a-m-s, director, Division of Behavioral Health, Department of Health and Human Services. I'd like to thank Senator Johnson for introducing this bill on behalf of the Department of Health and Human Services, and I'm here today to testify in support of LB882. The proposed legislation would clarify certain sections of 83-380.01 of Nebraska statutes relating to the provision of prescription pharmaceuticals to persons who have been committed for inpatient or outpatient mental health treatment. This section of the statute was created by the passing of law of LB95 in 1981, and provides that the Department of Health and Human Services to provide prescription medicine to persons who are unable to pay for those drugs. Proposal makes it clear that those persons who have been committed for either inpatient or outpatient mental health treatment may be eligible to receive prescription medication necessary for the person's mental health treatment. Although the department has interpreted the statute to apply to persons either committed to inpatient or outpatient services, it's not always understood that way in the community and this would help to clarify that. For example, it could be interpreted that patients need to be committed to the regional center, when in fact all they need to be is committed by the mental health boards. They don't have to pass through the doors of a regional center to obtain these medications. The proposal would clarify the language of the statute. Proposal also adds language outlining the process to be followed by the department when reviewing the request for medication provided by the patient's treating physician. The patient is required to provide the personal financial information necessary to determine whether the patient is, in fact, indigent. Current language does not describe the department's role in describing the request...in reviewing the request and determining whether the request should be approved. This bill provides the department the authority to review. There's also a provision that will allow the department, in the case of an emergency, such as if a patient runs out of medication or when the use of a local pharmacy is a more effective and efficient method

of delivery, to contract with the local pharmacy to deliver prescriptions. Finally, the proposal provides the department may develop rules and regulations to define indigent persons, standards for determining ability to pay, and the types of medications to be dispensed. Thank you. Be happy to answer questions you may have. [LB882]

SENATOR STUTHMAN: Thank you, Mr. Adams. Does the committee have any questions? Senator Howard. [LB882]

SENATOR HOWARD: Thank you. Thank you, Senator Stuthman. I'm just curious. Was this a bill that was introduced at the request of the department? [LB882]

SCOT ADAMS: Yes, it is, Senator. [LB882]

SENATOR HOWARD: Is there another connection, say, to the Beatrice facility that we should be aware of? [LB882]

SCOT ADAMS: You know, we had...this LB95 largely links to the regional centers, the mental health regional centers traditionally, and to mental health commitments fully. I'm not aware of a direct connection to Beatrice at this point. [LB882]

SENATOR HOWARD: But the regional centers are the... [LB882]

SCOT ADAMS: Or the... [LB882]

SENATOR HOWARD: Okay. I understand. [LB882]

SCOT ADAMS: Well, it's really the targeted population of people who have been mental health board committed. Some of those go to the regional centers; some of those don't. All of them are eligible for the medication and this bill helps to clarify that. In the past, I think some people have felt that you had to be in the regional center only to be able to be eligible, and certainly there was a primary constituency, if you will, for use of the LB95 program. But this would...this would clarify that it is for persons who are committed. If medication can help keep a person out of the regional center, that's a plus and a win, and so we wanted to ensure that that was clarified. [LB882]

SENATOR HOWARD: Absolutely. So this would have, say, positive effects for folks that were, say, in a community alliance facility? [LB882]

SCOT ADAMS: Could. [LB882]

SENATOR HOWARD: Okay. [LB882]

SCOT ADAMS: They would have to be board...they'd have to be found indigent, they'd

have to be found committed by a board of mental health, but certainly there would be linkage there to that and other facilities. [LB882]

SENATOR HOWARD: Okay. Thank you. [LB882]

SCOT ADAMS: Yes, ma'am. [LB882]

SENATOR STUTHMAN: Thank you. Is there any other questions from the board? Otherwise, thank you, Mr. Adams. [LB882]

SCOT ADAMS: Thank you very much. [LB882]

SENATOR STUTHMAN: Are there any other testifiers in the proponent? I would also like to mention at this time that we do have a letter from the Nebraska Hospital Association in support of LB882, and that will get into the record. (See Exhibit 2) Are there any opponents to this bill? Anyone in the neutral position? Seeing none, I close the hearing on LB882, and open the hearing on LB885. Mr. Keetle. [LB882]

ROGER KEETLE: Good afternoon, Acting Chairman Stuthman and members of the Health and Human Services Committee. For the record, my name is Roger Keetle, K-e-e-t-l-e. I'm the legislative aide to Senator Joel Johnson, who wishes he were here, again. LB885 expands the current definition of prescription to include an order for a dose sample of a drug for research purposes. The bill is intended to assist in the use of blood testing equipment by emergency room physicians. Advanced technology, for example, has led to the development of more sophisticated testing devices to identify drugs and other substances in a patient's blood. Within ten seconds, these new devices can identify commonly used drugs, such as high blood pressure medicine, diabetes medicine, and antidepressants that are quickly fatal in children. Fast action saves lives. A single dose sample of the drug is necessary, however, to calibrate these new devices. Current Nebraska law does not allow a prescription to be written for a single-dose sample drug for such a purpose. It is my understanding that clarifying language is necessary, and other testifiers from the Nebraska Pharmacy (sic) Association will present proposed amendments for your consideration. Thank you. [LB885]

SENATOR STUTHMAN: Thank you, Mr. Keetle. Does the board, the members of the committee have any questions? Seeing none, thank you. [LB885]

ROGER KEETLE: I get the easy ones. I didn't think there were any. [LB885]

SENATOR HOWARD: Thank you. [LB885]

SENATOR STUTHMAN: Are there any proponents for this bill? Seeing none, are there any opponents for this bill? [LB885]

JONI COVER: I swear this is the last bill I'm going to testify in opposition to today. (Laugh) [LB885]

SENATOR STUTHMAN: Well, it will be in this committee. [LB885]

JONI COVER: Yes, exactly. Good afternoon. My name is Joni Cover, J-o-n-i C-o-v-e-r, and I'm the executive vice president of the Nebraska Pharmacists Association and I'm here today to offer our opposition to LB885 as drafted. We have some very big problems in changing a definition for this single purpose. And I had spoken with Dr. Plantz and with various members of Senator Johnson's staff to talk about one of the things the Pharmacists Association do...would be to do would to recommend other opportunities for obtaining the medication without having to change the definition. Currently in Nebraska statute, physicians can order medicines for office use, so you do not have to change the definition of prescription. They also can be licensed as dispensing practitioners and obtain the medication, and then they can dispense those meds to patients, which is not what the intent of this is but that's another way around this. A third way that...and I'm not very knowledgeable about this but as a suggestion, research opportunities are available if you apply for a research grant or become a researcher through the FDA and the DEA, so that's a third alternative that is available. So it is our position that the statute would not need to be changed for the obtaining of the medications to calibrate the machine, and that what is currently in statute would allow that to occur. And I know that Dr. Plantz has been unsuccessful in several states in trying to get this...trying to get this, I guess idea, passed. We are certainly supportive of the concept. We think this is a very inventive device. We think it has a lot of potential and so we appreciate what he's trying to do. It's just we're not comfortable with changing our statute to define the word "prescription" to allow it to occur since there are already other mechanisms in statute that would allow that to happen. So I would encourage the committee to indefinitely postpone this bill and would be happy to answer any questions. [LB885]

SENATOR STUTHMAN: Okay, thank you, Joni. Does the committee have any questions? Senator Pankonin. [LB885]

SENATOR PANKONIN: Thank you, Senator Stuthman. So, Joni, you think by...indefinitely postpone, but you...so you don't think there's something we could work out and get this figured out? [LB885]

JONI COVER: I guess I don't know that we need to since you can already do it under current statute. [LB885]

SENATOR PANKONIN: You can already do it. That's...so you're just thinking it's like a moot point almost. [LB885]

JONI COVER: Exactly. Physicians in Nebraska can call pharmacies and say, I need this drug, I intend to use it within my practice, within my office, whatever. And that's allowed. They have to pay for it and maybe the pharmacy...maybe he can request one dose. I don't...you know, that's an arrangement he'd have to work out with... [LB885]

SENATOR PANKONIN: Right. Roger will get to close so he'll...yeah, all right. [LB885]

JONI COVER: (Laugh) So that's my understanding with talking to the Medical Association and talking to the Board of Pharmacy. So I think part of it is a cost issue that it's costly to do that, but I just don't think that this is the solution to get him to where he wants to be. [LB885]

SENATOR PANKONIN: Okay. [LB885]

JONI COVER: So our alternative was look and see what's already in statute and see if you can do something with that. I know...I know that this physician has spoken with the Board of Pharmacy and I don't know that they've given him guidance. I don't know. I don't speak for them. But just from our perspective, just changing this definition like this is very problematic. I think there's some unintended consequences that, while we mean for only one person to use it in this way, that there's a whole lot of things that could occur and there's nobody saying, you know, approval of the board or approval of department or anything like that. So we just...we just don't like the bill. (Laugh) [LB885]

SENATOR PANKONIN: Okay. Thank you. [LB885]

SENATOR STUTHMAN: Thank you. Any other questions? Senator Hansen. [LB885]

SENATOR HANSEN: Thank you. Would this help with the jail situation, the jail inmate situation, if we had daily doses? [LB885]

JONI COVER: Hey, you know, I don't know. I asked somebody that if you had drugs that you could...if you were going to destroy, if they could use those, and I don't know that I ever got an answer for sure on whether. But, you know, I think the goal is to get a dosage of every medication known to man, and I would best...my best guess is that you would not find every dose of medication in pharmacies in Nebraska, so I don't even know if you'd still be able to achieve the goal, because a lot of our pharmacies don't carry certain kinds of medication. So I don't really know. [LB885]

SENATOR HANSEN: I've read this gentleman's information and it seems like it's a good research idea. [LB885]

JONI COVER: Uh-huh. Yeah. [LB885]

SENATOR HANSEN: And he needs those drugs to calibrate his machinery, so... [LB885]

JONI COVER: Uh-huh. [LB885]

SENATOR HANSEN: So he needs to get them somewhere. But if you think we can...if he...if you think he can do this in a different form other than allowing an individual dose, maybe... [LB885]

JONI COVER: Uh-huh. Well, and you know, you could, you know, physicians get samples, which... [LB885]

SENATOR HANSEN: Right. [LB885]

JONI COVER: ...there's not sample available for every drug, too. And I don't know that there's still sample available for generic drugs. So...I mean he...I mean, there are some hurdles there that he's going to have to deal with, but I just don't like the changing of the definition of prescription. I just think there's too many unintended consequences for that, so... [LB885]

SENATOR STUTHMAN: Okay. Thank you. [LB885]

JONI COVER: You're welcome. [LB885]

SENATOR STUTHMAN: Any other questions? [LB885]

JONI COVER: Thank you. (Laugh) [LB885]

SENATOR STUTHMAN: Are there any more opponents? Anyone in the neutral that want to speak to this bill? If not, Roger, you want to close? [LB885]

ROGER KEETLE: I want to get you out of here before 4:00. [LB885]

SENATOR HOWARD: Ooh, that would be good. [LB885]

ROGER KEETLE: Good afternoon, members. I do want to take the opportunity to close on this one. [LB885]

SENATOR STUTHMAN: And I...and, Mr. Keetle, I apologize for not allowing you to close on the last bill. [LB885]

ROGER KEETLE: Oh, no, the last one was fine. Current law allows single doses of

narcotics, but it doesn't allow it for prescription drugs. So there already...is my understanding there's a current law that allows single dose for narcotics. What I've got in my file from Dr. Plantz is they went through these alternative methods and his response back is none of them work. And I hate to see this bill go down. I hate to see this new technology not being available for the emergency room physicians because you are left with the impression that those other alternatives work. Let me read...this is really poorly prepared, but basically the alternative methods are to obtain noncontrolled prescription drugs and his response back, it would take ten years to get the pill samples in all the various forms that would be necessary for that option to be...to be used. So he doesn't like that option. The other one is an opinion from a manufacturer/wholesale distributor and, again, wholesale supplies have minimum lots. His response is they have minimum lots. I have to buy approximately 20,000 drugs of 100-some pills to get the samples I need. So when you look at the letter that's in the file, which Joni may not have, he's already looked at those options and he's not...he doesn't think they're possible. So I would hope there's some way we could work this out yet. Maybe it isn't the definition. Perhaps narrowing this down to allow for the calibration of emergency room...you know, there ought to be some way to make this work because I don't want to see our kids and our emergency room physicians have to send something to the lab and find out, you know, four hours later they could have saved somebody. So with that, I would close. [LB885]

SENATOR STUTHMAN: Okay, thank you. Any questions? Senator Howard. [LB885]

SENATOR HOWARD: Thank you. Thank you, Senator Stuthman. I just...I'm just curious as to why he doesn't work in partnership with, like, the Med Center or one of the agencies that could certainly provide a lot of the information that he seems to need. [LB885]

ROGER KEETLE: Well, you know, that's a good question, and I guess, you know, what he's obviously very passionate about is trying to get this new technology available to the ER room physicians. It's not research. It's down in the ER room providing patient care. He's obviously not a researcher and not familiar with those, so... [LB885]

SENATOR HOWARD: Well, I think the Med Center certainly cares about those same issues of... [LB885]

ROGER KEETLE: Yeah, you'd think. [LB885]

SENATOR HOWARD: ...diagnosing for children in speedy fashion. But that seems like that would be a clear resource. [LB885]

ROGER KEETLE: Right. Well, that's... [LB885]

SENATOR STUTHMAN: Senator Pankonin. [LB885]

SENATOR PANKONIN: Thank you, Senator Stuthman. I guess that goes back to my earlier comment, Roger, and Joni is over here looking stricken and whatever (laughter) and you know these are one...this is one of these things about getting a law passed when it seems like there should be some, you know, some mechanism to get this done. I hope that there is, before we talk about it again in Exec, there's some continuing dialogue and try to include her and Senator Howard had a suggestion. I would just think that maybe we could get this worked out without having a statute. But, you know, if we do, we do. We'll take it up. [LB885]

ROGER KEETLE: Okay. [LB885]

SENATOR PANKONIN: But hopefully, I'm just suggesting that you get with them and see what we can do. [LB885]

ROGER KEETLE: Okay. Thank you very much. [LB885]

SENATOR PANKONIN: Some good suggestions. [LB885]

SENATOR STUTHMAN: Any other questions? Otherwise, thank you, Mr. Keetle. At this time I would like to have read into the testimony the Nebraska Board of Pharmacy. They are in opposition of LB885. (Exhibit 1) So with that, I close the hearing on LB885 and that closes the hearing for the day. Thank you. [LB885]

Disposition of Bills:

LB759 - Advanced to General File.
LB830 - Advanced to General File.
LB866 - Held in committee.
LB882 - Held in committee.
LB885 - Indefinitely postponed.

Chairperson

Committee Clerk