

TRANSCRIPT

marketplace  of ideas



featuring Maine State Representative

## **SHARON TREAT**

On making prescription drugs  
more affordable.

DECEMBER 11, 2006  
THE HARVARD CLUB  
NEW YORK CITY

**DRUM  
MAJOR**  
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POLICY

**TABLE OF CONTENTS**

About the Speakers	2
Transcript	5
Who Is Drum Major Institute for Public Policy	34
Also From the Drum Major Institute for Public Policy	35

# THE DRUM MAJOR INSTITUTE FOR PUBLIC POLICY MARKETPLACE OF IDEAS SERIES

## **SPEAKERS:**

### **HON. SHARON TREAT**

Maine State House of Representatives

### **HON. RICHARD GOTTFRIED**

New York State Assembly

### **DR. JON COHEN**

Former Chief Medical Officer for the  
North Shore Long Island Jewish Health System

### **CHARLES BELL**

Program Director of Consumers Union

Introduction by **HON. H. CARL MCCALL**

Principal of Convent Capital, LLC.

New York State Comptroller from 1993 to 2002

Moderated by **ANDREA BATISTA SCHLESINGER**

Executive Director of

the Drum Major Institute for Public Policy

## **ABOUT DMI'S "MARKETPLACE OF IDEAS" SERIES:**

Never content just to argue theory, the Drum Major Institute provides a platform for policymakers who have successfully worked for social and economic fairness in our public institutions. For far too long the conservative right has defined the limits of what is "possible" in society and politics. The "Marketplace of Ideas" shows that we can transcend these artificial boundaries: it is possible to be progressive, practical, and effective. Previous speakers in the series have included Congresswoman Hilda Solis, who authored the nation's first environmental justice law; New York State Governor Eliot Spitzer, who fought as Attorney General to achieve new standards of corporate accountability; Oklahoma State Senator Penny Williams who ushered in universal preschool in her state; and Maine State Rep. Sharon Treat, who passed legislation increasing access to affordable prescription drugs.

# PANELISTS AND SPEAKERS

**SHARON TREAT** has served 14 years in both the House and Senate of the Maine Legislature, including two years as Senate Majority Leader. In the Legislature, Rep. Treat has chaired the Health and Human Services, Judiciary, and Natural Resources committees, and has sponsored significant environmental and health care legislation including reducing mercury and other toxics in the environment, increasing recycling, supporting downtown revitalization and smart growth, Maine Rx Plus discount drug program, drug marketing disclosure, PBM regulation, and Maine's uninsured health access law creating Dirigo Health. Rep. Treat is also the Executive Director of the National Legislative Association on Prescription Drug Prices, a nonpartisan organization of state legislators working jointly across state lines to reduce prescription drug prices and expand access. Treat has an A.B. degree from Princeton University's Woodrow Wilson School of Public and International Affairs and graduated with honors from Georgetown University Law Center. As an attorney, she has practiced law with the Natural Resources Council of Maine, as well as in state government and private practices. She has taught environmental law at several colleges in Maine and at the University of Maine Law School. Additionally, she was the coordinator of the Environmental Studies Program at Colby College from 2000 to 2004. Senator Treat was born in Brattleboro, Vermont in 1956. She lives in Farmingdale, Maine with her partner Bob Collins.

**RICHARD GOTTFRIED** represents New York's 75th Assembly District in Manhattan and serves as chair of the Assembly Health Committee. Assemblyman Gottfried was a major architect of New York's landmark managed care reforms, and is continuing to fight for stronger protections for consumers and health care providers, and public support for universal access to quality, affordable health care. Highlights of his legislative work include: the Prenatal Care Assistance Program for low income women; the Child Health Plus Program, which allows low- and moderate-income parents to get free or low-cost health insurance for their children; the Physician Profiling Law, which gives patients access to information about a doctor's record; Family Health Plus, which provides free health coverage for low-income adults; the Health Care Proxy Law, which allows people to designate an agent to make health care decisions for them if they lose capacity; and the HIV Testing and Confidentiality Law. He also sponsors the N.Y. Health bill to create a universal publicly funded health coverage plan for New York State. Assemblyman Gottfried previously served as Deputy Majority Leader, Assistant Majority Leader, chair of the Assembly committees on Codes (covering the criminal justice system) and Children and Families, and chair of the Assembly task forces on the Homeless, Campaign Finance Reform, and Crime Victims. Mr. Gottfried was first elected to the Assembly in 1970, at the age of 23, while a student at Columbia Law School.

**JON COHEN** is the former Chief Medical Officer of the North Shore-Long Island Jewish Health System and Professor of Surgery, Albert Einstein College of Medicine. As Chief Medical Officer, Dr. Cohen was the Health System's senior physician, responsible for all clinical programs and medical staff affairs for the nation's third largest not-for-profit healthcare system. With a revenue base of \$4 billion, the North Shore-LIJ Health System includes 15 hospitals, two skilled nursing centers, 7,000 physicians, and more than 35,000 employees. A vascular surgeon with a national reputation in the treatment of abdominal aortic aneurysms, Dr. Cohen's academic accomplishments include publication of over 100 peer review articles, two books and multiple book chapters. Dr. Cohen is past president of both the New York Surgical Society and the New York Society for Cardiovascular Surgery, a member of the nation's most prestigious medical societies and a Board member of New York American Red Cross. Dr. Cohen is on the faculty of Columbia University's Mailman School of Public Health where he teaches a capstone on health policy. Dr. Cohen served as the Senior Healthcare advisor to H. Carl McCall during the McCall for Governor race in New York, 2002 and to the John Kerry 2004 Presidential campaign. Dr. Cohen was a candidate for Lieutenant Governor of New York State in 2006.

**CHARLES BELL** is the Programs Director for Consumers Union, the nation's leading consumer advocacy organization, and the non-profit publisher of Consumer Reports magazine. In that capacity, he provides fiscal and administrative oversight of Consumer Reports WebWatch, and assists with research, media work, policy development and coordination. Mr. Bell oversees the Center for Consumer Health Choices, which provides comparative information on health insurance and health care. He also manages the Colston E. Warne Program, which provides financial and technical support for consumer organizations. Since joining Consumers Union in 1989, Bell has written articles on health care and consumer affairs topics which have been published in the *Charlotte Observer*, the *Journal News*, the *San Francisco Examiner*, the *San Francisco Chronicle*, the *Seattle Times*, and the *Bulletin* of the New York Academy of Medicine. Bell holds a bachelor of arts degree in political science from Antioch University, Seattle, Wash. He studied at the Atkinson Graduate School of Management at Willamette University, Salem, Ore., and is currently pursuing a master's degree in international business at the Columbia University School of International and Public Affairs.

**H. CARL MCCALL** served as Comptroller of the State of New York from 1993 until November 2002, when he became the Democratic nominee for Governor of the State of New York. Prior to his position as Comptroller, Mr. McCall was a Vice President of Citicorp for eight years. He has also served as President of the New York City Board of Education, a U.S. ambassador to the United Nations, Commissioner of the Port Authority of New York and New Jersey, Commissioner of the New York State Division of Human Rights and was elected to three terms as New York State Senator. Mr. McCall received a Bachelor's degree from Dartmouth College and a Master's of divinity degree from Andover-Newton Theological School. Mr. McCall serves as a director of New Plan, a real estate investment corporation and

Standard Commercial Corporation, one of the world's largest leaf tobacco dealers. Mr. McCall has served as a principal of Convent Capital, LLC, a financial advisory firm, since April 2004.

**ANDREA BATISTA SCHLESINGER** Since 2002, Andrea Batista Schlesinger has led the effort to turn the Drum Major Institute, originally founded by an advisor to Rev. Dr. Martin Luther King, Jr. during the civil rights movement, into a progressive policy institute with national impact. Under Andrea's leadership as Executive Director, DMI has released several important policy papers to national audiences including: 'Congress at the Midterm: Their Middle-Class Record' and 'Principles for an Immigration Policy to Strengthen and Expand the American Middle Class.' Andrea studied public policy at the University of Chicago. Andrea has worked in various capacities to promote educational equity and youth empowerment. She directed a national campaign to engage college students in the discussion on the future of Social Security for the Pew Charitable Trusts, and served as Director of Public Relations of Teach For America before working as the education advisor to Bronx Borough President Fernando Ferrer. Andrea has been profiled in the *New York Times*, *New Yorker* magazine, *Latina Magazine* and in 'Hear us Now,' an award-winning documentary about her tenure as the student member of the New York City Board of Education. She has appeared on the 'Lou Dobbs Tonight' show on CNN and has been published in *New York Newsday*, *Crain's New York Business*, *The Mississippi Sun Herald*, *New York Daily News*, *Alternet.com*, *Tom Paine.com*, *New York Sun*, *Colorlines Magazine*, *The Chief-Leader* and *City Limits* magazine. She is a contributor to The Huffington Post, on the Editorial Board of The Nation and was named a '40 under 40 Rising Star' by *Crain's New York Business*.

# TRANSCRIPT

*The transcript from this event has been edited for length and readability.*

*Internet links are provided in footnotes throughout this transcript as resources for readers seeking to better understand the policy discussion. While we hope they are helpful, the Drum Major Institute for Public Policy is not responsible for the content or continued functioning of these links.*

**H. CARL MCCALL:** It is my pleasure to welcome you here this morning for another informative, exciting session under the auspices of the Drum Major Institute. I want to thank all of you for coming. I also want to thank Andrea Batista Schlesinger and the leaders of the Drum Major Institute for giving us this opportunity to have this conversation. The Drum Major Institute says it is never content to just argue theory. The Marketplace of Ideas series is meant to provide a platform for policymakers who have successfully worked for social and economic fairness in our public institutions. For far too long, the conservative right has defined the limits of what is possible in society and politics. Events like this one are meant to show that we can transcend these artificial boundaries and that it is possible to be progressive, practical and effective. I think you all believe that, and that is why you are here this morning.

The focus of our discussion today is going to be on this very troubling question: how can we bring down the cost of prescription drugs? If any of you have had a prescription filled lately, you know what the problem is. Here in New York, we're paying a lot of money for prescription drugs, and then we hear about other places where prices are actually coming down, where politicians are providing the leadership to begin to constrain prices. Today we are going to talk about how we do this in New York. To lead us in this discussion, we look forward to hearing from Rep. Sharon Treat. She is going to talk about what she did in her state of Maine in terms of supporting and introducing bills that have helped to contain the prices of prescriptions. A lot of the bright and sophisticated people in New York wonder how Maine is doing all these good things and why we are so far behind.

**How can we bring down the cost of prescription drugs? If any of you have had a prescription filled lately, you know what the problem is. Here in New York, we're paying a lot of money for prescription drugs, and then we hear about other places where prices are actually coming down.**

—H. Carl McCall  
New York State Comptroller 1993–2002

The state of Maine has had an extensive history of involvement with prescription drug laws and policies.<sup>1</sup> In 1975, Maine was one of the first two states to create a senior pharmaceutical assistance program. They have continued this program, and it has been quite effective. Like all good programs, there's somebody behind it. Rep. Sharon Anglin Treat, who was first elected to the Maine Senate in 1996, has been the driving force behind this program in Maine. She has been a member of

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1 For an overview and history of Maine's prescription drug programs, see [http://www.familiesusa.org/assets/pdfs/14\\_Maine-Case-study\\_1.pdf](http://www.familiesusa.org/assets/pdfs/14_Maine-Case-study_1.pdf)

the Senate, where she served as the Senate Majority Leader, and is now a member of the House in the State of Maine. After we hear from Sharon Treat, we have two very distinguished panelists: New York State Assemblymember Richard Gottfried<sup>2</sup> and Dr. Jon R. Cohen, who was the Senior Vice President of North Shore-Long Island Jewish Health System.<sup>3</sup> Andrea Batista Schlesinger, the executive director of DMI, will lead a discussion.

Let me tell you a little bit about the panelists. There are a lot of things you can say about Richard Gottfried, but the thing that I am going to say about him is that he's my assemblyman. I am very proud that he represents me. I couldn't believe this when I looked at it, but Richard has been in the legislature for 36 years. That is because he was 23 when he was first elected. He was then a student at Columbia Law School and he's gone on to become the chair of the Health Committee. All of the good things that have happened in the area of health in New York State really have been because of Richard's leadership. I can say that without any reservation. He has just provided tremendous leadership in this very complicated area.

**PhRMA and its allies have really bought off a lot of legislators around the country with tremendous campaign finance contributions, with contributions to various advocacy groups, so that they are often speaking the pharmaceutical companies' line.**

—Maine State Representative Sharon Treat

Also on the panel will be Dr. Jon Cohen. Dr. Cohen has done amazing things. He was my health advisor when I ran for office. I have personal connections with these people. Dr. Cohen is the former Chief Medical Officer of the North Shore Long Island Jewish Health System, which is the

nation's third largest not-for-profit health system. He did a wonderful job in terms of bringing together some sixteen hospitals and other medical facilities as the CEO. Then Jon did something that you would think a very bright, very accomplished surgeon and physician would never do. He ran for office. Can you believe that? He did it because he believes and understands that if you are really going to advance public policy you have got to do it through the political system. I applaud you for what you have done, Jon, and we look forward to hearing from you.

Let us begin with Representative Sharon Treat, from the state of Maine, who will tell us how Maine has moved so far ahead of New York State. Thank you very much.

**REP. SHARON TREAT:** Thank you. It is a pleasure to be here. I do have kind of an identity crisis, because I've been a senator. We have term limits in Maine, so then I was no longer a senator. Then I decided to run for the House, where I had been before, and I am kind of enjoying it. We just got sworn in and we have about a third of the legislature that is brand new, partly because of this huge Democratic wave that actually caught me a little bit by surprise. We had a somewhat beleaguered

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<sup>2</sup> <http://assembly.state.ny.us/mem/?ad=075&sh=bio>

<sup>3</sup> <http://www.northshorelij.com/>

governor, a Democrat, who barely won.<sup>4</sup> But in the house we got about 30 new Democrats that no one really expected. I am one of them, and I am having a lot of fun back in the House.

Meanwhile, over the last two years, I've been running an organization that was founded by legislators, an organization that Assemblyman Gottfried is a very active member of, called the National Legislative Association on Prescription Drug Prices.<sup>5</sup> It is an organization of legislators working together around the country to try to take their ideas from the state level out across the country to share strategies, to come up with model bills, to come up with ways of dealing with the opposition.

PhRMA<sup>6</sup> and its allies have really bought off a lot of legislators around the country with tremendous campaign finance contributions, with contributions to various advocacy groups, so that they are often speaking the pharmaceutical companies' line. Our organization has really taken to the road to try to combat that, and actually had some very significant successes, not only in the area of price negotiation and price controls, but also around issues of advertising and marketing—combating misleading advertising, publicizing clinical trials data, finding out what is safe and effective.

I was sent the promotional materials for this event, which read: What can Speaker Pelosi learn from Sharon Treat? I thought that was too good an opportunity to miss. I do have a few words of advice for Speaker Pelosi, and they aren't really from me so

much as from state legislators. First of all, I would say this: you have the majority so, for God's sake, use it. And use it quickly, and use it decisively.

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—Maine State Representative Sharon Treat

I have been working on the issue of drug importation<sup>7</sup> with members of my own legislative delegation who are split party—Republicans and Democrats—and this is an issue that has had bipartisan support in Congress. For at least the last

two years they have had enough votes to pass it. But somehow, it just can't get to the floor. These are things that the leadership can take hold of and change. The majority should to go ahead and start working on that issue as well as on fixing Medicare Part D.<sup>8</sup>

4 Maine Governor John Baldacci <http://www.maine.gov/governor/baldacci/about/index.shtml>

5 <http://www.nlarx.com/>

6 The Pharmaceutical Research and Manufacturers of America, a trade group for the pharmaceutical industry <http://www.phrma.org/>

7 [http://www.aarp.org/bulletin/prescription/a2004-10-08-fda\\_importation.html](http://www.aarp.org/bulletin/prescription/a2004-10-08-fda_importation.html)

8 [http://www.medicareadvocacy.org/FAQ\\_PartD\\_Info.htm#whatIsD](http://www.medicareadvocacy.org/FAQ_PartD_Info.htm#whatIsD)

**The Medicare Part D prescription drug benefit is a private program right now. It is run through private companies. The people who are doing the negotiation of drug prices—and I do not think they are negotiating very much—are private insurance companies. Unless you completely restructure the program in some way to have the government involved in the negotiation, not just allowed to negotiate, you haven't changed anything. We can't let people get away with rhetoric.**

—Maine State Representative Sharon Treat

I would like to talk a little bit about the price negotiation issue.<sup>9</sup> There are a number of bills out there in Congress. Some of them would just say the government can negotiate prices for Medicare Part D. That does absolutely nothing, and if that is the way they go, we will not have changed anything except tried to put a snow job over on people. The Medicare Part D prescription drug benefit is a private program right now. It is run through private companies. The people who are doing the negotiation

of drug prices—and I do not think they are negotiating very much—are private insurance companies. Unless you completely restructure the program in some way to have the government involved in the negotiation, not just allowed to negotiate, you haven't changed anything. We can't let people get away with rhetoric. This has to be substantive change, and the time to do it is now. On price negotiation, I think that Maine does have something to say to the rest of the country and to Congress.

Our Maine RX program<sup>10</sup> piggybacks on our state Medicaid<sup>11</sup> negotiation model. Maine has kept the increase of Medicaid prescription drug prices to below 3% for the last five years. I was recently at a meeting where a state representative from New Hampshire, Cindy Rosenwald,<sup>12</sup> who is another real leader on prescription drug issues. Cindy was talking about the prices in New Hampshire and what has been spent there. Many of the increases have been in the double digits. Sometimes when you hear “double digit” you don't really think, what is “double digit?” That is 10%, possibly. I was totally shocked to hear Cindy's figures about New Hampshire. Medicaid drug costs were up 68% in five years. Sixty-eight, that is a double digit. The per-person cost was actually up 85%.

**Maine has kept the increase of Medicaid prescription drug prices to below 3% for the last five years. In New Hampshire and many other states, increases have been in the double digits. Sometimes when you hear “double digit” you don't really think, what is “double digit?” That is 10%, possibly. I was totally shocked to hear figures about New Hampshire. Medicaid drug costs were up 68% in five years. Sixty-eight, that is a double digit. The per-person cost was actually up 85%.**

—Maine State Representative Sharon Treat

New Hampshire is not doing a lot of the things Maine is doing. I know that Assemblyman Gottfried has been working very hard to get New York on a path

9 For more about the potential for the federal government to negotiate Medicare Part D prescription drug prices, see [http://www.ncpssm.org/news/archive/vp\\_pricenegotiation/](http://www.ncpssm.org/news/archive/vp_pricenegotiation/)

10 <http://www.maine.gov/legis/lawlib/mainerx.htm>

11 <http://www.cms.hhs.gov/MedicaidGenInfo/>

12 <http://cindyrosenwaldfornh.org/aboutus.aspx>

We accomplished Maine RX not because somebody had this big idea up at the top of the legislature. Maine RX came from the bottom up. We heard about it going door to door. In Maine, elections are cheap. Someone who cannot raise very much money could manage with three or four thousand dollars to get themselves elected to the House of Representatives. How did they do that? They literally walked or had someone drive them down the long back roads, door to door. And what did they hear when they went door to door? They heard, 'My prescription drug costs are out of control. We have to do something about it.'

—Maine State Representative Sharon Treat

toward significant price negotiation around a Preferred Drug List.<sup>13</sup> He deserves a lot of credit for that, because it is a very, very difficult thing to get passed throughout this country. The 68% increase in New Hampshire indicates the kind of figures that we're dealing with nationally. Certainly, the national figures around Part D have been very similar. Every year the prices go up, and what we're saving in Maine is the kind of money we could be saving nationally.

My second point for Speaker Pelosi is the following: the people will back you

up. We accomplished Maine RX not because somebody had this big idea up at the top of the legislature. It did not come from the Governor. Maine RX came from the bottom up. It was a petition drive.<sup>14</sup> We heard about it going door to door. People ask, "what's in the water in Maine?" We do have clean water—mostly. There is a lot of mercury deposition. But we do have something else clean in Maine: elections, which are publicly financed. Before they were publicly financed, elections were cheap, which is to say that someone who cannot raise very much money could manage with three or four thousand dollars to get themselves elected to the House of Representatives. How did they do that? They literally walked or had someone drive them down the long back roads, door to door. And what did they hear when they went door to door? They heard, 'My prescription drug costs are out of control. We have to do something about it. You go in there and do something. Go after those drug companies. We don't like 'em.' That is what we heard in Maine. We didn't have polls to tell us that but because of how we do elections, we heard it anyway.

**In response to the poll question on whether there should be price negotiation in Medicare Part D, 85% of the people that were surveyed said yes. Among Democrats, it was 92%. Even among Republicans, 74% favor price negotiation. It is just kind of hard to imagine a consensus that great. If Pelosi and Congress can't take action on this, or New York State can't take action on this, then I don't know what they're waiting for.**

—Maine State Representative Sharon Treat

I believe yesterday or the day before, the Kaiser Family Foundation, along with the Harvard School of Public Health, released a survey on people's attitudes after the elections.<sup>15</sup> What should Congress do? The figures on prescription drug costs are amazing. If Pelosi and Congress can't take action on this, or New York State can't

13 For a summary of how states negotiate drug prices for Medicaid through the creation of Preferred Drug Lists (PDLs), see <http://www.nlrx.com/policy/pdfs/pijipFactSheet2007.pdf>

14 For more on the bottom-up organizing that led to Maine Rx, see [http://www.prospect.org/cs/articles?article=remember\\_the\\_maine](http://www.prospect.org/cs/articles?article=remember_the_maine)

15 <http://www.kff.org/kaiserpolls/pomr120806nr.cfm>

take action on this, then I don't know what they're waiting for. In response to the question on whether there should be price negotiation in Medicare Part D—and I am sure the people are smart enough to know it means real price negotiation, not like some line in a bill—85 % of the people that were surveyed said yes. Among Democrats, it was 92 %. It is just kind of hard to imagine a consensus that great. Eighty-five percent of independents surveyed were in favor of price negotiation, and everyone knows independents really swung the election this time around. Even among Republicans, 74 % favor price negotiation. This is a bipartisan—tri-partisan—general consensus that something needs to be done on the issue of importation, which I would really call parallel trade.

**Maine Rx was really designed to fill around the edges of a failed federal policy. Any of you who have been working on this know states are constrained and sometimes we come up with models that are based on those constraints. If you were coming up with an ideal model it might not be the same thing, but it is better to do something than nothing.**

—Maine State Representative Sharon Treat

Price negotiation has been going on in the European Union for decades. It is a safe way of simply being part of the marketplace and it is a free trade concept. The only free trade we do not have in the country, by the way, is in prescription drugs. One thing that my group is working on is the fact that PhRMA is out there trying to carve out non-free trade provisions in free trade agreements that exclude prescription drug importation, and actually reach into the state and federal level and tell you that you can't do things like create a Preferred Drug List.<sup>16</sup> That is another story, but you should be paying attention to it.

On the issue of importation, 79 % of all people support it.<sup>17</sup> I know I think this way, but you sometimes wonder, am I representative of the rest of the country, being away up there in Maine? The question was: are drug prices reasonable? The choices were: 'reasonable' or 'unreasonable' or 'don't know.' Anyone want to hazard a guess what percentage nationally say brand name drug prices are unreasonable? Eighty-three percent. Thirteen percent said they were reasonable and 3 % don't know. Those numbers comprise the totally healthy component out there who never have to go into a drug store. On generic drugs, 20 % said that pricing was unreasonable. My guess is that these people are probably buying the cancer drugs that are still expensive. Seventy-six percent said generic prices are reasonable and 4 % didn't know. On the question of should Congress do something, 77 % said yes, 21 % no. So there you have it. Certainly, the will is out there. If you do it, Speaker Pelosi, the people will be there with you. And if you don't, I think it may be at your own peril. We have a serious problem and the public is ready to support public action on it.

16 For an overview of the pharmaceutical industry's use of international trade agreements to limit state efforts to reduce prescription drug costs, see [http://forumdemocracy.net/documents/PD\\_Trade\\_Health\\_Overview.pdf](http://forumdemocracy.net/documents/PD_Trade_Health_Overview.pdf)

17 See the Kaiser Family Foundation poll cited above

On to Maine RX. I want to give just a little bit of a disclaimer. Please remember that Maine RX was passed in the year 2000. It is now almost 2007 and a lot has happened in those seven years. I am not going to represent this as the last, best, greatest thing that could ever be done on the issue of prescription drugs. For one thing, the law was really designed to fill around the edges of a failed federal policy and that is why we need to focus on what is going on in Congress. I forgot my last little lesson to Speaker Pelosi, which is the following: states are sick of being the laboratories of democracy. I am someone who uses this phrase almost once a day: states are the laboratories of democracy. We are doing great stuff, but we've been the laboratories for far too long. On some of these issues—and certainly health care and prescription drugs are prime ones—it is time to go from the laboratory out into

the marketplace and start to do these ideas nationally. We have experiments all over the country. Maine RX is certainly one of them. It is about time we had a national policy that implemented them.

**Maine Rx has resulted in substantially cheaper prices across the board for those who are participating in our program. It is a discount off whatever that retail price is. But it can be a very good discount of about 50% overall on generic prices, and about 25% off of the brand name price. These discounts range as well, so there are drugs that actually are substantially cheaper than that and indeed, have even beat the Canadian price or the federal supply schedule price, which is what the VA uses as its price schedule.**

—Maine State Representative Sharon Treat

That being said, I do not want to discourage states from moving forward because, quite honestly, I am kind of cynical about the national level. I do not think we should sit back and say, 'Well, now they are all in there and they're going to fix things.' I don't have that confidence. PhRMA is running around trying to lobby us from the Democratic

side, dumping money in, and dumping it in at the grassroots. A lot of these state policies are trying to do what states can within the confines of the law, within the confines of a system of health care in which they do not have control over all of the federal dollars that go into that health care system. Any of you who have been working on this know states are constrained and sometimes we come up with models that are based on those constraints. If you were coming up with an ideal model it might not be the same thing, but it is better to do something than nothing.

That is what Maine RX certainly is. This bill came from a petition drive to set prices and I think that is very important to remember. Maine RX is a discount program that leverages the ability of the state to establish requirements to get drugs under Medicaid. There is a Preferred Drug List in Medicaid, as you now have in New York.<sup>18</sup> In Maine, if the state deems that a certain drug is not cost effective or the best drug in the class, you need to go to your doctor and get prior authorization, or permission, before you get that prescription. I want to be clear on this: if you really need it, you can get it. What Maine RX does is it says we are going to use

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<sup>18</sup> [https://newyork.fhsc.com/enrollees/PDP\\_about.asp](https://newyork.fhsc.com/enrollees/PDP_about.asp)

the authority of the state to set prior authorization standards if a company does not agree to negotiate with us on providing prescription drugs at a lower price for people who are not on Medicaid. Then we will hold in reserve this leverage provision, and we can use it selectively as we choose. If there is a company out there that will not deal with us, then the leverage provision is there. What does that mean? It means that if a drug company has a market share its wants to sell to lots of people, the price could dramatically drop. It is very much using the marketplace to drive the willingness of the drug companies to negotiate.

This system has resulted in substantially cheaper prices across the board for those who are participating in our program. If you are not eligible for Medicaid, which is a far better benefit, Maine RX still allows you to pay significantly less because it is a discount off whatever that retail price is. Maine RX, though, can be a very good discount of about 50% overall on generic prices, and about 25% off of the brand name price. These discounts range as well, so there are drugs that actually are substantially cheaper than that 25% off and indeed, have even beat the Canadian price or the federal supply schedule price, which is what the VA<sup>19</sup> uses as its price schedule, and is considered by most people in the country to be the lowest negotiated federal price out there. Maine RX has been successful in that regard.

**The bill was just about to go into effect, and PhRMA, of course, sued. Any good law that you pass, they will sue. The legislature knew this. And, again, giving our legislature credit, they put money in, in advance – extra money – to defend this law in court. And we won in court. And we went all the way up to the US Supreme Court which, in June 2005, ruled in favor of the State and said that it was something the State had authority to do.**

—Maine State Representative Sharon Treat

Maine RX started as a bill that intended to set prices in Maine at no higher than the Canadian price. It actually passed in that form. I have to say that at the time I was in the Senate. The sponsor of the bill was the majority leader who preceded me by two terms. Chellie Pingree,<sup>20</sup> who is now head of Common Cause,<sup>21</sup> championed

the bill initially when the bill was tied to Canadian prices. We had, at the time, Democrats controlling both the House and Senate, but not by very much. It was a bipartisan bill and it passed. The Governor said,<sup>22</sup> ‘I cannot sign this bill. This is radical, and I am not sure it is legal. But, gee, I want to sign something.’ I think if polling had been done, the numbers would be similar to what you are seeing now from the Kaiser survey. Nevertheless, the Governor sent it back to the legislature with his message. Actually, before the formal message, he said, ‘Okay, we have ten days to just work it out and come up with something.’ What they came up with was the current discount plan and the leverage provision in it. That version passed in the Senate; every single Senator voted for it. That should give you an idea of the mettle of consensus and support behind this bill. Obviously, the Senators were

19 The U.S. Department of Veteran Affairs, [http://www.va.gov/about\\_va/](http://www.va.gov/about_va/)

20 [http://www.motherjones.com/radio/2006/03/pingree\\_bio.html](http://www.motherjones.com/radio/2006/03/pingree_bio.html)

21 Chellie Pingree left Common Cause in February 2007 to run for U.S. Congress. For more on Common Cause, see <http://www.commoncause.org>

22 Maine's Governor at the time was Angus King [http://en.wikipedia.org/wiki/Angus\\_King](http://en.wikipedia.org/wiki/Angus_King)

representing their constituents in that vote. The Senators did not want to be seen voting against this bill at all. Whether they totally supported it or not, it was clear politically this was a bad thing to vote against.

Then the bill was just about to go into effect, and PhRMA, of course, sued. Any good law that you pass, they will sue. The legislature knew this. And, again, giving our legislature credit, they put money in, in advance—extra money—to defend this law in court. And we won in court. And we went all the way up to the US Supreme Court which ruled in favor of the State and said that it was something the State had authority to do under the Constitution as the laboratory of democracy.<sup>23</sup> The Court of Appeals decision was very clear, and it had some wonderful language about the role of the states in trying out things and making things better for their people. And

**I think Medicare Part D also drained a lot of energy at a state level away from doing innovative things like Maine RX. Everyone was just in crisis mode, trying to figure out how to keep people who are on Medicaid from losing all their medications under Part D, and people shifted away from doing a lot of the things at a state level that are still needed, unfortunately.**

—Maine State Representative Sharon Treat

even, especially, when Congress has failed to take action. So that is how Maine RX did go into effect. It was quite popular. You have to put these numbers in Maine perspectives. It had nearly 100,000 people in it. Now, that sounds like completely peanuts, I realize, in the State of New York. But what you need to know is about 325,000 people in the state did not have any prescription drug coverage. So about a third of the people signed up for it. And since Medicare Part D, that has dropped about half, because a lot of people have moved over to Part D. Now, they now have found out that that was a mistake, because they're paying more than they would have if they had stayed in the discount program.

And one of the things I want to mention about Maine Rx is that it was really designed in part as wraparound coverage, so that if you were in the state's Drugs for the Elderly Program,<sup>24</sup> or any kind of program, but that program didn't cover drug X that was super expensive, you could use Maine RX to supplement your prescription drug coverage. And it does cover people up to 350% of the federal poverty level<sup>25</sup> which is, unfortunately, a very large percentage of the people in the State of Maine. Very large. So most people are covered by it. But unfortunately, under Medicare Part D—and this is another major problem with Part D—the money you spend under Maine Rx or importing drugs from Canada does not count towards filling the Medicare Part D donut hole.<sup>26</sup> This is another one of those federal problems. So in a way, that has really lessened the utility of the program. And I think Medicare Part D also drained a lot of energy at a state level away from doing innovative things like Maine RX. Everyone was just in crisis mode, trying to figure out how to keep

23 *PhRMA v. Walsh*, 538 US 644, 123 S.Ct. 1855 (2003) <http://www.supremecourt.us/opinions/02pdf/01-188.pdf>

24 [http://www.maine.gov/dhhs/beas/hiap/del\\_exp.htm](http://www.maine.gov/dhhs/beas/hiap/del_exp.htm)

25 <http://aspe.hhs.gov/poverty/07poverty.shtml>

26 For an explanation of the Medicare Part D "donut hole" see:

<http://www.washingtonpost.com/wp-dyn/content/article/2006/09/24/AR2006092400957.html>

people who are on Medicaid from losing all their medications under Part D, and people really shifted away from doing a lot of the things at a state level that are still needed, unfortunately.

Just to finish up, I think it is important to mention that other states have moved forward with this model. Now there are about half the states that have a discount plan. Only one, though, has the leverage provision. That is California. It lost in a citizens' initiated bill but won in the legislature, signed by Governor Schwarzenegger.<sup>27</sup> It gives the drug companies three years to come up with the discounts. And then, if they don't, the leverage kicks in. And I want to mention also states that focus more on the price limitation side of Maine RX, because that is still out there. West Virginia has taken an approach where they say, we're going to set the federal supply schedule as the baseline that we're going to use to negotiate drug prices.<sup>28</sup> And that is the very low price, as you know. And the District of Columbia has passed a law, which other states are going to introduce this year, which is in court, and we're defending that, which says that drugs that are priced at 30% more than what the prices are in five rich countries will be considered to be overpriced.<sup>29</sup> And the burden will be on the drug companies to come back and defend their pricing. So other states are looking more directly at this pricing issue. And I think that both of these approaches are worth doing perhaps in tandem. Bigger is better. That means, the more programs and states you have in the purchasing pool<sup>30</sup> the better. Maine is now in a purchasing pool with several other states to further drive down the price for Medicaid and Maine RX. I would also encourage you to get rid of any middlemen in there. Don't slough off your rebate negotiation authority to a PBM<sup>31</sup> or someone else. You be in charge of it, so the state gets 100% of the rebates. And thirdly: just be bold and listen to what the citizens are saying. They could not be clearer. I can't imagine any issue where they are more united than this one. So it is time to take action. Thank you.

I can testify personally in preparing for this panel, between PBMs, PDLs, negotiation, and bulk purchasing power, I had to set up my own little glossary to prepare to ask you guys questions this morning. And I think we all agree that if we are to build a constituency to actually take action, we have to clarify the terms.

—Andrea Batista Schlesinger  
Drum Major Institute for Public Policy

[APPLAUSE]

**ANDREA BATISTA SCHLESINGER:** All right. Thank you everybody for coming this morning. My name is Andrea Batista Schlesinger. It is my honor to work for the Drum Major Institute, and we have a fantastic panel who I will introduce in turn

27 For more on California's prescription drug discount plan see

[http://www.californiaprogessreport.com/2006/09/california\\_gove.html](http://www.californiaprogessreport.com/2006/09/california_gove.html)

28 For more on West Virginia's approach, see <http://www.cga.ct.gov/2004/rpt/2004-R-0310.htm>

29 For more on Washington D.C.'s "Prescription Drug Excessive Pricing Act of 2005," see

<http://www.dccouncil.washington.dc.us/images/00001/20050927163237.pdf>

30 <http://www.ncsl.org/programs/health/bulkrx.htm>

31 Pharmacy Benefits Manager. See [http://en.wikipedia.org/wiki/Pharmacy\\_Benefit\\_Management](http://en.wikipedia.org/wiki/Pharmacy_Benefit_Management)

so that we can get right to the conversation. But I want to ask the panel one thing. And I can testify personally in preparing for this panel, between PBMs, PDLs, negotiation, and bulk purchasing power, I had to set up my own little glossary to prepare to ask you guys questions this morning. And I think we all agree that if we are to build a constituency to actually take action, especially on a federal level, that we have to clarify the terms and make clear exactly what it is we're talking about in all these different approaches, which I think Representative Treat—formally Senator Treat—did a good job of. So I am going to encourage the panel to keep up to Representative Treat's level. So let me first introduce Dr. Jon Cohen, who is the former Chief Medical

**When the Medicare Part D plan was passed, the biggest give back to the pharmaceutical industry was that Congress said that the U.S. Government could not negotiate bulk purchasing of drugs. Let me give you an idea of the scope and size of that: there are probably over one billion Lasix pills that are taken by the members of the citizenry every year. Can you imagine if the U.S. Government went to the drug manufacturer and said, 'We want to purchase a billion Lasix pills. How much is it going to cost us?' It would be one thousandth of a cent. But instead they outlawed that.**

— Dr. Jon Cohen

Officer of the North Shore Long Island Jewish Health System, Professor of Surgery at Albert Einstein College of Medicine, and a former candidate for Lieutenant Governor of New York. Dr. Cohen, there's a huge health care crisis. We've got 47 million uninsured. We've got significantly more underinsured. On this whole continuum of problems with the health care system, of which there are many, where does this prescription drugs piece fit in?

**DR. JON COHEN:** Well, thank you Andrea, and the Drum Major Institute for the kind invitation. Thanks Carl for his remarks, and Sharon. And certainly Assemblyman Gottfried sitting to my right, for all that he's done on behalf of New York and its residents. Prescription drugs are a pretty big piece. There are probably five or six major causes for the cost of health care in this country. One of the major ones, obviously, is prescription drugs. To put it in some perspective, New York State spent \$48 billion on Medicaid last year –\$ 4.8 billion on prescription drugs alone.<sup>32</sup> If you look at what is called “dual eligibles,” which is people eligible for both Medicare and Medicaid, and

**If a genie came to me in the night and said that he or she would grant me one wish on health policy, it would be for universal health coverage. But if I were granted three wishes, I think controlling prescription drug prices would be on that list.**

— New York State Assemblyman  
Richard Gottfried

remove those, and you remove the drugs that would not be accessible through a Preferred Drug List, you save at least \$1.2 billion in New York State alone. just to give you an idea.

**ANDREA BATISTA SCHLESINGER:** Does everybody know what a Preferred Drug List is?

<sup>32</sup> For the latest statistics on New York's Medicaid spending, see <http://www.statehealthfacts.org/profilecat.jsp?rgn=34&cat=4>

**DR. JON COHEN:** I am sorry. A Preferred Drug List is a list that is set up that physicians can prescribe off of. If you get a prescription for a drug that's not on the list, then you have to go outside and either pay an additional co-pay or a significant amount of money. So people's access is limited to a significant number of generic drugs and other drugs that are non-generic drugs. And that is what the Preferred Drug List does. And we should talk about the authorization for drugs that are not on the list.

The other reform which I just mentioned is bulk purchasing. Let me give you an idea on the federal level what bulk purchasing meant for Medicare Part D. When the Medicare Part D plan was passed, the biggest give back to the pharmaceutical industry was that Congress said that the U.S. Government could not negotiate bulk purchasing of drugs for the Medicare program. Let me give you an idea of the scope and size of that: I have estimated that there are probably over one billion Lasix<sup>33</sup> pills that are taken by the members of the citizenry every year. Can you imagine if the U.S. Government went to the drug manufacturer and said, 'We want to purchase a billion Lasix pills. How much is it going to cost us?' It would be one thousandth, maybe, of a cent to buy those. But instead they outlawed that. Instead Congress said, 'We'll give you a discount off of the full fair price.' That gives you an idea why bulk purchasing is so important. A lot of states have said, 'We're going to bulk purchase drugs on behalf of the state,' which is a significant savings. The federal government hasn't done it.

We have some good proposals on the table, [including] the so-called bulk purchasing bill—I say 'so-called' because the bill actually has nothing to do with bulk purchasing. You use the word 'bulk purchasing' and everybody's mind conjures up warehouses filled with amoxicillin, which is not what the bill involves. The bill is about having the state negotiate, as in Maine, for the large number of prescriptions we estimate we would be covering.

— New York State Assemblyman Richard Gottfried

**ANDREA BATISTA SCHLESINGER:**

Then my basic question is: on the continuum and the level of urgency of this particular piece as part of the larger health care problem, you would say this is a top priority? This is something we have to address?

**DR. JON COHEN:** Absolutely. And the two big pieces of it are bulk purchasing and a real substantive Preferred Drug List.

**ANDREA BATISTA SCHLESINGER:** I'd like to introduce Assemblyman Richard Gottfried, who's Chair of the New York State Assembly Health Committee. He represents the 35th Assembly District here in Manhattan. He's the major architect of New York's landmark managed care reforms, and is continuing to fight for stronger protections for consumers and health care providers and public support for universal access to quality affordable health care. Since we are a teeny bit competitive, can you briefly give us the lay of the land when it comes to how New

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33 Lasix is used to treat fluid retention and high blood pressure.

York is doing? Carl McCall set us up to be a little bit jealous of what is happening in Maine. How are we doing here in New York?

**ASSEMBLYMAN RICHARD GOTTFRIED:** Good question. By the way, just to first touch on your previous question, if a genie came to me in the night and said that he or she would grant me one wish on health policy, it would be for universal health coverage. [Applause] But if I were granted three wishes—

**ANDREA BATISTA SCHLESINGER:** We only do one.

**ASSEMBLYMAN RICHARD GOTTFRIED:** I think controlling prescription drug prices would be on that list. One of the good things about my line of work is that plagiarism is not punished. In some ways it is encouraged. Some of the best things that I have been associated with, and some of the best things New York has done in health policy, are things that we have enviously looked at other states and either copied or, hopefully, dressed up a little before we copied. I think one reason we are more often copying other states than being copied, (although people do sometimes copy the things we do) is because for the last twelve years we have had a governor who has been, shall we say, not particularly interested in aggressively developing and improving state government.<sup>34</sup> That is the ideology he brought to the office. It is not because he's not smart, it is not because he doesn't have energy. It is because he's not interested in addressing his smarts or energy to topics like this.

**ANDREA BATISTA SCHLESINGER:** But I see him in all those commercials, with the children—

**ASSEMBLYMAN RICHARD GOTTFRIED:** Yes. You know, I have sometimes compared his bragging about Child Health Plus<sup>35</sup> and Family Health Plus<sup>36</sup> to, if the Japanese

It is hard to use the term 'free market' when you are in an area that, first of all, is dominated virtually entirely by huge multi-national corporations. And second of all, most of their products are strongly patent protected. You are dealing with monopolists in almost everything. So the notion of a free market is really not entirely functional when you are talking about prescription drugs.

— New York State Assemblyman Richard Gottfried

were taking credit for bringing peace to the Pacific in 1945. He fought us tooth and nail, we beat him, and now he's taking credit. I hear about everything changing on day one,<sup>37</sup> but certainly that changes on day one. We also have, for almost all of recorded history, had a Republican Senate in this state. And while New York Republicans are nowhere near as reactionary as Republicans in many other places—I

mean, our Republicans sometimes would look like Democrats in some other states—on many issues they are far from interested in energetic policy making. And this

34 The reference is to New York State Governor George Pataki, who served from 1995 to 2007. See [http://en.wikipedia.org/wiki/George\\_Pataki](http://en.wikipedia.org/wiki/George_Pataki)

35 [http://www.health.state.ny.us/nysdoh/chplus/what\\_is\\_chp.htm](http://www.health.state.ny.us/nysdoh/chplus/what_is_chp.htm)

36 <http://www.health.state.ny.us/nysdoh/fhplus/>

37 A reference to the campaign slogan of Eliot Spitzer, then Governor-elect of New York State, due to take office several weeks after this event.

has certainly been one of them. It has really been a major effort to pull them along. We have some good proposals on the table, specifically in this area, the so-called bulk purchasing bill<sup>38</sup>—I say ‘so-called’ because the bill actually has nothing to do with bulk purchasing. You use the word ‘bulk purchasing’ and everybody’s mind conjures up warehouses filled with amoxicillin, which is not what the bill involves. In fact, I’ve had legislators say to me, ‘Dick, I’d support your bill, but where are we going to put the warehouses? Or the trucks? I don’t want anymore truck traffic in my district.’ The bill is about having the state negotiate, as in Maine, for the large number of prescriptions we estimate we would be covering. So I am hopeful that, starting in a couple of weeks, New York will be back in the business of moving forward on prescription drugs, on expanding health coverage, on a lot of things.

**Every health insurance company negotiates prescription drug prices if it covers prescription drugs. Some of the bigger ones are more able to do that than others. Some pass on their savings to consumers. Some pocket them. Maybe they all pocket them, to at least some degree. What the bulk purchasing concept does is take that to a much larger scale, and would have the state of negotiating.**

— New York State Assemblyman Richard Gottfried

**ANDREA BATISTA SCHLESINGER:** And, finally, let me introduce Charles Bell.<sup>39</sup> Charles is the Program Director for Consumers Union<sup>40</sup> based in Yonkers. He works closely with Consumers Union’s advocacy offices in California, New York, Texas and D.C. on a wide range of consumer policy issues, including prescription drugs, financial privacy and health care restructuring. And Charles, there were two themes in all the papers that I read and that lead up to this. One is that people looking to bring down prices were just a bunch of socialists. The second was that, conversely, we were a bunch of capitalists trying to unlock and unleash the power of the free market. So which one is it? Are we socialists or are we capitalists?

**I think everybody agrees that the free market has failed the health care system. I would challenge anybody to state otherwise. The question is, what is the role of government? The role of government is to step in to provide the public good when the free market has failed.**

— Dr. Jon Cohen

**CHARLES BELL:** Well, I think if people know Consumers Union, we’re the people that publish Consumer Reports.<sup>41</sup> We’re very happy to be a magazine that is based here in New York State. We think of it as

smart shopping. And we believe that Assemblyman Gottfried’s bill that would create the prescription drug discount program is a very important bill for New York, both for consumers and for taxpayers. New York should not overpay for prescription drugs, just from the standpoint of fiscal and fiduciary responsibility. And at the same time it is an excellent bill for consumers because this is a bill that

38 <http://assembly.state.ny.us/mem/?ad=075&sh=story&story=19650>

39 [http://www.consumersunion.org/about/2006/10/charles\\_bell.html](http://www.consumersunion.org/about/2006/10/charles_bell.html)

40 <http://www.consumersunion.org/about/>

41 <http://www.consumerreports.org/cro/index.htm>

will allow us to stretch the dollars we're paying to enhance the quality of drug coverage for our consumers that are in the state's public programs, and it will also create a discount program similar to Maine's, where as many as five million New Yorkers could get significant discounts on brand name and generic drug prices. We see Maine and we see California now adopting this program. It is important that New York not be left behind as the last deep pocket in the system. We need to keep up with what other states are doing. So we think it is very important that the Senate take action on Assemblyman Gottfried's bill. And we've been working with a statewide coalition of groups, including AARP,<sup>42</sup> the Statewide Senior Action Council,<sup>43</sup> and the Alliance of Retired Americans.<sup>44</sup> We'll be working very hard through our [prescription] affordability campaign to support those bills here in New York State.

**ANDREA BATISTA SCHLESINGER:** Let's talk about our relationship to this industry. Because that is really what a lot of this conversation is about—the pharmaceutical industry and what the role of responsibility is of government, and taking this industry on. What is our position? Are we, as Representative Treat alluded to earlier, just trying to have a free market? Or are we trying to do a price control that puts a lock on an industry that is thriving, that brings money into the economy, and that creates jobs? I am just reading what the Manhattan Institute<sup>45</sup> told me.

**The unfortunate part is that the pharmaceutical industry has this incredible, pervasive impact on physician behavior, starting in medical school. It is the free pens, the free cups, the free T-shirts, the things that support their pharmaceuticals. And then they have the free lunches and they have the other givebacks that they give to physicians to start modifying the behavior since day one of medical school.**

— Dr. Jon Cohen

**ASSEMBLYMAN RICHARD GOTTFRIED:**

It is hard to use the term 'free market' when you are in an area that, first of all, is dominated virtually entirely by

huge multi-national corporations. And second of all, most of their products are strongly patent protected.<sup>46</sup> You are dealing with monopolists in almost everything. So the notion of a free market is really not entirely functional when you are talking about prescription drugs. That is why it is important for the buyers of those drugs to band together, and to negotiate, not on behalf of an individual purchaser but on behalf of millions of purchasers. Every health insurance company negotiates prescription drug prices if it covers prescription drugs. Some of the bigger ones are more able to do that than others. Some pass on their savings to consumers. Some pocket them. Maybe they all pocket them, to at least some degree. What the bulk purchasing concept does is take that to a much larger scale, and would have the state

42 <http://www.aarp.org/>

43 <http://www.nysenior.org/>

44 <http://www.retiredamericans.org/>

45 A conservative think tank <http://www.manhattan-institute.org/>

46 For more on the patent protection of pharmaceuticals, see <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp354-e.htm#PATENTUNITE%20STATSTxt>

of negotiating on behalf of Medicaid and EPIC<sup>47</sup>—our senior citizen prescription program—and state public employees and retirees, which is a huge group. My bill would also invite any insurance company that wanted to piggyback on our plan to use our negotiating power, and we do that because the more people we can have covered, the better. And finally, probably the biggest single group would be any individual who lacks or has gaps in their prescription drug coverage—they would be able to buy their drugs at the state’s negotiated discount price.

**ANDREA BATISTA SCHLESINGER:**  
Dr. Cohen? Socialist, capitalist?

**DR. JON COHEN:** It is actually a very interesting question. Everybody talks about the free market. I think everybody agrees that the free market has failed the health care system. I would challenge anybody to state

otherwise. The question is, what is the role of government? The role of government is to step in to provide the public good when the free market has failed. So if you look at transportation, you look at education, or you look at national defense, the role of the government is to come in because the markets have failed. And I just don’t believe there is anybody who believes that the free market, at this point, has had the impact it should on the health care system. I would argue that, at this point, we should step up and finally say it is time for government to have a bigger role in the health care system because that is what is needed for the greater public good.

In terms of the Preferred Drug List, a lot of this has to do with actual physician behavior. I am a physician, and I actually went through this at my health system. Most of the drugs are ordered by a physician and the question is, how do you not just alter things by bulk purchasing, but how do you alter physician behavior to prescribe drugs? I can tell you, we had that experience. I’ll give you one anecdote. We had 127 narcotics on our formulary<sup>48</sup> for fifteen hospitals. I would say that probably twenty of them were never used. Yet we stocked them every year and we kept them up to date. And you say to the physician, ‘well, we want to remove these 80 drugs from the formulary.’ The physician usually says, ‘Who are you to tell me what I can prescribe for my patients?’ So the question is, how does physicians’ behavior get modified? And I will tell you; the unfortunate part is that the pharmaceutical industry has this incredible, pervasive impact on physician behavior, starting in medical school. It is the free pens, the free cups, the free T-shirts, the things that support their pharmaceuticals. And then they have the free

**The pharmaceutical companies affect not only people in Dr. Cohen’s line of work but [legislators] as well. Because when the drug company people are the people who took you to a conference, paid for your organization’s conference, helped to fund a Little League program in your district, or what have you, and then they come and explain to you why this Preferred Drug List bill is evil and will kill half your constituents, it is a lot easier to be seduced into believing them.**

— New York State Assemblyman Richard Gottfried

<sup>47</sup> [http://www.health.state.ny.us/health\\_care/epic/](http://www.health.state.ny.us/health_care/epic/)

<sup>48</sup> A formulary is equivalent to a preferred drug list – it is the list of drugs that doctors in that hospital system may prescribe without prior authorization.

lunches and they have the other givebacks that they give to physicians to start modifying the behavior since day one of medical school. And when you become a physician, you order the drugs that you ordered when you were a resident. You get used to ordering them. And the only way so far that we've been able to alter physician behavior is by limiting their access and by prior authorization.

There's a drug out there that is called Epogen. It is a great cancer drug for increasing people's blood count. It costs thousands of dollars for every single dose that you give. And it has become an indication, not just for cancer patients but for a lot of other patients. We said, 'If you want to order Epogen, you need to fill out a form.' Use of that drug went down to 80%. Physicians said, 'I am not filling out a form. It is too hard to do.' So there are very specific things you can do at the state level: prior authorization; limiting drugs; deciding which ones. And then there's the other issue I'll tell you about for a second. It is called therapeutic substitution.<sup>49</sup> That means you order a drug and are given a substitute that is much cheaper, or a generic. And I use the analogy that it is like Sweet and Low, and Equal. I know everybody says they love either Sweet and Low or Equal. But the fact is they are pretty similar because they are both non-sugar substitutes. And that is what therapeutic substitution is. Those are very, very important issues for how you change physician behavior.

**ASSEMBLYMAN RICHARD GOTTFRIED:** By the way, I would comment that the pharmaceutical companies affect not only people in Dr. Cohen's line of work but people in my line of work and Sharon's line of work as well. There is probably some of that behavioral impact that is pure, crude, old-fashioned corruption, where people are influenced simply by a campaign contribution. I would say, though, that an awful lot of the influence is not as clearly illegal, but may be more insidious. Because when the drug company people are the people who took you to a conference, paid for your organization's conference, helped to fund a Little League program in your district, or what have you, and then they come and explain to you why this Preferred Drug List bill is evil and will kill half your constituents, it is a lot easier to be seduced into believing them. Human beings are human beings. I find it either distressing or shocking, depending on how you interpret people's behavior, the extent to which so many of my colleagues' voting behavior tracks where the drug industry is.

**There is a consensus on prescription drugs that isn't yet there to the same degree on health care. So it is a way to move into the health care debate and to bring people along. Secondly, it is going to help fund that larger picture because we are talking about billions of dollars just for one drug. Multiply that by the hundreds and hundreds of drugs that are out there and you are talking about substantial money that could be redirected into either expanding access to prescription drugs or health care generally.**

— Maine State Representative Sharon Treat

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49 [http://www.healthdecisions.org/Glossary/Default.aspx?doc\\_id=25526](http://www.healthdecisions.org/Glossary/Default.aspx?doc_id=25526)

**ANDREA BATISTA SCHLESINGER:** I believe the drug industry is number 13 out of 80 industries where it comes to spending money on politicians.<sup>50</sup> So to underline the point, they are a significant player. I believe the news was, with Senator Santorum<sup>51</sup> out, that they were scrambling to find other representatives in Congress in leadership roles who would relay their agenda.<sup>52</sup> So I don't think we can put too fine a point that we're talking about major players when it comes to the policy making spectrum.

**A tremendous amount of public dollars go into funding the basic research upon which these huge profits are based.**

— Maine State Representative Sharon Treat

**REP. SHARON TREAT:** I just came back from a conference of progressive legislators, a bipartisan group of legislators that identify themselves as progressive at the Center for Policy Alternatives.<sup>53</sup> One of the discussion groups was about women's health care. There was a discussion about this HPV vaccine for women to prevent cervical cancer.<sup>54</sup> And someone raised the question, 'Well, do we know yet whether the clinical trials are safe yet? And it is expensive. I just have questions.' And one woman stood up and said, 'Oh, well, I went to the Women in Government<sup>55</sup> program'—this is a program totally funded by the drug industry and other large companies<sup>56</sup>—I've never gone to any of their programs for that reason. And she said,

**New Hampshire has passed a bill which says drug companies cannot use the information about what doctors prescribe to then market back to the doctor and say, 'Hey, you are not prescribing enough of this really expensive brand name drug. You really ought to be doing that.' New Hampshire has said no to that. You can monitor prescribing habits to see that there aren't abuses for safety problems, but no commercial use.**

— Maine State Representative Sharon Treat

'I went to the Women in Government program. We got to tour Merck's<sup>57</sup> labs. So I feel totally confident that this is a good thing.' In a previous discussion someone else stood up and talked about the epidemic of AIDS in black women. Apparently it is off the charts. And she said, 'But we're doing something about it in Georgia. We've started a group funded by GlaxoSmithKline.<sup>58</sup> They're funding us for three years to go out there and educate about this issue.'

So it is not just paying off doctors or contributions to candidates, it is really quite insidious. And in the trade area there are these advisory groups to the US Trade Representative that are entirely made up of pharmaceutical industry representatives.

50 According to the Center for Responsive Politics, the pharmaceutical and health products industry was tenth in campaign contributions to Members of Congress in 2006.

<http://www.opensecrets.org/industries/mems.asp?party=A&cycle=2006>

51 [http://en.wikipedia.org/wiki/Rick\\_Santorum](http://en.wikipedia.org/wiki/Rick_Santorum)

52 <http://www.washingtonpost.com/wp-dyn/content/article/2006/11/22/AR2006112201940.html>

53 <http://www.stateaction.org/>

54 [http://www.kaiseredu.org/topics\\_im.asp?parentID=72&imID=1&id=609](http://www.kaiseredu.org/topics_im.asp?parentID=72&imID=1&id=609)

55 <http://www.womeningovernment.org/home/>

56 [http://www.womeningovernment.org/home/support\\_sponsors.asp](http://www.womeningovernment.org/home/support_sponsors.asp)

57 Merck & Co. Inc, a pharmaceutical company <http://www.merck.com/>

58 A pharmaceutical company <http://www.gsk.com/>

And, in fact, high up members of the US Trade Representative,<sup>59</sup> the people doing the international trade negotiations, came from PhRMA or the drug companies. The public health community had to sue to get onto these advisory committees.<sup>60</sup> And they've opened up two of them—the lawsuit is still going on with the rest—and every single one of us who applied to get on it as a public health representative have gotten letters blowing us off. They say they are going to appoint someone. I am going to be fascinated to see who that is.

I just wanted to comment on these other questions. The question about why prescription drugs as opposed to health care generally? I would just say that I sponsor Dirigo Health,<sup>61</sup> which is an innovative health access program in Maine, and I believe in universal health care, but I think that the polling figures I gave you are quite instructive. There is a consensus on prescription drugs that isn't yet there to the same degree on health care. So it is a way to move into the health care debate and to bring people along. Secondly, it is going to help fund that larger picture because we are talking about billions of dollars just for one drug. Multiply that by the hundreds and hundreds of drugs that are out there and you are talking about substantial money that could be redirected into either expanding access to prescription drugs or health care generally. So I think it is important there. And it is not only a key budget issue for state budgets, but it is a key personal budget issue for anyone that does not have health care right now, who has substantial costs.

The other question was about whether this is a capitalist or socialist thing—I just point out that every other country in the world does engage in negotiations over prescription drugs. It is a little different because they do have national health insurance, generally. And so that is what they're doing. They are buying drugs for the national health insurance, and then that essentially sets the price for everybody else. We do not have national health insurance, but of course the more people and drug purchases you pool together, we would be engaging in the same behavior as everyone else. Secondly, PhRMA itself, as I mentioned, is trying to prevent that behavior in others states through trade agreements. What they are trying to do is harmonize the activities overseas with what we are doing here in the United States. Which would mean what? Jacking up the prices in other countries, preventing them from doing Preferred Drug Lists, and there are even lawsuits going on right now suing Australia for not putting an osteoporosis drug on their drug list, which they deem to be insufficiently effective and very, very expensive.<sup>62</sup> So this is the way the world is, and basically the drug industry is trying to carve itself out of free trade.

And I need to mention too, that a tremendous amount of public dollars go into funding the basic research upon which these huge profits are based. And I think

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59 <http://www.ustr.gov/>

60 For background on this issue, see <http://www.cpath.org/id4.html>

61 <http://www.dirigohealth.maine.gov/>

62 <http://www.smh.com.au/news/national/drug-subsidy-appeal-to-test-new-review/2006/05/07/1146940413807.html>

what is interesting with the West Virginia<sup>63</sup> and the District of Columbia<sup>64</sup> approaches is they are saying, ‘Look, we want you to have your profit but let’s subtract out money that is going to things like marketing that really is unnecessary. Let’s not pay for that. And you come to us and tell us why you have to have this drug priced at whatever the market will bear, because you have a monopoly on that.’ In the lawsuit on that right now, in D.C., the District Court agreed with the drug industry and the biotech came in a big way, and basically said, ‘If we have a patent we can charge anything we want.’ Now think about that. Patents are part of everything. For decades, for generations, we’ve said that you can prevent price gouging during emergencies. And this line says ‘no, we can charge anything we want.’ So I think we need to think about that.

**I think drug industry profits actually work against medical research, and against good health. The extraordinary profits they can make give them an enormous incentive to a) bring drugs to market that may not be very good for us and b) the bulk of drug company research goes into developing drugs that replace drugs whose patent is running out. So that they can make a small change in the molecule, get a brand new patent, a brand new marketing effort, convince you that no, you don’t want Claritin anymore now that it is no longer patented, you want blah-blah, the successor to Claritin, that doesn’t do anything better or different.**

— New York State Assemblyman Richard Gottfried

And then finally, on this issue of doctor behavior, the Preferred Drug List is very effective, certainly, in changing doctor behavior. There are other programs out there that I think are worth also looking into. Pennsylvania is putting significant money into a program called Academic Detailing that sends trained physicians, nurses and pharmacists out to doctors’ offices.<sup>65</sup> Unlike the cheerleaders that represent the drug companies,<sup>66</sup> these are people that actually have background in the field.

**ANDREA BATISTA SCHLESINGER:** Do they have pens?

**REP. SHARON TREAT:** Well, they don’t have pens. But they have had this issue over whether they should do lunch because the problem is that lunch may be the only time available to talk. And they realize they have to deal with that. But that is one program that is very interesting, and they’re trying to compete with the drug companies by producing very glossy materials, some of which say, ‘You don’t need a drug for this condition; there are other things that are really better for that.’

Can I just give one other example? It goes to the question of marketing to doctors. New Hampshire has passed a bill,<sup>67</sup> again, one that we are defending in the courts, which says drug companies cannot use the information about what doctors prescribe to then market back to the doctor and say, ‘Hey, you

63 For more on West Virginia’s approach, see <http://www.cga.ct.gov/2004/rpt/2004-R-0310.htm>

64 For more on Washington D.C.’s “Prescription Drug Excessive Pricing Act of 2005,” see <http://www.dccouncil.washington.dc.us/images/00001/20050927163237.pdf>

65 [http://www.prescriptionproject.org/casestudies/public\\_policies\\_and\\_programs?id=0004](http://www.prescriptionproject.org/casestudies/public_policies_and_programs?id=0004)

66 For more on pharmaceutical companies hiring former cheerleaders to promote their products, see <http://www.nytimes.com/2005/11/28/business/28cheer.html?ex=1186632000&en=ad63bede77183334&ei=5070>

67 <http://www.nlarx.com/news/2006/2006-12-15NLARxFilesDataminingLawsuit.html>

are not prescribing enough of this really expensive brand name drug. You really ought to be doing that.’ And New Hampshire has said no to that. You can monitor prescribing habits to see that there aren’t abuses for safety problems, but no commercial use. And it is going to be very interesting to see what happens with that.

**ANDREA BATISTA SCHLESINGER:** The Drum Major Institute loves to disagree with the Manhattan Institute. But we like to make sure that we’re right. So last week the Manhattan Institute and the *Wall Street Journal* talked about this drug, which I am sure that I am mispronouncing—the Pfizer drug—Dr. Cohen, come on, help me out.<sup>68</sup> Anyway, they spent a billion dollars—this is the drug they realized last week didn’t work—they spent a billion dollars on research and development, spent fifteen years trying to develop this drug.

They’ve lost about—this is according to the *Journal* and Manhattan Institute—about \$20 billion in market share since the failure was announced. Their point is that they invested a lot into trying to find a drug that could potentially have very positive health effects. If you were bringing down prices—and you talk about the flip side of this, which is all the revenue that would then be given back to states, money that could be used towards providing other kinds of health care, but that money

has to come from someplace. So what kind of incentive does Pfizer have to invest that money and that time if they won’t be able to be profitable? I am not saying I agree—

I take Zocor. It is a cholesterol lowering drug. If I went to the drugstore down the street it would cost me \$140 a month. If I was a veteran and went to get the same drug, it would cost me \$70 a month, because the VA does bulk purchasing of drugs. If I went to Canada it would be about \$40. Same drug, same prescription, same person.

— Dr. Jon Cohen

Drug companies may be giving as much as \$75 million to \$100 million in gifts every year to medical providers here in New York. We really think that consumers need to know that. What kind of impact does that have on doctors’ prescribing patterns? What impact does that have on the cost we all have to pay? We know that these gifts must have some impact, or else the drug companies as an economic proposition would not be making them.

— Charles Bell  
Consumers Union

**DR. JON COHEN:** The drug is a cardiac drug that actually was going to increase good cholesterol and decrease the bad. And it failed. My response to you is, it is a matter of how much. How much profit is okay and how much is not, and at what expense to the seniors and the disabled and people who really can’t afford it? And we get back to the market issue. What is the balance?

What is the appropriate balance between what is good for people and patients as opposed to how much money a pharmaceutical industry makes?

68 The drug is Torcetrapib. See the Manhattan Institute article here [http://www.examiner.com/a-487292-Paul\\_Howard\\_What\\_policymakers\\_can\\_learn\\_from\\_a\\_21\\_billion\\_failure.html](http://www.examiner.com/a-487292-Paul_Howard_What_policymakers_can_learn_from_a_21_billion_failure.html) and the *Wall Street Journal* article here (subscription required) <http://online.wsj.com/PA2VJBNA4R/public/article/SB116537272090741897.html>

**ASSEMBLYMAN RICHARD GOTTFRIED:** I think drug industry profits actually work against medical research, and against good health. Because I would say this was a drug where the drug company got caught selling a bad drug, or preparing a bad drug, before they had brought it to the market, unlike what seems to happen more often, where the harm of a drug is discovered after they've made a ton of profit on it. And the extraordinary profits they can make give them an enormous incentive to a) bring drugs to market that may not be very good for us and b) the bulk of drug company research goes into developing drugs that replace drugs whose patent is running out. So that they can make a small change in the molecule, get a brand new patent, a brand new marketing effort, convince you that no, you don't want Claritin<sup>69</sup> anymore now that it is no longer patented, you want blah-blah, the successor to Claritin, that doesn't do anything better or different from Claritin. And that is what the extraordinary reward of drug company profits produces. It gives them an enormous incentive to put a ton of money into developing drugs that don't do us any more good than the ones whose patents are expiring. All they do is create something they can advertise about to induce us to spend \$30 for a pill that has a patent instead of 30 cents for a pill whose patent has expired. That is what the current market produces. It is not a market that produces extraordinary health benefits. Occasionally there are health benefits produced, but I think our market process drives vastly more health care dollars into junk science that does nobody any good except stockholders.

**Preferred Drug Lists come with perils if they are not done properly. One of the dangers of the PDL could be if it was solely based on who gives you the best rebate, and not based on what is the most effective medication as well as the most cost-effective medication. So my first recommendation would be to make sure it is evidence-based.**

— Maine State Representative Sharon Treat

**ANDREA BATISTA SCHLESINGER:** Let me open it up, and then we will come back. We have asked some people to join us to bring their own unique perspectives to the discussions. Is Beth Finkel here? Okay. Beth Finkel is manager for State Operations at the New York State AARP.<sup>70</sup> She has been at the AARP for ten years. Beth?

**BETH FINKEL:** First of all, I would really like to give our sincere thanks to Assemblyman Gottfried for everything he has done in trying to make drugs more affordable in New York State. [Applause] Also, Chuck, thank you. We love working with your group. We are really hoping that the discount drug bill gets passed this year in New York State. We are working strongly for that and our volunteers are out there. I am just curious down the pike – I know you have mentioned the Detailing Bill, which is another bill that AARP has been working on at the state level. You also mentioned the data mining issue, which is something that we are also looking at. But what else do you see coming down the pike in terms of states doing something effectively to bring down drug prices?

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<sup>69</sup> An allergy medication.

<sup>70</sup> <http://www.aarp.org/states/ny/>

**DR. JON COHEN:** I can tell you that Minnesota has taken on the federal government relative to importing drugs from Canada.<sup>71</sup> To give you again another example, I take Zocor. It is a cholesterol lowering drug. If I went to the drugstore down the street it would cost me \$140 a month. If I was a veteran and went to get the same drug, it would cost me \$70 a month, because the VA does bulk purchasing of drugs. If I went to Canada it would be about \$40. Same drug, same prescription, same person. So the impact of importation on prices is highly significant. The problem, as you know, is that although we talk about free market, the pharmaceutical industry is obviously interested in limiting the free market, because they don't want importation of drugs from other countries. Minnesota and some other states are trying to address the safety issue so they could get importation back on the radar screen. There are seniors in New York State every day that leave the state and go to Canada to purchase their drugs. There were 900,000 people in this state last year who did not purchase drugs they had a prescription to because they couldn't afford it.

**CHARLES BELL:** Can I just say a little bit about the Detailing Bill? This is Assembly Bill 5574 and S696.<sup>72</sup> And this is a bill that would require drug companies and wholesalers in New York State to file annual reports with the State Department of Health that publicly disclose all the gifts the drug companies are making to doctors and medical providers in excess of \$75 or more. The bill does not include free samples, which some of our groups did support but it was not possible to get. And then this information would be posted on a free state website. We think that disclosure is a critically important step for revealing what are some of the commercial pressures on doctors and medical providers. And we

**Consumers Union has been very effective in showing people that the most expensive drug is not necessarily the best drug. It may actually be the least effective drug. It may be the drug with the most side effects. It may be the drug that is least studied because clinical trials are very short and then it goes on the market.**

— Maine State Representative Sharon Treat

have extrapolated by looking at the statistics that have been disclosed in Vermont that drug companies may be giving as much as \$75 million to \$100 million in gifts every year to medical providers here in New York. We really think that consumers need to know that. What kind of impact does that have on doctors' prescribing patterns? What impact does that have on the cost that we all have to pay? We know that these gifts must have some impact, or else the drug companies as an economic proposition would not be making them. So we think a first step to getting a handle on the drug company influence on the medical system itself is to bring that information out into the light.

**ANDREA BATISTA SCHLESINGER:** All DMI does is give out mugs. Let me turn this over to Robert Hayes. Robert is an attorney, President and General Counsel of the

71 [http://www.state.mn.us/mn/externalDocs/Rx/Rx\\_Fact\\_sheet\\_pdf\\_012804101245\\_Rxplanfactsheet021904.pdf](http://www.state.mn.us/mn/externalDocs/Rx/Rx_Fact_sheet_pdf_012804101245_Rxplanfactsheet021904.pdf)

72 <http://www.nyhpa.org/Images/File/RX%20provider%20spending%20reform.pdf>

Medicare Rights Center,<sup>73</sup> the largest independent source of health care information and assistance in the United States for people with Medicare. And Mr. Hayes is also a McArthur Foundation Fellow.<sup>74</sup>

**ROBERT HAYES:** Thanks for having us. I am one of the folks who actually left Maine to come back to New York to run the Medicare Rights Center. So I was in

the Sharon Treat fan club before she came into this business. I have got to say, though, on the pharmaceutical companies' insidious presence, I can remember a few years back spending time with the medical director of the Maine state psychiatric hospital system, who was defending to me why the drug companies were in charge of the continuing medical education, and ran lunches. He said that was the only option they had and there was no support. So the insidiousness is not just up in Albany and Washington, but even in Augusta and places like that. My quick question goes to the Preferred Drug List. Those of us who have been battling private insurers, particularly these private drug plans that are now running the Medicare drug benefit, have been seeing a lot of formularies, lists of covered drugs, that have all sorts of trap doors for folks who need drugs that they cannot get. And we are used to a bottom line, financially-driven list of covered drugs and restricted drugs given to us by the private plans. Sharon, can you give us a sense of the best practices in the states for intelligently using the good of a preferred list, driving down prices, balanced against the need for access for patients who really do have a clinical need? And then maybe Dick and John could give us a sense of how New York is going to strike that balance properly?

**REP. SHARON TREAT:** Sure. That is a really good question because Preferred Drug Lists come with perils if they are not done properly. And I know in Maine they went into it very quickly. They did it without legislative standards and we have had to go back and fill in a lot of those things that should have been in there in the first place, but frankly the legislature didn't even understand it. I actually have put together some best practices for an organization called Prescription Policy Choices.<sup>75</sup> One of the things I think is very important for a Preferred Drug List is something that Assemblyman Gottfried has already done in his legislation, which is to tie it to an evidence-based standard.<sup>76</sup> In his case, he included participation in the drug effectiveness review program out in Oregon.<sup>77</sup> One of the dangers of the PDL could be if it was solely based on who gives you the best rebate, and not based on what is the most effective medication as well as the most cost-effective medication. So

**We should never lose sight of the fact that drug importation, even though it is being fought by the drug companies, is also controlled by the drug companies. They are the ones shipping the drugs up to the great pharmacies that are shipping them back. And if it ever became a significant issue in terms of their profitability, it is not very difficult for them to cut back on the drugs.**

— Nassau County Comptroller Howard Weitzman

73 <http://www.medicarerights.org/aboutmrcframeset.html>

74 [http://www.macfound.org/site/c.lkLXJ8MQKRH/b.959463/k.9D7D/Fellows\\_Program.htm](http://www.macfound.org/site/c.lkLXJ8MQKRH/b.959463/k.9D7D/Fellows_Program.htm)

75 <http://www.policychoices.org/>

76 For a definition of evidence-based medicine, see <http://www.cebm.net/?o=1014>

77 <http://www.ohsu.edu/drugeffectiveness/>

my first recommendation would be to make sure it is evidence-based. Secondly, some people are already stabilized on a specific medication, particularly in certain vulnerable populations. Someone with Alzheimer's. Someone with other kinds of mental health illnesses. Those are areas where I think a Preferred Drug List, the procedure for it, needs to be particularly sensitive to people: not switching them over right away, giving them some time, perhaps exempting some of those situations entirely.

Another issue is quick turnaround. No bureaucracy. These are issues that doctors face. The process needs to be very seamless so that if somebody does need a medication that is not part of the Preferred Drug List they can get it. Again, these lists can be set up very different ways. In some states, as soon as a doctor says, 'I want this other drug,' then it is automatically allowed. And that is a very soft Preferred Drug List. At the other end of the spectrum, you have to jump through all kinds of hoops, you have to first try drug A, then try drug B, then try drug C, which is very similar to what a lot of HMOs have. And I think there may be a happy medium somewhere in between there where we really try to give the less expensive and also frequently more effective drugs a chance to work before you go and say, 'okay, go for the most expensive thing out there.'

Consumers Union has been very effective in showing people that the most expensive drug is not necessarily the best drug. It may actually be the least effective drug. It may be the drug with the most side effects. It may be the drug that is least studied

because clinical trials are very short and then it goes on the market. We find the problems after it has been prescribed for a year or two in a population that is actually representative of the entire population. And then we find out, oh, my goodness, there are serious problems here. And as Bob certainly knows, from dealing with the Medicare system, you need to have some process so the public can appeal – I don't like the word appeal, because that makes it sound like it was

**The Institute of Medicine recently recommended that during the first two years that a new pharmaceutical product is on the market, there be no direct to consumer advertising. The first two years are particularly critical because when the drug first comes onto the market, most of its potential side effects have not yet been discovered.**

— Sidney Socolar  
Public Health Association of New York City

litigation or something. But some way to challenge a decision that they feel is not right, and have very quick turnaround on that decision as well.

**ASSEMBLYMAN RICHARD GOTTFRIED:** I think the Preferred Drug List law that we enacted in New York for the Medicaid program and EPIC is an excellent piece of legislation. It wouldn't have been quite as good if we had gone along with what the governor wanted, and that is why it took us two and a half years to enact. But we enacted it in the 2005 budget. It creates a Preferred Drug List in which the first drug that gets to be on the list in a particular class of drugs is the one that is clinically indicated as being the safest and most effective, if there is one such drug

in the class. Only after that do you get to also look at adding less expensive drugs to the list. And the second and, I think, most important factor is that, under the New York law, under Medicaid, if a physician wants to prescribe a drug that is not on the list, while he or she is obligated to call and argue with the people at the state's 800 number, after arguing with them, if they still disagree, the physician is entitled to prevail. So what we tried to draft, and I hope we have done it successfully, is not a speed bump that is too low to affect physician behavior, but also not a speed bump that is not too high to discourage a busy, overworked physician from sticking to his or her guns for a drug that they think really is the right one for that patient.

**ANDREA BATISTA SCHLESINGER:** John, is it the right height for the speed bump?

**DR. JON COHEN:** I think time will tell. It just started. New York just started its Preferred Drug List in 2006. Some people believe at this point early on that the bump is too low. That is what I am hearing in the community. It is still a little bit too easy to actually get drugs that are off the list and go away from the non-generics again. That is just anecdotal feedback I have heard in the last couple months. I don't have any data.

**ANDREA BATISTA SCHLESINGER:** Do we have question in the back?

**HOWARD WEITZMAN:** My name is Howard Weitzman and I am the Nassau County Comptroller.<sup>78</sup> I spent 35 years in the health care field, five of them running a mail service pharmaceutical company. So this is an area that I have tremendous compassion in. And I have a couple questions for Representative Treat. Before I do, there are a couple of points I did want to make. Number one, with respect to drug importation. Obviously this is an important issue. The differentials in cost are tremendous. For the people who live in the border areas it is especially important. But I would hope we would not use this as a means of draining energy from the real issue, which is negotiating prices. We should never lose sight of the fact that drug importation, even though it is being fought by the drug companies, is also controlled by the drug companies. They are the ones shipping the drugs up to the great pharmacies that are shipping them back. And if it ever became a significant issue in terms of their profitability, it is not very difficult for them to cut back on the drugs. In fact, Pfizer is already cutting back on how much they ship to Canada. So while it is an important issue, we shouldn't take our eye off the ball on the real issue, which is negotiating prices.

**I would love to see New York, with its many millions of people, join in the Sovereign States Purchasing Pool, which benefits the state I live in, Maine, which has hardly anybody in it, and which would give us tremendous clout. And I also think it is the best model that is out there, so it would benefit New Yorkers, as well, because they would be getting the best price.**

— Maine State Representative Sharon Treat

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78 <http://www.nassaucountyny.gov/agencies/Comptroller/index.html>

Now, in Nassau County, what we did was, we put together an RX program which was very simple and a little less sophisticated than the one you did in Maine.<sup>79</sup> It was just a discount card program and we gave it to every resident. And the results were stunning. We got an average of about 24% discount on drugs. That is about \$17.00 a prescription. For three million people in Nassau County, that program saves now about \$2 million a year and it doesn't cost the county anything because we brought in a pharmacy benefit manager to administer it. We gave them the rebates instead of taking out what we could have taken out, and charged no fee for the cards. We set no eligibility standards and just gave the cards out. The only downside was that the program was paid for by the pharmacists, who took lower prices, not the drug companies. So that is why I have the questions that I have for Representative Treat. Number one, we didn't negotiate prices. We just took the price list the pharmacy benefit manager gave us. Who negotiated the prices on behalf of Maine? Number two, how did those prices compare to the VA prices, which is generally the standard for low prices in the country. And number three, how did you insure that those prices actually got to the consumers and the pharmacies didn't mark them up or down to take advantage of the marketplace?

**REP. SHARON TREAT:** Maine has a wonderful person named Jude Walsh<sup>80</sup> who negotiates all of the Medicaid pricing, and the price that the state gets for Medicaid is the same price that is charged under Maine RX at the pharmacy level. Under Maine RX there is also the authority to negotiate supplemental rebates over and above the purchase price under Medicaid. One of the issues we have had with Part D is that Jude has been sucked into trying to deal with this whole wraparound issue—the fact that Part D didn't cover a lot of what was previously covered under Medicaid. We are a very small state, with small government. So her attention has really been diverted from implementing the second phase of the supplemental rebates, which would bring the price down substantially more. I did a study for Prescription Policy Choices,<sup>81</sup> which goes into great detail about the prices that are achieved under the Maine RX and actually compares it to a drug industry discount program in Ohio. You also mentioned the pharmacists, and the pharmacists are sort of taking it on the chin. In Maine they are not required to participate in the Maine RX program. So it is voluntary.

**ANDREA BATISTA SCHLESINGER:** One more question and then we have to close.

**SIDNEY SOCOLAR:** I am Sid Socolar. I am associated with the activities on pharmaceutical policy in the American Public Health Association<sup>82</sup> and in the New York City area, I am connected with Rekindling Reform.<sup>83</sup> The Institute of Medicine<sup>84</sup> recently recommended that during the first two years that a new

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79 <http://www.nassaucountyny.gov/agencies/Comptroller/NewsRelease/2004/6-29-04.html>

80 [http://www.maine.gov/tools/whatsnew/index.php?topic=Gov\\_Staff&id=36673&v=Article](http://www.maine.gov/tools/whatsnew/index.php?topic=Gov_Staff&id=36673&v=Article)

81 <http://www.policychoices.org/reports/CutDrugCostsReportFINAL.pdf>

82 <http://www.apha.org/>

83 <http://www.rekindlingreform.org/aboutus/index.htm>

84 <http://www.iom.edu/>

pharmaceutical product is on the market, there be no direct to consumer advertising. The first two years are particularly critical because when the drug first comes onto the market, most of its potential side effects have not yet been discovered.

**ANDREA BATISTA SCHLESINGER:** We may not be able to discuss that now, but one of the things that the panel has unwittingly agreed to is continuing this conversation on our blog.<sup>85</sup> I am going to ask the panel to close, but to do so in the following way. One thing you would ask our incoming governor, Elliot Spitzer to do on day one, when everything else is taking place. And maybe day two. One thing you want Speaker Pelosi to do. Just those two things. Charles?

**CHARLES BELL:** Well, I would like to see our two pending prescription drug affordability bills be passed in the next session, and for Governor Spitzer to put the prescription drug assistance program in his budget. I think that would be a critical step forward. Neither of these bills cost New York State much of anything and they will have a profound effect. We'll have one of the largest prescription drug purchasing pools in the country on day one that the program is implemented. So that is what I would like to see.

**ASSEMBLYMAN RICHARD GOTTFRIED:** Since we're focusing on day one, I would want the new governor to stand up for extending the Part D Medicaid wrap.<sup>86</sup>

[APPLAUSE]

**DR. JON COHEN:** I would say, it has to be the issue around significant Medicaid reform, since it is such a big piece of the state budget. And I think that part of that would be, again, bulk purchasing of drugs, and some further modification of the Preferred Drug List to substantially reduce the cost for the Medicaid population.

**REP. SHARON TREAT:** Who am I to tell someone in New York what to do? But I would love to see New York, with its many millions of people, join in the Sovereign States Purchasing Pool, which benefits the state I live in, Maine, which has hardly anybody in it, and which would give us tremendous clout. And I also think it is the best model that is out there, so it would benefit New Yorkers, as well, because they would be getting the best price. And for Speaker Pelosi, I think she could pass a real Medicare Part D price negotiation, which would be offering a government-run Part D. And she should do it.

[APPLAUSE]

**ANDREA BATISTA SCHLESINGER:** I want to thank this panel and I want to thank Carl McCall for opening up this conversation. As always, with DMI's Marketplace of Ideas, this is just the start of the conversation. You'll be able to watch it on CUNY-TV and on our web site, download it to your iPod—which I've never done,

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<sup>85</sup> [http://www.dmiblog.com/archives/2006/12/from\\_maine\\_to\\_america\\_lowering.html](http://www.dmiblog.com/archives/2006/12/from_maine_to_america_lowering.html)

<sup>86</sup> <http://www.ncsl.org/programs/health/SPAPCoordination.htm>

but apparently you can do. You'll be able to read the transcript, which we will be sending to policy makers, heavily in New York but also nationally. And we will be continuing the conversation on the DMI Blog, so look later this afternoon. We'll have some thoughts, and we'll encourage yours. This wraps up our 2006 Marketplace of Ideas series, which has never been more relevant than now because essentially what we do is highlight pioneering legislators, like Representative Sharon Treat, who has actually shown that this isn't just about theory. It is about putting these ideas in practice. So never let it be said that we don't have the ideas and the capacity to get them through. So thank you all very much for coming. Thank you.

**[APPLAUSE]**

**[END]**

# WHO IS THE DRUM MAJOR INSTITUTE FOR PUBLIC POLICY?

**DRUM  
MAJOR**  
INSTITUTE FOR PUBLIC  
POLICY

The Drum Major Institute for Public Policy is a non-partisan, non-profit organization dedicated to challenging the tired orthodoxies of both the right and the left. The goal: progressive public policy for social and economic fairness. DMI's approach is unwavering: We do not issue reports to see our name in print or hold forums for the sake of mere talk. We seek to change policy by conducting research into overlooked but important social and economic issues, by leveraging our strategic relationships to engage policymakers and opinion leaders in our work and by offering platforms to amplify the ideas of those who are working for social and economic fairness.

Originally called the Drum Major Foundation, DMI was founded by Harry Wachtel, lawyer and advisor to Rev. Dr. Martin Luther King, Jr. during the turbulent years of the civil rights movement. DMI was relaunched in 1999 by New York attorney William Wachtel, Harry's son, Martin Luther King III and Ambassador Andrew Young.

From releasing nationally recognized studies of our increasingly fragile middle class, the relationship between schools and communities and the impact of changing demographics on politics to launching an exciting and frequently-visited Web site that serves as a source of ideas and argument, DMI has demonstrated the strength of its mission and strategy.

Please visit [www.drummajorinstitute.org](http://www.drummajorinstitute.org) for more information.

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# ALSO FROM DMI

## LESSONS FROM THE MARKETPLACE: FOUR PROVEN PROGRESSIVE POLICIES FROM DMI'S MARKETPLACE OF IDEAS

May 2007 / In Maine, moderate-income residents buy prescription drugs for as little as half the retail price. In San Francisco, some violent criminals are 82 percent less likely to commit new crimes after their release from prison. In Minnesota, the public can reclaim subsidies when economic development incentives don't produce the promised results. In Oklahoma, 92 percent of four-year-olds attend a high-quality public preschool. This report recounts how these successful policies got started, and how they can be replicated across the nation.



## SAVING OUR MIDDLE CLASS: A SURVEY OF NEW YORK'S LEADERS

April 2007 / It's harder for New Yorkers to enter the middle class today than ten years ago, according to DMI's groundbreaking survey of 101 top leaders from New York City's academic, business, political, policy advocacy and civic-institutional sectors. The survey analyzed top challenges for the city's current and aspiring middle class and evaluated city, state and federal policies to address New York's middle-class squeeze.



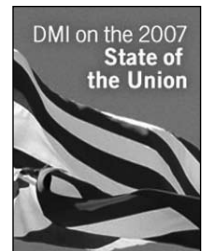
## PRINCIPLES FOR AN IMMIGRATION POLICY TO STRENGTHEN AND EXPAND THE AMERICAN MIDDLE CLASS: 2007 EDITION

March 2007/ This report finds that immigrants contribute to middle-class prosperity as workers, taxpayers, and consumers, while also concluding that undocumented immigrants' lack of workplace rights undercuts the middle class. DMI's complete immigration toolkit includes an update of our 2005 report, talking points, a discussion guide, legislative analyses, and Spanish translation.



## DMI ON THE 2007 STATE OF THE UNION

January 2007/ There was little for current and aspiring middle-class Americans in President Bush's State of the Union Address this year. DMI's "instant analysis," released just hours after the speech, examines the President's domestic policy agenda in-depth. We find that the President's proposals, at their core, are driven by a conservative ideology that doggedly protects the wealthiest Americas from tax hikes by sharply cutting social programs, while also absolving corporations of their obligation to protect the health and welfare of their employees by shifting those burdens to the workers themselves.



## THE 2006 DMI YEAR IN REVIEW

December 2006/ 2006 was the year of Systems Failure. Most Americans were tired of the status quo—on the war, on the economy, on the lapsed ethics of those entrusted to represent our interests. The result: on Election Day, they rebooted, ready to try again. The DMI 2006 Year in Review explores the year's best and worst of public policy, tunes into the voices of 2006 and profiles eight Americans advancing progressive policy. Also featured: a report from the front lines in six states and from the blogosphere, our recommended reading list, a recap of what the think tanks of the conservative right are up to and, as always, the 2006 Injustice Index.



# Marketplace of Ideas

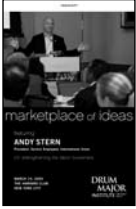
In the Marketplace of Ideas, we don't just talk about problems, we highlight policies to address them and the policymakers that made them work.

"The Drum Major Institute's recent forum on increasing accountability and developing better uses for economic development subsidies with Minnesota State Senator John Hottinger was both informative and enlightening. I found it so useful to hear about the ideas of both colleagues in government and well-informed advocates about effective legislation in other states, particularly Minnesota's progressive and far reaching bill."

—NEW YORK STATE SENATOR LIZ KRUEGER



# IDEAS WE BROUGHT TO MARKET:



Strengthening the Labor Movement



Tackling Environmental Injustice



Holding Corporations Accountable for Their Fair Share of Employee Health Costs



Reducing Recidivism Through Restorative Justice



Leveraging Government to Protect People from Corporate Malfeasance



Lowering the Cost of Insurance



Increasing Accountability for Economic Development Subsidies



Promoting Access to Pre-School Education

Making Prescription Drugs More Affordable

Making Health Care Universal

Combatting Global Warming Through Congestion Pricing

Confronting the Need for Massive School Construction



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